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	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIC HEALTH SERVICES	5401 VOGEL RD, STE 110 EVANSVILLE, IN 47715

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N 0000 Bldg. 00	This visit was for a state home health initial survey. Survey Dates: May 15th and May 16th of 2017 Facility ID: 014115 Medicaid Vendor Skilled Unduplicated Admissions: 2 Current Census: 4	N 0000		
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 observation and personnel record review the Administrator failed to ensure personnel received adequate staff education for 1 of 4 personnel files reviewed (employee B).	N 0446	1. Employee B received re-education about hand hygiene during PICC dressing change on 6/12/17. Employee B had PICC line education on 3/16/17, but evidence of this education was not in their personnel file during the survey. It was placed into their personnel file on 6/12/17. Routine	06/12/2017

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

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

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	Findings Include: 1. Personnel record B, date of hire 2/26/17, was reviewed on 5/16/17. A. During a home visit on 5/15/17 at 5:30pm, employee B was observed while providing care to patient #3. Employee B who is a registered nurse applied and removed gloves but failed to perform hygiene while performing a PICC (peripherally inserted central-line) dressing change. B. A document titled Annual Clinical Competency Checklist contained in employee B personnel record dated 2/26/17 failed to evidence that skill/technique/education on IV (intravenous) Access on PICC/Central/Peripheral was provided. C. In an interview with the Director of Nursing and Executive Director on 5/16/17 both employees acknowledge that PICC-line education was not provided for staff prior to providing care for the patient.		hand hygiene will be added to the Agency onboarding process by 6/30/17 and evidence of education to all field nurses working with IV clients will be placed in each personnel file. The Director of Nursing will be responsible for completion and ongoing compliance by verifying completion for any and all nurses who work with infusion cases 2. A PICC line dressing change checklist process has been put in place as of 6/12/17. Checklist is to be completed every time a PICC dressing change is provided. 10% of check lists will be reviewed each quarter or completeness of hand hygiene during PICC dressing changes. A process of reviewing all nursing files, prior to placement with a patient for the appropriate competencies was initiated on 6/12/17 and will be ongoing. 10% of actively working nursing personnel files will be reviewed each quarter for appropriate nursing competencies based on the patients they care for. Audits will last for a period of 2 quarters. The Director of Nursing and/or Executive director will oversee the task as listed going forward. 3. Re-education to employee B was provided by the Regional Nursing Director. Review of nursing files for competencies prior to placement with a patient will be conducted by the ED. The Executive Director will be	

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			responsible for review of all competencies prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED or designated person for a minimum of 2 quarters. 4. 6/12/16	
N 0449 Bldg. 00	410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure. Based on clinical record review, policy review, observation and interview the Administrator failed to organize and direct the agency's ongoing functions and failed to ensure state rules and regulations were followed for 1 of 1 agency. Findings include: 1. The Administrator failed ensure that a PICC (peripherally inserted central catheter) line policy was developed and implemented for 1 out 1 records reviewed of patients with a PICC. 2. The administrator failed to ensure personnel received adequate staff	N 0449	1. A PICC line process was in place at the time of the survey, but was not provided in writing to the surveyors at that time. The process was made available for review, within the office, on 6/12/17. Employee B had PICC line education on 3/16/17, but evidence of this education was not in their personnel file during the survey. It was placed into their personnel file on 6/12/17. The Executive Director or designated person will be responsible for review of all competencies prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED or designated person for a minimum of 2 quarters.	06/12/2017

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	education to manage a PICC-line for 1 of 5 personnel files reviewed (employee B). A document titled Annual Clinical Competency Checklist contained in employee B personnel record dated 2/26/17 failed to evidence that skill/technique/education on IV (intravenous) Access on PICC/Central/Peripheral was provided. 3. The administrator failed to ensure documentation of adequate orientation to the job for 3 out of 5 (employees A, B, and E) personnel files reviewed 4. The administrator failed to ensure personnel files included a physical examination not more than 180 days prior to direct patient contact for 1 of 2 direct care givers whose personnel records were reviewed (Employee B). Personnel file of Employee B was reviewed and evidenced the individual had been hired on 2/26/17 as a RN, Director of Nursing, first date of patient contact 3/1/17. The file evidenced a physical examination by a physician dated 2/4/15, 2 years before the date of first patient contact. 5. The administrator failed to ensure staff complied with the agency's policy for handwashing for 1 of 2 (#3) home visit observations. During a home visit (#3 of 2) on 5/15/17 at 5:30pm, employee		Administrator, director of nursing and executive director all received job specific orientation on 1/4/17, but documentation was not in their personal files during time of survey. Evidence of such orientation was placed into each personal file on 6/16/17. The Executive Director or designated person will be responsible for review of all competencies prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED for a minimum of 2 quarters. Reeducation was provided to executive director regarding the need for physical examination for all direct care staff to be present in the personal file, dated no more than 180 days prior to direct patient contact, before providing patient care. (Regardless of transfer from parent agency to the independent agency). Current employee files will be audited and, if no physical is present, the employee will obtain a physical. The Executive Director will be responsible for this going forward. Outstanding physicals will be completed by September 9, 2017. Moving forward, all new employees will have a qualifying physical prior to providing care. The Executive Director or designated person will be responsible for review of completion prior to employee placement with a patient. 10% of files will be reviewed each quarter	

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	B was observed while providing care to patient #3. Employee B who is a RN (registered nurse) applied and removed gloves but failed to perform hygiene while performing a PICC-line dressing change . 6. The administrator failed to ensure the agency discharge policy included a 15 day notice before services are stopped. A policy titled Termination of Services Against the Family's Wishes 3-22, Rev. 10/2009 stated that notification will be provided to the family in writing not less than 72 hours prior to discontinuation of service, exempt when staff is in immediate jeopardy or the physician refuses orders to continue care. 7. The administrator failed to ensure that all pertinent information was included on the plan of care in 4 out of 4 (#1,#2,#3,#4) records reviewed. A. The clinical record #1 included a plan of care established by the physician for the certification period 4/21/17 through 6/19/17 with orders to provide HHA (home health aide) services 2-4 hours a day for 2-4 days a week of unskilled care and provide skilled nursing visits 1-3 times a week ongoing per MD (medical director) orders. The plan of care failed to specify a specific duration		for completeness by the ED for a minimum of 2 quarters. Employee B received re-education about hand hygiene during PICC dressing change on 6/12/17. Routine hand hygiene will be added to the Agency onboarding process by 6/30/17 and evidence of education to all field nurses working with IV clients will be placed in each personnel file. The Director of Nursing will be responsible for completion and ongoing compliance by verifying completion for any and all nurses who work with infusion cases Policy titled Termination of Services against the Family's Wishes 3-22, will be revised to include a 15-day notice before services are stopped. Revision will be in place by 6/16/17. The Director of Nursing will be responsible for compliance. On 5/19/16, the care plans of patients #1, 2 and 4 were updated by obtaining orders from their physicians, clarifying that the duration of ordered care indicated on the plans of care was for 60 days. On 5/19/17, the care plans of patients #1, 2, 3 and 4 were updated by obtaining orders from their physicians, clarifying patient specific vital sign parameters. All applicable clinicians will be educated as to how to properly complete a Plan of Care to include vital sign parameters and discipline frequency and duration. This will be completed	

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	for services. B. The clinical record #1 plan of care included orders for "vital sign parameters" and for SN (skilled nurse) to notify MD and/or RN (registered nurse) supervisor for a T (temperature), P (pulse), and R (respiration) outside of listed parameters greater than 30-60 minutes. The plan of care failed to specify the specific vital sign parameters. C. The clinical record #2 included a plan of care established by the physician for the certification period 5/3/17 through 7/1/17 with orders to provide HHA services 2-4 hours a day for 2-4 days a week of unskilled care. The plan of care failed to specify a specific duration for services. D. The plan of care for clinical record #2 included orders for "vital sign parameters" (patient specific). The plan of care failed to specify specific vital sign parameters. E. The clinical record #3 included a plan of care established by the physician for the certification period 3/30/17 through 5/28/17 with orders for "vital sign parameters" (patient specific) and to notify MD for any T-P-R outside of patient's baseline greater than 30-60		by September 9, 2017. The Director of Nursing or designated person will ensure compliance. Plans of Care will be reviewed at 100% for compliance x 2 months and then at 10% per quarter thereafter. Policy titled Monitoring Patient Care 3-14, will be revised to state that non-skilled supervisory visits will be conducted every 30 days, instead of every 60 days. Revision will be in place by 6/16/17. The Director of Nursing or designated person will ensure compliance. On 5/15/17, evidence of home health aide supervision every 2 weeks was placed into clinical record #1. The supervisory visit had been completed on 5/2/17, but the documentation was not found during the survey. The Director of Nursing or designated person will ensure compliance. 2. Starting 6/12/17, all processes involving patient care, will be available for immediate review, at all times, and will be ongoing. Quarterly, 5 patient-care-related processes will be selected, and an audit will be conducted to ensure the written processes are available for immediate review. This audit will take place for 2 quarters under the direction of the ED and/or designee A process of reviewing all nursing files, prior to placement with a patient for the appropriate competencies was initiated on 6/12/17 and will be ongoing. The	

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	minutes post intervention that are not resolved. The plan of care failed to specify specific vital sign parameters. F. The clinical record #4 included a plan of care established by the physician for the certification period 4/28/17 through 6/26/17 with orders to provide HHA services 2-4 hours a day for 2-4 days a week of unskilled care. The plan of care failed to specify a duration for services. G. The plan of care for clinical record #4 included orders/goals for the patient to maintain adequate cardiac output as evidenced by HR (heart rate) within ordered parameters and no s/s (signs or symptoms) of cardiac failure. The plan of care failed to specify specific vital sign parameters 8. The administrator failed to ensure home health aides were supervised by a health care professional to ensure competent provision of care in 1 out of 4 (#1) records reviewed. Clinical record #1 failed to evidence home health aide supervisory visits were conducted every 2 weeks. 9. The agency failed to evidence an updated policy that supervisor visits will be done every 30 days, either when the		Executive Director or designated person will be responsible for review of completion prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED or designee for a minimum of 2 quarters. 10% of all new administrative staff personal files will be audited for evidence of documented job specific orientation. The Executive Director or designated person will be responsible for review of completion prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED for a minimum of 2 quarters. A process of reviewing all direct care staff files, prior to placement with a patient for the appropriate physical examination dated within 180 days is present in the personal file before providing patient care was initiated on 6/15/17 and will be ongoing. 10% of actively working direct care staff personal files will be reviewed each quarter for the presence of a physical examination dated within 180 days of direct patient care. Audits will be conducted for 2 quarters. Current employee files will be audited and, if no physical is present, the employee will obtain a physical. The Executive Director will be responsible for this going forward. Outstanding	

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	HHA is present or absent. The agency's policy titled Monitoring Patient Care 3-14, Rev. 10/2009, stated the frequency of care supervision is as follows: Frequency of on-site patient monitoring visits are conducted every 60 days for personal care aide/HHA services (provided in conjunction with skilled services) ** an aide must be present during the supervisory visit.		physicals will be completed by September 9, 2017. Moving forward, all new employees will have a qualifying physical prior to providing care. The Executive Director or designated person will be responsible for review of completion prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED for a minimum of 2 quarters. A PICC line dressing change checklist process has been put in place as of 6/12/17. Checklist is to be completed every time a PICC dressing change is provided. 10% of check lists will be reviewed each quarter for completeness of hand hygiene during PICC dressing changes. Audits will last for a period of 2 quarters.. The Director of Nursing will be responsible for compliance through audit as mentioned above Administrator or Nursing Director will work with Regional to ensure that corporate compliance is aware of any law changes that require policy revision going forward. Beginning 5/19/17, all new staff, responsible for the development of patient care plans, will receive education regarding the need for orders indicating duration of care and patient specific vital signs on every plan of care. Education will be provided during job specific orientation. 10% of all patient	

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			charts will be audited quarterly for the presence of duration and patient specific v/s. All applicable clinicians will be educated as to how to properly complete a Plan of Care to include vital sign parameters and discipline frequency and duration. This will be completed by September 9, 2017. The Director of Nursing or designated person will ensure compliance. Plans of Care will be reviewed at 100% for compliance x 2 months and then at 10% per quarter thereafter. Administrator or Nursing Director will work with Regional to ensure that corporate compliance is aware of any law changes that require policy revision going forward. Any clinical team member responsible for supervisory visits will be required to have documentation of such supervision placed into the clinical file within 72 hours of completion. 10% off all patients' charts, receiving both skilled and unskilled care, will be audited quarterly for q 2 week supervisory visits, x 2 quarters. The Director of Nursing or designee will be responsible for completion. Results of all audits will be communicated to the Administrator ongoing upon their completion by the individual responsible for conducting the audit. 3. The Director of Nursing will be	

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			responsible for ensuring that all patient care related processes in use are available for immediate review. Audits will be conducted by the Director of Nursing or designated clinician weekly of 10% of weekly charting per nurse for a period no less than 2 quarters Review of nursing files for competencies prior to placement with a patient will be conducted by the ED. The Executive Director will be responsible for review of all competencies prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED or designated person for a minimum of 2 quarters. The regional nursing director will insure that documentation of job specific orientation for all administrator staff is place in personal files upon completion of orientation. The executive director will audit 10% of all new administrative staff personal files for the documentation evidencing job specific orientation upon its completion. Regional nursing director provided re-education. The ED or designee will review files of direct care staff, prior to the staff member providing patient care. The Executive Director will be responsible for review of all files prior to employee placement with a patient. 10% of files will be reviewed each quarter	

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			for completeness by the ED or designated person for a minimum of 2 quarters. ED will conduct audits. Re-education to employee B was provided by the Regional Nursing Director. Administator and Nursing Director Education and audits will be provided by the Director of Nursing. Administator and Nursing Director Education will be provided by the Director of Nursing. ND will also complete audits. The administrator will be responsible for review of all audit results and the initiation of further process implementation for less than compliant results 4. 6/16/17	
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 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.			

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	Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.			
	Based on personnel record review and interview the agency failed to include documentation of orientation to the job for 3 out of 5 (employees A, B, and E) personnel files reviewed. Findings include: 1. Personnel record A was reviewed on 5/16/17 and failed to evidence job orientation documentation for the Executive Director. 2. Personnel record B was reviewed on 5/16/17 and failed to evidence job orientation documentation for the Director of Nursing. 3. Personnel record E was reviewed on 5/16/17 and failed to evidence job orientation documentation for the Administrator. 4. In an interview with employee A and employee B on 5/16/17 neither employees was able to provide additional information regarding job orientation documentation for employee (A, B, and E) personnel records.	N 0460	1. Administrator, director of nursing and executive director all received job specific orientation on 1/4/17, but documentation was not in personal file during time of survey. Evidence of such orientation was placed into each personal file on 6/16/17. Moving forward, the ED and/ or ND will ensure that all positions receive proper job specific orientation. 10% of all files will be audited quarterly for a minimum of 2 quarters 2. 10% of all new administrative staff personal files will be audited for the documentation evidencing job specific orientation upon its completion. the ED and/ or ND will ensure that all positions receive proper job specific orientation. 10% of all files will be audited quarterly for a minimum of 2 quarters 3. The regional nursing director will insure that documentation of job specific orientation for the Administrator and Director of Nursing is placed in their personnel files upon completion of orientation. The Director of Nursing and/or Executive Director will ensure that all other administrative staff will	06/16/2017

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			receive job specific orientation and evidence of this orientation will be placed in their personnel file. The executive director will audit 10% of all new administrative staff personal files within 30 days of hire for the documentation evidencing job specific orientation upon its completion 4. 6/16/17	
N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.			
	Based on record review and interview, the agency failed to ensure personnel files included a physical examination not more than 180 days prior to direct patient contact for 1 of 2 direct care givers whose personnel records were reviewed (Employee B). Findings include: 1. Personnel file of Employee B was	N 0462	1. Reeducation was provided to executive director regarding the need for physical examination for all direct care staff to be present in the personal file, dated no more than 180 days prior to direct patient contact, before providing paitent care. (Regardless of transfer from parent agency to the independent agency). This education was provided on 6/15/17. Current employee files will be audited and, if no physical	06/15/2017

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	reviewed and evidenced the individual had been hired on 2/26/17 as a RN, Director of Nursing, first date of patient contact 3/1/17. The file evidenced a physical examination by a physician dated 2/4/15, 2 years before the date of first patient contact. 2. In an interview with the Executive Director on 5/16/17 s/he stated the physical examination provided was from previous employment at the parent agency and no employee physical had been completed for this agency.		is present, the employee will obtain a physical. The Executive Director will be responsible for this going forward. Outstanding physicals will be completed by September 9, 2017. Moving forward, all new employees will have a qualifying physical prior to providing care. The Executive Director or designated person will be responsible for review of completion prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED for a minimum of 2 quarters. 2. A process of reviewing all direct care staff files, prior to placement with a patient for the appropriate physical examination dated within 180 days is present in the personal file before providing patient care was initiated on 6/15/17 and will be ongoing. 10% of actively working direct care staff personal files will be reviewed each quarter for the presence of a physical examination dated within 180 days of direct patient care. Audits will be conducted for 2 quarters. Current employee files will be audited and, if no physical is present, the employee will obtain a physical. The Executive Director will be responsible for this going forward. Outstanding physicals will be completed by September 9, 2017. Moving forward, all new employees will have a qualifying	

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			physical prior to providing care. The Executive Director or designated person will be responsible for review of completion prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED for a minimum of 2 quarters. 3. Regional nursing director provided re-education to the ED and ND. The ED will review files of direct care staff, prior to the staff member providing patient care. ED will conduct audits on every newly on boarded staff member, random monthly audits on current staff members as well as quarterly audits by the internal compliance team 4. 6/15/17	
N 0470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.			
	Based on observation, policy review, and interview the agency failed to ensure staff complied with the agency's policy for handwashing for 1 of 2 (#3) home visit observations. Findings include:	N 0470	1. Employee B received re-education about hand hygiene during PICC dressing change on 6/12/17. Routine hand hygiene will be added to the Agency onboarding process by 6/30/17 and evidence of education to all field nurses working with IV clients will be placed in each personnel file. The Director of	06/12/2017

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	1. During a home visit on 5/15/17 at 5:30pm, employee B, an RN was observed while providing care to patient #3. The RN applied and removed gloves but failed to perform hygiene while performing a peripherally inserted central catherter (PICC) dressing change. 2. An undated agency policy titled, Hand Washing N-130 stated that the CDC (Center for Disease Control) recommends hand washing before and after handling dressings or touching open wounds. 3. In an interview with the Director of Nursing on 5/16/17 at 11am s/he a policy on hand hygiene that is utilized by the agency which indicated that hand hygiene is done prior to and after any contact with tubing, ports, dressings, infusion fluids, and the patient. The policy on Infection Prevention and Control the agency utilized stated gloves do not replace the need for hand washing or alcohol gel use.		Nursing will be responsible for completion and ongoing compliance by verifying completion for any and all nurses who work with infusion cases. 2. A PICC line dressing change checklist process has been put in place as of 6/12/17. Checklist is to be completed every time a PICC dressing change is provided. 10% of checklists will be reviewed each quarter for completeness of hand hygiene during PICC dressing changes. Audits will be conducted for 2 quarters. A process of reviewing all nursing files, prior to placement with a patient for the appropriate competencies was initiated on 6/12/17 and will be ongoing. 10% of actively working nursing personnel files will be reviewed each quarter for appropriate nursing competencies based on the patients they care for. Audits will last for a period of 2 quarters. The Director of Nursing will be responsible for compliance through audit as mentioned above. 3. Re-education to employee B was provided by the Regional Nursing Director. Audits will be completed by the ED. 4. 6/12/16	

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N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped. (j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.			
	Based on policy review and interview the agency failed to ensure the agency discharge policy included a 15 day notice before services are stopped. Findings Include: 1. A policy titled Termination of	N 0488	1. Policy titled Termination of Services Against the Family's Wishes 3-22, will be revised to include a 15 day notice before services are stopped. Revision will be in place by 6/16/17. 2.Administrator or Nursing Director will work with Regional to ensure that corporate compliance is aware of any law changes that	06/16/2017

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	Services Against the Family's Wishes 3-22, Rev. 10/2009 stated that notification will be provided to the family in writing not less than 72 hours prior to discontinuation of service, exempt when staff is in immediate jeopardy or the physician refuses orders to continue care. 2. In an interview with the Executive Director and Director of Nursing/alternate administrator on 5/16/17 at 1:30pm, neither was able to provide a current discharge policy stating the 15 day notice before services were .		require policy revision going forward. 3.Administator and Nursing Director 4. 6/16/17	
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			

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	against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record review, policy review, and interview the agency failed to ensure that all pertinent information was included on the plan of care in 4 out of 4 (#1,#2,#3,#4) records reviewed. Findings Include: 1. Clinical record #1, SOC (start of care) date 4/21/17, certification period 4/21/17 through 6/19/17 was reviewed on 5/15/17 and included a home health plan of care and assignment completed by the registered nurse, dated 4/21/17. A. The clinical record included a plan of care established by the physician for the certification period 4/21/17 through 6/19/17 with orders to provide HHA (home health aide) services 2-4 hours a day for 2-4 days a week of unskilled care and provide skilled nursing visits 1-3 times a week ongoing per MD (medical director) orders. The agency failed to specify a specific duration for services.	N 0524	1. On 5/19/16, the care plans of patients #1, 2 and 4 were updated by obtaining orders from their physicians, clarifying that the duration of ordered care indicated on the plans of care was for 60 days. On 5/19/17, the care plans of patients #1, 2, 3 and 4 were updated by obtaining orders from their physicians, clarifying patient specific vital sign parameters. All applicable clinicians will be educated as to how to properly complete a Plan of Care to include vital sign parameters and discipline frequency and duration. This will be completed by September 9, 2017 with oversight by the Director of Nursing. 2.Beginning 5/19/17, all applicable clinicians will be educated as to how to properly complete a Plan of Care to include vital sign parameters and discipline frequency and duration. This will be completed by September 9, 2017. The Director of Nursing or designated person will ensure compliance. Plans of Care will be reviewed at 100% for compliance x 2 months and then at 10% per quarter thereafter. 3. Education and audits will be provided by the Director of Nursing.	05/19/2017

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	B. The plan of care included orders for "vital sign parameters" and for SN (skilled nurse) to notify MD and/or RN (registered nurse) supervisor for a T (temperature), P (pulse), and R (respiration) outside of listed parameters greater than 30-60 minutes. The agency failed to specify the specific vital sign parameters. C. In an interview with the director of nursing on 5/16/17, s/he was unable to provide additional information as to why vital sign parameters was not established by the physician on the start of care date and was unaware specific duration for services need to be included on the plan of care. 2. Clinical record #2, SOC date 5/3/17, certification period 5/3/17 through 7/1/17 was reviewed on 5/15/17 and included a home health plan of care and assignment completed by the registered nurse, dated 5/3/17. A. The clinical record included a plan of care established by the physician for the certification period 5/3/17 through 7/1/17 with orders to provide HHA services 2-4 hours a day for 2-4 days a week of unskilled care. The agency failed to specify a specific duration for services.		4, 5/19/17	

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	B. The plan of care included orders for "vital sign parameters" (patient specific). The agency failed to specify specific vital sign parameters. C. In an interview with the director of nursing on 5/16/17, s/he was unable to provide additional information as to why vital sign parameters was not established by the physician at the start of care date. The director of nursing was unaware specific duration of services need to be included on the plan of care. 3. Clinical record #3, SOC date 3/30/17, certification period 3/30/17 through 5/28/17 was reviewed on 5/15/17 and included a home health plan of care and assignment completed by the registered nurse, dated 4/6/17. A. The clinical record included a plan of care established by the physician for the certification period 3/30/17 through 5/28/17 with orders for "vital sign parameters" (patient specific) and to notify MD for any T-P-R outside of patient's baseline greater than 30-60 minutes post intervention that are not resolved. The agency failed to specify specific vital sign parameters. B. In an interview with the director of			

nursing on 5/16/17, s/he was unable to provide additional information as to why vital sign parameters were not established by the physician at the start of care date.

4. Clinical record #4, SOC date 4/28/17, certification period 4/28/17 through 6/26/17 was reviewed on 5/15/17 and included a home health plan of care and assignment completed by the registered nurse, dated 4/28/17.

A. The clinical record included a plan of care established by the physician for the certification period 4/28/17 through 6/26/17 with orders to provide HHA services 2-4 hours a day for 2-4 days a week of unskilled care. The agency failed to specify a specific duration for services.

B. The plan of care included orders/goals for the patient to maintain adequate cardiac output as evidenced by HR (heart rate) within ordered parameters and no s/s (signs or symptoms) of cardiac failure. The agency failed to specify specific vital sign parameters.

C. In an interview with the director of nursing/alternate administrator on 5/16/17, s/he was unable to provide additional information to evidence compliance.

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N 0584 Bldg. 00	410 IAC 17-14-1(g) Scope of Services Rule 14 Sec. 1(g) Home health aides shall be supervised by a health care professional to ensure competent provision of care. Supervision of services must be within the scope of practice of the health care professional providing the supervision. Based on clinical record review, policy review, and interview the agency failed to ensure home health aides were supervised by a health care professional to ensure competent provision of care in 1 out of 4 (#1) records reviewed. Findings include: 1. Clinical record #1 was reviewed on 5/15/17 and failed to evidence home health aide supervisory visits were conducted every 2 weeks. B. A policy titled Monitoring Patient Care 3-14 stated the frequency of care supervision is as follows: Frequency of on-site patient monitoring visits is every 2 weeks for personal care aide/HHA services (provided in conjunction with skilled services. C. In an interview on 5/16/17 at 130 PM, the Executive Director and Director of	N 0584	1. On 5/15/17, evidence of home health aide supervision every 2 weeks was placed into clinical record #1. The supervisory visit had been completed on 5/2/17, but the documentation was not found during the survey. Moving forward, 10% of applicable charts will be audited each quarter to ensure compliance. The Director of Nursing or designee will be responsible for the audits 2. Any clinical team member responsible for supervisory visits, will be required to have documentation of such supervision placed into the clinical file within 72 hours of completion. 10% off all patients' charts, receiving both skilled and unskilled care, will be audited quarterly for q 2 week supervisory visits, x 2 quarters. The Director of Nursing or designee will be responsible for the audits 3. Education will be provided by the Director of Nursing. 10% off all patients' charts, receiving	05/16/2017

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	Nursing/Alternate administrator were unable to evidence documentation that supervisory visits were conducted every 2 weeks in accordance agency policy.		both skilled and unskilled care, will be audited quarterly for q 2 week supervisory visits, x 2 quarters. The Director of Nursing or designee will be responsible for the audits 4. 5/16/17	
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.			
	Based on policy review and interview the agency failed to evidence a policy that supervisory visits will be done every 30 days, either when the HHA is present or absent. Findings include: 1. The policy titled Monitoring Patient Care 3-14, Rev. 10/2009, stated the frequency of care supervision is as follows: Frequency of on-site patient monitoring visits are conducted every 60 days for personal care aide/HHA services (provided in conjunction with skilled services) ** an aide must be present during the supervisory visit. 2. Indiana Law states "a registered nurse	N 0606	1. Policy titled Monitoring Patient Care 3-14, will be revised to state that non-skilled supervisory visits will be conducted every 30 days, instead of every 60 days. Revision will be in place by 6/16/17. 2.Administrator or Nursing Director will work with Regional to ensure that corporate compliance is aware of any law changes that require policy revision going forward. 3.Administator and Nursing Director 4. 6/16/17	06/16/2017

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	, or therapist only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. (Indiana State Department of Health; 410 IAC 17-14-1)." 3. In an interview with the Executive Director and Director of Nursing on 5/16/17 at 1:30pm, both were unaware the agency policy stated that non-skilled supervisory visits are to be conducted every 60 days instead of 30 days.			