STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADMIRAL HOME HEALTH	5730 DR MLK BLVD ANDERSON, IN 46013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00		G 0000		

This visit was for an Initial Medicaid certification survey of a home health agency.

Survey dates: 5-15-17, 5-16-17, 5-17-17, and 5-18-17

Facility # 014092

Unduplicated skilled admissions: 6

Unduplicated non-skilled admissions: 4

Current Census: 7 patients, 1 skilled care patient and 6 home health aide only patients.

Discharged Patients: 3

Home Visits with record review : 4

Discharged records reviewed : 3

Total charts reviewed: 10

Admiral Home Health, is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 5-18-2017, for having been found out of compliance with the Conditions of

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

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	Participation at 42 CFR 484.14, Organization, Services, and Administration; 42 CFR 484.16 Group of Professional Personnel; 42 CFR 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision; and 42 CFR 484.30, Skilled Nursing Services.			
G 0108 Bldg. 00	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. Based on record review and interview, the agency failed to advise the patient in advance of the frequency of proposed visits for the disciplines to be provided care for 2 of 10 patients (Patients #3 and	G 0108	no response	08/11/2017

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	7). The findings included: 1. Review of the clinical record of patient # 3, evidenced a start of care date of 3-23-17, and contained a plan of care for the certification period 3-15- to 5-13-17,with order for home health aide (HHA) services 2 times a week for 8 weeks. Review of an admission document "Admiral Home Health" evidenced "The Plan of Care involves the following Discipline(s):" and the box for home health aide was checked. The admission document, signed and dated 3-23-17, by the registered nurse (employee A), and by patient #3, failed to evidence the frequency of proposed HHA visits. 2. Review of the clinical record of patient # 7, evidenced a start of care date of 2-17-17, and contained a plan of are for the certification period of 2-17 to 4-17-17, with order for skilled nursing visits 1 time a week for 1 week, then 2 times a week for 8 weeks. Review of an admission document "Admiral Home Health" evidenced "The Plan of Care involves the following Discipline(s)." The box for skilled nurse was checked. The admission document, signed and dated 2-17-17, by the registered nurse			

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	(employee # A), and by patient # 7, failed to evidence the frequency of proposed visits. 3. On 5-18-17 at 12:04, the nursing supervisor stated the documents did not provide the patient's notice of the frequency of proposed visits, and stated there was no further documentation to provide for review.			
G 0122 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Based on record review and interview, the agency failed to maintain compliance with this condition of participation. The governing body failed to assume responsibility for the operation of the agency to include appointing a group of professional personnel to establish the agency's policies (See G 128); the governing body failed to adopt agency bylaws prior to survey entrance (See G 131); (See G 133); the agency failed to ensure adequate staff education for 1 of 1 alternate	G 0122	no response	08/11/2017

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	administrator/alternate nursing supervisor (See G 134); the agency failed to ensure the alternate administrator, employee B, was oriented to the position and was ready to respond to an emergencies, provide guidance to staff, answer questions, and resolve issues within a reasonable amount of time for 1 of 1 alternate administrator, and failed to ensure the alternate nursing supervisor, employee B, was oriented to the position and prepared to assume the duties of nursing supervisor if required, for 1 of 1 alternate nursing supervisor (G 141); failed to ensure all personnel coordinated care for 2 of 10 patients (See G 143); and failed to implement its advance directive policy to coordinate care for 1 of 1 patients with an advance directive (Patient #3), and failed to document coordination of care activities for 2 of 10 patients (See G 144). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the Condition of Participation, 42 CFR 484.14, Organization, Services, and Administration.			

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G 0128 Bldg. 00	484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. Based on record review and interview, the governing body failed to assume responsibility for the operation of the agency to include appointing a group of professional personnel to establish the agency's policies for 1 of 1 home health agency. The findings included: 1. Review of the policies presented during the survey evidenced a date of adoption of 9-6-17. 2. On 5-17-17 at 1:17 PM, the meeting minutes of the governing body dated 4-19-17, 4-5-17, 12-14-16, 12-6-16, 11-20-16, 9-6-16, 8-30-16, 8-25-16, 8-24-16, 8-21-16, 8-18-16, 8-1-16, 7-29-16, and 6-16-16, were reviewed and failed to evidence the governing body had appointed a group of professional	G 0128	no response	08/11/2017

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	personnel to establish the agency's policies. 3. On 5-17-17 at 10:47 AM, the administrator stated agency personnel used the policies in the the agency policy binder to direct care and processes. The administrator stated a group of professional personnel had not been appointed.			
G 0131 Bldg. 00	484.14(b) GOVERNING BODY The governing body adopts and periodically reviews written bylaws or an acceptable equivalent. Based on record review and interview, the governing body failed to adopt agency bylaws prior to survey entrance for 1 of 1 home health agency. The findings included:	G 0131	no response	08/11/2017

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	1. On 5-17-17 at :15 PM, the agency provided a list of the names of the 2 members of the governing body to include a non-employee owner, and employee G, the agency office manager. 2. On 5-17-17, an unsigned and undated document titled "Bylaws of Admiral Medical Home Health Inc.," was reviewed. 3. On 5-18-17 at 9:30 AM, a 2nd copy of the same document was presented, which included the signature of one member of the governing body, the agency's owner, dated 9-6-16. The office manager (employee G) stated the owner had signed and dated the bylaws the evening of 5-17-17, and documented the date of signature as 9-6-16. Employee G stated, "That was my fault I didn't get signature in September." 4. On 5-17-17 at 4:11 PM, the administrator verified the above findings and stated there was no additional documentation to provide to be reviewed.			

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G 0133 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Based on record review and interview, the administrator failed to organize and direct the agency's ongoing functions and be an effective liaison between the staff and the governing body, to include failure to ensure the orientation for the alternate administrator and alternate nursing	G 0133	n/a	08/11/2017

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	supervisor, failure to ensure the governing body had reviewed the agency bylaws, and failure to ensure the agency had appointed a group of professional personnel to establish the agency's policies. The findings included: 1. The administrator failed to ensure the governing body had reviewed the agency bylaws (See G 131) 2. The administrator failed to ensure the agency's policies were adopted by the group of professional personnel (See G 153). 3. The administrator failed to organize and direct the agency's ongoing functions to include failure to ensure the orientation for the alternate administrator and alternate nursing supervisor (See G 134). 4. On 5-18-17 at 3 PM, the administrator verified the above findings.			
G 0134 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.			

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	Based on record review and interview, the administrator failed to ensure adequate staff education for 1 of 1 alternate administrator/alternate nursing supervisor (employee B). The findings included: 1. Review of a list of agency employees prepared by the office manager, employee G, evidenced the name of employee B as the alternate administrator role and the alternate nursing supervisor. 2. Review on 5-17-17, of the personnel file for employee B, alternate administrator and alternate nursing supervisor, evidenced a date of hire of 1-18-17. A. The personnel file evidenced a self-assessment of nursing clinical skills for employee B. Employee B's personnel file failed to evidence documentation of orientation to skilled nurse visits, failed to evidence documentation of: establishment of registered nurse competency for clinical skills; orientation to the agency's standards of documentation; orientation to supervision of staff; orientation to agency procedures to include on call responsibilities to patients, all duties of the alternate nursing	G 0134	n/a	08/11/2017

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	supervisor. B. The personnel file failed to evidence documentation employee B had been provided an orientation to the skills required to perform the duties of the alternate administrator. 3. Review of a job description "Alternate Administrator" evidenced employee B's signature dated 1-18-17. The job description stated, "Alternate Administrator will act as Administrator in the absence of the Administrator." 4. Review of a job description "Assistant Director of Nursing" evidenced it was signed and dated by employee B on 9-6-16, and stated, "Assistant Director of Nursing will act as director of nursing in the absence the director of nursing." 5. Employee B was interviewed by phone on 5-17-17 at 1:10 PM, regarding her orientation to the role of alternate administrator and alternate nursing supervisor, stated "I would be back up to (employee A). I am learning process, home health system is new to me... I have reviewed process paperwork... as we grow I would go out to do home visits... I could do med set up and blood pressure control and take orders... I would follow through...I would be on call if needed... I			

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	would handle complaints, issues with physical therapy or home health aide, on boarding, hiring and training... I guess I would be on call for (employee A) ... Right now I am trying to understand process for referral...." When asked about the 7 current cases in agency, Employee B reported ... I know there is a person that needed physical therapy, a young lady needed additional testing under anesthesia for rectal abscess ... (patient 8) has seizures ... 2 people need RN to set up meds (sic medications) and BP (blood pressure)" ...Asked if employee B had nursing experience in home health, replied " I have not been a Home Health Nurse." Denied having gone on any home visits during orientation. Did a self- assessment check list. Denied having been present for any committee meetings. Denied having current physical if required to immediately assume the role of nursing supervisor. 6. The administrator/nursing supervisor, employee A, was interviewed on 5-18-17 at 2 PM and stated, "We need to set up TB test and health exam for (employee B) to be ready... (employee B) needs to be mandated to go with me on visits... has not made any home visits ...we had discussion and (employee B) said " it's not my favorite thing to do (home visits)"			

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	... nursing is nursing... We haven't been assertive enough to have (employee B) come in and do it... if needed we could probably talk through things." Regarding current patient case conference communication with employee B, employee A stated "we talk... my patient load hasn't changed a bunch, (employee B) he knows what I do in a visit." Employee A denied there was any documentation of case conference with Employee B.			
G 0141 Bldg. 00	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. Based on record review and interview, the agency failed to ensure the alternate administrator, employee B, was oriented to the position and was ready to respond	G 0141	n/a	08/15/2017

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	to an emergencies, provide guidance to staff, answer questions, and resolve issues within a reasonable amount of time for 1 of 1 alternate administrator, and failed to ensure the alternate nursing supervisor, employee B, was oriented to the position and prepared to assume the duties of nursing supervisor if required, for 1 of 1 alternate nursing supervisor. The findings included: 1. Review of a job description "Alternate Administrator" evidenced employee B's signature dated 1-18-17. The job description stated, "Alternate Administrator will act as Administrator in the absence of the Administrator." 2. Review of a job description "Assistant Director of Nursing" evidenced it was signed and dated by employee B on 9-6-16, and stated, "Assistant Director of Nursing will act as director of nursing in the absence the director of nursing." 3. The personnel file of employee B, the alternate administrator and alternate nursing supervisor, date of hire 1-18-17, and no first patient contact was reviewed on 5-17-17. A self-assessment of skills was in the file. The personnel file failed to evidence documentation of orientation to skilled nurse visits in the home, failed			

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	to evidence documentation of home skilled nursing visit establishment of competency, and failed to evidence orientation for the alternate administrator position. 4. Employee B was interviewed by phone on 5-17-17 at 1:10 PM, regarding her orientation to the role of alternate administrator and alternate nursing supervisor, stated "I would be back up to (employee A). I am learning process, home health system is new to me... I have reviewed process paperwork... as we grow I would go out to do home visits... I could do med set up and blood pressure control and take orders... I would follow through...I would be on call if needed... I would handle complaints, issues with physical therapy or home health aide, on boarding, hiring and training... I guess I would be on call for (employee A) ... Right now I am trying to understand process for referral...." When asked about the 7 current cases in agency, Employee B reported ... I know there is a person that needed physical therapy, a young lady needed additional testing under anesthesia for rectal abscess ... (patient 8) has seizures ... 2 people need RN to set up meds (sic medications) and BP (blood pressure)" ...Asked if employee B had nursing experience in home health, replied " I have not been a			

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	Home Health Nurse." Denied having gone on any home visits during orientation. Did a self- assessment check list. Denied having been present for any committee meetings. Denied having current physical if required to immediately assume the role of nursing supervisor. 5. The administrator/nursing supervisor, employee A, was interviewed on 5-18-17 at 2 PM and stated, "We need to set up TB test and health exam for (employee B) to be ready... (employee B) needs to be mandated to go with me on visits... has not made any home visits ...we had discussion and (employee B) said " it's not my favorite thing to do (home visits)" ... nursing is nursing... We haven't been assertive enough to have (employee B) come in and do it... if needed we could probably talk through things." Regarding current patient case conference communication with employee B, employee A stated "we talk... my patient load hasn't changed a bunch, (employee B) he knows what I do in a visit." Employee A denied there was any documentation of case conference with Employee B.			

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G 0143 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on record review and interview, the agency failed to ensure all personnel coordinated care for 2 of 10 patients (Patient #3 and 5). The findings included: 1. A policy titled, "Advanced Directives", which evidenced an effective date of 9-6-16, was reviewed on 5-18-17 at 9:30 AM, and stated, "Purpose ... Advanced Directives. Refer to a written statement ... about how individual wants medical decisions made ... care will be provided in accordance with the advance directives pending orders from patients physician ... Agency will provide staff [sic education] on issues concerning Advance Directives ... Procedure: ... If a patient has advance directives which include - not to be resuscitated, then a	G 0143	n/a	08/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADMIRAL HOME HEALTH	5730 DR MLK BLVD ANDERSON, IN 46013

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	written and signed order for DNR (do not resuscitate), DNI (do not intubate), AND, (allow natural death) ... must be obtained from the physician and placed in the patient's clinical record prior to being honored by the agency ... Order is added to the admission 485 [plan of care] ... The original authorization/consent DNR/DNI/AND will be posted in a visible location in the patient's home as per patient/caregiver request, and a copy of the physician's order maintained in the patient's in-home chart/folder. Copies are placed in the patient's clinical record and a copy sent to the physician. On call book will reflect patient ... status. Appropriate staff will be made aware of the request by means of patient care conferences, care plans, flagging of medical records, a copy of DNR/DNI/AND order in the on-call book, or by verbal and written communication." 2. During home visit of a home health aide (HHA), employee F, for patient #3, on 5-16-17 at 11 AM, the HHA stated prior to entering patient #3's home, the patient was a DNR (do not resuscitate). Observation of patient #3's home failed to evidence the DNR order was posted as required by agency policy. A. Review of the clinical record of			

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	patient #3 on 5-16-17, evidenced a start of care date of 3-23-17, and contained plan of care for the certification period 3-23-17 to 5-21-17, signed by the physician on 4-12-17, with order "Pt [patient] is a DNR (do not resuscitate)." B. Review of the on call log failed to evidence documentation of patient #3's DNR status. 3. Review of the clinical record of patient #5 on 5-15-17, evidenced a referral document dated 3-13-17, to include documentation "Diagnosis: fibromyalgia, arthritis, hypertension, weakness, fallen 11 X [times] in 3 weeks," and was signed by the nursing supervisor (employee A). The document evidenced patient #5's falls had started the week of 2-19-17, one week after a doctor visit on 2-14-17, when the doctor changed patient #5's medications; Buspirone 10 mg, 1 tablet by mouth, 3 times a day (anti-depressant), was added; Cholecalciferol (Vitamin D) 1,000 units, 1 capsule by mouth daily, was added; and Hyzaar was increased from 110/12.5 mg, to 100/25mg, 1 tablet by mouth daily (to lower blood pressure). Known side effects of Buspirone and Hyzaar are dizziness or lightheadedness. A. Review of a document dated 2-14			

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	-17, titled "office visit" evidenced documentation by patient # 5's physician "anxiety is bad, daughter with breast cancer, not sleeping well ... plan: increase losartan-HCTZ (a blood pressure and diuretic), try buspar for anxiety (an antidepressant), discontinue furosemide (a diuretic), discontinue tramadol (a pain medication)." B. Review of a comprehensive adult nursing assessment dated 3-15-17, completed by the nursing supervisor, evidenced the care coordination boxes were checked for physician and aide. C. Review of patient #5's plan of care evidenced a start of care date of 3-15 -17, and a certification period of 3-15-17 to 5-13-17, with order for "Home health aide (HHA) 2 hours per day, 2 times a week, for ADLs (activities of daily living) and light housekeeping. Registered nurse (RN) to do supervisory visit 1 time a month." The established goals included "patient will be free from falls or falls will decrease." D. During an interview with the nursing supervisor, who admitted patient #5, and the home health aide (employee G), on 5-17-17 at 3:55 PM, the nursing supervisor stated not having considered providing skilled nursing services for			

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	patient #5 to assess the development of frequent falls 1 week after prescribed medication changes (2-14-17), and not having considered a physical therapy referral to address possible gait improvement and safe transfers. Employee G, the HHA stated having met a home health care provider from an outside provider, who told employee G, patient #5 received skilled nursing and physical therapy services from the outside agency. Employee G could not recall the name of the other agency, and stated not having reported this information to the nursing supervisor. The nursing supervisor reported the agency admitted the patient for home health aide services only, and there there had been no coordination of care with the outside agency. The HHA failed to coordinate care with the supervising RN related to knowledge of an outside provider of skilled nursing and physical therapy services for patient #5. E. On 5-18-17 at 9:30 AM, during telephone interview, patient #5 stated the name of the outside provider and verified the services provided by the agency were skilled nursing and physical therapy. 4. On 5-18-17 at 3:00 PM, the administrator/nursing supervisor verified			

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	the above findings and stated not having any further documentation to present for review.			
G 0144 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on home visit observation, record review, and interview, the agency failed to implement its advance directive policy to coordinate care for 1 of 1 patients with an advance directive (Patient #3), and failed to document coordination of care activities for 2 of 10 patients (Patient #3 and 5). The findings included: 1. A policy titled, "Advanced Directives", which evidenced an effective date of 9-6-16, was reviewed on 5-18-17 at 9:30 AM, and stated, "Purpose ... Advanced Directives. Refer to a written statement ... about how individual wants	G 0144	n/a	08/02/2017

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	medical decisions made ... care will be provided in accordance with the advance directives pending orders from patients physician ... Agency will provide staff [sic education] on issues concerning Advance Directives ... Procedure: ... If a patient has advance directives which include - not to be resuscitated, then a written and signed order for DNR (do not resuscitate), DNI (do not intubate), AND, (allow natural death) ... must be obtained from the physician and placed in the patient's clinical record prior to being honored by the agency ... Order is added to the admission 485 [plan of care] ... The original authorization/consent DNR/DNI/AND will be posted in a visible location in the patient's home as per patient/caregiver request, and a copy of the physician's order maintained in the patient's in-home chart/folder. Copies are placed in the patient's clinical record and a copy sent to the physician. On call book will reflect patient ... status. Appropriate staff will be made aware of the request by means of patient care conferences, care plans, flagging of medical records, a copy of DNR/DNI/AND order in the on-call book, or by verbal and written communication." 2. During home visit of a home health aide (HHA), employee F, for patient #3,			

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	on 5-16-17 at 11 AM, the HHA stated prior to entering patient #3's home, the patient was a DNR (do not resuscitate). Observation of patient #3's home failed to evidence the DNR order was posted as required by agency policy. A. Review of the clinical record of patient #3 on 5-16-17, evidenced a start of care date of 3-23-17, and contained plan of care for the certification period 3-23-17 to 5-21-17, signed by the physician on 4-12-17, with order "Pt [patient] is a DNR (do not resuscitate)." B. Review of the on call log failed to evidence documentation of patient #3's DNR status. 3. Review of the clinical record of patient #5 on 5-15-17, evidenced a referral document dated 3-13-17, to include documentation "Diagnosis: fibromyalgia, arthritis, hypertension, weakness, fallen 11 X [times] in 3 weeks," and was signed by the nursing supervisor (employee A). The document evidenced patient #5's falls had started the week of 2-19-17, one week after a doctor visit on 2-14-17, when the doctor changed patient #5's medications; Buspirone 10 mg, 1 tablet by mouth, 3 times a day (anti-depressant), was added; Cholecalciferol (Vitamin D) 1,000 units,			

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	1 capsule by mouth daily, was added; and Hyzaar was increased from 110/12.5 mg, to 100/25mg, 1 tablet by mouth daily (to lower blood pressure). Known side effects of Buspirone and Hyzaar are dizziness or lightheadedness. A. Review of a document dated 2-14 -17, titled "office visit" evidenced documentation by patient # 5's physician "anxiety is bad, daughter with breast cancer, not sleeping well ... plan: increase losartan-HCTZ (a blood pressure and diuretic), try buspar for anxiety (an antidepressant), discontinue furosemide (a diuretic), discontinue tramadol (a pain medication)." B. Review of a comprehensive adult nursing assessment dated 3-15-17, completed by the nursing supervisor, evidenced the care coordination boxes were checked for physician and aide. C. Review of patient #5's plan of care evidenced a start of care date of 3-15 -17, and a certification period of 3-15-17 to 5-13-17, with order for "Home health aide (HHA) 2 hours per day, 2 times a week, for ADLs (activities of daily living) and light housekeeping. Registered nurse (RN) to do supervisory visit 1 time a month." The established goals included "patient will be free from			

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	falls or falls will decrease." D. During an interview with the nursing supervisor, who admitted patient #5, and the home health aide (employee F), on 5-17-17 at 3:55 PM, the nursing supervisor stated not having considered providing skilled nursing services for patient #5 to assess the development of frequent falls 1 week after prescribed medication changes (2-14-17), and not having considered a physical therapy referral to address possible gait improvement and safe transfers. Employee F, the HHA stated having met a home health care provider from an outside provider, who told employee F, patient #5 received skilled nursing and physical therapy services from the outside agency. Employee F could not recall the name of the other agency, and stated not having reported this information to the nursing supervisor. The nursing supervisor reported the agency admitted the patient for home health aide services only, and there there had been no coordination of care with the outside agency. The HHA failed to coordinate care with the supervising RN related to knowledge of an outside provider of skilled nursing and physical therapy services for patient #5. E. On 5-18-17 at 9:30 AM, during			

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	telephone interview, patient #5 stated the name of the outside provider and verified the services provided by the agency were skilled nursing and physical therapy. 4. On 5-18-17 at 3:00 PM, the administrator/nursing supervisor verified the above findings and stated not having any further documentation to present for review.			
G 0151 Bldg. 00	484.16 GROUP OF PROFESSIONAL PERSONNEL Based on record review and interview, the agency failed to maintain compliance with this Condition of Participation. The agency failed to ensure a group of professional personnel was appointed (G 152); failed to ensure a group of professional personnel was appointed to establish the agency's policies (G 153);	G 0151	n/a	08/04/2017

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	and failed to ensure a group of professional personnel was appointed to advise the agency on professional issues (See G 154). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the Condition of Participation, 42 CFR 484.16, Group of Professional Personnel.			
G 0152 Bldg. 00	484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines. Based on record review and interview, the agency failed to ensure a group of professional personnel was appointed for 1 of 1 home health agency. The findings included: 1. On 5-17-17 at 1:17 PM, the meeting minutes of the governing body dated 4-19-17, 4-5-17, 12-14-16, 12-6-16, 11-20-16, 9-6-16, 8-30-16, 8-25-16,	G 0152	n/a	08/16/2017

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	8-24-16, 8-21-16, 8-18-16, 8-1-16, 7-29-16, and 6-16-16, were reviewed and failed to evidence the governing body had appointed a group of professional personnel to establish the agency's policies. 2. On 5-17-17 at 10:47 AM, the administrator stated the agency did not have a group of professional personnel.			
G 0153 Bldg. 00	484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. Based on record review and interview, the agency failed to ensure a group of professional personnel was appointed to establish the agency's policies for 1 of 1 home health agency.	G 0153	n/a	08/15/2017

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	The findings included: 1. On 5-17-17 at 1:17 PM, the meeting minutes of the governing body dated 4-19-17, 4-5-17, 12-14-16, 12-6-16, 11-20-16, 9-6-16, 8-30-16, 8-25-16, 8-24-16, 8-21-16, 8-18-16, 8-1-16, 7-29-16, and 6-16-16, were reviewed and failed to evidence the governing body had appointed a group of professional personnel to establish the agency's policies. 2. On 5-17-17 at 10:47 AM, the administrator stated the agency did not have a group of professional personnel.			
G 0154 Bldg. 00	484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the			

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	evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. Based on record review and interview, the agency failed to ensure a group of professional personnel was appointed to advise the agency on professional issues for 1 of 1 home health agency. The findings included: 1. On 5-17-17 at 1:17 PM, the meeting minutes of the governing body dated 4-19-17, 4-5-17, 12-14-16, 12-6-16, 11-20-16, 9-6-16, 8-30-16, 8-25-16, 8-24-16, 8-21-16, 8-18-16, 8-1-16, 7-29-16, and 6-16-16, were reviewed and failed to evidence the governing body had appointed a group of professional personnel to establish the agency's policies. 2. On 5-17-17 at 10:47 AM, the administrator stated the agency did not have a group of professional personnel.	G 0154	n/a	08/09/2017
G 0156	484.18 ACCEPTANCE OF PATIENTS, POC, MED			

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Bldg. 00	SUPER Based on record review and interview, the agency failed to maintain compliance with this condition of participation. The agency failed to ensure visits were made in accordance with plan of care orders for 1 of 10 patients (Patient #1)(See G 158); failed to ensure the plan of care included all durable medical equipment, nutritional requirement, complete medication order,safety measures, and a discharge plan for of 10 patients (Patients #1-10), and failed to ensure the plan of care start of care date and certification periods were correct for 4 of 10 patient's whose clinical record was reviewed (Patients # 1, 3, 5 and 9)(See G 159); failed to alert the physician the patient had attained the established goals, which suggested a need to alter the medical plan of care to include discharge, for 1 of 10 patients whose clinical record was reviewed (Patient #10)(See G 164); and failed to ensure the registered nurse requested a verbal order for disciplines, frequencies, and care orders at the start of care for 9 of 10 patients (Patient #1, 2, 3, 4, 5, 6, 7, 8, and 10) and failed to ensure the registered nurse requested a verbal order to continue agency services to include disciplines, frequencies, and care orders for 2 of 2 patients on service more than 60 days (Patients #1 and 10)(See G	G 0156	n/a	08/03/2017

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	166). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the Condition of Participation, 42 CFR 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision.			

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		A. BUILDING 00 B. WING	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADMIRAL HOME HEALTH	5730 DR MLK BLVD ANDERSON, IN 46013

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G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on record review and interview, the agency failed to ensure visits were made in accordance with plan of care orders for 1 of 10 patients (Patient #1). The findings included: 1. Review of the clinical record of patient #1, evidenced a start of care of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17, with orders for physical therapy services 2 times a week for 4 weeks. Review of physical therapy visit notes evidenced 1 visit was made the week of 3-26 to 4-1-17, on 3-31-17. The visit notes failed to evidence 2 physical therapy visits were made as ordered. 2. On 5-18-17 at 3 PM, the administrator confirmed the above finding and stated there was no further documentation to present to be reviewed.	G 0158	n/a	08/11/2017

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G 0159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on observation, record review, and interview, the agency failed to ensure the plan of care included all durable medical equipment, nutritional requirement, complete medication order,safety measures, and a discharge plan for of 10 patients (Patients #1-10), and failed to ensure the plan of care start of care date and certification periods were correct for 4 of 10 patient's whose clinical record was reviewed (Patients # 1, 3, 5 and 9). The findings included: 1. Review of the clinical record of patient #1, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15-17 to	G 0159	none	08/29/2017

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	5-13-17. A. Review of nutritional requirement evidenced "none", durable medical equipment and supplies evidenced "walker", Medications: Dose/Frequency/Route, evidenced "Tobramycin (an antibiotic) 300 mg/4 ml every 12 hours P.O. (by mouth)." Safety Measure evidenced "Universal precautions"' Goals/rehabilitation Potential /Discharge Plans evidenced "independence in transfers and is steady on feet without use of furniture. Independence with all ADL's (activity of daily living), personal care, transfers and light housekeeping. Independence with walking on a walker if that is what she needs. Remain free from falls, injuries and hospitalization." B. During home visit observation of a home health aide (HHA) on 5-17-17, at 2 PM, patient #1 stated the Tobramyacin was administered by nebulizer, not by mouth. A cane, a nebulizer, an oxygen concentrator, oxygen tubing and cannula, were observed in the home. C. Review of the plan of care failed to evidence the cane, nebulizer, oxygen concentrator, oxygen tubing and cannula, failed to evidence fall precautions and oxygen safety as safety measures, failed			

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	to evidence a diet order, and failed to evidence a discharge plan. 2. Review of the clinical record of patient# 2, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15-17 to 5-13-17. Diagnoses included of Thrombocytopenia (a disease that alters the clotting factor of the blood and increases the risk of bleeding). A. Review of plan of care medications evidenced "Hydrochlorthiazide, Metroprolol, Lisinipril, Rantidine, Citralopram, Clonidine and Vitamin D3." Established goals included "Patient will be free from hospitalizations and falls with injury. Patient will be able to set up all medications on own and will have reminders/cues established in the home. Patient will have understanding of importance of medications and the need to not miss any doses." B. During home visit observation of a registered nurse (RN) on 5-16-17 at 11 AM, patient #2 stated taking the following medications not evidenced on the plan of care "B.C. packets (845 mg of Aspirin and 65 mg of caffeine) for pain, (aspirin is an anti-platelet medication and decreases the clotting of the blood,			

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	caffeine can increase blood pressure), bio freeze (a topical pain medication) for joint pain, and polyethylene glycol (a fiber medication) for constipation." C. The nursing supervisor stated on 5 -18-17 at 3 PM, having failed to document all the medications for patient #2 on the plan of care. 3. Review of the clinical record of patient #3, evidenced a start of care date of 3-23-17, and contained a plan of care for the certification period of 3-23-17 to 5-23-17. A. Review of durable medical equipment evidenced "walker, cane, motorized wheel chair." B. During home visit observation of a HHA, on 5-16-17 at 11 AM, patient #3 was observed to have a "medical guardian", a safety/emergency call button. C. Review of the plan of care failed to evidence the medical guardian as durable medical equipment. 4. Review of the clinical record of patient #4, evidenced a start of care date of 2-15-17, and contained a plan of care for the certification period of 2-15-17 to			

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	4-15-17. A. Review of the nutritional requirements evidenced "none," established goals included "shortness of breath resolution is the goal and that the client is using the CPAP (continuous positive airway pressure) machine correctly. Client will have no adverse effects. Client will remain free from falls and hospitalizations and injuries. Client will be able to return to her own home independently." B. Review of the plan of care failed to evidence the CPAP machine as durable medical equipment, failed to evidence an ordered diet, and failed to evidence a discharge plan. 5. The clinical record of patient # 5 was reviewed, and evidenced a start 3-15-17, and a plan of care for the certification period of 3-15-17 to 5-13-17. Review of the plan of care Goals/Rehabilitation potential/discharge plans evidenced "Patient will be free from falls or falls will decrease. Patient will not have any hospitalization or injuries. ADLs and IADLs will be met." The plan of care failed to evidence a discharge plan for patient #5. 6. The clinical record of patient #6			

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	medical plan of care was reviewed, evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 2-17-17 to 4-17-17. The patient had diagnosis of Type 2 diabetes mellitus and was insulin dependent. A. The plan of care evidenced durable medical equipment (DME) of "none". The nutritional requirement section evidenced "none". B. Review of a comprehensive adult nursing assessment, dated 2-17-17, evidenced patient #6 required "Diabetes and Diabetic diet." The form evidenced " Lantus 30 units ... blood sugar monitored ... by self...TID (3 times daily) ... and competency with use of glucometer." C. The plan of care failed to evidence a diet order, and DME of a glucometer, needles, and diabetic testing supplies. D. Review of the Goals/Rehabilitation potential /discharge plans evidenced "Goal is that patient will take medications as ordered and have an understanding why she is on each medication. Client will have no adverse effects. Patient will be free from			

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	hospitalization". The plan of care failed to evidence a discharge plan for patient #6 7. The clinical record of patient #7, was reviewed and evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 4-18-17 to 6-16-17. A. DME on the plan of care evidenced "none". B. The Goals /Rehabilitation potential /discharge plans evidenced "Patient will remain compliant with medications as ordered by MD and remain free from adverse effects. Patient will remain free from injuries and hospitalizations." C. The plan of care failed to evidence DME of a glucometer, needles, and diabetic testing supplies and failed to evidence a discharge plan. 8. The clinical record of patient #8, was reviewed and evidenced a start of care of 4-11-17, and contained a plan of care for the certification period of 4-11-17 to 6-9-17. The patient had a diagnosis of obstructive sleep apnea. The order section of the plan of care evidenced "Pt just received CPAP machine and requires teaching and care of machine."			

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	A. Review of the plan of care DME evidenced "none". B. Review of the Goals /Rehabilitation potential /discharge plans evidenced "Goal is that patient will be confident in use of CPAP, BP will continue to be controlled, pain will be better controlled and more comfortable. Will notify MD as needed. Will remain free of injury and have no hospitalizations." C. The plan of care evidenced for nutritional requirements "none". D. The plan of care failed to evidence patient #8's diet, DME and supplies of glucometer, needles, diabetic testing supplies, and failed to evidence a discharge plan. 9. Review of the clinical record of patient # 9 evidenced a start of care date of 4-12-17, and contained a plan of care for the certification period of 4-12-17 to 6-10-17. A. Review of the nutritional requirements evidenced "none". B. Review of the comprehensive nursing assessment dated 4-12-17,			

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	evidenced the Nutritional requirement "regular" as patient #9's diet. C. Review of the Goals /Rehabilitation potential /discharge plans evidenced "Will be compliant with ADL oversight and be odor free daily. Will be free from injury and no falls and no hospitalizations. Will be free of seizures and comply with medication reminders." D. The plan of care failed to evidence a diet order and failed to evidence a discharge plan. 10. Review of the clinical record of patient #10 evidenced a start of care date of 3-4-17, and contained a plan of care for the certification period of 3-4-17 to 5-2-17, and a plan of care for the certification period of 5-3-17 to 7-3-17. A. Review of DME evidenced "none." B. Review of a comprehensive adult nursing assessment dated 3-4-17, evidenced "Diabetes ... type 2, diabetic diet ... injectable medication, Lantus ... Humalog ... monitored by self ... bid." The plan of care failed to evidence patient #10's glucometer, diabetic test strips, and needles as DME and supplies.			

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	C. Review of the Goals /Rehabilitation potential /discharge plans evidenced "Goal is that pt. [patient] will take all medication on time and as ordered and have an understanding why she is on each medication. Pt [patient] will have no adverse reaction. Pt [patient] will be free from hospitalization." D. The plan of care failed to evidence a discharge plan for patient #10. 11. Review of the clinical record of patient #1 evidenced a start of care date of 3-15-17, and a certification period of 3-15 to 5-13-17. The start of care comprehensive assessment was dated 3-15-17. The first billable visit, which defines the start of care, was by a home health aide on 3-22-17. The comprehensive assessment was performed 7 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 12. Review of the clinical record of patient #3 evidenced a start of care date of 3-23-17, and a certification period of 3-23 to 5-21-17. The start of care comprehensive assessment was dated 3-23-17. The first billable visit, which defines the start of care, was by a home health aide on 3-24-17. The			

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	comprehensive assessment was performed 1 day prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 13. Review of the clinical record of patient #5 evidenced a start of care date of 3-15-17, and a certification period of 3-15 to 5-13-17. The start of care comprehensive assessment was dated 3-15-17. The first billable visit, which defines the start of care, was by a home health aide on 3-17-17. The comprehensive assessment was performed 2 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 14. Review of the clinical record of patient #9 evidenced a start of care date of 4-12-17, and a certification period of 4-12 to 6-10-17. The start of care comprehensive assessment was dated 4-12-17. The first billable visit, which defines the start of care, was by a home health aide on 4-18-17. The comprehensive assessment was performed 6 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care.			

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	15. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above findings and stated there was no further documentation to present to be reviewed.			
G 0164 Bldg. 00	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on observation, record review, and interview, the agency failed to alert the physician the patient had attained the established goals, which suggested a need to alter the medical plan of care to include discharge, for 1 of 10 patients whose clinical record was reviewed (Patient #10). The findings included: 1. Review of the clinical record of patient # 10, evidenced a start of care date of 3-4-17, and contained a first certification period of 3-4-17 to 5-2-17, with order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with DM (diabetes mellitus)	G 0164	none	09/04/2017

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	and follow B/P (blood pressure) readings and notify MD PRN (as needed) and med (medication) set up." Review of a plan of care for the second recertification period of 5-3-17 to 7-1-17, signed by the physician on 5-8-17, evidenced an order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with DM (diabetes mellitus) and follow B/P (blood pressure) readings and notify MD PRN (as needed)." 2. Review of skilled nurse visit note dated 4-19-17, evidenced "Medication set up by patient with skilled nurse oversight. No errors made ... Blood pressure is well controlled ... Continues to use calendar for reminders ... continues to be complaint with DM (diabetes mellitus)." 3. Review of communication notes and physician orders failed to evidence documentation the agency had notified the physician patient #10 had met established goals during the 1st certification period on 4-19-17, no skilled service was being furnished the 2nd certification period, and discharge was appropriate prior to recertification. 4. An interview with the nursing supervisor was conducted on 5-18-17 at			

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	1:30 PM. The administrator stated patient #10 "does well with insulin, I could probably discharge [patient #10]." The nursing supervisor stated there was no skilled service being provided during the 2nd recertification period, as the patient had demonstrated competency with insulin administration and met other goals by the end of the 1st certification period. The nursing supervisor stated, " I need to talk to (employee G), the office manager to decide on discharging."			
G 0166 Bldg. 00	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on record review and interview, the agency failed to ensure the registered nurse requested a verbal order for disciplines, frequencies, and care orders at the start of care for 9 of 10 patients (Patient #1, 2, 3, 4, 5, 6, 7, 8, and 10) and	G 0166	none	09/04/2017

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	failed to ensure the registered nurse requested a verbal order to continue agency services to include disciplines, frequencies, and care orders for 2 of 2 patients on service more than 60 days (Patients #1 and 10). The findings included: 1. Review of a policy, "Physician Orders,", date of board approval documented as 9-6-17, stated, " Agency and staff Wilf [sic Will] administer services and treatments only as ordered by the physician." 2. Review of the physician's orders in the clinical record of patient #1 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-9, 3-16, and 3-22-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 4-3-17.			

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		A. BUILDING 00 B. WING	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADMIRAL HOME HEALTH	5730 DR MLK BLVD ANDERSON, IN 46013

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	C. Review of physician's order about the time of recertification on 5-1-17, failed to evidence a physician's order to continue care. As of 5-18-17, the physician had not signed the plan of care. A home health aide furnished care on 5-17-17. 3. Review of the physician's orders in the clinical record of patient #2 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-22, 3-29, and 3-22-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up. Review of visit notes evidenced the home health aide (HHA) had furnished assistance with ADLs (activities of daily living) and IADLs (instrumental activities of daily living) during care visits on 3-17, 3-19, 3-23, 3-27, and 3-30-17. B. The plan of care evidenced signature of the attending physician dated 4-3-17.			

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	4. Review of the physician's orders in the clinical record of patient #3 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced the HHA had furnished assistance with ADLs and IADLS during care visits on 3-24, 3-27, 3-29, 3-31, 4-3, 4-5, 4-7, 4-9, and 4-11-17. B. The plan of care evidenced signature of the attending physician dated 4-12-17. 5. Review of the physician's orders in the clinical record of patient #4 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 2-20 and 2-27-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had assessed vital signs, and instructed the patient on the use of CPAP machine (continuous positive airway pressure) during visits.			

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	B. The plan of care evidenced signature of the attending physician dated 2-28-17. 6. Review of the physician's orders in the clinical record of patient #5 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits for assistance with ADLs and IADLs were furnished by the HHA on 3-17 and 3-22-17. B. The plan of care evidenced signature of the attending physician dated 3-29-17. 7. Review of the physician's orders in the clinical record of patient #6 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 2-21, 2-28, and 3-7-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up.			

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	B. The plan of care evidenced signature of the attending physician dated 3-9-17. 8. Review of the physician's orders in the clinical record of patient #7 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 2-20, 2-23, and 2-27-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 2-28-17. 9. Review of the physician's orders in the clinical record of patient #8 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-11-17, prior to obtaining physician authorization for care. Visit notes			

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	evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 4-13-17. 10. Review of the physician's orders in the clinical record of patient #10 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-9, 3-16, and 3-22-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 4-3-17. C. Review of physician's order about the time of recertification on 5-2-17, failed to evidence a physician's order to continue care. The physician signed the plan of care orders on 5-8-17. D. Review of visit notes evidenced a			

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	registered nurse visit note dated 5-3-17, when the RN monitored patient #10 compliance with diabetes mellitus diet and medication and took vital signs. 12. On 5-18-17 at 3 PM, the nursing supervisor verified the above findings and stated the agency practice did not include calling the physician prior to furnishing services to obtain a verbal order for disciplines, frequencies, and care orders. The nursing supervisor stated the first signed order for care for patients 1, 2, 3, 4, 5, 6, 7, 8, and 10 occurred upon return of a signed plan of care, up to 30 days after the agency had begun providing care. The nursing services stated the agency practice did not include obtaining a verbal order to continue services prior to the expiration of the previous certification period. The nursing supervisor stated there was no further documentation to present to be reviewed.			
G 0168 Bldg. 00	484.30 SKILLED NURSING SERVICES			

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	Based on record review and interview, the agency failed to maintain compliance with this condition of participation. The agency failed to ensure the registered nurse (RN) case manager initiated necessary revisions to the plan of care for 10 of 10 patients (See G 173); the agency failed to ensure the registered nurse implemented oxygen precautions for 1 of 2 patients with oxygen therapy (Patient #1), and failed to ensure the registered nurse implemented nursing interventions to monitor the weight of a patient with the diagnosis of weight loss for 1 of 1 patient with a diagnosis of weight loss (Patient #2)(See G 175); and failed to ensure the registered nurse implemented agency policy to color code mark the clinical record of patient's at risk for a fall for 2 of 2 patients at risk for falls (Patients #3 and 5)(See G 176). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the Condition of Participation, 42 CFR 484.30, Skilled Nursing Services.	G 0168	none	09/04/2017

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G 0173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on record review and interview, the agency failed to ensure the registered nurse (RN) case manager initiated necessary revisions to the plan of care for 10 of 10 patients (Patient #1-10). The findings included: 1. Review of the clinical record of patient #1, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17. A. Review of the plan of care narrative evidenced patient #1 used oxygen at night. The plan of care failed to evidence an oxygen order and the registered nurse failed to initiate revision to the plan of care to update to include an order for oxygen, rate, delivery method, and instructions for use. B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-22-17, which	G 0173	none	09/04/2017

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	defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-22-17, and the certification period to 3-22 to 5-20-17. C. Review of the plan of care evidenced a Nutritional Requirement of "None." The RN failed to initiate revision of the plan of care to document a nutritional requirement for patient #1. The plan of care goals/rehabilitation/discharge plans section failed to evidence any discharge plan for patient #1. The RN failed to initiate revision of the plan of care to document a discharge plan for patient #1. D. Review of the referral order, dated 3-13-17, for patient #1 was to "evaluate and treat." Patient #1 had not had an initial assessment or physician orders for care on 3-13-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 2. Review of the clinical record of patient #2, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17.			

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	A. Review of the plan of care narrative evidenced patient #2 had a diagnosis of weight loss. The RN failed to initiate revision to the plan of care to include monitoring of weight as an appropriate nursing order. B. Review of the referral order, dated 3-13-17, for patient #2 was to "evaluate and treat." Patient #2 had not had an initial assessment or physician orders for care on 3-13-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 3. Review of the clinical record of patient #3, evidenced a start of care date of 3-23-17, and contained a plan of care for the certification period of 3-23 to 5-21-17. A. During a home visit observation of a HHA on 5-17-17 at 11 AM, patient #3 was observed to have a "medical guardian" device. Patient #3 stated using the medical guardian device. B. Review of the plan of care narrative evidenced patient #3 had durable medical equipment of walker, can, and motorized wheel chair. The RN failed to initiate revision of the plan of			

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	care to document the durable medical equipment of a medical guardian. B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-24-17, which defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-24-17, and the certification period to 3-24 to 5-22-17. 4. Review of the clinical record of patient #4, evidenced a start of care date of 2-15-17, and contained a plan of care for the certification period of 2-15 to 4-15-17. A. Review of the plan of care failed to evidence a discharge plan for patient #4. The registered nurse failed to initiate revision to the plan of care to document a discharge plan. B. Review of the referral order, dated 2-13-17, for patient #4 was to "evaluate and treat." Patient #4 had not had an initial assessment or physician orders for care on 2-13-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services.			

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	5. Review of the clinical record of patient #5, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17. A. Review of the plan of care failed to evidence a discharge plan for patient #5. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-17-17, which defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-17-17, and the certification period to 3-17 to 5-15-17. C. Review of the referral order, dated 2-14-17, for patient #5 was to "evaluate and treat." Patient #6 had not had an initial assessment or physician orders for care on 2-14-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 6. Review of the clinical record of patient #6, evidenced a start of care date of 2-17-17, and contained a plan of care			

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	for the certification period of 2-17 to 4-17-17. A. Review of the plan of care failed to evidence a discharge plan for patient #6. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of the plan of care evidenced an order for Flonase nasal spray as needed (a medication to treat allergies). The medication order failed to evidence the strength of the spray ordered and how often the interval for the as needed medication was ordered. C. Review of the referral order, dated 3-13-17, for patient #1 was to "evaluate and treat." Patient #6 had not had an initial assessment or physician orders for care on 3-13-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 7. Review of the clinical record of patient #7, evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 2-17 to 4-17-17. A. Review of the plan of care failed			

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	to evidence a discharge plan for patient #7. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of the referral order, dated 2-15-17, for patient #7 was to "evaluate and treat." Patient #7 had not had an initial assessment or physician orders for care on 2-15-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 8. Review of the clinical record of patient #8, evidenced a start of care date of 4-11-17, and contained a plan of care for the certification period of 4-11 to 6-9-17. A. Review of the plan of care narrative evidenced patient #8 used a CPAP (continuous positive airway pressure) machine. The plan of care failed to evidence the CPAP machine as durable medical equipment and the registered nurse failed to initiate revision to the plan of care to update to include the CPAP as durable medical equipment. B. Review of the plan of care failed to evidence a discharge plan for patient #8. The RN failed to initiate revision to			

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	the plan of care to document a discharge plan. B. Review of the referral order, dated 4-10-17, for patient #8 was to "evaluate and treat." Patient #8 had not had an initial assessment or physician orders for care on 4-10-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 9. Review of the clinical record of patient #9, evidenced a start of care date of 4-12-17, and contained a plan of care for the certification period of 4-12 to 6-10-17. A. Review of the plan of care failed to evidence a nutritional requirement for patient #9, and the registered nurse failed to initiate revision to the plan of care to update to include an nutrition order. B. Review of the plan of care failed to evidence a discharge plan for patient #9. The RN failed to initiate revision to the plan of care to document a discharge plan. C. Review of the referral order, dated 4-11-17, for patient #9 was to "evaluate and treat." Patient #9 had not had an			

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	initial assessment or physician orders for care on 4-11-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 10. Review of the clinical record of patient #10, evidenced a start of care date of 3-4-17, and contained a plan of care for the certification period of 3-4 to 5-2-17. A. Review of the plan of care narrative evidenced patient #10 was diabetic and tested blood sugar at home. The RN failed to revise the plan of care to include patient #10's glucometer and testing strips as durable medical equipment and supplies. B. Review of the referral order, dated 3-2-17, for patient #10 was to "evaluate and treat." Patient #10 had not had an initial assessment or physician orders for care on 3-2-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 11. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above findings and stated there was			

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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) COMPLETION DATE
	no further documentation to present to be reviewed.			
G 0175 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on observation, record review, and interview, the agency failed to ensure the registered nurse (RN) implemented oxygen precautions for 1 of 2 patients with oxygen therapy (Patient #1), and failed to ensure the registered nurse implemented nursing interventions to monitor the weight of a patient with the diagnosis of weight loss for 1 of 1 patient with a diagnosis of weight loss (Patient #2), of a total sample of 10. The findings included: 1. During home visit observation of a home health aide for patient #1 on 5-17-17 at 2 PM, an oxygen concentrator was observed in the home. Patient #1 stated using it at night. Review of the plan of care failed to evidence the RN	G 0175	None	09/04/2017

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		A. BUILDING 00 B. WING	05/18/2017

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	had implemented oxygen precautions as a safety measure. 2. Review of the plan of care for patient #2 evidenced a diagnosis of weight loss. Review of the skilled nursing orders evidenced "Skilled Nursing 1 time a week for medication set up, B/P (blood pressure) monitoring at each visit." The RN failed to implement monitoring of weight as an appropriate nursing preventative and rehabilitative measure. 3. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above finding and stated there was no further documentation to present to be reviewed.			
G 0176 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on record review and interview, the agency failed to ensure the registered nurse implemented agency policy to color code mark the clinical record of patient's at risk for a fall for 2 of 2 patients at risk	G 0176	No responsse	08/21/2017

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	for falls (Patients #3 and 5), of a total sample of 10. The findings included: 1. Policy, "Patient Assessment Guidelines," with date of board approval of 9-6-17, stated, "It is the responsibility of of the patient's nurse or therapist to routinely assess the patient for the need for appropriate interventions related to fall prevention ... A color code is placed on the patient's chart and on the patient assignment board, if applicable. This will alert agency personnel that the patient is "At Risk." 2. Review of the clinical record of patient #3 failed to evidence any color code had been placed on the chart. 3. Review of the clinical record of patient #5 failed to evidence any color code had been placed on the chart. 4. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above findings and stated agency policy had not been implemented.			

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G 0224 Bldg. 00	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on record review and interview, the registered nurse failed to include a nutritional requirement on the prepared a home health aide care plan for 1 of 6 patients who received home health aide services (Patient #1) The findings included: 1. Review of the clinical record for patient #1, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17, with order for home health aide services. Review of the home health aide care plan, dated 3-15-17, and updated on 5-11-17, failed to evidence a nutritional requirement (diet order). 2. On 5-18-17 at 3:00 PM, the nursing supervisor verified the above finding and stated there was no further documentation to present for review.	G 0224	No response	08/21/2017

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G 0250 Bldg. 00	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. Based on record review and interview, the agency failed to ensure the clinical record review was performed by personnel representing the scope of agency services, and failed to ensure clinical record audits identified failure to follow agency policies and to meet home health agency regulations for 2 of 2 patients' clinical record audits reviewed (Patient #1 and 6), of a total sample of 10. The findings included: 1. A policy "Performance Improvement Plan" was reviewed on 5-17-17 at 9:30 AM. The policy stated, "Admiral Home Health collects data and monitors performance in at least the following areas ... Quality Improvement Data Indicators ... risk management/occurrences(effectiveness of fall reduction program and overall occurrences rate) ... customer complaints ... patient satisfaction ... infection control	G 0250	No response	09/04/2017

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	surveillance and reporting ... quality control ... potentially avoidable event investigation ... home health compare ... medical record review ... clinical records are systematically reviewed on a quarterly basis... a group of health professionals representative of the scope of care and services provided by the agency review a sample of both active and closed records." 2. A chart audit was documented on 4-18-17, for patient #1. Review of clinical record # 1 evidenced patient #1 had received physical therapy and home health aide services. The chart audit was conducted by (employee # G), the office manager/ home health aide. The documents were signed, but not dated, by the administrator/nursing supervisor (employee A). The chart audit of patient #1's clinical record, lines 56-73, were specific to physical therapy services. There was no documentation of the physical therapist's participation in the chart audit. Review of the chart audit failed to evidence the audit had identified agency failure to coordinate care, failure to perform an initial assessment, failure to obtain a physician's verbal start of care order prior to furnishing services, failure to document a complete and accurate comprehensive assessment as required by agency policy, failure to identify a diet			

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	order on the plan of care, as required by agency policy, failure to identify the patient's diet on the home health aide care plan, and failure to identify physical therapy visits were not provided per plan of care frequency order, as required by agency policy. 3. A chart audit was documented on 4-19-17, for patient #6. Review of patient #6's clinical record evidenced patient #6 had received skilled nursing services only. The chart audit was conducted by (employee # G), the office manager/ home health aide. The documents were signed, but not dated, by the administrator/nursing supervisor (employee A). The chart audit of patient #6's clinical record failed to evidence the participation of a registered nurse in the chart audit, and failed to evidence the chart audit identified failure to document a complete medication order on the plan of care, as required by agency policy, failure to perform an initial assessment, and failure to obtain a physician's verbal order prior to furnishing services. 4. The administrator was interviewed on 5-18-17 at 2:56 PM and stated having signed the chart audits after reviewing them, but not documenting the date of review. The administrator/nursing supervisor could not explain the failure			

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	of the agency's chart audits to identify deficiencies, and stated not being aware the office manager/home health aide could not perform all the agency's chart audits.			
G 0251 Bldg. 00	484.52(b) CLINICAL RECORD REVIEW There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care. Based on observation, record review, and interview, the agency failed to ensure the agency's 60 day review of a clinical record identified the patient had attained the established goals, and the inappropriateness of continuing care for 1 of 2 patients on service more than 60 days (Patient #10), of a total sample of 10.	G 0251	No response	08/21/2017

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	The findings included: 1. Review of the clinical record of patient # 10, evidenced a start of care date of 3-4-17, and contained a 1st certification period of 3-4-17 to 5-2-17, with order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with DM (diabetes mellitus) and follow B/P (blood pressure) readings and notify MD PRN (as needed) and med (medication) set up." Review of a plan of care for the 2nd recertification period of 5-3-17 to 7-1-17, signed by the physician on 5-8-17, evidenced an order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with DM (diabetes mellitus) and follow B/P (blood pressure) readings and notify MD PRN (as needed)." 2. Review of skilled nurse visit note dated 4-19-17, evidenced "Medication set up by patient with skilled nurse oversight. No errors made ... Blood pressure is well controlled ... Continues to use calendar for reminders ... continues to be complaint with DM (diabetes mellitus)." 3. Review of communication notes and			

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	physician orders failed to evidence documentation the agency had notified the physician patient #10 had met established goals during the 1st certification period on 4-19-17, no skilled service was being furnished the 2nd certification period, and discharge was appropriate prior to recertification. 4. An interview with the nursing supervisor was conducted on 5-18-17 at 1:30 PM. The administrator stated patient #10 "does well with insulin, I could probably discharge [patient #10]." The nursing supervisor stated there was no skilled service being provided during the 2nd recertification period, as the patient had demonstrated competency with insulin administration and met other goals by the end of the 1st certification period. The nursing supervisor stated, " I need to talk to (employee G), the office manager to decide on discharging."			
G 0332 Bldg. 00	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.	G 0332	No responses	08/21/2017

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	Based on record review and interview, the agency failed to ensure the registered nurse performed an initial assessment to determine the patients' immediate care needs and support for 10 of 10 patients (Patients #1-10). The findings included: 1. Review of the clinical record of patient #1 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 2. Review of the clinical record of patient #2 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 3. Review of the clinical record of patient #3 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 4. Review of the clinical record of patient #4 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 5. Review of the clinical record of			

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	patient #5 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 6. Review of the clinical record of patient #6 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 7. Review of the clinical record of patient #7 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 8. Review of the clinical record of patient #8 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 9. Review of the clinical record of patient #9 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support. 10. Review of the clinical record of patient #10 failed to evidence an initial assessment had been performed to determine the patients' immediate care needs and support.			

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	11. On 5-17-17 at 9:00 AM, the nursing supervisor stated agency practice did not include performing an initial assessment within 48 hours of referral to establish the patients' immediate care needs and support.			
G 0334 Bldg. 00	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the agency failed to ensure the comprehensive assessment was complete and accurate for 1 of 10 patients (Patient # 7) and failed to ensure the comprehensive assessment was not performed before the establishment of a start of care for 4 of 10 patients (Patients #1, 3, 5, and 9). The findings included:	G 0334	No response	08/15/2017

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	1. Review of a start of care comprehensive assessment for patient #7, dated 2-17-17, failed to evidence completion of the nutritional status of patient #7. The risk assessment scale was not completed and was not scored. Review of plan of care medications evidenced patient #7 was taking Humalog, Lipitor, Prevastatin, Levemir, and Clonidine. Patient #7 should have had a score of 1 on the nutrition risk assessment, for taking 3 or more prescribed or over the counter medications. The comprehensive assessment evidenced patient #7 had lost 15 pounds in 1 month, and no documentation the weight loss was according to physician recommendation. Patient #7 should have been scored 2 on the nutrition risk assessment for weight loss of 10 or more pounds in the last 6 months, with a total nutrition risk score of 3. 2. Review of the clinical record of patient #1 evidenced a start of care date of 3-15-17, and a certification period of 3-15 to 5-13-17. The start of care comprehensive assessment was dated 3-15-17. The first billable visit, which defines the start of care, was by a home health aide on 3-22-17. The comprehensive assessment was performed 7 days prior to the			

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	establishment of a start of care date, rather than not more than 5 days after the start of care. 3. Review of the clinical record of patient #3 evidenced a start of care date of 3-23-17, and a certification period of 3-23 to 5-21-17. The start of care comprehensive assessment was dated 3-23-17. The first billable visit, which defines the start of care, was by a home health aide on 3-24-17. The comprehensive assessment was performed 1 day prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 4. Review of the clinical record of patient #5 evidenced a start of care date of 3-15-17, and a certification period of 3-15 to 5-13-17. The start of care comprehensive assessment was dated 3-15-17. The first billable visit, which defines the start of care, was by a home health aide on 3-17-17. The comprehensive assessment was performed 2 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 5. Review of the clinical record of patient #9 evidenced a start of care date of			

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	4-12-17, and a certification period of 4-12 to 6-10-17. The start of care comprehensive assessment was dated 4-12-17. The first billable visit, which defines the start of care, was by a home health aide on 4-18-17. The comprehensive assessment was performed 6 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 6. On 5-18-17 at 3 PM, the administrator/nursing supervisor stated the agency had considered the date of the comprehensive assessment to be the start of care date, although no billable visit was furnished pursuant to a physician's order. The nursing supervisor verified the nutritional risk assessment for patient #7 was not completed.			
N 0000 Bldg. 00	This visit was for an Initial State Licensure survey of a home health agency.	N 0000		

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	Survey dates: 5-15-17, 5-16-17, 5-17-17, and 5-18-17 Facility # 014092 Unduplicated skilled admissions: 6 Unduplicated non-skilled admissions: 4 Current Census: 7 patients, 1 skilled care patient and 6 home health aide only patients. Discharged Patients: 3 Home Visits with record review : 4 Discharged records reviewed : 3 Total clinical records reviewed: 10			
N 0442 Bldg. 00	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on record review and interview,	N 0442	On 05/19/2017 By-Laws were signed, On 05/22/2017 Governing	05/22/2017

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	the governing body failed to adopt agency bylaws prior to survey entrance for 1 of 1 home health agency. The findings included: 1. On 5-17-17 at :15 PM, the agency provided a list of the names of the 2 members of the governing body to include a non-employee owner, and employee G, the agency office manager. 2. On 5-17-17, an unsigned and undated document titled "Bylaws of Admiral Medical Home Health Inc.," was reviewed. 3. On 5-18-17 at 9:30 AM, a 2nd copy of the same document was presented, which included the signature of one member of the governing body, the agency's owner, dated 9-6-16. The office manager (employee G) stated the owner had signed and dated the bylaws the evening of 5-17-17, and documented the date of signature as 9-6-16. Employee G stated, "That was my fault I didn't get signature in September." 4. On 5-17-17 at 4:11 PM, the administrator verified the above findings and stated there was no additional documentation to provide to be reviewed.		Body meet to adopt the by-Laws for agency. Governing Body will review By-Laws Annually as well as the PAC committee will review annually. Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	

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		A. BUILDING 00 B. WING	05/18/2017

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N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on record review and interview, the administrator failed to organize and direct the agency's ongoing functions to include failure to ensure the orientation for the alternate administrator and alternate nursing supervisor, and failure to ensure the agency had appointed a quality assessment and performance improvement committee. The findings included: 1. The administrator failed to organize and direct the agency's ongoing functions to include failure to ensure the orientation for the alternate administrator and alternate nursing supervisor (See N 446). 2. The administrator failed to ensure the agency had appointed a quality assessment and performance	N 0444	Alternate Nursing Supervisor and Alternate Administrator will be re-orientated to agencies policy and procedures and job description. On June 1, 2017 Quality Assessment & Performance Improvement committee was formed. QAPI will meet at least Bi-monthly for 6 months then quarterly. Alternate Nursing Supervisor/Alternate Administrator will be monitored by Director of Nursing/Administrator , which will meet with Governing Board quarterly to discuss progress or lack of progress. The process will be used on all new hires to ensure compliance with regulations.	08/25/2017

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	improvement committee (See N 456 and N 472). 3. On 5-18-17 at 3 PM, the administrator verified the above findings.		Administrator will be responsible for monitoring these corrective actions to insure that deficiencies are corrected and will not recur.	
N 0445 Bldg. 00	410 IAC 17-12-1(c)(2) Home health agency administration/management Rule 12 Sec. 1(c)(2) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (2) Maintain ongoing liaison among the governing body and the staff. Based on record review and interview, the administrator failed to be an effective liaison between the staff and the governing body, to include failure to ensure the orientation for the alternate administrator and alternate nursing supervisor, failure to ensure the governing body had reviewed the agency bylaws, and failure to ensure the agency had appointed a group of professional personnel to establish the agency's policies. The findings included: 1. The administrator failed to ensure the	N 0445	Governing Body reviewed agency By-Laws on 05/19/2017, on 05/22/2017 Governing Body adopted By-Laws. On 05/29/2017 the Governing Board adopted a group of professional personnel to establish the agency's policies. PAC adopted agency policies. PAC meetings will be every six (6) months to evaluate that systems are in place and followed. PAC meetings will go annually after one (1) year after meeting every six (6) months if no issues are identified. Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will	08/25/2017

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	governing body had reviewed the agency bylaws (See G 131) 2. The administrator failed to ensure the agency's policies were adopted by the group of professional personnel (See G 153). 3. On 5-18-17 at 3 PM, the administrator verified the above findings.		not recur	
N 0446 Bldg. 00	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on record review and interview, the administrator failed to ensure adequate staff education for 1 of 1 alternate administrator/alternate nursing supervisor (employee B). The findings included: 1. Review of a list of agency employees prepared by the office manager, employee G, evidenced the name of employee B as the alternate administrator	N 0446	Alternate Nursing Supervisor will be re-orientated to position on a on-going basis until skills competency checklist has been achieved. Orientation will be on all aspects of the Alternate Nursing Supervisory job description. Director of Nursing will monitor and be responsible for compliance. Director of Nursing will report back to Governing Board with findings and recommendations.	08/25/2017

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	role and the alternate nursing supervisor. 2. Review on 5-17-17, of the personnel file for employee B, alternate administrator and alternate nursing supervisor, evidenced a date of hire of 1-18-17. A. The personnel file evidenced a self-assessment of nursing clinical skills for employee B. Employee B's personnel file failed to evidence documentation of orientation to skilled nurse visits, failed to evidence documentation of: establishment of registered nurse competency for clinical skills; orientation to the agency's standards of documentation; orientation to supervision of staff; orientation to agency procedures to include on call responsibilities to patients, all duties of the alternate nursing supervisor. B. The personnel file failed to evidence documentation employee B had been provided an orientation to the skills required to perform the duties of the alternate administrator. 3. Review of a job description "Alternate Administrator" evidenced employee B's signature dated 1-18-17. The job description stated, "Alternate Administrator will act as Administrator		Alternate Administrator will be re-orientated to job requirements and agency policies and all aspects of Alternate Administrator job description to assure competency with the skills needed for Alternate Administrator position have been achieved. This process will be used with all new hires to ensure compliance with regulations. Administrator will monitor compliance and report back to the Governing Board with findings and recommendations to ensure deficiency will not recur.	

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	in the absence of the Administrator." 4. Review of a job description "Assistant Director of Nursing" evidenced it was signed and dated by employee B on 9-6-16, and stated, "Assistant Director of Nursing will act as director of nursing in the absence the director of nursing." 5. Employee B was interviewed by phone on 5-17-17 at 1:10 PM, regarding her orientation to the role of alternate administrator and alternate nursing supervisor, stated "I would be back up to (employee A). I am learning process, home health system is new to me... I have reviewed process paperwork... as we grow I would go out to do home visits... I could do med set up and blood pressure control and take orders... I would follow through...I would be on call if needed... I would handle complaints, issues with physical therapy or home health aide, on boarding, hiring and training... I guess I would be on call for (employee A) ... Right now I am trying to understand process for referral...." When asked about the 7 current cases in agency, Employee B reported ... I know there is a person that needed physical therapy, a young lady needed additional testing under anesthesia for rectal abscess ... (patient 8) has seizures ... 2 people need RN to set up meds (sic medications) and			

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	BP (blood pressure)" ...Asked if employee B had nursing experience in home health, replied " I have not been a Home Health Nurse." Denied having gone on any home visits during orientation. Did a self- assessment check list. Denied having been present for any committee meetings. Denied having current physical if required to immediately assume the role of nursing supervisor. 6. The administrator/nursing supervisor, employee A, was interviewed on 5-18-17 at 2 PM and stated, "We need to set up TB test and health exam for (employee B) to be ready... (employee B) needs to be mandated to go with me on visits... has not made any home visits ...we had discussion and (employee B) said " it's not my favorite thing to do (home visits)" ... nursing is nursing... We haven't been assertive enough to have (employee B) come in and do it... if needed we could probably talk through things." Regarding current patient case conference communication with employee B, employee A stated "we talk... my patient load hasn't changed a bunch, (employee B) he knows what I do in a visit." Employee A denied there was any documentation of case conference with Employee B.			

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N 0456 Bldg. 00	410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview, the administrator failed to implement an on-going quality assurance and performance improvement (QAPI) program to include review of agency data points by a QAPI committee for 1 of 1 home health agency. The findings included: 1. A policy "Performance Improvement Plan" was reviewed on 5-17-17 at 9:30 AM. The policy stated, "Admiral Home Health collects data and monitors performance in at least the following	N 0456	On June 1, 2017 a QAPI committee was formed and will meet at least Bi-monthly for 6 months, then quarterly there after to ensure compliance on: reviewing patient satisfaction,patient needs, appropriateness of care and any agency issues. Administrator will monitor for compliance of committee and report back to governing board, to ensure deficiency will not recur. Meeting minutes will be taken at all meetings. Operation Manager will monitor for compliance. Operation Manager will report	08/25/2017

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	areas ... Quality Improvement Data Indicators ... risk management/occurrences(effectiveness of fall reduction program and overall occurrences rate) ... customer complaints ... patient satisfaction ... infection control surveillance and reporting ... quality control ... potentially avoidable event investigation ... home health compare ... medical record review ... clinical records are systematically reviewed on a quarterly basis... a group of health professionals representative of the scope of care and services provided by the agency review a sample of both active and closed records." 2. Review of agency administrative documents failed to evidence meetings of the QAPI committee. 3. On 5-18-17 at 3:00 PM, the administrator verified the QAPI committee had not met to review agency data points related to improvement in patient care, appropriateness of care, and had not identified and addressed agency problems.		back to Administrator with issues, to ensure deficiency will not recur.	
N 0460 Bldg. 00	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed			

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	under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on record review and interview, the agency failed to ensure the alternate administrator, employee B, was oriented to the position and was ready to respond to an emergencies, provide guidance to staff, answer questions, and resolve issues within a reasonable amount of time for 1 of 1 alternate administrator, and failed to ensure the alternate nursing supervisor, employee B, was oriented to the position and prepared to assume the duties of nursing supervisor if required, for 1 of 1 alternate nursing supervisor. The findings included: 1. Review of a job description "Alternate Administrator" evidenced employee B's signature dated 1-18-17. The job description stated, "Alternate Administrator will act as Administrator in the absence of the Administrator."	N 0460	Re-orientation for the Alternate Supervising Nurse will be on the skilled Nurse visit and skilled nurse documentation of home visits, with Director of Nursing at current patients home. Some job training will be in the office for day to day operations. Nursing skill competency is in process to review basic skill required. Alternate Supervisory Nurse has been attending client case conferences, QAPI meetings and Pac meeting for more education on the day to day operations. Alternate Administrator has been Re-orientated to job description and has been attending QAPI meetings and PAC meetings on a regular basis to obtain additional education for day to day operations. Employee B has given agency	08/25/2017

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	2. Review of a job description "Assistant Director of Nursing" evidenced it was signed and dated by employee B on 9-6-16, and stated, "Assistant Director of Nursing will act as director of nursing in the absence the director of nursing." 3. The personnel file of employee B, the alternate administrator and alternate nursing supervisor, date of hire 1-18-17, and no first patient contact was reviewed on 5-17-17. A self-assessment of skills was in the file. The personnel file failed to evidence documentation of orientation to skilled nurse visits in the home, failed to evidence documentation of home skilled nursing visit establishment of competency, and failed to evidence orientation for the alternate administrator position. 4. Employee B was interviewed by phone on 5-17-17 at 1:10 PM, regarding her orientation to the role of alternate administrator and alternate nursing supervisor, stated "I would be back up to (employee A). I am learning process, home health system is new to me... I have reviewed process paperwork... as we grow I would go out to do home visits... I could do med set up and blood pressure control and take orders... I would follow through...I would be on call if needed... I would handle complaints, issues with		new physical and supplied agency with copy of 2015, 2016 and new 2017 TB. Tickler system has been put in place to reorganize missing items or items that need updated in employee charts. Operation Manager will monitor for compliance. If out of compliance Administrator will be notified. Director will report back to Governing Body and QAPI. This process will be utilized for all newly hired staff. Administrator/Director of Nursing will monitor for compliance and report back to QAPI and Governing Body with any issues to ensure deficiency will not recur.	

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	physical therapy or home health aide, on boarding, hiring and training... I guess I would be on call for (employee A) ... Right now I am trying to understand process for referral...." When asked about the 7 current cases in agency, Employee B reported ... I know there is a person that needed physical therapy, a young lady needed additional testing under anesthesia for rectal abscess ... (patient 8) has seizures ... 2 people need RN to set up meds (sic medications) and BP (blood pressure)" ...Asked if employee B had nursing experience in home health, replied " I have not been a Home Health Nurse." Denied having gone on any home visits during orientation. Did a self- assessment check list. Denied having been present for any committee meetings. Denied having current physical if required to immediately assume the role of nursing supervisor. 5. The administrator/nursing supervisor, employee A, was interviewed on 5-18-17 at 2 PM and stated, "We need to set up TB test and health exam for (employee B) to be ready... (employee B) needs to be mandated to go with me on visits... has not made any home visits ...we had discussion and (employee B) said " it's not my favorite thing to do (home visits)" ... nursing is nursing... We haven't been			

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	assertive enough to have (employee B) come in and do it... if needed we could probably talk through things." Regarding current patient case conference communication with employee B, employee A stated "we talk... my patient load hasn't changed a bunch, (employee B) he knows what I do in a visit." Employee A denied there was any documentation of case conference with Employee B.			
N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview,	N 0472	QAPI committee has been put in place and will meeting at least	08/25/2017

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	the administrator failed to implement an on-going quality assurance and performance improvement (QAPI) program and failed to ensure the clinical record review was performed by personnel representing the scope of agency services, and failed to ensure clinical record audits identified failure to follow agency policies and to meet home health agency regulations for 2 of 2 patients' clinical record audits reviewed (Patient #1 and 6), of a total sample of 10. The findings included: 1. A policy "Performance Improvement Plan" was reviewed on 5-17-17 at 9:30 AM. The policy stated, "Admiral Home Health collects data and monitors performance in at least the following areas ... Quality Improvement Data Indicators ... risk management/occurrences(effectiveness of fall reduction program and overall occurrences rate) ... customer complaints ... patient satisfaction ... infection control surveillance and reporting ... quality control ... potentially avoidable event investigation ... home health compare ... medical record review ... clinical records are systematically reviewed on a quarterly basis... a group of health professionals representative of the scope		Bi-monthly for 6 months then quarterly. Charts will now be audited by appropriate discipline who has participated in care that was delivered. All paperwork will show date audit was completed. New admission process is in place and will include initial assessment and all verbal orders for start of care, prior to starting services. Admitting nurse was re-educated on plan of care and plan of care documentation to ensure that diet and all other areas are completed upon admission and as needed. Education of admitting nurse includes, transcription of diet order from plan of care and is included on home health aide care plan. Admitting nurse/physical therapist have been re-educated on initial assessment process and having all verbal orders to be able to complete the comprehensive assessment. The medication list will include over the counter medications and prescription orders. The comprehensive assessment will be done completely and accurately. Staff have been educated that	

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	of care and services provided by the agency review a sample of both active and closed records." 2. Review of agency administrative documents failed to evidence meetings of the QAPI committee. 3. On 5-18-17 at 3:00 PM, the administrator verified the QAPI committee had not met to review agency data points related to improvement in patient care, appropriateness of care, and had not identified and addressed agency problems. 4. A chart audit was documented on 4-18-17, for patient #1. Review of clinical record # 1 evidenced patient #1 had received physical therapy and home health aide services. The chart audit was conducted by (employee # G), the office manager/ home health aide. The documents were signed, but not dated, by the administrator/nursing supervisor (employee A). The chart audit of patient #1's clinical record, lines 56-73, were specific to physical therapy services. There was no documentation of the physical therapist's participation in the chart audit. Review of the chart audit failed to evidence the audit had identified agency failure to coordinate care, failure to perform an initial assessment, failure		there should not be any missed visits with clients. Staff have been educated on documentation needs for missed visits after all other options of rescheduling the visit have been exhausted. Notification of physician will be made for coordination of care. Director of Nursing will monitor process to ensure compliance and report back to QAPI and Governing Board with any deficiencies that are found to ensure that this will not recur.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADMIRAL HOME HEALTH	5730 DR MLK BLVD ANDERSON, IN 46013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to obtain a physician's verbal start of care order prior to furnishing services, failure to document a complete and accurate comprehensive assessment as required by agency policy, failure to identify a diet order on the plan of care, as required by agency policy, failure to identify the patient's diet on the home health aide care plan, and failure to identify physical therapy visits were not provided per plan of care frequency order, as required by agency policy. 5. A chart audit was documented on 4-19-17, for patient #6. Review of patient #6's clinical record evidenced patient #6 had received skilled nursing services only. The chart audit was conducted by (employee # G), the office manager/ home health aide. The documents were signed, but not dated, by the administrator/nursing supervisor (employee A). The chart audit of patient #6's clinical record failed to evidence the participation of a registered nurse in the chart audit, and failed to evidence the chart audit identified failure to document a complete medication order on the plan of care, as required by agency policy, failure to perform an initial assessment, and failure to obtain a physician's verbal order prior to furnishing services. 6. The administrator was interviewed on			

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	5-18-17 at 2:56 PM and stated having signed the chart audits after reviewing them, but not documenting the date of review. The administrator/nursing supervisor could not explain the failure of the agency's chart audits to identify deficiencies, and stated not being aware the office manager/home health aide could not perform all the agency's chart audits.			
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview, the agency failed to ensure all agency personnel coordinated care for 1 of 10 patients (Patient #3). The findings included: 1. A policy titled, "Advanced Directives", which evidenced an effective date of 9-6-16, was reviewed on 5-18-17	N 0484	DNR orders were placed in clients home, office chart, on call book. Home folder and office chart now have stickers noting "DNR" to alert staff. DNR has been added to Plan of Care and home health aide care plan. A case conference has taken place to make all staff aware of DNR. Stickers will be put on all new patient charts, on call book and in home folders. Admitting Nurse/Physical	08/25/2017

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	at 9:30 AM, and stated, "Purpose ... Advanced Directives. Refer to a written statement ... about how individual wants medical decisions made ... care will be provided in accordance with the advance directives pending orders from patients physician ... Agency will provide staff [sic education] on issues concerning Advance Directives ... Procedure: ... If a patient has advance directives which include - not to be resuscitated, then a written and signed order for DNR (do not resuscitate), DNI (do not intubate), AND, (allow natural death) ... must be obtained from the physician and placed in the patient's clinical record prior to being honored by the agency ... Order is added to the admission 485 [plan of care] ... The original authorization/consent DNR/DNI/AND will be posted in a visible location in the patient's home as per patient/caregiver request, and a copy of the physician's order maintained in the patient's in-home chart/folder. Copies are placed in the patient's clinical record and a copy sent to the physician. On call book will reflect patient ... status. Appropriate staff will be made aware of the request by means of patient care conferences, care plans, flagging of medical records, a copy of DNR/DNI/AND order in the on-call book, or by verbal and written communication."		Therapist re-educated on making sure admission process is complete and accurate from initial assessment to start of care. All staff have been re-educated on coordination of care process to include, client, caregivers, representatives and physicians to ensure this deficient practice will not recur. Director of Nursing will audit all new admission paperwork when admission has been completed to ensure compliance. Director of Nursing will report to QAPI and Governing Board with deficiencies, to ensure that this deficiency will not recur.	

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	2. During home visit of a home health aide (HHA), employee F, for patient #3, on 5-16-17 at 11 AM, the HHA stated prior to entering patient #3's home, the patient was a DNR (do not resuscitate). Observation of patient #3's home failed to evidence the DNR order was posted as required by agency policy. A. Review of the clinical record of patient #3 on 5-16-17, evidenced a start of care date of 3-23-17, and contained plan of care for the certification period 3-23-17 to 5-21-17, signed by the physician on 4-12-17, with order "Pt [patient] is a DNR (do not resuscitate)." B. Review of the on call log failed to evidence documentation of patient #3's DNR status. 3. On 5-18-17 at 3:00 PM, the administrator/nursing supervisor verified the above findings and stated not having any further documentation to present for review.			

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N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on home visit observation, record review, and interview, the agency failed to document coordination of care activities with an outside provider for 1 of 10 patients (Patient #5). The findings included: 1. Review of the clinical record of patient #5 on 5-15-17, evidenced a referral document dated 3-13-17, to include documentation "Diagnosis: fibromyalgia, arthritis, hypertension, weakness, fallen 11 X [times] in 3 weeks," and was signed by the nursing supervisor (employee A). The document evidenced patient #5's falls had started the week of 2-19-17, one week after a doctor visit on 2-14-17, when the doctor changed patient #5's medications; Buspirone 10 mg, 1 tablet by mouth, 3 times a day (anti-depressant), was added; Cholecalciferol (Vitamin D) 1,000 units, 1 capsule by mouth daily, was added; and Hyzaar was increased from 110/12.5 mg, to 100/25mg, 1 tablet by mouth daily (to lower blood pressure).	N 0486	Home health aide re-educated about coordination of care.(When there is another agency servicing same client) All Staff educated on using communication form to inform appropriate staff of pertinent patient information. Director of Nursing will monitor this through weekly case conference meetings to ensure all shared information is given to appropriate staff members. Director of Nursing will monitor for compliance and report any findings to QAPI/Governing Body to prevent deficiency from recurring.	08/25/2017

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	Known side effects of Buspirone and Hyzaar are dizziness or lightheadedness. A. Review of a document dated 2-14 -17, titled "office visit" evidenced documentation by patient # 5's physician "anxiety is bad, daughter with breast cancer, not sleeping well ... plan: increase losartan-HCTZ (a blood pressure and diuretic), try buspar for anxiety (an antidepressant), discontinue furosemide (a diuretic), discontinue tramadol (a pain medication)." B. Review of a comprehensive adult nursing assessment dated 3-15-17, completed by the nursing supervisor, evidenced the care coordination boxes were checked for physician and aide. C. Review of patient #5's plan of care evidenced a start of care date of 3-15 -17, and a certification period of 3-15-17 to 5-13-17, with order for "Home health aide (HHA) 2 hours per day, 2 times a week, for ADLs (activities of daily living) and light housekeeping. Registered nurse (RN) to do supervisory visit 1 time a month." The established goals included "patient will be free from falls or falls will decrease." D. During an interview with the nursing supervisor, who admitted patient			

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	#5, and the home health aide (employee F), on 5-17-17 at 3:55 PM, the nursing supervisor stated not having considered providing skilled nursing services for patient #5 to assess the development of frequent falls 1 week after prescribed medication changes (2-14-17), and not having considered a physical therapy referral to address possible gait improvement and safe transfers. Employee F, the HHA stated having met a home health care provider from an outside provider, who told employee F, patient #5 received skilled nursing and physical therapy services from the outside agency. Employee F could not recall the name of the other agency, and stated not having reported this information to the nursing supervisor. The nursing supervisor reported the agency admitted the patient for home health aide services only, and there there had been no coordination of care with the outside agency. The HHA failed to coordinate care with the supervising RN related to knowledge of an outside provider of skilled nursing and physical therapy services for patient #5. E. On 5-18-17 at 9:30 AM, during telephone interview, patient #5 stated the name of the outside provider and verified the services provided by the agency were skilled nursing and physical			

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	therapy. 2. On 5-18-17 at 3:00 PM, the administrator/nursing supervisor verified the above findings and stated not having any further documentation to present for review.			
N 0504 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on record review and interview,	N 0504	Governing Body and QAPI approved revised consent for treatment to include frequencies	08/25/2017

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	the agency failed to advise the patient in advance of the frequency of proposed visits for the disciplines to be provided care for 2 of 10 patients (Patients #3 and 7). The findings included: 1. Review of the clinical record of patient # 3, evidenced a start of care date of 3-23-17, and contained a plan of care for the certification period 3-15- to 5-13-17,with order for home health aide (HHA) services 2 times a week for 8 weeks. Review of an admission document "Admiral Home Health" evidenced "The Plan of Care involves the following Discipline(s):" and the box for home health aide was checked. The admission document, signed and dated 3-23-17, by the registered nurse (employee A), and by patient #3, failed to evidence the frequency of proposed HHA visits. 2. Review of the clinical record of patient # 7, evidenced a start of care date of 2-17-17, and contained a plan of are for the certification period of 2-17 to 4-17-17, with order for skilled nursing visits 1 time a week for 1 week, then 2 times a week for 8 weeks. Review of an admission document "Admiral Home Health" evidenced "The Plan of Care		of proposed visits. All current clients were given new consent forms. Director of Nursing will audit admission chart for compliance and report to QAPI and Governing Body of any deficiencies found, to ensure deficiency is corrected and will not recur.	

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	involves the following Discipline(s)." The box for skilled nurse was checked. The admission document, signed and dated 2-17-17, by the registered nurse (employee # A), and by patient # 7, failed to evidence the frequency of proposed visits. 3. On 5-18-17 at 12:04, the nursing supervisor stated the documents did not provide the patient's notice of the frequency of proposed visits, and stated there was no further documentation to provide for review.			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to ensure visits were made in accordance with plan of care orders for 1 of 10 patients (Patient #1). The findings included: 1. Review of the clinical record of patient #1, evidenced a start of care of 3-15-17, and contained a plan of care for	N 0522	Staff re-educated on missed visits and educated on documentation of missed visit. Staff educated on explaining to client/caregiver the importance of keeping all future appointments. Case managers will be responsible for missed visits and the correct documentation. 10% of agency charts will be audited randomly quarterly for compliance by Director of	08/25/2017

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	the certification period of 3-15 to 5-13-17, with orders for physical therapy services 2 times a week for 4 weeks. Review of physical therapy visit notes evidenced 1 visit was made the week of 3-26 to 4-1-17, on 3-31-17. The visit notes failed to evidence 2 physical therapy visits were made as ordered. 2. On 5-18-17 at 3 PM, the administrator confirmed the above finding and stated there was no further documentation to present to be reviewed.		Nursing/Designee who will report to QAPI and Governing Body with any issues, to ensure deficient practice does not recur.	
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or			

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	referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, record review, and interview, the agency failed to ensure the plan of care included all durable medical equipment, nutritional requirement, complete medication order,safety measures, and a discharge plan for 10 of 10 patients (Patients #1-10), and failed to ensure the plan of care start of care date and certification periods were correct for 4 of 10 patient's whose clinical record was reviewed (Patients # 1, 3, 5 and 9). The findings included: 1. Review of the clinical record of patient #1, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15-17 to 5-13-17. A. Review of nutritional requirement evidenced "none", durable medical equipment and supplies evidenced "walker", Medications: Dose/Frequency/Route, evidenced "Tobramycin (an antibiotic) 300 mg/4 ml every 12 hours P.O. (by mouth)." Safety Measure evidenced "Universal precautions"' Goals/rehabilitation Potential /Discharge Plans evidenced	N 0524	Staff re-educated on admission process to ensure that all DME is listed on Plan of Care. Accuracy will be maintained through out the plan of care dates by communicating with the patients doctor. Staff re-educated on nutritional requirements on Plan of Care and to verify diet by patients doctor to ensure coordination of care. Staff re-educated on proper medication list upon admission. Medication orders will be complete to include route and over the counter medications. To maintain accuracy through out the plan of care staff will communicate with patients doctor to verify orders for accuracy. Staff re-educated on safety measures on plan of care. Staff re-educated on documentation and education that will be given to client/caregiver on safety measures. Staff re-educated on discharge planning. Discharge planning will start with client upon admission and re visited at re-certification, resumptions and	08/25/2017

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	"independence in transfers and is steady on feet without use of furniture. Independence with all ADL's (activity of daily living), personal care, transfers and light housekeeping. Independence with walking on a walker if that is what she needs. Remain free from falls, injuries and hospitalization." B. During home visit observation of a home health aide (HHA) on 5-17-17, at 2 PM, patient #1 stated the Tobramyacin was administered by nebulizer, not by mouth. A cane, a nebulizer, an oxygen concentrator, oxygen tubing and cannula, were observed in the home. C. Review of the plan of care failed to evidence the cane, nebulizer, oxygen concentrator, oxygen tubing and cannula, failed to evidence fall precautions and oxygen safety as safety measures, failed to evidence a diet order, and failed to evidence a discharge plan. 2. Review of the clinical record of patient# 2, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15-17 to 5-13-17. Diagnoses included of Thrombocytopenia (a disease that alters the clotting factor of the blood and increases the risk of bleeding).		case conferences. Staff re-educated on admission process that start of care is the first billable date of services. The Director of Nursing will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur. Director will report back to QAPI/Governing Board with any findings.	

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	A. Review of plan of care medications evidenced "Hydrochlorthiazide, Metroprolol, Lisinipril, Rantidine, Citralopram, Clonidine and Vitamin D3." Established goals included "Patient will be free from hospitalizations and falls with injury. Patient will be able to set up all medications on own and will have reminders/cues established in the home. Patient will have understanding of importance of medications and the need to not miss any doses." B. During home visit observation of a registered nurse (RN) on 5-16-17 at 11 AM, patient #2 stated taking the following medications not evidenced on the plan of care "B.C. packets (845 mg of Aspirin and 65 mg of caffeine) for pain, (aspirin is an anti-platelet medication and decreases the clotting of the blood, caffeine can increase blood pressure), bio freeze (a topical pain medication) for joint pain, and polyethylene glycol (a fiber medication) for constipation." C. The nursing supervisor stated on 5 -18-17 at 3 PM, having failed to document all the medications for patient #2 on the plan of care. 3. Review of the clinical record of patient #3, evidenced a start of care date of			

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	3-23-17, and contained a plan of care for the certification period of 3-23-17 to 5-23-17. A. Review of durable medical equipment evidenced "walker, cane, motorized wheel chair." B. During home visit observation of a HHA, on 5-16-17 at 11 AM, patient #3 was observed to have a "medical guardian", a safety/emergency call button. C. Review of the plan of care failed to evidence the medical guardian as durable medical equipment. 4. Review of the clinical record of patient #4, evidenced a start of care date of 2-15-17, and contained a plan of care for the certification period of 2-15-17 to 4-15-17. A. Review of the nutritional requirements evidenced "none," established goals included "shortness of breath resolution is the goal and that the client is using the CPAP (continuous positive airway pressure) machine correctly. Client will have no adverse effects. Client will remain free from falls and hospitalizations and injuries. Client will be able to return to her own home			

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		A. BUILDING 00 B. WING	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADMIRAL HOME HEALTH	5730 DR MLK BLVD ANDERSON, IN 46013

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	independently." B. Review of the plan of care failed to evidence the CPAP machine as durable medical equipment, failed to evidence an ordered diet, and failed to evidence a discharge plan. 5. The clinical record of patient # 5 was reviewed, and evidenced a start 3-15-17, and a plan of care for the certification period of 3-15-17 to 5-13-17. Review of the plan of care Goals/Rehabilitation potential/discharge plans evidenced "Patient will be free from falls or falls will decrease. Patient will not have any hospitalization or injuries. ADLs and IADLs will be met." The plan of care failed to evidence a discharge plan for patient #5. 6. The clinical record of patient #6 medical plan of care was reviewed, evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 2-17-17 to 4-17-17. The patient had diagnosis of Type 2 diabetes mellitus and was insulin dependent. A. The plan of care evidenced durable medical equipment (DME) of "none". The nutritional requirement section evidenced "none".			

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	B. Review of a comprehensive adult nursing assessment, dated 2-17-17, evidenced patient #6 required "Diabetes and Diabetic diet." The form evidenced " Lantus 30 units ... blood sugar monitored ... by self...TID (3 times daily) ... and competency with use of glucometer." C. The plan of care failed to evidence a diet order, and DME of a glucometer, needles, and diabetic testing supplies. D. Review of the Goals/Rehabilitation potential /discharge plans evidenced "Goal is that patient will take medications as ordered and have an understanding why she is on each medication. Client will have no adverse effects. Patient will be free from hospitalization". The plan of care failed to evidence a discharge plan for patient #6 7. The clinical record of patient #7, was reviewed and evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 4-18-17 to 6-16-17. A. DME on the plan of care evidenced "none".			

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	B. The Goals /Rehabilitation potential /discharge plans evidenced "Patient will remain compliant with medications as ordered by MD and remain free from adverse effects. Patient will remain free from injuries and hospitalizations." C. The plan of care failed to evidence DME of a glucometer, needles, and diabetic testing supplies and failed to evidence a discharge plan. 8. The clinical record of patient #8, was reviewed and evidenced a start of care of 4-11-17, and contained a plan of care for the certification period of 4-11-17 to 6-9-17. The patient had a diagnosis of obstructive sleep apnea. The order section of the plan of care evidenced "Pt just received CPAP machine and requires teaching and care of machine." A. Review of the plan of care DME evidenced "none". B. Review of the Goals /Rehabilitation potential /discharge plans evidenced "Goal is that patient will be confident in use of CPAP, BP will continue to be controlled, pain will be better controlled and more comfortable. Will notify MD as needed. Will remain free of injury and have no			

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	hospitalizations." C. The plan of care evidenced for nutritional requirements "none". D. The plan of care failed to evidence patient #8's diet, DME and supplies of glucometer, needles, diabetic testing supplies, and failed to evidence a discharge plan. 9. Review of the clinical record of patient # 9 evidenced a start of care date of 4-12-17, and contained a plan of care for the certification period of 4-12-17 to 6-10-17. A. Review of the nutritional requirements evidenced "none". B. Review of the comprehensive nursing assessment dated 4-12-17, evidenced the Nutritional requirement "regular" as patient #9's diet. C. Review of the Goals /Rehabilitation potential /discharge plans evidenced "Will be compliant with ADL oversight and be odor free daily. Will be free from injury and no falls and no hospitalizations. Will be free of seizures and comply with medication reminders." D. The plan of care failed to evidence			

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	a diet order and failed to evidence a discharge plan. 10. Review of the clinical record of patient #10 evidenced a start of care date of 3-4-17, and contained a plan of care for the certification period of 3-4-17 to 5-2-17, and a plan of care for the certification period of 5-3-17 to 7-3-17. A. Review of DME evidenced "none." B. Review of a comprehensive adult nursing assessment dated 3-4-17, evidenced "Diabetes ... type 2, diabetic diet ... injectable medication, Lantus ... Humalog ... monitored by self ... bid." The plan of care failed to evidence patient #10's glucometer, diabetic test strips, and needles as DME and supplies. C. Review of the Goals /Rehabilitation potential /discharge plans evidenced "Goal is that pt. [patient] will take all medication on time and as ordered and have an understanding why she is on each medication. Pt [patient] will have no adverse reaction. Pt [patient] will be free from hospitalization." D. The plan of care failed to evidence a discharge plan for patient #10.			

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	11. Review of the clinical record of patient #1 evidenced a start of care date of 3-15-17, and a certification period of 3-15 to 5-13-17. The start of care comprehensive assessment was dated 3-15-17. The first billable visit, which defines the start of care, was by a home health aide on 3-22-17. The comprehensive assessment was performed 7 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 12. Review of the clinical record of patient #3 evidenced a start of care date of 3-23-17, and a certification period of 3-23 to 5-21-17. The start of care comprehensive assessment was dated 3-23-17. The first billable visit, which defines the start of care, was by a home health aide on 3-24-17. The comprehensive assessment was performed 1 day prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 13. Review of the clinical record of patient #5 evidenced a start of care date of 3-15-17, and a certification period of 3-15 to 5-13-17. The start of care comprehensive assessment was dated 3-15-17. The first billable visit, which			

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	defines the start of care, was by a home health aide on 3-17-17. The comprehensive assessment was performed 2 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 14. Review of the clinical record of patient #9 evidenced a start of care date of 4-12-17, and a certification period of 4-12 to 6-10-17. The start of care comprehensive assessment was dated 4-12-17. The first billable visit, which defines the start of care, was by a home health aide on 4-18-17. The comprehensive assessment was performed 6 days prior to the establishment of a start of care date, rather than not more than 5 days after the start of care. 15. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above findings and stated there was no further documentation to present to be reviewed.			
N 0527	410 IAC 17-13-1(a)(2) Patient Care			

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Bldg. 00	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. Based on observation, record review, and interview, the agency failed to alert the physician the patient had attained the established goals, which suggested a need to alter the medical plan of care to include discharge, for 1 of 10 patients whose clinical record was reviewed (Patient #10). The findings included: 1. Review of the clinical record of patient # 10, evidenced a start of care date of 3-4-17, and contained a first certification period of 3-4-17 to 5-2-17, with order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with DM (diabetes mellitus) and follow B/P (blood pressure) readings and notify MD PRN (as needed) and med (medication) set up." Review of a plan of care for the second recertification period of 5-3-17 to 7-1-17, signed by the physician on 5-8-17, evidenced an order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with	N 0527	Staff re-educated on appropriateness of skilled need and coordination of care with clients doctor to include discharge plans by communicating with doctors office . Director of nursing/Designee will monitor through weekly case management meetings to validate skill care needs are present. Doctors will be notified of changes in level of care. Director of Nursing will report to QAPI and Governing Body with any findings and deficiencies to prevent this deficiency from recurring.	08/25/2017

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	DM (diabetes mellitus) and follow B/P (blood pressure) readings and notify MD PRN (as needed)." 2. Review of skilled nurse visit note dated 4-19-17, evidenced "Medication set up by patient with skilled nurse oversight. No errors made ... Blood pressure is well controlled ... Continues to use calendar for reminders ... continues to be complaint with DM (diabetes mellitus)." 3. Review of communication notes and physician orders failed to evidence documentation the agency had notified the physician patient #10 had met established goals during the 1st certification period on 4-19-17, no skilled service was being furnished the 2nd certification period, and discharge was appropriate prior to recertification. 4. An interview with the nursing supervisor was conducted on 5-18-17 at 1:30 PM. The administrator stated patient #10 "does well with insulin, I could probably discharge [patient #10]." The nursing supervisor stated there was no skilled service being provided during the 2nd recertification period, as the patient had demonstrated competency with insulin administration and met other goals by the end of the 1st certification			

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	period. The nursing supervisor stated, " I need to talk to (employee G), the office manager to decide on discharging."			
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the agency failed to ensure the registered nurse (RN) case manager initiated necessary revisions to the plan of care for 10 of 10 patients (Patient #1-10). The findings included: 1. Review of the clinical record of patient #1, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17. A. Review of the plan of care	N 0542	Staff re-educated to the process of accurately documenting all forms of DME/Medication to include Rate/order/delivery method/instruction for use and to communicate with patients doctor with any findings. Staff re-educated on start of care dates/ re-certification dates. SOC are always the first billable visit. Staff re-educated on the need to revise plan of care with any additional orders from patients doctor in regards to diet, discharge planning, goals, and any changes are communicated	08/25/2017

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	narrative evidenced patient #1 used oxygen at night. The plan of care failed to evidence an oxygen order and the registered nurse failed to initiate revision to the plan of care to update to include an order for oxygen, rate, delivery method, and instructions for use. B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-22-17, which defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-22-17, and the certification period to 3-22 to 5-20-17. C. Review of the plan of care evidenced a Nutritional Requirement of "None." The RN failed to initiate revision of the plan of care to document a nutritional requirement for patient #1. The plan of care goals/rehabilitation/discharge plans section failed to evidence any discharge plan for patient #1. The RN failed to initiate revision of the plan of care to document a discharge plan for patient #1. D. Review of the referral order, dated 3-13-17, for patient #1 was to "evaluate and treat." Patient #1 had not had an initial assessment or physician orders for care on 3-13-17. The RN failed to		to the doctor. Admission process will meet all requirements of how to correctly admit patient from initial assessment to start of care. Director of Nursing will monitor through auditing all new admissions to ensure process is followed and done correctly. Director of Nursing will follow up with the QAPI and the Governing Board with any findings, to prevent the recurrence of this deficiency.	

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	initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 2. Review of the clinical record of patient #2, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17. A. Review of the plan of care narrative evidenced patient #2 had a diagnosis of weight loss. The RN failed to initiate revision to the plan of care to include monitoring of weight as an appropriate nursing order. B. Review of the referral order, dated 3-13-17, for patient #2 was to "evaluate and treat." Patient #2 had not had an initial assessment or physician orders for care on 3-13-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 3. Review of the clinical record of patient #3, evidenced a start of care date of 3-23-17, and contained a plan of care for the certification period of 3-23 to 5-21-17.			

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	A. During a home visit observation of a HHA on 5-17-17 at 11 AM, patient #3 was observed to have a "medical guardian" device. Patient #3 stated using the medical guardian device. B. Review of the plan of care narrative evidenced patient #3 had durable medical equipment of walker, can, and motorized wheel chair. The RN failed to initiate revision of the plan of care to document the durable medical equipment of a medical guardian. B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-24-17, which defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-24-17, and the certification period to 3-24 to 5-22-17. 4. Review of the clinical record of patient #4, evidenced a start of care date of 2-15-17, and contained a plan of care for the certification period of 2-15 to 4-15-17. A. Review of the plan of care failed to evidence a discharge plan for patient #4. The registered nurse failed to initiate revision to the plan of care to document a discharge plan.			

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B. Review of the referral order, dated 2-13-17, for patient #4 was to "evaluate and treat." Patient #4 had not had an initial assessment or physician orders for care on 2-13-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services.

5. Review of the clinical record of patient #5, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17.

A. Review of the plan of care failed to evidence a discharge plan for patient #5. The RN failed to initiate revision to the plan of care to document a discharge plan.

B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-17-17, which defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-17-17, and the certification period to 3-17 to 5-15-17.

C. Review of the referral order, dated 2-14-17, for patient #5 was to "evaluate

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	and treat." Patient #6 had not had an initial assessment or physician orders for care on 2-14-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 6. Review of the clinical record of patient #6, evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 2-17 to 4-17-17. A. Review of the plan of care failed to evidence a discharge plan for patient #6. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of the plan of care evidenced an order for Flonase nasal spray as needed (a medication to treat allergies). The medication order failed to evidence the strength of the spray ordered and how often the interval for the as needed medication was ordered. C. Review of the referral order, dated 3-13-17, for patient #1 was to "evaluate and treat." Patient #6 had not had an initial assessment or physician orders for care on 3-13-17. The RN failed to initiate revision to the referral order to			

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	clarify the order was to evaluate only for the appropriateness of home health agency services. 7. Review of the clinical record of patient #7, evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 2-17 to 4-17-17. A. Review of the plan of care failed to evidence a discharge plan for patient #7. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of the referral order, dated 2-15-17, for patient #7 was to "evaluate and treat." Patient #7 had not had an initial assessment or physician orders for care on 2-15-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 8. Review of the clinical record of patient #8, evidenced a start of care date of 4-11-17, and contained a plan of care for the certification period of 4-11 to 6-9-17. A. Review of the plan of care narrative evidenced patient #8 used a			

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	CPAP (continuous positive airway pressure) machine. The plan of care failed to evidence the CPAP machine as durable medical equipment and the registered nurse failed to initiate revision to the plan of care to update to include the CPAP as durable medical equipment. B. Review of the plan of care failed to evidence a discharge plan for patient #8. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of the referral order, dated 4-10-17, for patient #8 was to "evaluate and treat." Patient #8 had not had an initial assessment or physician orders for care on 4-10-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 9. Review of the clinical record of patient #9, evidenced a start of care date of 4-12-17, and contained a plan of care for the certification period of 4-12 to 6-10-17. A. Review of the plan of care failed to evidence a nutritional requirement for patient #9, and the registered nurse failed to initiate revision to the plan of care to			

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	update to include an nutrition order. B. Review of the plan of care failed to evidence a discharge plan for patient #9. The RN failed to initiate revision to the plan of care to document a discharge plan. C. Review of the referral order, dated 4-11-17, for patient #9 was to "evaluate and treat." Patient #9 had not had an initial assessment or physician orders for care on 4-11-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 10. Review of the clinical record of patient #10, evidenced a start of care date of 3-4-17, and contained a plan of care for the certification period of 3-4 to 5-2-17. A. Review of the plan of care narrative evidenced patient #10 was diabetic and tested blood sugar at home. The RN failed to revise the plan of care to include patient #10's glucometer and testing strips as durable medical equipment and supplies. B. Review of the referral order, dated 3-2-17, for patient #10 was to "evaluate			

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	and treat." Patient #10 had not had an initial assessment or physician orders for care on 3-2-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 11. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above findings and stated there was no further documentation to present to be reviewed.			
N 0543 Bldg. 00	410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on observation, record review, and interview, the agency failed to ensure the registered nurse (RN) implemented oxygen precautions for 1 of 2 patients with oxygen therapy (Patient #1), and failed to ensure the registered nurse	N 0543	Nursing re-educated on safety measures regarding oxygen use and weight loss. Re-education was given on how to appropriately document and communicate with the patients doctor and educate the patient/caregiver. Nursing staff re-educated on	08/25/2017

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	implemented nursing interventions to monitor the weight of a patient with the diagnosis of weight loss for 1 of 1 patient with a diagnosis of weight loss (Patient #2), of a total sample of 10. The findings included: 1. During home visit observation of a home health aide for patient #1 on 5-17-17 at 2 PM, an oxygen concentrator was observed in the home. Patient #1 stated using it at night. Review of the plan of care failed to evidence the RN had implemented oxygen precautions as a safety measure. 2. Review of the plan of care for patient #2 evidenced a diagnosis of weight loss. Review of the skilled nursing orders evidenced "Skilled Nursing 1 time a week for medication set up, B/P (blood pressure) monitoring at each visit." The RN failed to implement monitoring of weight as an appropriate nursing preventative and rehabilitative measure. 3. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above finding and stated there was no further documentation to present to be reviewed.		scope of services to include, appropriate preventive nursing measures and rehabilitative measures. 10% of agency charts will be randomly audited for compliance every quarter until 100% are in compliance. Director of Nursing will be responsible for audit and informing QAPI/Governing Body of any deficiencies to prevent deficiency from recurring.	

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N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the agency failed to ensure the registered nurse implemented agency policy to color code mark the clinical record of patient's at risk for a fall for 2 of 2 patients at risk for falls (Patients #3 and 5), of a total sample of 10. The findings included: 1. Policy, "Patient Assessment Guidelines," with date of board approval of 9-6-17, stated, "It is the responsibility of of the patient's nurse or therapist to routinely assess the patient for the need for appropriate interventions related to fall prevention ... A color code is placed on the patient's chart and on the patient assignment board, if applicable. This will alert agency personnel that the patient is "At Risk." 2. Review of the clinical record of patient #3 failed to evidence any color code had been placed on the chart. 3. Review of the clinical record of	N 0545	Patient assessment guidelines were reviewed and put into place. All "at risk" patients charts are coded and identified through case conference meetings with staff, client/caregiver and through assessment and communication with patients doctor. Director of nursing/Designee will audit 10% of charts quarterly to monitor for compliance. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	08/25/2017

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	patient #5 failed to evidence any color code had been placed on the chart. 4. On 5-18-17 at 3 PM, the administrator/nursing supervisor verified the above findings and stated agency policy had not been implemented.			
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on observation, record review, and interview, the agency failed to alert the physician the patient had attained the established goals, which suggested a need to alter the medical plan of care to include discharge, for 1 of 10 patients whose clinical record was reviewed (Patient #10). The findings included: 1. Review of the clinical record of patient # 10, evidenced a start of care	N 0546	Nursing re-educated on recognizing when goals are met by patient and when to appropriately discharge. Doctor will be notified of changes for coordination of care. During weekly case conferences patient level of care will be discussed to assess progress toward goals met and including possible discharge. Patients physician will be notified of all findings to ensure coordination of care.	08/25/2017

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	date of 3-4-17, and contained a first certification period of 3-4-17 to 5-2-17, with order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with DM (diabetes mellitus) and follow B/P (blood pressure) readings and notify MD PRN (as needed) and med (medication) set up." Review of a plan of care for the second recertification period of 5-3-17 to 7-1-17, signed by the physician on 5-8-17, evidenced an order for "Skilled Nurse biweekly until end of certification period for memory technique, monitor for compliance with DM (diabetes mellitus) and follow B/P (blood pressure) readings and notify MD PRN (as needed)." 2. Review of skilled nurse visit note dated 4-19-17, evidenced "Medication set up by patient with skilled nurse oversight. No errors made ... Blood pressure is well controlled ... Continues to use calendar for reminders ... continues to be complaint with DM (diabetes mellitus)." 3. Review of communication notes and physician orders failed to evidence documentation the agency had notified the physician patient #10 had met established goals during the 1st certification period on 4-19-17, no skilled		Director of nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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	service was being furnished the 2nd certification period, and discharge was appropriate prior to recertification. 4. An interview with the nursing supervisor was conducted on 5-18-17 at 1:30 PM. The administrator stated patient #10 "does well with insulin, I could probably discharge [patient #10]." The nursing supervisor stated there was no skilled service being provided during the 2nd recertification period, as the patient had demonstrated competency with insulin administration and met other goals by the end of the 1st certification period. The nursing supervisor stated, " I need to talk to (employee G), the office manager to decide on discharging."			
N 0547 Bldg. 00	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written).			

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	Based on record review and interview, the agency failed to ensure the registered nurse requested a verbal order for disciplines, frequencies, and care orders at the start of care for 9 of 10 patients (Patient #1, 2, 3, 4, 5, 6, 7, 8, and 10) and failed to ensure the registered nurse requested a verbal order to continue agency services to include disciplines, frequencies, and care orders for 2 of 2 patients on service more than 60 days (Patients #1 and 10). The findings included: 1. Review of a policy, "Physician Orders,", date of board approval documented as 9-6-17, stated, " Agency and staff Wilf [sic Will] administer services and treatments only as ordered by the physician." 2. Review of the physician's orders in the clinical record of patient #1 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-9, 3-16, and 3-22-17, prior to obtaining physician authorization for care. Visit	N 0547	Consent for treatment form has been revised to include frequencies. Admitting nurse/Physical Therapist will use new form on all new admissions. Staff re-educated on new admission process to include verbal orders and frequencies. This education also includes recerts/resumptions, to ensure that all orders are in place at time of starting services. Director of Nursing/Designee will audit 100% of admission, recert and resumption charts for compliance. Director of Nursing will be responsible for audit and informing QAPI/Governing Body of any findings to prevent deficiency from recurring.	08/25/2017

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	notes evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 4-3-17. C. Review of physician's order about the time of recertification on 5-1-17, failed to evidence a physician's order to continue care. As of 5-18-17, the physician had not signed the plan of care. A home health aide furnished care on 5-17-17. 3. Review of the physician's orders in the clinical record of patient #2 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-22, 3-29, and 3-22-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up. Review of visit notes evidenced the home health aide (HHA) had furnished assistance with ADLs (activities of daily living) and IADLs (instrumental activities of daily living) during care			

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	visits on 3-17, 3-19, 3-23, 3-27, and 3-30 -17. B. The plan of care evidenced signature of the attending physician dated 4-3-17. 4. Review of the physician's orders in the clinical record of patient #3 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced the HHA had furnished assistance with ADLs and IADLS during care visits on 3-24, 3-27, 3-29, 3-31, 4-3, 4-5, 4-7, 4-9, and 4-11-17. B. The plan of care evidenced signature of the attending physician dated 4-12-17. 5. Review of the physician's orders in the clinical record of patient #4 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 2-20 and 2-27-17, prior to obtaining			

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	physician authorization for care. Visit notes evidenced the registered nurse had assessed vital signs, and instructed the patient on the use of CPAP machine (continuous positive airway pressure) during visits. B. The plan of care evidenced signature of the attending physician dated 2-28-17. 6. Review of the physician's orders in the clinical record of patient #5 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits for assistance with ADLs and IADLs were furnished by the HHA on 3-17 and 3-22-17. B. The plan of care evidenced signature of the attending physician dated 3-29-17. 7. Review of the physician's orders in the clinical record of patient #6 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services.			

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	A. Review of visit notes evidenced care visits were furnished by the nurse on 2-21, 2-28, and 3-7-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up. B. The plan of care evidenced signature of the attending physician dated 3-9-17. 8. Review of the physician's orders in the clinical record of patient #7 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 2-20, 2-23, and 2-27-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 2-28-17. 9. Review of the physician's orders in the clinical record of patient #8 failed to evidence the registered nurse had requested a verbal order for disciplines,			

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	frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-11-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 4-13-17. 10. Review of the physician's orders in the clinical record of patient #10 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-9, 3-16, and 3-22-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up and monitored vital signs. B. The plan of care evidenced signature of the attending physician dated 4-3-17.			

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	C. Review of physician's order about the time of recertification on 5-2-17, failed to evidence a physician's order to continue care. The physician signed the plan of care orders on 5-8-17. D. Review of visit notes evidenced a registered nurse visit note dated 5-3-17, when the RN monitored patient #10 compliance with diabetes mellitus diet and medication and took vital signs. 12. On 5-18-17 at 3 PM, the nursing supervisor verified the above findings and stated the agency practice did not include calling the physician prior to furnishing services to obtain a verbal order for disciplines, frequencies, and care orders. The nursing supervisor stated the first signed order for care for patients 1, 2, 3, 4, 5, 6, 7, 8, and 10 occurred upon return of a signed plan of care, up to 30 days after the agency had begun providing care. The nursing services stated the agency practice did not include obtaining a verbal order to continue services prior to the expiration of the previous certification period. The nursing supervisor stated there was no further documentation to present to be reviewed.			

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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) COMPLETION DATE
N 0550 Bldg. 00	410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on record review and interview, the registered nurse failed to include a nutritional requirement on the prepared a home health aide care plan for 1 of 6 patients who received home health aide services (Patient #1) The findings included: 1. Review of the clinical record for patient #1, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17, with order for home health aide services. Review of the home health aide care plan, dated 3-15-17, and updated on 5-11-17, failed to evidence a nutritional requirement (diet order). 2. On 5-18-17 at 3:00 PM, the nursing supervisor verified the above finding and	N 0550	Re-educated admitting Nurse/Physical Therapy staff to obtain diet order on all admission/Re-cert/Resumptions through communication with the patient and the patients doctor. Director of Nursing will audit newly admitted/Re-certs/Resumption charts for compliance and audits will be on going. Director of Nursing will be responsible for audits and informing QAPI/Governing Body of any findings to prevent deficiency from recurring.	08/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/18/2017

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	stated there was no further documentation to present for review.			