

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011160</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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N 000	<p>Initial Comments</p> <p>This was a State Complaint Survey that was extended on 4/8/16.</p> <p>Survey Dates: April 6, 7, 8, 12, 13, 14, 15, and 18, 2016.</p> <p>Complaint number: IN00197325 Substantiated; State deficiencies were cited. Complaint number: IN00185401 Substantiated; State deficiencies were cited. Complaint number: IN00181930 Substantiated; State deficiencies were cited Complaint number: IN00181526 Substantiated; State deficiencies were cited Complaint number: IN00178606 Substantiated; State deficiencies were cited</p> <p>Facility Number: 011160</p> <p>Medicaid Number: 200836920A</p> <p>Census: 659</p> <p>Sample: 11</p>	N 000		
N 440	<p>410 IAC 17-12-1(a) Home health agency administration/management</p> <p>Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the Administrator failed to ensure there was delineation of agencies between Individual</p>	N 440		

Indiana State Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 440	<p>Continued From page 1</p> <p>Support Home Health Agency and with the personal care service agency, and failed to ensure that lines of authority were clearly defined for delegation of responsibility down to the patient care level.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the entrance conference on 04/06/16 at 10:30 AM, the Alternate Administrator, Director of Clinical Services, and Assisting Director of Clinical Services, indicated there were drop sites in Martinsville and Noblesville. The drop sites were located within the personal service agency that was also owned by the Administrator.</li> <li>2. On 04/06/16 at 11:15 AM, an employee list was provided by the Administrator. The employee list indicated Employee L was an ADM [administrator] and Employee M was AADM [assisting administrator]. The Administrator had stated Employee L managed the personal service branch in Martinsville.</li> <li>3. On 04/11/16 at 10:30 AM, the personal service branch was visited. The doors were locked and a sign on the back door provided Employee L and the Administrator's name and phone number as well as the Middletown office phone number. There were 7 company vehicles in the parking lot. Six (6) of the 7 vehicles had Individual Support Home Health Agency advertisement on the vehicles.</li> <li>4. During a home visit with patient number 5 on 04/12/16 at 9:00 AM, Employee P, a home health aide, stated he / she works from the "Martinsville office" and he / she provided both attendant care and home health aide services from both [name of personal service agency] and Individual</li> </ol>	N 440		

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N 440	<p>Continued From page 2</p> <p>Support Home Health Agency. Employee P stated Employee L was the supervisor for both companies. Patient number 5 stated when he / she needs to contact the office, he / she starts with Employee L and would go down the list of phone numbers. The patient also stated he / she would text Employee L as well. The patient stated he / she received services from both the home health agency and personal service agency.</p> <p>a. Review of the patient's agency folder during the home visit, a form titled "Emergency Back Up Plans" listed Middletown / Noblesville with the phone numbers of the Administrator, Employee M, and the office number. The next paragraph listed Martinsville area and the name of Employee L and Employee U with their phone numbers, then provided an on-call line.</p> <p>b. Another form in the patient's agency folder titled "Welcome to ISHHA ... If you have any questions or concerns please call us. Martinsville Workstation," Name of Employee L, Program Director, office number and cell number, on call line for after hours, home office number, the Administrator's name and cell number, Employee M as the VP [vice president] with cell number, followed by a title of "Supervisor" and Employee L signature.</p> <p>c. There was another form in the patient's agency folder that indicated [name of personal service agency] with the Administrator and Employee M listed with phone numbers to contact first followed by "Martinsville area" with the name of Employee L and Employee U with phone numbers, followed by an on call number. The form was signed with Employee L signature.</p>	N 440		

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N 440	<p>Continued From page 3</p> <p>5. During a home visit with patient number 6 on 04/12/16 at 10:30 AM, Employee I, a home health aide, stated he / she reported to Employee Q, the Administrator with the Noblesville office. The employee stated he / she had orientation in Middletown but had paperwork orientation in Noblesville. According to Employee I and patient number 6, they don't know who the Administrator, Alternate Administrator, Assistant Director of Clinical Services, or Employee M were. Both stated they had just recently met the Director of Clinical Services a few weeks ago. The patient stated he / she received services from both the home health agency and personal service agency.</p> <p>6. During a home visit with patient number 7 on 04/12/16 at 12:20 PM, the patient's spouse stated he / she contacted the "Martinsville" office when there was a need. The patient stated he / she only received services from the home health agency.</p> <p>7. During a home visit to patient number 8 with Employee K on 04/12/16 at 3:40 PM, the patient's parent stated he / she contacted Employee L at the Martinsville office when he / she needed anything.</p> <p>a. The patient's agency folder was reviewed. A business card with Employee R's name and discipline was observed in the folder with an address of 1920 Old State Rd 44, Martinsville, IN [address on the card was that of a branch to the sister agency / name of personal service agency]. Employee K, a Registered Nurse for patient number 7, stated Employee R had recently been transferred to the Noblesville office, which was also a branch of the sister agency.</p>	N 440		

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N 440	<p>Continued From page 4</p> <p>b. Employee K stated he / she did not go to the Middletown office for anything, that he / she did everything from the Martinsville office. The employee stated the last time he / she was in the Middletown office, was upon hire and he / she had been with the company for a few years.</p> <p>8. The Quality Assessment Performance Improvement was reviewed on 04/15/16 at 1:15 PM. The notes reviewed indicated the last two meetings dated 09/23/15 and 12/2015, combined both Individual Support Home Health Agency and [name of personal service agency] discussion of hired employees in the Middletown, Martinsville, and Noblesville offices. The notes also included a notation about how to track the attendant care and homemakers.</p> <p>9. Review of the personnel files on 04/15/16 at 1:30 PM, Employee L job title / job description indicated he / she was a Program Coordinator for the personal service agency. Employee M job title / job description indicated he / she was the Alternate Administrator.</p> <p>10. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she would meet with staff operating from the drop site / personal service agency branch during annual meetings and that staff were asked to come to Middletown for those meetings. The Director of Clinical services also stated other forms of communication with the staff was through text messaging or phone calls. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of Clinical Services stated if it was a staffing issue such as</p>	N 440		

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N 440	Continued From page 5  scheduling, the local coordinators were closer to the source.  11. The Administrator and Employee M was interviewed on 04/18/16 at 2:25 PM. Employee M stated he /she was a home health aide and did not hold an administrative title. The Administrator stated Employee M was an administrative assistant and helped out in the office occasionally. The Administrator stated the vehicles in Martinsville were for the employees to drive.  12. Employee L and Q was contacted and messages left for return call on 04/18/16 between 10:30 AM and 10:38 AM. Neither employees returned the calls by exit conference on 04/18/16 at 3:10 PM.	N 440		
N 441	410 IAC 17-12-1(a) Home health agency administration/management  Rule 12 Sec. 1(a) Administrative and supervisory responsibilities shall not be delegated to another agency or organization, and all services not furnished directly, including services provided through a branch office, shall be monitored and controlled by the parent agency.  This RULE is not met as evidenced by: Based on record review and interview, the Administrator failed to ensure supervisory functions were not delegated to another agency or organization.  Findings include:  1. During the entrance conference on 04/06/16 at 10:30 AM, the Alternate Administrator, Director of	N 441		

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N 441	<p>Continued From page 6</p> <p>Clinical Services, and Assistant Director of Clinical Services, indicated there was a drop site in Martinsville and Noblesville. The drop sites were located within the personal service agency that was also owned by the Administrator.</p> <p>2. On 04/06/16 at 11:15 AM, an employee list was provided by the Administrator. The employee list indicated Employee L was an ADM [administrator] and Employee M was AADM [assistant administrator]. The Administrator had stated Employee L managed the personal service branch in Martinsville.</p> <p>3. On 04/11/16 at 10:30 AM, the personal service branch was visited. The doors were locked and a sign on the back door provided Employee L and the Administrator's name and phone number as well as the Middletown office phone number. There were 7 company vehicles in the parking lot. Six (6) of the 7 vehicles had Individual Support Home Health Agency advertisement on the vehicles.</p> <p>4. During a home visit with patient number 5 on 04/12/16 at 9:00 AM, Employee P, a home health aide, stated he / she worked from the "Martinsville office" and he / she provided both attendant care and home health aide services from both [name of personal service agency]and Individual Support Home Health Agency. Employee P stated Employee L was the supervisor for both companies. Patient number 5 stated when he / she needed to contact the office, he / she would start with Employee L and would go down the list of phone numbers until he / she reached someone. The patient also stated he / she would text Employee L as well. The patient stated he / she received services from both the home health agency and personal service</p>	N 441		

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N 441	<p>Continued From page 7</p> <p>agency.</p> <p>a. Review of the patient's agency folder during the home visit, a form titled "Emergency Back Up Plans" listed Middletown / Noblesville with the phone numbers of the Administrator, Employee M, and the office number. The next paragraph listed Martinsville area and the name of Employee L and Employee U with their phone numbers, then provided an on-call line.</p> <p>b. Another form in the patient's agency folder titled "Welcome to ISHHA ... If you have any questions or concerns please call us. Martinsville Workstation," Name of Employee L, Program Director, office number and cell number, on call line for after hours, home office number, Administrator name and cell number, Employee M as the VP [vice president] with cell number, followed by a title of "Supervisor" and Employee L signature.</p> <p>c. There was another form in the patient's agency folder that indicated Individual Support Services with the Administrator and Employee M listed with phone numbers to contact first followed by "Martinsville area" with the name of Employee L and Employee U with phone numbers, followed by on call number. The form was signed with Employee L signature.</p> <p>5. During a home visit with patient number 6 on 04/12/16 at 10:30 AM, Employee I, a home health aide, stated he / she reported to Employee Q, the Administrator with the Noblesville office. The employee stated he / she had orientation in Middletown but had paperwork orientation in Noblesville. According to Employee I and patient number 6, they don't know who the Administrator, Alternate Administrator, Assistant Director of</p>	N 441		

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N 441	<p>Continued From page 8</p> <p>Clinical Services, or Employee M were. Both stated they had just recently met the Director of Clinical Services a few weeks ago. The patient stated he / she received services from both the home health agency and personal service agency.</p> <p>6. During a home visit with patient number 7 on 04/12/16 at 12:20 PM, the patient's spouse stated he / she contacted the "Martinsville" office when there was a need. The patient stated he / she only received services from the home health agency.</p> <p>7. During a home visit with patient number 8 on 04/12/16 at 3:40 PM, the patient's parent stated he / she contacts Employee L at the Martinsville office when he / she needed anything.</p> <p>a. The patient's agency folder was reviewed. A business card with Employee R's name and discipline was observed in the folder with an address of 1920 Old State Rd 44, Martinsville, IN [address on the card was that of a branch to the sister agency Individual Support Services). Employee K, a Registered Nurse for patient number 7, stated Employee R had recently been transferred to the Noblesville office, which was also a branch of the sister agency.</p> <p>b. During the home visit, Employee K stated he / she did not go to the Middletown office for anything, that he / she did everything from the Martinsville office. The employee stated the last time he / she was in the Middletown office, was upon hire and he / she had been with the company for a few years.</p> <p>8. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director</p>	N 441		

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N 441	<p>Continued From page 9</p> <p>of Clinical Services stated she would meet with staff operating from the personal service agency branch during annual meetings and that staff were asked to come to Middletown for annual meetings. The Director of Clinical Services also stated other forms of communication with the staff was through text messaging or phone calls. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to the source.</p> <p>9. The Administrator and Employee M was interviewed on 04/18/16 at 2:25 PM. Employee M stated he /she was a home health aide and did not hold an administrative title. The Administrator stated Employee M was an administrative assistant and helped out in the office occasionally. The Administrator stated the vehicles in Martinsville were for the employees to drive.</p> <p>10. Employee L and Q was contacted and messages left for return call on 04/18/16 between 10:30 AM and 10:38 AM. Neither employees returned the calls by exit conference on 04/18/16 at 3:10 PM.</p>	N 441		
N 458	<p>410 IAC 17-12-1(f) Home health agency administration/management</p> <p>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</p>	N 458		

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N 458	<p>Continued From page 10</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) Receipt of job description.</li> <li>(2) Qualifications.</li> <li>(3) A copy of limited criminal history pursuant to IC 16-27-2.</li> <li>(4) A copy of current license, certification, or registration.</li> <li>(5) Annual performance evaluations.</li> </ol> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure performance evaluations had been conducted and signed at the time of the evaluation for 10 of 18 employee files reviewed. (#F, G, H, I, J, K, L, O, Q, and V)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following:               <ol style="list-style-type: none"> <li>a. Employee F, Date of Hire (DOH) 01/28/15, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation.</li> <li>b. Employee G, DOH 10/21/14, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 03/19/16. The evaluation failed to be signed by the employee at the time of the evaluation.</li> <li>c. Employee H, DOH 09/24/13, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation.</li> </ol> </li> </ol>	N 458		
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N 458	<p>Continued From page 11</p> <p>d. Employee I, DOH 05/12/15, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 03/17/16. The evaluation failed to be signed by the employee at the time of evaluation.</p> <p>e. Employee J, DOH 12/07/12, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation.</p> <p>f. Employee K, DOH 01/09/14, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation.</p> <p>g. Employee L, DOH 02/01/06, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 04/01/16. The evaluation failed to be signed by the employee at the time of the evaluation.</p> <p>h. Employee O, DOH 01/28/15, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation.</p> <p>i. Employee Q, DOH 11/18/14, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 02/16/16. The evaluation failed to be signed by the employee at the time of the evaluation.</p> <p>j. Employee V, DOH, 11/29/11, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 02/19/16. The evaluation failed to be signed by the employee at the time of the evaluation.</p> <p>2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not provide any further information by the end of the exit</p>	N 458		

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(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) COMPLETE DATE
N 458	Continued From page 12 conference on 04/18/16 at 03:40 PM.	N 458		
N 494	<p>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights</p> <p>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:</p> <p>(1) Provide the patient with a written notice of the patient's right:</p> <p>(A) in advance of furnishing care to the patient; or</p> <p>(B) during the initial evaluation visit before the initiation of treatment.</p> <p>(2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that a patient had received the care and services that were to be provided and ordered by a physician. (#1)</p> <p>Findings include:</p> <p>1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute,</p>	N 494		

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N 494	<p>Continued From page 13</p> <p>teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension.</p> <p>a. On 04/06/16 at 11:00 AM, the Administrator stated that the complaint visit must have been in regards to patient number 1.</p> <p>b. Review of patient number 1 clinical record on 04/06/16 at 12:40 PM, a discharge summary dated 03/29/16, indicated the patient had died at home.</p> <p>c. Review of the OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his home at 08:00 AM. The patient was in his wheelchair at the kitchen table.</p> <p>d. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16.</p> <p>e. Review of the agency's investigative note dated 03/29/16 at 9:57 AM, indicated the Director of Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient</p>	N 494		

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N 494	<p>Continued From page 14</p> <p>around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation.</p> <p>f. The Administrator, Director of Clinical Services, and Assisting Director of Clinical Services was interviewed on 04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assisting Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measures included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago.</p> <p>g. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did</p>	N 494		

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N 494	<p>Continued From page 15</p> <p>not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care.</p> <p>h. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter</p>	N 494		

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N 494	<p>Continued From page 16</p> <p>stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided.</p> <p>i. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturate when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a \$20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because</p>	N 494		

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N 494	<p>Continued From page 17</p> <p>the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case.</p> <p>j. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded about notifying the office about call offs and the repercussions.</p> <p>k. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions.</p> <p>l. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received.</p> <p>m. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date.</p>	N 494		

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N 494	<p>Continued From page 18</p> <p>n. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions.</p> <p>o. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions.</p> <p>p. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time. The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the policy station the previous week and obtained a copy of the report.</p> <p>2. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15,</p>	N 494		

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N 494	<p>Continued From page 19</p> <p>indicated " ... The qualifications and competence of the individual(s) providing services are appropriate to patient needs and the required services and comply with applicable laws and regulations .... "</p> <p>3. A policy titled Standard of Practice dated 07/10/15, indicated ISHHA staff will deliver services based on each patient's unique and individual needs and clinical decisions will not be altered ... Patient care will be provided in a coordinated, effective, appropriate ... and safe manner in accordance with ISHHA goals, objectives, and philosophy."</p> <p>4. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "</p>	N 494		
N 514	<p>410 IAC 17-12-3(c) Patient Rights</p> <p>Rule 12 Sec. 3(c)</p> <p>(c) The home health agency shall do the following:</p> <p>(1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following:</p> <p>(A) Treatment or care that is (or fails to be) furnished.</p> <p>(B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency.</p> <p>(2) Document both the existence of the complaint and the resolution of the complaint.</p>	N 514		

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N 514	<p>Continued From page 20</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure complaints made by patients / or caregivers were reported, documented and / or investigated with a resolution for 4 of 9 interviews. (#1, 4, 8, and 11)</p> <p>Findings include:</p> <p>1. Employee F, LPN (Licensed Practical Nurse), was interviewed on 04/08/16 at 3:00 PM. A text message was observed on Employee F phone dating 10/05/15. The text message was a conversation between the employee and the Director of Nursing. The text message indicated a confirmation of the Director of Clinical Services visiting patient number 1 on 10/05/15. The employee indicated the patient was having problems with Employee O, a LPN, and the Director of Clinical Services was meeting with the patient to discuss the problems.</p> <p>a. Review of the complaint book failed to include an investigation of the patient's problems with Employee O.</p> <p>b. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated the patient was complaining about Employee O being bossy, telling him what to do, and speaking for him. The Director of Clinical Services stated Employee O had taken care of the patient for many years and she had spoken with Employee O about professional boundaries. The Director of Clinical Services stated the patient reported he / she felt safe with Employee O. The Director of Clinical Services did not provide any documentation in regards to the investigation.</p>	N 514		

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N 514	<p>Continued From page 21</p> <p>2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week.</p> <p>a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15.</p> <p>b. Patient number 4 was interviewed on 04/12/16 at 7:30 PM. The patient indicated he / she had received two letters of discharge. The patient stated he / she did not refuse nursing nor did he / she refused home health aides. The patient stated he / she did not like the team leaders that came into his / her home and his / her last complaint was over a home health aide that spit over his / her food when he / she spoke. The patient stated he / she had to be fed and he / she would lose his / her appetite and couldn't eat. The patient stated he / she was falsely being accused of refusing visits.</p> <p>c. Review of the complaint book, the complaint book failed to include an investigation of the patient's complaint.</p> <p>d. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to</p>	N 514		

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N 514	<p>Continued From page 22</p> <p>the source.</p> <p>e. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator stated the patient constantly wanted team leaders and refused the home health aides. The Administrator. The Administrator was not able to provide any further of documentation of the patient's history of complaints.</p> <p>3. During a home visit with Employee K, a Registered Nurse, on 04/12/16 at 3:40 PM, a parent for patient number 8 was interviewed. The parent had stated he / she had contacted the office several times to ask for a back up nurse. The parent stated that he / she was very particular in who was allowed in the home and wanted the nurse to meet the patient prior to providing care. Employee K stated there had been no back up nurse since May, 2015.</p> <p>a. The Administrator was interviewed on 04/14/16 at 12:15 PM. The Administrator stated every patient has a back up person and also stated it was difficult to train a back up person due to no reimbursement. By 5:00 PM, the Administrator did not provide any further documentation in relation to the parent's concern / complaint.</p> <p>b. Review of the complaint book, the complaint book failed to include an investigation of the parent's complaint.</p> <p>3. The clinical record for patient number 11 was reviewed on 04/15/16 at 11:56 AM. The clinical record evidenced multiple missed visit reports. A parent for patient number 11 was interviewed on 04/15/16 at 12:05 PM. The parent had stated he / she was having problems with Employee V, a</p>	N 514		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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(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) COMPLETE DATE
N 514	<p>Continued From page 23</p> <p>home health aide. The parent stated Employee V was "more of a hassle and did cancel visits" with Employee V. The parent stated the employee refused to use equipment such as the hooyer lift and felt the employee was not adequately trained to be a home health aide. The parent stated he / she had informed Employee W of his / her concern. The parent also stated he / she would call the Middletown branch and would get told he / she needed to call the Noblesville office and the other office would tell him / her to contact Middletown. The parent stated he / she kept getting the "run around."</p> <p>a. Review of the complaint book, the complaint book failed to include an investigation of the parent's complaint.</p> <p>b. The Administrator was interviewed on 04/18/16 at 2:55 PM. The Administrator stated she was not made aware of the parent's concern and the parent's call should have stayed within the Middletown office and not referred to the other office.</p> <p>4. A policy titled Bill of Rights / Grievance Procedure dated 07/10/15, indicated " ... ISHHA will investigate complaints made by a patient / family member or guardian regarding care or treatment furnished or that was not furnished. ISHHA will investigate complaints made identifying a lack of respect for patient property by anyone providing services on behalf of ISHHA. ISHHA will document the existence of a complaint and the resolution. The documentation will be placed in a confidential 'Patient Complaint' filed. If the patient verbalizes a complaint to ISHHA staff in the home the complaint will be communicated to the Supervising Nurse or designee who will ensure that the complaint will</p>	N 514		

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N 514	Continued From page 24  be handled, investigated and documented in a manner consistent with the nature of the complaint. The Patient or Responsible party will be informed of the progress of the investigation and proposed action plan .... "	N 514		
N 522	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:  This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the skilled nurse and the home health aide followed the plan of care for 11 of 11 records reviewed in a sample of 11. (# 1 to 11)  Findings include:  1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and	N 522		

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N 522	<p>Continued From page 25</p> <p>as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension.</p> <p>a. The clinical record of patient number 1 was reviewed on 04/06/16 at 12:40 PM and indicated the following:</p> <p>1. The OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his / her home at 08:00 AM. The patient was in his wheelchair at the kitchen table.</p> <p>2. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16.</p> <p>b. An agency investigation note dated 03/29/16 at 9:57 AM, was reviewed and indicated the Director of Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that</p>	N 522		

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N 522	<p>Continued From page 26</p> <p>was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation.</p> <p>c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assistant Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measure included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign-in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago.</p> <p>d. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did</p>	N 522		

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N 522	<p>Continued From page 27</p> <p>not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care.</p> <p>e. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided.</p> <p>f. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the</p>	N 522		

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N 522	<p>Continued From page 28</p> <p>patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturation when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a \$20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case.</p> <p>g. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but</p>	N 522		

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N 522	<p>Continued From page 29</p> <p>then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded about notifying the office about call offs and the repercussions.</p> <p>h. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions.</p> <p>i. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received.</p> <p>j. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date.</p> <p>k. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions.</p>	N 522		

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N 522	<p>Continued From page 30</p> <p>I. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions.</p> <p>m. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time. The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the police station the previous week and obtained a copy of the report.</p> <p>2. The clinical record for number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing. The patient's diagnoses included RSV (Respiratory Syncytial Virus), Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance.</p> <p>a. A "Notification of Client Status" dated</p>	N 522		

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N 522	<p>Continued From page 31</p> <p>02/11/16, indicated the patient had been admitted for respite nursing and "PA" (meaning prior authorization from Medicaid to provide ongoing nursing services on a routine basis). The note also indicated the parents wanted a routine nurse for overnights and no float nurses.</p> <p>b. The initial plan of care (undated) had orders for skilled nursing to evaluate but failed to include a nursing frequency / duration. The agency provided respite nursing visits on 02/24, 02/26, 03/01, and 03/03/16. The plan of care also indicated the patient was to receive 1 liter of oxygen during naps / bedtime. A respite nursing notes dated 03/01/16 and 03/03/16, indicated the patient had received 3 liters of oxygen per the trach tube. The nurse failed to follow the plan of care.</p> <p>c. The second plan of care dated 03/22/16, had orders for skilled nursing 8 hours per day, 5 days a week for 9 weeks and respite nursing up to 60 hours per month for 12 months. Review of the clinical record, the agency failed to provide skilled nursing visits 8 hours a day, 5 days a week.</p> <p>d. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/07/16 at 12:30 PM. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services stated that the initial plan of care was developed upon admission and the agency were to provide respite nursing services. The patient was transferred into the hospital and returned home on 3/22/16. The Administrator and Assistant Director of Clinical Services stated that Medicaid had instructed the agency to develop a new plan of care versus writing orders and</p>	N 522		

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N 522	<p>Continued From page 32</p> <p>updating the current plan of care. The Assistant Director of Clinical Services stated there was a delay in routine nursing services due to the father's lack of ability to provide job information. The Director of Clinical Services stated the PA (Prior Authorization) came on 3/25/16, but the mother did not want floating nurses in the home and requested that the patient be staffed with a permanent nurse. The Assistant Director of Clinical Services stated the requested visit notes may have been in the patient's home. At 1:00 PM, missed visit notes were provided and the Director of Clinical Services stated she had been interviewing for a permanent nurse and a nurse had been hired and was due to start "today."</p> <p>e. The parent of patient number 2 was interviewed on 04/07/16 at 3:50 PM. The parent had stated that he / she did not recall telling the agency that he / she wanted to hold services or refused services until a permanent nurse was available. The parent stated he / she preferred a permanent nurse but would have taken anyone due to the exhaustion between him / her and their spouse, need for rest during the night due to pregnancy / work, and how the patient needed constant supervision during the night due to getting the trach tubing around his / her neck. The parent indicated the patient had respite nursing a few times prior to his / her hospitalization, but when the patient came out of the hospital, his / her respite nurse was in the hospital his / herself and that a replacement respite nurse had not been provided.</p> <p>3. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day,</p>	N 522		

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N 522	<p>Continued From page 33</p> <p>7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes, and autonomic instability.</p> <p>a. The clinical record was reviewed on 04/07/16 at 1:54 PM, and failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15.</p> <p>b. The Administrator provided a typed statement on 04/07/16 at 4:00 PM, indicating Employee E, a Registered Nurse / Case Manager, had reported that the patient was complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in one day." During this time, the Administrator stated new</p>	N 522		

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N 522	<p>Continued From page 34</p> <p>staff must have orientation for approximately 1 week.</p> <p>c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned sister. The patient stated he / she would never ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occasion, a home health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency.</p> <p>d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM. The Director of Clinical Services stated she was not aware of the missing home health aide visits. The Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides.</p> <p>e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated</p>	N 522		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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N 522	<p>Continued From page 35</p> <p>Employee M did helped with coordination as well. Employee M was not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong.</p> <p>4. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to provide 2 visits during the week of 07/19 to 07/25/15 and during the week of 07/26 to 08/01/15. The skilled nurse failed to provide a 2nd visit during the week of 08/09 to 08/15/15. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes indicated the following:</p> <p>1. The home health aide provided (4) 2 hour visits on 07/19, 07/20, 07/22, 07/23, 08/04, and 08/30/15.</p> <p>2. The home health aide provided a 4 plus hour visits on 07/24, 08/10, and 08/17 (6:30 PM to 10:30 PM), 07/27, 07/31, 08/18 (6:00 PM to 10:15 PM), 07/28, 07/30, 08/11, 08/16, 08/20, 08/25, 08/27 (6:00 PM to 10:00 PM), 08/21/15 (6:20 PM - 10:20 PM), and 08/10 and 08/17/15</p>	N 522		

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N 522	<p>Continued From page 36 (6:00 PM to 10:30 PM).</p> <p>3. The home health aide provided a 6 plus hour visit on 08/30/15 (9:00 AM to 3:15 PM).</p> <p>4. The home health aide provided (2) 3 hour visits on 09/01 to 09/08/15 (6:00 PM to 9:00 PM / 8:00 PM to 11:00 PM) and a single 3 hour visit on 07/25/15 (8:00 PM to 11:00 PM).</p> <p>5. The home health aide provided (2) visits on 07/21, 07/25, 07/31, 08/03, 08/10, 08/11, 08/14, 08/17, 08/25, 08/27, 08/29, and 09/01 to 09/08/15. The home health aides failed to follow the plan of care.</p> <p>c. The plan of care indicated the home health aide was to provide assistance with tub / shower, assist bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and range of motion to all extremities.</p> <p>1. Review of the home health aide visits notes dated 07/19 to 07/24/15, 07/27 to 07/29, 08/02, 08/04 to 08/07, 08/10, 08/12, 08/14, 08/16, 08/17, 08/18, 08/19, 08/20, 08/24, 08/27, 08/28, 08/30, 08/31, and 09/01 to 09/08, 2015, failed to evidence that tub / shower, assist bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and / or range of motion to all extremities had been provided. The home health aide failed to follow the plan of care.</p>	N 522		

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N 522	<p>Continued From page 37</p> <p>5. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area.</p> <p>a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care, foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16, and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he /</p>	N 522		

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N 522	<p>Continued From page 38</p> <p>she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care.</p> <p>c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency.</p> <p>d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the personal care services from 3:00 PM to 4:45 PM.</p> <p>e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care.</p> <p>6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and home health aide services (2) 2 hour visits and (1) 1 hour visits per day 7 days a week.</p>	N 522		

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N 522	<p>Continued From page 39</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes dated 03/17, 03/18, 03/21 to 03/25/16, the home health aide provided services from 9:00 AM to 3:45 PM. Review of the home health aide visit notes dated 03/19, /03/20, and 03/26/16, the home health aide provided services from 9:00 AM to 2:00 PM. The home health aide failed to follow the plan of care.</p> <p>c. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 a.m., the employee stated he / she did not have a written plan of care to follow and did not know his / her hours of care between the home health agency and the personal service agency that was also owned by the Administrator. The patient stated that he / she had to cancel a few nursing visits due to a nurse who caused him / her pain during a catheterization and he / she wanted to get rid of the pain before the next catheterization. The patient also stated that he / she had a problem with nurses not coming as scheduled and would not call to let her know that they would be late. The patient stated the times should be 9:00 to 10:00 AM, 1:00 to 2:00 PM, and 5:00 to 6:00 PM. The patient stated that he / she had things to do and can't wait all day for the nurses to come.</p> <p>d. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 p.m. The Director of Clinical Services stated the home health aide new his / her schedule and a written plan of care was put in the patient's home a few</p>	N 522		

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N 522	<p>Continued From page 40</p> <p>weeks prior. The Director of Clinical Services also stated the patient had the tendency to not be home when nurses arrived even when the visits were prescheduled.</p> <p>7. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadiazine cream to wounds, wrap with gauze dressing.</p> <p>a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The LPN failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visit notes dated 03/01, 03/02, 03/07, 03/09, and 03/12/16, the skilled nurses failed to assess the cardiovascular system, respiratory system, and / or failed to obtain vital signs.</p> <p>8. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months.</p>	N 522		

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N 522	<p>Continued From page 41</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. The skilled nurse failed to follow the plan of care.</p> <p>9. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month for 12 months.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse provided 3 of 5 visits each week between the dates of 02/14 to 03/12/16.</p> <p>b. During a home visit with the patient and Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H also stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. The skilled nurse failed to follow the plan of care.</p> <p>10. The clinical record for patient number 10,</p>	N 522		

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N 522	<p>Continued From page 42</p> <p>SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas.</p> <p>a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home health aide failed to follow the plan of care.</p> <p>b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide failed to follow the plan of care.</p> <p>11. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities).</p> <p>a. Review of the home health aide visit notes</p>	N 522		

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N 522	<p>Continued From page 43</p> <p>during the certification period of 08/19/15 to 10/17/15, the home health aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9.</p> <p>b. Review of the home health aide visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed to follow the plan of care.</p> <p>c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care.</p> <p>12. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided.</p> <p>13. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.</p> <p>14. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic</p>	N 522		

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N 522	Continued From page 44  process that addresses the care, treatment and services to be provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... "  15. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "	N 522		
N 524	410 IAC 17-13-1(a)(1) Patient Care  Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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.	N 524		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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N 524	<p>Continued From page 45</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed (#5, 6, 7, 9, and 10), failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program (#4), failed to include the type, frequency and duration of services to be provided (#2), ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's (#1, 2, and 9), failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces (#2), failed to include the type of feeding, rate, and frequency of gastrointestinal tube feedings in 2 of 2 records reviewed of patients with tube feedings (#2 and 8), failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and out catheterizations (#1 and 6), failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters (#9), failed to include instructions for foley catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations (#1), failed to include instructions for wound treatments in 1 of 1 records reviewed of patients with wound treatments (#7), failed to include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep. (# 1)</p>	N 524		

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N 524	<p>Continued From page 46</p> <p>Findings include:</p> <p>1. The clinical record for patient number 1, SOC 01/20/15, included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing " to ... O2 [oxygen] at 0.5 - 6 liters 1 minute [per minute] ... administer trach [sic] care, change trach collar QD [every day], suction trach ... I &amp; O cath [in and out catheter] TID [three times a day] and prn [as needed]. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks.</p> <p>b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline.</p> <p>c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep.</p> <p>d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician.</p>	N 524		

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N 524	<p>Continued From page 47</p> <p>The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had.</p> <p>e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings.</p> <p>The plan of care failed to include instructions for trach care, size of foley catheter to use for catheterizations, instructions for foley catheter irrigation, vent settings, specific treatment areas for the application of zinc oxide and Nystatin powder, and instructions for assistance with bathing and meal preps. The goals on the plan of care failed to be reflective of the patient's current status and treatment.</p> <p>2. The clinical record for patient number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance.</p>	N 524		

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N 524	<p>Continued From page 48</p> <p>a. A start of care comprehensive assessment dated 02/11/16, indicated Pediasure 1.0, 720 milliliters through out the night, Pediasure 410 [sic] milliliters per hour, and Pediasure 1.5, 4 ounce bolus 4 times a day, the patient had both a gastric and jejunostomy feeding tubes, the patient was receiving bolus and continuous feedings, with 35 milliliter flushes of water to the gastric feeding tube and 10 milliliter flushes of water to the jejunostomy feeding tube after night feedings, NPO (nothing by mouth) a 4 x 4 dressing under the patient's trach with 1 liter of oxygen via concentrator when sleeping, the patient had a trach, humidifier for oxygen, ventilator, pulse oximetry to be done every visit and "AFO in progress."</p> <p>b. Section 16 of the initial plan of care titled "Nutritional Req [requirements]" indicated Pediasure 1.0, 720 milliliters overnight.</p> <p>c. Section 18 of the initial plan of care titled "Activities Permitted" indicated AFOs [braces] were in progress.</p> <p>1. The plan of care failed to be updated and revised to include the type, amount, and frequency of "flushes", failed to include the route of oxygen usage, failed to include the type of trach and frequency of trach care [including suctioning protocols], failed to include ventilator settings and management of the ventilator, failed to include the management of the humidifier, failed to include pulse oximetry, failed to include the amount of flushes and frequency to both gastric and jejunostomy feeding tubes, failed to include both types of Pediasure feedings along with the the specific tube used for feedings, the amount and rate of all tube feedings, failed to include that the patient was NPO, and failed to</p>	N 524		

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N 524	<p>Continued From page 49</p> <p>indicate the location and frequency of the AFOs to be placed and worn by the patient.</p> <p>3. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation.</p> <p>a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program.</p> <p>b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The plan of care failed to be supported by the comprehensive assessment.</p> <p>4. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders,</p>	N 524		

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N 524	<p>Continued From page 50</p> <p>make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis.</p> <p>a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship.</p> <p>b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional Status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and</p>	N 524		

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N 524	<p>Continued From page 51</p> <p>transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The plan of care failed to be supported by the comprehensive assessment.</p> <p>c. The Administrator, Director of Nursing, and Assistant Director of Nursing was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM.</p> <p>6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention.</p> <p>a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college</p>	N 524		

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N 524	<p>Continued From page 52</p> <p>during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room.</p> <p>b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment</p>	N 524		

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N 524	<p>Continued From page 53</p> <p>did not include the size of the pediatric catheter. The plan of care failed to be supported by the comprehensive assessment. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals.</p> <p>7. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadiazine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for recertification was incomplete and failed to support the services provided as written in the plan of care. The plan of care failed to be supported by the comprehensive assessment.</p>	N 524		

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N 524	<p>Continued From page 54</p> <p>b. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities.</p> <p>c. The plan of care failed to be updated and revised to include type of solution to cleanse the lower extremities and the location of wounds to be treated. The goals on the plan of care failed to be reflective of the patient's current status and treatment.</p> <p>8. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days to to administer medication as ordered, administer gastric tube feedings / flushes as ordered.</p> <p>a. The plan of care failed to be updated and revised to include the amount of tube feeding to be provided, as well as the amount and frequency of flushes.</p> <p>9. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination,</p>	N 524		

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N 524	<p>Continued From page 55</p> <p>evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence.</p> <p>a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed.</p> <p>b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The plan of care failed to be supported by the comprehensive assessment.</p> <p>10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a</p>	N 524		

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(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) COMPLETE DATE
N 524	<p>Continued From page 56</p> <p>week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease.</p> <p>a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011.</p> <p>b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning.</p> <p>c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder, failed to complete the musculoskeletal system and functional limitations, failed to complete the neurological assessment, and failed to complete the summary of care (including progress toward goals to date. The primary diagnosis and plan of care failed to be supported by the comprehensive assessment and physician visit note</p> <p>11. The Administrator, Alternate Administrator, Director of Nursing, and Assistant Director of Nursing was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.</p>	N 524		

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N 524	Continued From page 57  12. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... "	N 524		
N 527	410 IAC 17-13-1(a)(2) Patient Care  Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.  This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure skilled nurses notified the physician in relation to discharges for 1 of 5 (# 4) records reviewed of patients discharged by the agency and failed to notify the physician in relation to elevated blood pressures for 1 of 6 records reviewed of active / current patients in a sample of 11. (# 6)  Findings include:  1. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders	N 527		

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N 527	<p>Continued From page 58</p> <p>for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week.</p> <p>a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15.</p> <p>b. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15.</p> <p>c. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15.</p> <p>d. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15.</p> <p>e. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges.</p> <p>2. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses</p>	N 527		

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N 527	<p>Continued From page 59</p> <p>include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The agency failed to provide documentation that the physician had been notified of the missed visits.</p> <p>b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified.</p> <p>c. Review of a skilled nursing visit note on 03/22/16 at 6:00 PM, the skilled nurse documented no urine output after 2 attempts of catheterizations. The clinical record failed to evidence that the physician had been notified.</p> <p>d. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified.</p> <p>e. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified.</p> <p>3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation.</p>	N 527		

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N 527	Continued From page 60  4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse informs the physician and other personnel of changes in the patient condition of needs ... The Licensed Practical Nurse ... Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "	N 527		
N 529	410 IAC 17-13-1(a)(2) Patient Care  Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.  This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that 60 day summaries were individualized and had a clearly written synopsis of the patient's course of treatment, including all services provided for 9 of 9 records reviewed of patients recertified in a sample of 11. (#1, 2, 4, 5, 7, 8, 9, 10, and 11)  Findings include:  1. The clinical record for patient number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate	N 529		

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N 529	<p>Continued From page 61</p> <p>cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. Review of a form titled Clinical Summary / Case Conference dated 03/22/16, the form indicated the services provided were skilled nursing and attendant care services with [name of outside agency]. The form indicated to continue goals / care, response of current treatment / medications, summary of patients conditions / changes in patient condition was left blank, indication to problems / needs / goals were left blank, caregiver support system / home environment indicated the patient "lives with" but was left blank, and no anticipated discharge plans. The new certification order indicated skilled nursing 1 - 13 hour visit a day for 7 days, 1 to 3 hour visits for 5 days a week for 9 weeks and attendant care services with [name of agency] for the certification period of 03/23/16 to 05/21/16. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment.</p> <p>2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a</p>	N 529		

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N 529	<p>Continued From page 62</p> <p>week to evaluate cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / falls prevention, medication teaching, evaluate med effects / compliance, administer suppository per MD orders, teach bowel regimen, and provide pericare. The patient was also receiving home health aide services (3) 2 hour visits per day 7 days a week to assist with bathing and hygiene, light housekeeping, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care, and range of motion to all extremities. Goals indicated the patient would maintain good hygiene and comfort, safety would be maintained, demonstrates compliance with medications, Stabilization of cardiovascular pulmonary condition, demonstrates competence in following medical regimen, and verbalized pain controlled at acceptable level.</p> <p>a. Review of a form titled Clinical Summary / Case Conference dated 08/18/15, the form indicated the services provided were home health aide and attendant care services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition was left blank, no new problems had been identified, lived alone, no indication for anticipated discharge plan, and recertification order indicated skilled nursing 1 to 2 hour visit a day for 2 days a week for 9 weeks, home health aide services (3) 2 hour visits a day 7 days a week for 9 weeks, and attendant care services 58 - 62 hours a month through Medicaid Waiver, for the certification period 08/18/15 to 10/16/15.</p>	N 529		

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N 529	<p>Continued From page 63</p> <p>b. On 08/21/15, the patient was sent a letter for discharge by the agency due to the patient's frequent refusal of staff. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment, including all services provided, progress toward goals, and the anticipated plan for discharge. The summary included attendant care order / information which was not a part of a service that was provided by the home health agency.</p> <p>3. The clinical record for patient number 5, SOC 03/01/10, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16 with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing and hygiene, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, and light housekeeping. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. Review of the home health aide visit notes during the certification period indicated the home health aides was not breaking up their visits as ordered and was staying with the patient from 9:00 AM to 3:00 PM, then immediately providing attendant care services through a sister company from 3:00 PM to 4:45 PM.</p> <p>b. Review of the comprehensive recertification assessment dated 03/23/16, indicated the patient's oxygen saturation was 94% percent, patient was incontinent of bladder only, and no assessment of the nutritional status.</p> <p>c. A form titled Clinical Summary / Case</p>	N 529		

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N 529	<p>Continued From page 64</p> <p>Conference dated 03/23/16, the form indicated the services being provided were home health aide services and attendant care services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition indicated the patient's oxygen saturations was 93%, nutrition and hydration was adequate, bowel and bladder incontinence, problems / needs / concerns indicated no new problems had been identified, caregiver support / system / home environment indicated the patient lived alone, no planned discharge at the present time, and no change in the plan of treatment / plan of care goals. The recertification order indicated home health aide services (2) 2 hour and (2) 1 hour visits a day 7 days a week for 9 weeks and attendant care services 24 - 28 hours a month for the certification period from 03/27/16 to 05/25/16. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included attendant care order / information which was not a part of a service that was provided by the home health agency.</p> <p>4. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadiazine cream to wounds, wrap with gauze dressing. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p>	N 529		

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N 529	<p>Continued From page 65</p> <p>a. During a home visit on 04/12/16 at 12:20 PM, a skilled nurse was observed to clean the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The patient was observed to have a wound to the right outer leg between the knee and ankle.</p> <p>b. Review of a form titled Clinical Summary / Case Conference dated 01/06/16 and 03/04/16, the form indicated the services provided were skilled nursing services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition was reflected from the recertification reassessments which indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, abdomen soft with bowel sounds x 4 quads, nutrition and hydration adequate, lower extremity cellulitis continues with skilled nursing and daily dressing changes, no new problems had been identified, lived with a disabled wife, no planned discharge, and no change in plans of treatment / plan of care goals. The new certification indicated to continue skilled nursing 1 hour a day 7 days a week. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period.</p> <p>5. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2</p>	N 529		

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N 529	<p>Continued From page 66</p> <p>hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days.</p> <p>b. Review of a form titled Clinical Summary / Case Conference dated 10/14/15 and 12/11/15, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was reflected from the recertification reassessments which indicated indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, gastric tube intact and patent, abdomen soft with bowel sounds x4 quads, no signs and symptoms of distress or pain, no new problems had been identified, lived with parents, no planned discharge, and no change in plans of treatment / plan of care goals. The summaries failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care</p>	N 529		

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N 529	<p>Continued From page 67</p> <p>goals for the correct certification period.</p> <p>c. Review of a form titled Clinical Summary / Case Conference dated 02/13/16 and 04/13/16, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications were effective. The summary of patients conditions / changes in patient condition indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, gastric tube intact and patent, abdomen soft with bowel sounds x4 quads, and both forms also indicated the patient suffered a broken right femur shaft on 02/04/16 and underwent internal fixation device open approach on 02/05/16. Surgical incision was clean, dry, no drainage or odor, edges were approximated without signs and symptoms of infections, no new problems were identified, lived with parents, no planned discharge, and no change in plans of treatment / plan of care goals. The new certification indicated to continue skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days and respite nursing 1 - 30 hours for 12 months. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period. The 04/13/16 summary failed to include the patient's return to surgery for removal of appliances on 02/16/16.</p> <p>6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5</p>	N 529		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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(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) COMPLETE DATE
N 529	<p>Continued From page 68</p> <p>days a week and respite nursing up to 40 hours a month for 12 months to evaluate cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate and teach for signs and symptoms of infections and standard precautions, teach diet, teach home safety / fall prevention, and oxygen at 2 liters per trach at bedtime. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. Review of a form titled Clinical Summary / Case Conference dated 11/18/15 and two undated clinical summaries for the certification periods 11/22/15 to 01/20/16 and 01/21/16 to 03/20/16, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition indicated the patient was very stable and seems quite happy surrounded by her family. Problems / Needs / Concerns indicated in all 3 summaries that the patient seemed to have been suffering from a mild stomach flu, no new problems were identified, lived with parent, no planned discharge, and no change in plans of treatment / plan of care goals.</p> <p>b. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed,</p>	N 529		

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N 529	<p>Continued From page 69</p> <p>and provides supra pubic care 1 - 2 times a day and as needed. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period.</p> <p>7. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas.</p> <p>a. Review of a form titled Clinical Summary / Case Conference dated 09/23/15, indicated the services provided were home health aide services, attendant care services and homemaker services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was left blank, Problems / Needs / Concerns was left blank, caregiver support system was left blank, no planned discharge, and no indication of changes in plans of treatment / plan of care goals. The new certification indicated home health aide services to continue 1 hour a day 7 days a week and continue 30 hours of attendant care services and 21 - 23 hours of homemaker services for the certification period from 09/23/15 to 11/21/15. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included attendant care and homemaker orders / information which was not a part of the services</p>	N 529		

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N 529	<p>Continued From page 70</p> <p>that was provided by the home health agency.</p> <p>8. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bathing and hygiene, ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and light housekeeping, and range of motion exercises (all extremities). Goals indicated the patient would maintain good hygiene, comfort, and safety will be maintained.</p> <p>a. Review of a form titled Clinical Summary / Case Conference dated 10/18/15, indicated the services provided were home health aide services and PAC services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was left blank, no new problems identified, caregiver support system indicated the patient lived with parents, no planned discharge, and "NA" (not applicable) to changes in plans of treatment / plan of care goals. The new certification indicated home health aide services to continue (1) 3 hour / day for 5 days a week and PAC 15 hours per week through medicaid waiver for the certification period from 10/18/15 to 12/16/15. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included PAC orders / information which was not a part of the services that was provided by the home health agency.</p> <p>9. The Administrator, Director of Clinical</p>	N 529		

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N 529	<p>Continued From page 71</p> <p>Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.</p> <p>10. A policy titled Medical Supervision dated 07/10/15, indicated " ... Written reports on the patient's condition are provided to the physician at least every sixth [sic] [60] days.</p> <p>11. A policy titled Clinical Summary to Physician dated 07/10/15, indicated " ... The summary note will include: a. Clinical summary of the care, treatment and services provided during the previous sixty [60] day episode of care. b. Patient response to the services and progress toward established goals. Summary of current needs and involvement of other community / family caregivers or services .... "</p>	N 529		
N 532	<p>410 IAC 17-13-1(d) Patient Care</p> <p>Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to notify the primary care physician of missed visits in 1 of 6 active / current records reviewed (# 6), failed to notify the primary care physician of a patient's elevated blood pressures</p>	N 532		

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N 532	<p>Continued From page 72</p> <p>for 1 of 6 records reviewed of active / current patients (# 6), and failed to notify the primary care physician for a patient with no urinary output for 1 of 2 patients reviewed with in and out catheterizations (# 6), failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds (#7 and 8) and 1 of 1 records reviewed of patients receiving a bowel program (# 4) in a sample of 11.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week.               <ol style="list-style-type: none"> <li>Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The agency failed to ensure physician orders had been obtained prior to digital stimulation / conducting a bowel program.</li> </ol> </li> <li>The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and</li> </ol>	N 532		

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N 532	<p>Continued From page 73</p> <p>Urinary Retention.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The agency failed to provide documentation that the physician had been notified of the missed visits.</p> <p>b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified.</p> <p>c. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified.</p> <p>3. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadiazine cream to wounds, wrap with gauze dressing.</p> <p>a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the</p>	N 532		

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N 532	<p>Continued From page 74</p> <p>bilateral lower extremities. The clinical record failed to include a physician's order for the treatment that had been provided.</p> <p>4. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days.</p> <p>a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. Skilled nursing visit notes dated 03/09 and 03/10/16, indicated that the patient's surgical incision dressing had been changed. The clinical record failed to include a physician's order for the treatment to be provided.</p> <p>5. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation in relation to physician orders for wound treatments.</p> <p>6. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges.</p> <p>7. A policy titled Physician Orders dated 07/10/15, indicated "All medications, treatments and services provided to patients must be ordered by a physician</p> <p>8. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse</p>	N 532		

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N 532	Continued From page 75  informs the physician and other personnel of changes in the patient condition of needs ... The Licensed Practical Nurse ... Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "	N 532		
N 533	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 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.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the home health aide followed the plan of care for 4 of 4 records reviewed with	N 533		

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N 533	<p>Continued From page 76</p> <p>home health aide services in a sample of 11. (#3, 5, 10, and 11)</p> <p>Findings include:</p> <p>1. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes, and autonomic instability.</p> <p>a. Review of the clinical record on 04/07/16 at 1:54 PM, the clinical record failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15.</p> <p>b. The Administrator on 04/07/16 at 4:00 PM, and provided a typed statement indicating that employee E, a Registered Nurse / Case Manager, that the patient had been complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency</p>	N 533		

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N 533	<p>Continued From page 77</p> <p>and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in one day." The Administrator stated new staff must have orientation for approximately 1 week.</p> <p>c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned sister. The patient stated he / she would never ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occasion, a home health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency.</p> <p>d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM. The Director of Clinical Services stated she was not aware of</p>	N 533		

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N 533	<p>Continued From page 78</p> <p>the missing home health aide visits. The Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides.</p> <p>e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated Employee M did helped with coordination as well. Employee M was not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong.</p> <p>2. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area.</p> <p>a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care, foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure</p>	N 533		

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N 533	<p>Continued From page 79</p> <p>areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16, and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he / she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care.</p> <p>c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency.</p> <p>d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet</p>	N 533		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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N 533	<p>Continued From page 80</p> <p>from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the personal care services from 3:00 PM to 4:45 PM.</p> <p>e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care.</p> <p>4. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas.</p> <p>a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home health aide failed to follow the plan of care.</p> <p>b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide failed to follow the plan of care.</p> <p>5. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bedbath (as needed), tub / shower, bath /</p>	N 533		

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N 533	<p>Continued From page 81</p> <p>chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities).</p> <p>a. Review of the home health aide visit notes during the certification period of 08/19/15 to 10/17/15, the home health aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9.</p> <p>b. Review of the home health aide visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed to follow the plan of care.</p> <p>c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care.</p> <p>6. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all</p>	N 533		

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N 533	Continued From page 82  patient visit notes had been provided.  7. The Administrator, Alternate Administrator, Director of Clinical Services, and Assisting Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.  8. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to e provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... "	N 533		
N 537	410 IAC 17-14-1(a) Scope of Services  Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:  This RULE is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to followed the plan of care for 6 of 6 records reviewed of patients receiving services from a registered nurse in a sample of 11. (#2, 4, 6, 7, 8, 9, )  Findings include:  1. The clinical record for number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing. The patient's diagnoses included RSV (Respiratory Syncytial Virus), Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding	N 537		

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N 537	<p>Continued From page 83</p> <p>intolerance.</p> <p>a. A "Notification of Client Status" dated 02/11/16, indicated the patient had been admitted for respite nursing and "PA" (meaning prior authorization from Medicaid to provide ongoing nursing services on a routine basis). The note also indicated the parents wanted a routine nurse for overnights and no float nurses.</p> <p>b. The initial plan of care (undated) had orders for skilled nursing to evaluate but failed to include a nursing frequency / duration. The agency provided respite nursing visits on 02/24/16 and 02/26/16. The nurse failed to follow the plan of care.</p> <p>c. The second plan of care dated 03/22/16, had orders for skilled nursing 8 hours per day, 5 days a week for 9 weeks and respite nursing up to 60 hours per month for 12 months. Review of the clinical record, the agency failed to provide skilled nursing visits 8 hours a day, 5 days a week.</p> <p>d. The Administrator, Director of Clinical Services, and Assisting Director of Clinical Services was interviewed on 04/07/16 at 12:30 PM. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services stated that the initial plan of care was developed upon admission and the agency were to provide respite nursing services. The patient was transferred into the hospital and returned home on 3/22/16. The Administrator and Assistant Director of Clinical Services stated that Medicaid had instructed the agency to develop a new plan of care versus writing orders and updating the current plan of care. The Assistant Director of Clinical Services stated there was a</p>	N 537		

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N 537	<p>Continued From page 84</p> <p>delay in routine nursing services due to the father's lack of ability to provide job information. The Director of Clinical Services stated the PA (Prior Authorization) came on 3/25/16, but the mother did not want floating nurses in the home and requested that the patient be staffed with a permanent nurse. The Assistant Director of Clinical Services stated the requested visit notes may have been in the patient's home. At 1:00 PM, missed visit notes were provided and the Director of Clinical Services stated she had been interviewing for a permanent nurse and a nurse had been hired and was due to start "today."</p> <p>e. The parent of patient number 2 was interviewed on 04/07/16 at 3:50 PM. The parent had stated that he / she did not recall telling the agency that he / she wanted to hold services or refused services until a permanent nurse was available. The parent stated he / she preferred a permanent nurse but would have taken anyone due to the exhaustion between him / her and their spouse, need for rest during the night due to pregnancy / work, and how the patient needed constant supervision during the night due to getting the trach tubing around his / her neck. The parent indicated the patient had respite nursing a few times prior to his / her hospitalization, but when the patient came out of the hospital, his / her respite nurse was in the hospital his / herself and that a replacement respite nurse had not been provided.</p> <p>2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week. The patient diagnoses included, but limited to Multiple Sclerosis.</p>	N 537		

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N 537	<p>Continued From page 85</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to provide 2 visits during the week of 07/19 to 07/25/15 and during the week of 07/26 to 08/01/15. The skilled nurse failed to provide a 2nd visit during the week of 08/09 to 08/15/15. The skilled nurse failed to follow the plan of care.</p> <p>3. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and home health aide services (2) 2 hour visits and (1) 1 hour visits per day 7 days a week.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The skilled nurse failed to follow the plan of care.</p> <p>b. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 a.m., the employee stated he / she did not have a written plan of care to follow and did not know his / her hours of care between the home health agency and the personal service agency that was also owned by the Administrator. The patient stated that he / she had to cancel a few nursing visits due to a nurse who caused him / her pain during a catheterization and he / she wanted to get rid of the pain before the next catheterization. The patient also stated that he / she had a problem with nurses not coming as scheduled and would not call to let her know that they would be late. The patient stated the times should be 9:00 to</p>	N 537		

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N 537	<p>Continued From page 86</p> <p>10:00 AM, 1:00 to 2:00 PM, and 5:00 to 6:00 PM. The patient stated that he / she had things to do and can't wait all day for the nurses to come.</p> <p>c. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 p.m. The Director of Nursing stated the home health aide new his / her schedule and a written plan of care was put in the patient's home a few weeks prior. The Director of Nursing also stated the patient had the tendency to not be home when nurses arrived even when the visits were prescheduled.</p> <p>4. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. Review of the skilled nursing visit notes dated 03/01/16 and 03/07/16, the skilled nurses failed to assess the cardiovascular system, respiratory system, and / or failed to obtain vital signs.</p> <p>5. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7</p>	N 537		

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N 537	<p>Continued From page 87</p> <p>consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. The skilled nurse failed to follow the plan of care.</p> <p>6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month for 12 months.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse provided 3 of 5 visits each week between the dates of 02/14 to 03/12/16.</p> <p>b. During a home visit with the patient and Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H also stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. The skilled nurse failed to follow the plan of care.</p> <p>7. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided.</p> <p>8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.</p>	N 537		

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N 537	<p>Continued From page 88</p> <p>9. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... "</p> <p>10. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Registered Nurse ... b. Regularly reevaluates the patient needs, and coordinates the necessary services .... "</p> <p>11.. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... Services will be coordinated by the Registered Nurse managing the care .... "</p> <p>12. 4. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "</p>	N 537		
N 541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services</p> <p>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.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to ensure the comprehensive reassessments were accurate</p>	N 541		

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N 541	<p>Continued From page 89</p> <p>and / or completed to support the services provided as written in the plan of care for 7 of 9 records reviewed of patients recertified for another 60 days in a sample of 11. (#1, 4, 5, 6, 7, 9, an 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension.</li> <li> <ol style="list-style-type: none"> <li>Review of the comprehensive reassessment dated 03/22/16, the assessment failed to include that the patient needed to be placed on a ventilator at bedtime, failed to include settings of the ventilator, indicated the patient was short of breath in the respiratory section but indicated the patient tolerated suctioning with dyspnea, failed to include a size and type of a foley catheter used for in and out catheterizations, failed to include assessment / need for bladder irrigation, failed to include the patient was a paraplegic in the neurological assessment,</li> </ol> </li> </ol>	N 541		

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N 541	<p>Continued From page 90</p> <p>indicated the patient was able to dress his / her upper and lower body, including socks and shoes, indicated the patient has a need for home health aide services and an order had been obtained, indicated a home health health aide supervisory visit was made instead of a LPN supervisory visit, failed to include specific detail in the teaching / training (indicated "see ASV"), and failed to include documentation in the summary section.</p> <p>b. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks.</p> <p>b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline.</p> <p>c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep.</p> <p>d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not</p>	N 541		

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N 541	<p>Continued From page 91</p> <p>able to indicate what size or type of trach the patient had.</p> <p>e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings. The comprehensive reassessment failed to be accurate to support the written plan of care.</p> <p>2. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation.</p> <p>a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program.</p> <p>b. Review of the comprehensive</p>	N 541		

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N 541	<p>Continued From page 92</p> <p>reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The comprehensive reassessment failed to be accurate to support the written plan of care.</p> <p>3. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis.</p> <p>a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the</p>	N 541		

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N 541	<p>Continued From page 93</p> <p>apartment, runs errands, and provide companionship.</p> <p>b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional Status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The comprehensive reassessment failed to be accurate and completed to support the plan of care.</p> <p>c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM.</p> <p>4. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a</p>	N 541		

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N 541	<p>Continued From page 94</p> <p>week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention.</p> <p>a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room.</p> <p>b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment</p>	N 541		

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N 541	<p>Continued From page 95</p> <p>did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. The comprehensive reassessment failed to be accurate and completed to support the written plan of care.</p> <p>5. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadiazine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral</p>	N 541		

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N 541	<p>Continued From page 96</p> <p>lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities.</p> <p>b. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity as well as current treatment, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for was incomplete and failed to support the services provided as written in the plan of care.</p> <p>6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular</p>	N 541		

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N 541	<p>Continued From page 97</p> <p>accident, coarotation of aorta, and urinary incontinence.</p> <p>a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed.</p> <p>b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The comprehensive assessment failed to be accurate and completed to support the written plan of care.</p> <p>7. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary</p>	N 541		

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N 541	<p>Continued From page 98</p> <p>diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease.</p> <p>a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011.</p> <p>b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning.</p> <p>c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder. The musculoskeletal system and functional limitations, the neurological assessment, and the summary of care failed to be completed. The primary diagnosis failed to be supported by the comprehensive assessment and physician visit note. The comprehensive assessment failed to be accurate and completed to support the written plan of care.</p> <p>8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.</p> <p>9. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided y the patient / family and health team members. Planning for care is a dynamic</p>	N 541		

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N 541	<p>Continued From page 99</p> <p>process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... "</p> <p>10. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated 08/15/15, indicated " ... 1. Patients are reassessed to determine their response to care, when significant changes occurred in their condition, their diagnosis, in their environment or support system that affect the plan of care, and when they released from the hospital ... 3. The Registered Nurse is responsible for reassessing the need for Home Care Aide services. 4. Special attention will be paid to patient - centered goal setting, clarifying the patient's personal goals and his / her expectations of the home care services. 5. The assessment will identify the problems, needs, and strengths of the patient and the care the family can provide. The ... ongoing assessments include consideration ... a. Specific individualized patient needs pertinent to the care or service being provided. b. Description of any applicable strength the patient has including physical, psychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... d. Appropriateness of the level of care provided by the family or support system to safely meet the patient needs ... f. Need for continuing home care services. g. Ability / willingness of the patient / family to assume responsibility for healthcare needs .... "</p>	N 541		

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N 542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services</p> <p>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.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to ensure that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed (#5, 6, 7, 9, and 10), failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program (#4), failed to include the type, frequency and duration of services to be provided (#2), ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's (#1, 2, and 9), failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces (#2), failed to include the type of feeding, rate, and frequency of gastrointestinal tube feedings in 2 of 2 records reviewed of patients with tube feedings (#2 and 8), failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and out catheterizations (#1 and 6), failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters (#9), failed to include instructions for foley catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations (#1), failed to include instructions for wound treatments in 1 of 1 records reviewed of patients with wound treatments (#7), failed to</p>	N 542		

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N 542	<p>Continued From page 101</p> <p>include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep. (# 1)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 1, SOC 01/20/15, included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing " to ... O2 [oxygen] at 0.5 - 6 liters 1 minute [per minute] ... administer tach [sic] care, change trach collar QD [every day], suction trach ... I &amp; O cath [in and out catheter] TID [three times a day] and prn [as needed]. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks.</p> <p>b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline.</p> <p>c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by</p>	N 542		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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N 542	<p>Continued From page 102</p> <p>assistance with bathing, shampooed the patient's hair, and assisted with meal prep.</p> <p>d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had.</p> <p>e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings.</p> <p>The plan of care failed to include instructions for trach care, size of foley catheter to use for catheterizations, instructions for foley catheter irrigation, vent settings, specific treatment areas for the application of zinc oxide and Nystatin powder, and instructions for assistance with bathing and meal preps. The goals on the plan of care failed to be reflective of the patient's current status and treatment.</p> <p>2. The clinical record for patient number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to</p>	N 542		

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N 542	<p>Continued From page 103</p> <p>04/10/16, with orders for skilled nursing to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance.</p> <p>a. A start of care comprehensive assessment dated 02/11/16, indicated Pediasure 1.0, 720 milliliters through out the night, Pediasure 410 [sic] milliliters per hour, and Pediasure 1.5, 4 ounce bolus 4 times a day, the patient had both a gastric and jejunostomy feeding tubes, the patient was receiving bolus and continuous feedings, with 35 milliliter flushes of water to the gastric feeding tube and 10 milliliter flushes of water to the jejunostomy feeding tube after night feedings, NPO (nothing by mouth) a 4 x 4 dressing under the patient's trach with 1 liter of oxygen via concentrator when sleeping, the patient had a trach, humidifier for oxygen, ventilator, pulse oximetry to be done every visit and "AFO in progress."</p> <p>b. Section 16 of the initial plan of care titled "Nutritional Req [requirements]" indicated Pediasure 1.0, 720 milliliters overnight.</p> <p>c. Section 18 of the initial plan of care titled "Activities Permitted" indicated AFOs [braces] were in progress.</p> <p>1. The plan of care failed to be updated and revised to include the type, amount, and frequency of "flushes", failed to include the route of oxygen usage, failed to include the type of trach and frequency of trach care [including suctioning protocols], failed to include ventilator settings and management of the ventilator, failed</p>	N 542		

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N 542	<p>Continued From page 104</p> <p>to include the management of the humidifier, failed to include pulse oximetry, failed to include the amount of flushes and frequency to both gastric and jejunostomy feeding tubes, failed to include both types of Pediasure feedings along with the the specific tube used for feedings, the amount and rate of all tube feedings, failed to include that the patient was NPO, and failed to indicate the location and frequency of the AFOs to be placed and worn by the patient.</p> <p>3. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation.</p> <p>a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program.</p> <p>b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The plan of care failed to be supported by the comprehensive assessment.</p> <p>4. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a</p>	N 542		

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N 542	<p>Continued From page 105</p> <p>physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis.</p> <p>a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship.</p> <p>b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional status assessment was left blank and did not specify if the patient has</p>	N 542		

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N 542	<p>Continued From page 106</p> <p>physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The plan of care failed to be supported by the comprehensive assessment.</p> <p>c. The Administrator, Director of Nursing, and Assistant Director of Nursing was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM.</p> <p>6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was</p>	N 542		

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N 542	<p>Continued From page 107</p> <p>Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention.</p> <p>a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room.</p> <p>b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is</p>	N 542		

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N 542	<p>Continued From page 108</p> <p>able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to be supported by the comprehensive assessment. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals.</p> <p>7. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadiazine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.</p> <p>a. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to</p>	N 542		

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N 542	<p>Continued From page 109</p> <p>document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for recertification was incomplete and failed to support the services provided as written in the plan of care. The plan of care failed to be supported by the comprehensive assessment.</p> <p>b. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities.</p> <p>c. The plan of care failed to be updated and revised to include type of solution to cleanse the lower extremities and the location of wounds to be treated. The goals on the plan of care failed to be reflective of the patient's current status and treatment.</p> <p>8. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days to to administer medication as ordered, administer gastric tube feedings / flushes as ordered.</p> <p>a. The plan of care failed to be updated and revised to include the amount of tube feeding to be provided, as well as the amount and frequency of flushes.</p> <p>9. The clinical record for patient number 9, SOC</p>	N 542		

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N 542	<p>Continued From page 110</p> <p>11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence.</p> <p>a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed.</p> <p>b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The plan of care failed to be supported by</p>	N 542		

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N 542	<p>Continued From page 111</p> <p>the comprehensive assessment.</p> <p>10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease.</p> <p>a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011.</p> <p>b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning.</p> <p>c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder, failed to complete the musculoskeletal system and functional limitations, failed to complete the neurological assessment, and failed to complete the summary of care (including progress toward goals to date. The primary diagnosis and plan of care failed to be supported by the comprehensive assessment</p>	N 542		

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N 542	<p>Continued From page 112 and physician visit note</p> <p>11. The Administrator, Alternate Administrator, Director of Nursing, and Assistant Director of Nursing was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.</p> <p>12. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided y the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... "</p> <p>13. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Registered Nurse ... c. Initiates the Plan of Care and necessary revisions and updates to the plan care and the care plan .... "</p> <p>14. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... Services will be coordinated by the Registered Nurse managing the care. This will include implementing, revising, and updating the Plan of Care .... "</p> <p>15. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated 08/15/15, indicated " ... 1. Patients are reassessed to determine their response to care, when significant changes occurred in their</p>	N 542		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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(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) COMPLETE DATE
N 542	Continued From page 113  condition, their diagnosis, in their environment or support system that affect the plan of care, and when they released from the hospital ... 3. The Registered Nurse is responsible for reassessing the need for Home Care Aide services. 4. Special attention will be paid to patient - centered goal setting, clarifying the patient's personal goals and his / her expectations of the home care services. 5. The assessment will identify the problems, needs, and strengths of the patient and the care the family can provide. The ... ongoing assessments include consideration ... a. Specific individualized patient needs pertinent to the care or service being provided. b. Description of any applicable strength the patient has including physical, psychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... d. Appropriateness of the level of care provided by the family or support system to safely meet the patient needs ... f. Need for continuing home care services. g. Ability / willingness of the patient / family to assume responsibility for healthcare needs .... "	N 542		
N 544	410 IAC 17-14-1(a)(1)(E) Scope of Services  Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes.  This RULE is not met as evidenced by: Based on observation, record review and interview, the Registered Nurse failed to document a description / assessment of wounds being treated and failed to document the treatment provided for 2 of 2 records reviewed	N 544		

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N 544	<p>Continued From page 114</p> <p>and 1 of 1 home visit of patients with wounds in a sample of 11. (# 7 and 8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The patient's diagnoses were venous stasis ulcer and cellulitis.               <ol style="list-style-type: none"> <li>a. Review of the comprehensive reassessment for recertification dated 03/02/16, indicated the patient had stasis ulcers and wound #1 indicated left lower extremity had cellulitis, with edema, moderate amount of clear, thick drainage. Wound #2 indicated the right lower extremity had venous ulcer cellulitis, with edema, moderate amount of clear, thick drainage. The assessment failed to include measurements of the lower extremities as well as measurements and appearance of the venous ulcer.</li> <li>b. Review of the skilled nursing notes dated 03/01, 03/04, 03/05, 03/07, and 03/08/16, indicated the treatments were done as ordered. The RN failed to include a description / assessment of the wounds being treated and description of the treatment being provided. The RN also failed to provide weekly measurements of the venous stasis ulcer.</li> </ol> </li> <li>2. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and</li> </ol>	N 544		

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N 544	<p>Continued From page 115</p> <p>(1) 11 hour day on non school days.</p> <p>a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. The following skilled nursing visits failed to document a complete assessment to the incisional area - 02/18, 02/20, 02/22, 02/23, 02/24, 02/25, 02/26, 02/29, 03/02, 03/03, 03/04, 03/07, 03/08, 03/09, 03/10, and 03/11/16.</p> <p>3. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated that the expectation for the nurse to document treatments provided was "as ordered" in regards to clinical record number 7. The Director of Nursing was not able to provide any further documentation or comments in regards to clinical record number 8.</p> <p>4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse: a. Performs the initial assessment visit. b. Regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the Plan of Care an necessary revisions and updates to the plan of care and the care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. informs the physician and other personnel of changes in the patient condition and needs ... g. Prepares clinical and progress notes .... "</p>	N 544		
N 546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services</p> <p>Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of</p>	N 546		

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N 546	<p>Continued From page 116</p> <p>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.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to ensure skilled nurses notified the physician in relation to discharges for 1 of 5 (# 4) records reviewed of patients discharged by the agency, failed to notify the physician in relation to elevated blood pressures for 1 of 6 records reviewed of active / current patients in a sample of 11 (# 6), failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds (#7 and 8) and 1 of 1 records reviewed of patients receiving a bowel program in a sample of 11. (# 4)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week.</p> <p>a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was</p>	N 546		

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N 546	<p>Continued From page 117</p> <p>performing a digital stimulation / bowel program. The agency failed to ensure physician orders had been obtained prior to digital stimulation / conducting a bowel program.</p> <p>b. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15.</p> <p>c. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15.</p> <p>d. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15.</p> <p>e. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15.</p> <p>f. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges.</p> <p>2. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients</p>	N 546		

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N 546	<p>Continued From page 118</p> <p>cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The agency failed to provide documentation that the physician had been notified of the missed visits.</p> <p>b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified.</p> <p>c. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified.</p> <p>3. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days.</p> <p>a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. Skilled nursing visit notes dated 03/09 and 03/10/16, indicated that the patient's surgical incision dressing had been changed. The clinical record failed to include a physician's order for the</p>	N 546		

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N 546	Continued From page 119  treatment to be provided.  4. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation in relation to physician orders for wound treatments.  5. A policy titled Physician Orders dated 07/10/15, indicated "All medications, treatments and services provided to patients must be ordered by a physician  6. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse informs the physician and other personnel of changes in the patient condition of needs .... "	N 546		
N 554	410 IAC 17-14-1(a)(2)(B) Scope of Services  Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes.  This RULE is not met as evidenced by: Based on record review and interview, the Licensed Practical Nurse [licensed practical nurse] failed to ensure assessments / visit notes were clear, complete and accurate for 3 of 5 records reviewed with LPN providing services in a sample of 11. (#1, 2, and 7)  Findings include:  1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for	N 554		

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N 554	<p>Continued From page 120</p> <p>skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension.</p> <p>a. The clinical record of patient number 1 was reviewed on 04/06/16 at 12:40 PM and indicated the following:</p> <p>1. The OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his / her home at 08:00 AM. The patient was in his wheelchair at the kitchen table.</p> <p>2. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16.</p> <p>b. An agency investigation note dated 03/29/16 at 9:57 AM, was reviewed and indicated the Director of Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the</p>	N 554		

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N 554	<p>Continued From page 121</p> <p>patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation.</p> <p>c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assistant Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measure included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign-in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago.</p>	N 554		

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N 554	<p>Continued From page 122</p> <p>d. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care.</p> <p>e. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news</p>	N 554		

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N 554	<p>Continued From page 123</p> <p>letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided.</p> <p>f. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturation when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a \$20 gift card for meeting</p>	N 554		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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(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) COMPLETE DATE
N 554	<p>Continued From page 124</p> <p>with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case.</p> <p>g. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded about notifying the office about call offs and the repercussions.</p> <p>h. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions.</p> <p>i. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received.</p> <p>j. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the</p>	N 554		

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N 554	<p>Continued From page 125</p> <p>Director of Nursing for call offs but unable to provide a specific date.</p> <p>k. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions.</p> <p>l. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions.</p> <p>m. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time. The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the police station the previous week and obtained a copy of the report.</p>	N 554		

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N 554	<p>Continued From page 126</p> <p>2. The clinical record for number 2, SOC 02/11/16, included two plans of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance.</p> <p>a. A nursing visit note dated 2/24/16, failed to include a cardiovascular assessment, the type and rate of tube feedings [elaborate the meaning "2 hrs [hours] 6 hrs &gt; slow feed"] if the patient was having feeding intolerance's, flushes, a skin assessment, a pain assessment, if trach care had been provided, and the number of incontinent episodes of urine.</p> <p>b. A nursing visit note dated 2/26/16, failed to properly identify if the patient had a g/tube (gastric feeding tube) and / or j/tube (jejunostomy feeding tube), if the feedings had been provided and tolerance of feedings, flushes, if trach care had been provided, the number of incontinent episodes / assessment of the genitourinary (number of incontinent of urine episodes) and digestive system (bowel sounds and bowel movements).</p> <p>c. A nursing visit note dated 03/01/16, failed to properly identify if the patient had a g/tube and / or j/tube, the rate, frequency, and duration of the feedings, tolerance of feedings, if trach care had been provided, and assessment of the digestive system (bowel sounds and bowel movements).</p> <p>d. A nursing visit note dated 03/03/16, failed</p>	N 554		

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N 554	<p>Continued From page 127</p> <p>to properly identify if the patient had a g/tube and / or j/tube, the rate and duration of the feedings, tolerance feedings, an assessment of the digestive system (bowel sounds and bowel movements), assessment of the neurosensory system, and if trach care had been provided.</p> <p>e. The Assistant Director of Clinical Services was interviewed on 04/13/16 at 2:15 PM, and stated the patient had a j/tube.</p> <p>f. The Director of Clinical Services was interviewed on 04/13/16 at 2:25 PM, and stated the patient had both g/tube and j/tube.</p> <p>3. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care.</p> <p>a. Review of the skilled nursing notes dated 03/02, 03/06, 03/09 to 03/12/16, the LPN failed to include a description / assessment of the wounds being treated and description of the treatment being provided.</p> <p>4. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated the visit notes should have included an assessment of the wounds.</p> <p>5. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse: a. Provides service in accordance with ISHHA [Individual Services Home Health Agency] policy and nursing standards of practice ... d. Reports findings and observations to the Registered Nurse and other members of the</p>	N 554		

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N 554	Continued From page 128  team to assure coordination and timely response to client changes or needs. e. Prepares clinical and progress notes .... "	N 554		
N 555	<p>410 IAC 17-14-1(a)(2)(C) Scope of Services</p> <p>Rule 14 Sec. 1(a) (2)(C) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (C) Assist the physician and/or registered nurse in performing specialized procedures.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the Licensed Practical Nurse (Licensed Practical Nurse) failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds in a sample of 11. (# 6 and 7)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention.</p> <p>a. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified.</p>	N 555		

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N 555	<p>Continued From page 129</p> <p>b. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified.</p> <p>2. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadiazine cream to wounds, wrap with gauze dressing.</p> <p>a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The clinical record failed to include a physician's order for the treatment that had been provided.</p> <p>3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation.</p> <p>4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse: a. Provides service in accordance with ISHHA [Individual Services Home Health Agency] policy and nursing standards of practice ... d. Reports findings and observations to the Registered Nurse and other members of the</p>	N 555		

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N 555	Continued From page 130  team to assure coordination and timely response to client changes or needs .... "	N 555		
N 559	<p>410 IAC 17-14-1(a)(2)(G) Scope of Services</p> <p>Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency Licensed Practical Nurse failed to notify the physician after informing the Registered Nurse in relation to no urine output after in and out catheterizations for 1 of 6 records reviewed of active / current patients in a sample of 11. (# 6)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention.</p> <p>a. Review of a skilled nursing visit note on 03/22/16 at 6:00 PM, the skilled nurse documented no urine output after 2 attempts of catheterizations. The clinical record failed to evidence that the physician had been notified.</p>	N 559		

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N 559	Continued From page 131  b. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified.  3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation.  4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse ... Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "	N 559		
N 596	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  This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the home health aide skills competency check offs provided documentation of tasks, such as reading and recording temperature, pulse, and respiration, bed bath,	N 596		

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N 596	<p>Continued From page 132</p> <p>sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient for 3 of 3 home health aides hired in 2015. (Employees I, N, S)</p> <p>Findings include:</p> <p>1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following:</p> <p style="padding-left: 20px;">a. Employee I, Date of Hire (DOH) 05/12/14, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient.</p> <p style="padding-left: 20px;">b. Employee N, DOH 08/18/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient.</p> <p style="padding-left: 20px;">c. Employee S, DOH 02/24/15, failed to indicate that the home health aide skills competency check off, such as reading and</p>	N 596		

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N 596	Continued From page 133  recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient.  2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not provide any further information by the end of the exit conference on 04/18/16 at 03:40 PM.	N 596		
N 598	410 IAC 17-14-1(l)(2) Scope of Services  Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.  This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the home health aide skills competency check offs provided documentation of tasks, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient for 3 of 3 home health aides hired in 2015. (Employees I, N, S)  Findings include:	N 598		

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N 598	<p>Continued From page 134</p> <p>1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following:</p> <p style="padding-left: 40px;">a. Employee I, Date of Hire (DOH) 05/12/14, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient.</p> <p style="padding-left: 40px;">b. Employee N, DOH 08/18/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient.</p> <p style="padding-left: 40px;">c. Employee S, DOH 02/24/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient.</p> <p>2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not provide any</p>	N 598		

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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL SUPPORT HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356</b>
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N 598	Continued From page 135  further information by the end of the exit conference on 04/18/16 at 03:40 PM.	N 598		
N 606	<p>410 IAC 17-14-1(n) Scope of Services</p> <p>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.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the home health aide followed the plan of care for 4 of 4 records reviewed with home health aide services in a sample of 11. (#3, 5, 10, and 11)</p> <p>Findings include:</p> <p>1. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes, and autonomic instability.</p> <p>a. Review of the clinical record on 04/07/16 at 1:54 PM, the clinical record failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15.</p> <p>b. The Administrator on 04/07/16 at 4:00 PM,</p>	N 606		

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N 606	<p>Continued From page 136</p> <p>and provided a typed statement indicating that employee E, a Registered Nurse / Case Manager, that the patient had been complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in one day." The Administrator stated new staff must have orientation for approximately 1 week.</p> <p>c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned</p>	N 606		

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N 606	<p>Continued From page 137</p> <p>sister. The patient stated he / she would never ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occasion, a home health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency.</p> <p>d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM. The Director of Clinical Services stated she was not aware of the missing home health aide visits. The Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides.</p> <p>e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated Employee M did helped with coordination as well. Employee M was not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong.</p> <p>2. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16</p>	N 606		

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N 606	<p>Continued From page 138</p> <p>to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area.</p> <p>a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care, foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16, and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he / she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care.</p>	N 606		

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N 606	<p>Continued From page 139</p> <p>c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency.</p> <p>d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the personal care services from 3:00 PM to 4:45 PM.</p> <p>e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care.</p> <p>4. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas.</p> <p>a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home</p>	N 606		

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N 606	<p>Continued From page 140</p> <p>health aide failed to follow the plan of care.</p> <p>b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide failed to follow the plan of care.</p> <p>5. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities).</p> <p>a. Review of the home health aide visit notes during the certification period of 08/19/15 to 10/17/15, the home health aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9.</p> <p>b. Review of the home health aide visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed to follow the plan of care.</p>	N 606		

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N 606	<p>Continued From page 141</p> <p>c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care.</p> <p>6. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided.</p> <p>7. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.</p> <p>8. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to e provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... "</p>	N 606		
N 608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records</p> <p>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:</p>	N 608		

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N 608	<p>Continued From page 142</p> <p>(1) The medical plan of care and appropriate identifying information.</p> <p>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(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.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the missed visit notes (#3 and 11) and supervisory visits forms (#3) were filled out accurately for 2 of 11 records reviewed, failed to ensure nursing visit notes that were faxed to the office, were faxed in its entirety (#1 and 8) for 2 of 11 records reviewed, failed to ensure the plan of care included a date of the verbal order (#8) for 1 of 11 records reviewed, and failed to incorporate visit notes into the medical record within 14 days of the visit for 6 of 11 records reviewed. (#1, 5, 6, 7, 9, and 11)</p> <p>Findings include:</p> <p>1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week.</p> <p>a. Review of the skilled nursing visit notes between March 1, 2016 to March 26, 2016, the clinical record failed to evidence the back pages</p>	N 608		

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N 608	<p>Continued From page 143</p> <p>of the skilled nursing visit notes on 03/02/16 from 12:00 AM to 10:00 AM and 04:00 PM to 07:00 PM, 03/03/16 from 04:00 PM to 07:00 PM, 03/05/16 from 09:00 PM to 12:00 AM, 03/06/16 from 12:00 AM to 10:00 AM and 09:00 PM to 12:00 AM, 03/07/16 from 12:00 AM to 10:00 AM, 06:00 PM to 09:00 PM, and 09:00 PM to 12:00 AM, and 03/08/16 from 12:00 AM to 10:00 AM.</p> <p>b. The clinical record was reviewed on 04/06/16 at 12:40 PM. The clinical record failed to evidence visit notes from Employee F on 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16.</p> <p>c. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1. Skilled nursing visit notes dated 03/27 and 03/28/16 continued to be missing.</p> <p>2. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks.</p> <p>a. A form titled "Aide Supervision Note" dated 07/22/15, the note indicated the home health aide was present and the assessment of care given to the patient was good. The supervisory note failed to include the name of the home health aide present during the supervisory visit. A form titled "Missed Visit Report" indicated the patient had missed visits per patient request between 07/18/15 to 07/24/15. Review of the</p>	N 608		

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N 608	<p>Continued From page 144</p> <p>home health aide visit notes, the record failed to include a home health aide visit note for the date of 07/22/15.</p> <p>b. The patient was interviewed on 04/07/16 at 7:00 PM. The patient stated he / she did not cancel or refused services from the agency.</p> <p>c. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation when asked.</p> <p>3. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week.</p> <p>a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15.</p> <p>b. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15.</p> <p>c. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15.</p> <p>d. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped</p>	N 608		

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N 608	<p>Continued From page 145</p> <p>home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15. The record also failed to include a discharge OASIS assessment on or after 09/15/15.</p> <p>e. An interview with patient number 4 on 04/12/16 at 7:30 PM, the patient indicated he / she had received two letters of discharge. The patient stated he / she did not refuse nursing nor did he / she refused home health aides. The patient stated he / she did not like the team leaders that came into his / her home and his / her last complaint was over a home health aide that spit over his / her food when he / she spoke. The patient stated he / she had to be fed and he / she would lose his / her appetite and couldn't eat.</p> <p>f. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated the discharge comprehensive assessment was for the discontinuation of nursing only and home health aide to continue beyond the assessment date.</p> <p>g. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator stated the patient constantly wanted team leaders and refused the home health aides. The Administrator did not provided further information or documentation in regards to continuing services and providing the patient with a new discharge date.</p> <p>4. The clinical record for patient number 5, SOC 03/01/10, included a plan of care established by a physician for the certification period of 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week . The clinical record failed to include</p>	N 608		

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(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) COMPLETE DATE
N 608	<p>Continued From page 146</p> <p>visit notes after 03/28/16.</p> <p>5. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterization and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week. The clinical record failed to include visit notes after 03/26/16.</p> <p>6. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week. The clinical record failed to include visit notes after 03/12/16.</p> <p>7. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days.</p> <p>a. Review of the skilled nursing visit notes from 02/13 to 03/11/16, the progress notes on the back side of the assessment page contained information of care that the skilled nurse provided through out his / her visit. Skilled nursing visit notes after 03/14 to 03/23/16 failed to include progress notes on the back side of the assessment notes.</p> <p>8. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5</p>	N 608		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011160</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/07/2016</b>
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N 608	<p>Continued From page 147</p> <p>days a week, and respite nursing up to 40 hours a month .</p> <p>a. Review of the comprehensive reassessment for recertification dated 03/18/16 and review of the plan of care, the Registered Nurse failed to document date of the verbal accepted by the physician for the patient's recertification.</p> <p>b. The clinical record failed to include visit notes after 03/12/16.</p> <p>9. The clinical record for patient number 11, SOC 02/20/15, included two plans of care established by a physician for the certification periods of 08/19/15 to 10/17/15 and 10/18/15 to 12/16/15, with orders for home health aide services.</p> <p>a. A form titled "Missed Visit Report" dated 10/06/15, indicated there would be missed visits from 10/07/15 to 11/22/15, per family request due to a fall break. Review of the home health aide visit notes, the home health aide made visits from 10/07/15 to 10/17/15. The agency failed to ensure the clinical record contained accurate information.</p> <p>b. A form titled "Missed Visit Report" dated 10/24/15, indicated there would be missed visits from 10/25/15 to 10/27/15, per family request due to the holidays. Another form titled "Missed Visit Report" dated 10/26/15, indicated there would be missed visits from "10-18/26/15" and visits were rescheduled for 10/27/15, per family request. The agency failed to ensure missed visits missed visits were written in a timely manner and written in a clear understanding.</p> <p>c. A form titled "Missed Visit Report" dated</p>	N 608		

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N 608	<p>Continued From page 148</p> <p>11/06/15, indicated there would be a missed visit on 11/06/15, per family request. Review of the home health aide visit notes, a home health aide visit was made on 11/06/15. The agency failed to ensure the clinical record contained accurate information.</p> <p>d. A form titled "Missed Visit Report" dated 11/10/15, indicated there would be a missed visit on 11/10/15. The form failed to include if the cancellation was per family request or for other reasons.</p> <p>e. A form titled "Missed Visit Report" dated 11/13/15, indicated there would be a missed visit on 11/13/15. The form failed to include if the cancellation was per family request or for other reason.</p> <p>13. A form titled "Missed Visit Report" dated 11/06/15, indicated there would be a missed visit on 11/06/15, per family request. Review of the home health aide visit notes, a home health aide visit was made on 11/06/15. The agency failed to ensure the clinical record contained accurate information.</p> <p>10. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all clinical visit notes to date had been provided to the surveyor and nothing was waiting to be filed. By 4:00 PM, no further notes had been provided by the Administrator.</p> <p>11. The Administrator was interviewed on 04/18/15 at 2:25 PM. The Administrator had indicated that the patient / caregiver could have changed his / her mind about the missed visit after calling to cancel the visit.</p>	N 608		

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N 608	<p>Continued From page 149</p> <p>12. On 04/18/16 at 3:10 PM, the Assistant Director of Nursing had indicated the expectation of notes faxed from outlying areas, would be mailed to the office and the faxed note would be replaced with the original note.</p> <p>13. 12. A policy titled "Medical Record Management, Documentation of Changes, Confidentiality and Retention of Clinical Records" dated 07/10/15, indicated " ... Clinical Record ... Required documentation for each service or care provided must be completed on the day the services is rendered and filed in the clinical record within fourteen (14) days ... Documentation shall show effective interchange, reporting, and coordination of patient care that occurred. All documentation must be legible ... There shall be no obliteration of entries by erasures, whiting - out, and pasting over, et., in the patient's medical record. To correct an error in the clinical record, the following method should be used: a. Draw a single line though the entry in such a way that the written information underneath may still be read. Initial and date the entry. b. Write corrected information near the entry or where the correct information is found .... "</p> <p>14. A policy titled "Physician Orders" dated 07/10/15, indicated " ... When the nurse receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order .... "</p>	N 608		