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| | | A. BUILDING 00<br>B. WING | 12/04/2017 |

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| ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC | 9840 WESTPOINT DRIVE, SUITE 400<br>INDIANAPOLIS, IN 46256 |

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| G 0153<br>Bldg. 00 | 484.16<br>GROUP OF PROFESSIONAL PERSONNEL<br>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. | G 0153 | N/A | 01/02/2018 |
| G 0154<br>Bldg. 00 | 484.16(a)<br>ADVISORY AND EVALUATION FUNCTION<br>The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the 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. | G 0154 | N/A | 01/02/2018 |
| G 0156<br>Bldg. 00 | 484.18<br>ACCEPTANCE OF PATIENTS, POC, MED SUPER | G 0156 | N/A | 01/02/2018 |
| G 0157<br>Bldg. 00 | 484.18<br>ACCEPTANCE OF PATIENTS, POC, MED SUPER<br>Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the | | | |

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

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| | patient's place of residence. | G 0157 | N/A | 01/02/2018 |
| G 0158<br>Bldg. 00 | 484.18<br>ACCEPTANCE OF PATIENTS, POC, MED SUPER<br>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. | G 0158 | N/A | 01/02/2018 |
| G 0159<br>Bldg. 00 | 484.18(a)<br>PLAN OF CARE<br>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. | G 0159 | N/A | 01/02/2018 |
| G 0166<br>Bldg. 00 | 484.18(c)<br>CONFORMANCE WITH PHYSICIAN ORDERS<br>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. | G 0166 | N/A | 01/02/2018 |
| G 0168 | 484.30<br>SKILLED NURSING SERVICES | | | |

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| Bldg. 00 | | G 0168 | N/A | 01/02/2018 |
| G 0172<br>Bldg. 00 | 484.30(a)<br>DUTIES OF THE REGISTERED NURSE<br>The registered nurse regularly re-evaluates the patients nursing needs. | G 0172 | N/A | 01/02/2018 |
| G 0173<br>Bldg. 00 | 484.30(a)<br>DUTIES OF THE REGISTERED NURSE<br>The registered nurse initiates the plan of care and necessary revisions. | G 0173 | N/A | 01/02/2018 |
| G 0175<br>Bldg. 00 | 484.30(a)<br>DUTIES OF THE REGISTERED NURSE<br>The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. | G 0175 | N/A | 01/02/2018 |
| G 0176<br>Bldg. 00 | 484.30(a)<br>DUTIES OF THE REGISTERED NURSE<br>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. | G 0176 | N/A | 01/02/2018 |
| G 0178<br>Bldg. 00 | 484.30(a)<br>DUTIES OF THE REGISTERED NURSE<br>The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. | G 0178 | N/A | 01/02/2018 |
| G 0224<br>Bldg. 00 | 484.36(c)(1)<br>ASSIGNMENT & DUTIES OF HOME HEALTH AIDE | | | |

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| | 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. | G 0224 | N/A | 01/02/2018 |
| G 0235<br>Bldg. 00 | 484.48<br>CLINICAL RECORDS | G 0235 | N/A | 01/02/2018 |
| G 0236<br>Bldg. 00 | 484.48<br>CLINICAL RECORDS<br>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. | G 0236 | N/A | 01/02/2018 |
| G 0330<br>Bldg. 00 | 484.55<br>COMPREHENSIVE ASSESSMENT OF PATIENTS<br>Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's | | | |

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| | continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary | G 0330 | N/A | 01/02/2018 |
| G 0332<br>Bldg. 00 | 484.55(a)(1)<br>INITIAL ASSESSMENT VISIT<br>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 | N/A | 01/02/2018 |
| G 0334<br>Bldg. 00 | 484.55(b)(1)<br>COMPLETION OF THE COMPREHENSIVE ASSESSMENT<br>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. | G 0334 | N/A | 01/02/2018 |
| G 0337<br>Bldg. 00 | 484.55(c)<br>DRUG REGIMEN REVIEW<br>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, | | | |

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| | including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. | G 0337 | N/A | 01/02/2018 |
| G 0339<br>Bldg. 00 | 484.55(d)(1)<br>UPDATE OF THE COMPREHENSIVE ASSESSMENT<br>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. | G 0339 | N/A | 01/02/2018 |
| N 0000<br>Bldg. 00 | This was a follow up initial state licensure survey.<br><br>Survey dates: November 30 and December 1, 2017<br><br>Facility Number: 014118<br><br>Clinical Records Reviewed: 3 (2 active and 1 on hold)<br><br>Census: 3 | N 0000 | | |

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| N 0449<br><br>Bldg. 00 | 410 IAC 17-12-1(c)(6)<br>Home health agency administration/management<br>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:<br>(6) Ensure that the home health agency meets all rules and regulations for licensure.<br>Based on record review, the Administrator failed to ensure the home health agency met all the rules and regulations for licensure in 1 of 1 agency.<br><br>Findings include:<br><br>1. The Administrator failed to ensure that the Quality Assessment and Performance Improvement Program (QAPI) identified specific data in regards to patient care, coordination, and documentation. (See N 456 and N472)<br><br>2. The Adminstrator failed to ensure the case manager efforts were coordinated with an outlying home care agency, primary care physician listed on the plan of care, and specialty physicians in 1 out of 3 records reviewed. (See N 486)<br><br>3. The Administrator failed to ensure care and services was provided to a patient accepted for care on the basis that his / her | N 0449 | **N449**<br><br>**UPDATE:**<br>**In conjunction with the Director of Nursing and Compliance/designee, the Administrator is going to ensure that the agency meets all state laws and regulations for licensure by implementing and following this plan of correction. This will be done by reviewing chart documentation, audit results, and monitoring staff education for areas of concern.**<br>**The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.** | 02/16/2018 |

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| | health needs could adequately be met. (See N 520)<br><br>4. The Administrator failed to ensure the Registered Nurse followed the plan of care in regards to supervisory visits and the home health aide failed to follow the plan of care. (See N 522)<br><br>5. The Administrator failed to ensure that the development of the plans of care were supported by the comprehensive assessment and failed to include a duration of services to be provided. (See N 524 and N 542)<br><br>6. The Administrator failed to accurately identify a patient's dialysis access and failed to include all possible dialysis access sites. (See N 541)<br><br>7. The Administrator failed to ensure that appropriate preventative nursing measures were put into place with patient identified as a fall and nutritional risk. (See N 543)<br><br>8. The Administrator failed to ensure that a patient was educated on a new medication order upon a return home from the hospital. (See N 546)<br><br>9. The Administrator failed to ensure verbal orders in writing after an admission | | | |

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| | assessment. (See N 547)<br><br>10. The Administrator failed to ensure that the comprehensive 60 day reassessments were accurate, consistent and contained adequate amount of information to support the plan of care. (See N 563)<br><br>11. The Administrator failed to ensure supervisory visits included observance of care, assessment of the relationship between the patient and the home health aide and supervisory visits were conducted every 30 days. (See N 606) | | | |
| N 0456<br><br>Bldg. 00 | 410 IAC 17-12-1(e)<br>Home health agency administration/management<br>Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following:<br>(1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care.<br>(2) Resolve identified problems.<br>(3) Improve patient care.<br><br>Based on record review and interview, the administrator failed to ensure that the agency's Quality Assessment and Performance Improvement Program (QAPI) identified specific data in regards to patient care, coordination, and documentation. | N 0456 | **N456**<br>The Administrator will update the agency's Quality Assessment and Performance Improvement Program (QAPI) by 1/2/18.<br>The updated Chart Audit Form will include the following questions:<br>a. Has appropriate care been provided?<br>b. Is the Comprehensive Assessment complete and accurate? | 02/16/2018 |

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| | Findings include:<br><br>1. Review of the agency's QAPI binder on 11/30/17, the binding included an agency form titled "Medical Record Review) in October, 2017. The former indicated the agency exceeded expected thresholds in Administration, Assessment / Plan of Care / 485, Medication Review, and Plan of Care / 485.<br><br>2. Review of the chart audits performed on patient #9 and #11, the chart audit forms failed to include information to determine if appropriate care had been provided, failed to ensure the comprehensive assessment were complete, accurate, and supported the plans of care, failed to ensure the plans of care included interventions for prevention of falls and weight loss, failed to ensure coordination of care with the patients physicians after appointments, failed to ensure case managers were appropriately conducting home health aide supervisory visits and observing care and interaction between the patient and the home health aide, and failed to ensure the plans of care were being followed.<br><br>3. The Administrator and Alternate Administrator were interviewed on 12/1/17 | | c. Does the Comprehensive Assessment support the Plan of Care?<br>d. Does the Comprehensive Assessment include interventions for fall prevention?<br>e. Does the Comprehensive Assessment include interventions for weight loss?<br>f. Has care coordination with MDs been documented?<br>g. Were aide supervisory visits done timely?<br>h. During aide supervisory visits was care observed?<br>i. During aide supervisory visits was the interaction between patient and aide documented?<br>j. Was the aide plan of care followed?<br>k. Was the nursing plan of care followed?<br><br>On 12/26/17, this agency contracted with a Homecare Consultant.<br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Then quarterly, will be audited by Administrator or designee.<br>Administrator/designee will in-service current nurses on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed | |

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| | at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. | | being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To be done by 1/20/18.<br>Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going.<br>Administrator/designee will in-service current aides on following aide plan of care as written. To be done by 1/20/18.<br>Administrator/designee will ensure orientation of newly hired aides will include training on following the aide plan of care as written. To begin immediately and be on-going.<br>Consultant will train Administrator/designee on how to accurately do chart reviews by 1/20/18.<br>The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.<br>UPDATE:<br>**The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and** | |

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| | | | **appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items.**<br>**The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters.**<br>**The Administrator or designee will monitor corrective actions by reviewing every chart audit on a weekly basis for 2 months and then quarterly thereafter to ensure there is follow up to correct noted issues and that issues don't reoccur.**<br>**After 2 months, all charts that meet 100% of compliance will be audited on a quarterly basis by Director of Nursing and Compliance or designee. Any chart that does meet 100% on the QAPI tool will continue to be audited weekly until 100% compliance.**<br>**We have updated our QAPI tool that we will continue to use ongoing to ensure these standards are met. We will continue to use these weekly for the next 2 months and then quarterly. This tool includes issues cited from previous survey as well as other areas.**<br>**The agency will ensure the** | |

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| | | | **Director of Nursing and Compliance/designee are educated on chart audits and completing chart audits appropriately by meeting with the Consultant to be educated. The Administrator will ensure that compliance is met by teaming with the Director of Nursing and Compliance/designee to ensure chart audits are ongoing.** | |
| N 0472<br><br>Bldg. 00 | 410 IAC 17-12-2(a)<br>Q A and performance improvement<br>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.<br><br>Based on record review and interview, the agency failed to ensure that their Quality Assessment and Performance Improvement Program (QAPI) identified specific data in | N 0472 | N472<br>The Administrator will update the agency's Quality Assessment and Performance Improvement Program (QAPI) by 1/2/18.<br>The updated Chart Audit Form will include the following questions:<br>a. Has appropriate care been provided? | 02/16/2018 |

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| ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC | 9840 WESTPOINT DRIVE, SUITE 400<br>INDIANAPOLIS, IN 46256 |

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| | regards to patient care, coordination, and documentation.<br><br>Findings include:<br><br>1. Review of the agency's QAPI binder on 11/30/17, the binding included an agency form titled "Medical Record Review) in October, 2017. The former indicated the agency exceeded expected thresholds in Administration, Assessment / Plan of Care / 485, Medication Review, and Plan of Care / 485.<br><br>2. Review of the chart audits performed on patient #9 and #11, the chart audit forms failed to include information to determine if appropriate care had been provided, failed to ensure the comprehensive assessment were complete, accurate, and supported the plans of care, failed to ensure the plans of care included interventions for prevention of falls and weight loss, failed to ensure coordination of care with the patients physicians after appointments, failed to ensure case managers were appropriately conducting home health aide supervisory visits and observing care and interaction between the patient and the home health aide, and failed to ensure the plans of care were being followed. | | b. Is the Comprehensive Assessment complete and accurate?<br>c. Does the Comprehensive Assessment support the Plan of Care?<br>d. Does the Comprehensive Assessment include interventions for fall prevention?<br>e. Does the Comprehensive Assessment include interventions for weight loss?<br>f. Has care coordination with MDs been documented?<br>g. Were aide supervisory visits done timely?<br>h. During aide supervisory visits was care observed?<br>i. During aide supervisory visits was the interaction between patient and aide documented?<br>j. Was the aide plan of care followed?<br>k. Was the nursing plan of care followed?<br><br>On 12/26/17, this agency contracted with a Homecare Consultant.<br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Then quarterly, will be audited by Administrator or designee.<br>Administrator/designee will in-service current nurses on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, | |

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| | 3. The Administrator and Alternate Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. | | doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To be done by 1/20/18.<br>Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going.<br>**UPDATE:**<br>**The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items.**<br>**The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters.**<br>**The Administrator or designee will monitor corrective actions by reviewing every chart audit on a** | |

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| | | | **weekly basis for 2 months and then quarterly thereafter to ensure there is follow up to correct noted issues and that issues don't reoccur.**<br>**After 2 months, all charts that meet 100% of compliance will be audited on a quarterly basis by Director of Nursing and Compliance or designee. Any chart that does meet 100% on the QAPI tool will continue to be audited weekly until 100% compliance.**<br>**We have updated our QAPI tool that we will continue to use ongoing to ensure these standards are met. We will continue to use these weekly for the next 2 months and then quarterly. This tool includes issues cited from previous survey as well as other areas.**<br>**The agency will ensure the Director of Nursing and Compliance/designee are educated on chart audits and completing chart audits appropriately by meeting with the Consultant to be educated.**<br>**The Administrator will ensure that compliance is met by teaming with the Director of Nursing and Compliance/designee to ensure chart audits are ongoing.** | |
| N 0486<br><br>Bldg. 00 | 410 IAC 17-12-2(h)<br>Q A and performance improvement<br>Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. | N 0486 | N486<br><br>The Administrator will provide an | 02/16/2018 |

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| | Based on record review and interview, the agency failed to ensure their efforts were coordinated with an outlying home care agency, primary care physician listed on the plan of care, and specialty physicians in 1 out of 3 records reviewed. (#9)<br><br>Findings include:<br><br>1. The clinical record of patient #9, was reviewed on 12/1/17. The clinical record contained the following documents:<br><br>A. An agency document titled "Nursing Supervisory Note" dated 9/1/17, indicated the patient had an appointment with a surgeon on 9/8/17. The clinical record failed to evidenced documentation of coordination with the surgeon's office in regards to follow up / possible change in orders or patient condition and failed to include the services being provided by the shared agency along with dates and times.<br><br>B. An agency document titled "Nursing Supervisory Note" dated 9/25/17, indicated the patient had an appointment with a Nurse Practitioner for "[name of physician]" and the patient was receiving services from another home health agency. The clinical record failed to evidenced documentation of coordination with the Nurse Practitioner / | | in-service to all internal employees including Clinical Managers by 1/16/18. The in-service will review coordination of care with other healthcare providers. Clinical Managers should conduct coordination of care at a minimum of once per month to ensure no duplication of services. Supervisory note updated to include other services provided, dates, and times. Clinical Managers in-serviced to contact other providers providing care to client and document services, dates, and times they are in the home. The in-service will also review with Clinical Managers to follow up and document physician appointments to ensure possible changes in orders or condition of patient are documented and staff in the home is educated.<br><br>Administrator/designee will ensure orientation of newly hired Clinical Managers includes: coordination of care with other healthcare providers. Clinical Managers should conduct coordination of care at a minimum of once per month to ensure no duplication of services. Supervisory note updated to include other services provided, dates, and times. Clinical Managers to contact other providers providing care to client and document services, dates, and times they are in the home. Clinical Managers to follow up and | |

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| | physician office in regards to follow up / possible change in orders or patient condition and failed to include the services being provided by the shared agency along with dates and times.<br><br>C. An agency document titled "Nursing Supervisory Note" dated 10/5/17, indicated the patient had a vascular lab appointment on 11/7/17, dialysis on Tuesday, Thursday, and Saturday, and was receiving services from another home health agency. The clinical record failed to evidenced coordination with the physician or dialysis center in regards to follow up / possible change in orders or patient condition after the vascular lab and failed to include the services being provided by the shared agency along with dates and times.<br><br>D. An agency document titled "Patient Care Coordination" dated 10/5/17 and 11/2/17, indicated the patient continued to have another agency come into the home to help care for the patient's instrumental activities of daily living and that the agency was aware of the services being provided by Adaptive. The coordination document failed to include the services being provided by the shared agency along with dates and times.<br><br>2. The findings was reviewed with the | | document physician appointments to ensure possible changes in orders or condition of patient are documented and staff in the home is educated.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met.<br><br>The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | |

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| | Director of Clinical Services, Administrator, and Alternate Administrator on 12/1/17 at 4:30 PM and all management personnel acknowledged and agreed that follow up was needed by the case manager after the patient's physician appointments. | | | |
| N 0520<br><br>Bldg. 00 | 410 IAC 17-13-1(a)<br>Patient Care<br>Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.<br><br>Based on record review and interview, the agency failed to ensure care and services was provided to a patient accepted for care on the basis that his / her health needs could adequately be met in 1 out of 1 records reviewed of a patient newly admitted since 8/3/17.<br><br>Findings included:<br><br>1. The clinical record for patient #12, start of care 9/28/17, included a plan of care for the certification period of 9/28/17 to 11/26/17, with orders for Home Health aide services 2 hours a day, 2 to 3 days per week, to assist with all ADL's (activities of | N 0520 | N520<br>The Administrator will provide an in-service to all internal employees by 1/16/18. The in-service will review the agency bed bug policy. On 12/26/17, the Agency's bed bug policy was updated. The policy was updated to reflect that the agency has ensured care and services are provided adequately even in the event of bed bug infestation. The policy is uploaded as a supporting document.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that | 02/16/2018 |

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| | daily living) such as banking, you're care, dressing, nail care, incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>2. Review of the clinical record on 11/30/17, a Physician's order dated 11/6/17, indicated that Home Health aide services to be placed on hold as of 11/6/17, due to the patient having bed bugs. The clinical record failed to evidence any documentation of the agency following up with the patient or caregivers in regards to extermination of the infestation.<br><br>3. The director of clinical services and the administrator were queried on their expectations of services to be provided with a patient with known bed bugs on 11/30/17 at 3:45 PM. The director of clinical services indicated it was their policy to place services on hold. The administrator queried about Home Health aides refusing to provide services due to a fear of transporting the bed bugs to other patients' homes or into their own homes. The administrator then indicated that services should continue regardless of the bed begs because the patient was in need of services and if they could not provide services during this time, then the patient should be discharged and referred to another agency who could meet | | does not meet 100% compliance will be audited weekly until that threshold is met.<br>Administrator/designee will ensure orientation of newly hired clinical staff will include review of agency bed bug policy. To begin immediately and be on-going.<br>The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.<br>On 11/13/17, the agency followed up with the patient's primary caregiver in regards to the extermination of infestation. The primary caregiver understood that they would need to get the bed bugs taken care of before services would resume. On 11/21/17 the agency followed up with the patient's primary caregiver in regards to the extermination of infestation. On 12/1/17, the agency followed up with the patient's primary caregiver in regards to the extermination of infestation and confirmed a first treatment was being completed next week. On 12/8/17, the agency followed up with the patient's primary caregiver in regards to the extermination of infestation. On 12/15/17, the agency followed up with the patient's primary caregiver in regards to the extermination of infestation. On 12/21/17, the agency followed up with the patient's primary caregiver in regards to the extermination of infestation. On 12/26/17, when the bed bug policy was updated, the agency followed up with the | |

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| | the patient's needs. The administrator indicated he needed to follow up with the caregivers.<br><br>4. An agency policy titled "Bed Bug Policy" revised 2/15/16, indicated " ... Health care workers that routinely visit clients' homes as a part of their job are at risk for contacting bed bugs. Service workers that routinely visit clients homes as a part of their job .... " The policy went on to include a procedure to follow should the worker came into contact with a patient with bed bugs. The policy ended with "In order to ensure a safe working environment, Adaptive does not provide staff in the homes of clients / patients with a current bed bug infestation. After treatment of the bed bug infestation and verification that the home is bug free, services to the client / patient will resume."<br><br>5. An agency policy titled "Plan of Treatment" revised on 3/21/12, indicated " ... Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence .... " | | patient's primary caregiver to give her the option of offering other providers who may be able to staff in the event they were not able to finish the treatment of bed bugs within 15 days. On 12/29/17, the agency followed up with the patient's primary caregiver and confirmed that the final treatment was completed on 12/28/17. The extermination company will be coming out in the next week or two, to inspect to confirm no prescense of bed bugs. The primary caregiver asked if this agency could follow up next week to obtain an all clear letter at that point and then said she would prefer to resume services at that point rather than switching to another company. On 1/5/18, the agency followed up with the patient's primary caregiver and she said the extermination was scheduled to come out on 1/11/18. She asked for a follow up on 1/12/18.<br><br>**Update:**<br>**The Agency will ensure the patient's needs, as addressed by the plan of care, are met by communicating with the client and primary caregiver to ensure that someone is available to assist the client with their personal care needs, as needed. Agency will also inform the MD and, Case Manager if applicable, in the event they feel the client needs to be temporarily transferred to** | |

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| | | | **a facility/another agency. Agency will follow up with client/caregiver at least weekly to ensure personal care needs are being met. Director of Nursing and Compliance/designee will audit 100% of clinical documentation weekly to ensure documentation indicates patient's needs are being met.**<br>**Once 100% compliance is achieved Director of Nursing and Compliance will audit 25% of documentation quarterly to ensure compliance with patient needs being met. If patient needs aren't being met Director of Nursing and Compliance/designee will monitor for documentation showing attempts by agency staff to assist patient with getting needs met or assisting patient/caregiver with obtaining assistance with getting needs met.** | |
| N 0522<br><br>Bldg. 00 | 410 IAC 17-13-1(a)<br>Patient Care<br>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: | N 0522 | N522<br>The agency's supervisory note will be updated as of 1/2/18 to include | 02/16/2018 |

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| | Based on record review and interview, the agency failed to ensure the Registered Nurse followed the plan of care in regards to supervisory visits in 2 out of 3 records reviewed (#9 and 11) and the home health aide failed to follow the plan of care in regards to staying in a patient's home for an additional 2 hours without an order in 1 out of 3 records reviewed (#9).<br><br>Findings include:<br><br>1. Per Article 17, 410 IAC 17-14-1 (n), "A registered nurse ... make a supervisory visit at least every 30 days, wither when the home health aide is present or absent, to observed the care, to assess relationships, and to determine whether goals are being met." The Registered Nurse failed to follow the plan of care in regards to performing supervisory visits per state regulations.<br><br>2. The clinical record for patient #9 was reviewed on 12/1/17. The clinical record contained a plan of care for the certification period of 10/7/17 to 12/5/17, with orders for the Registered Nurse "to perform supervisory visits per state regulations ... RN to monitor vital signs and pulse oximetry at this time." The plan of care also included orders for the home health aide to provide services 2 hours a day 2 to 3 days a week. | | observation of Home Health Aide providing direct care to the patient at a minimum of at least every 30 days.<br>Administrator/designee will provide re-education to both internal staff, which refers to clinical managers and external staff, which refers to hourly caregivers working in the home, on following the plan of care. This will also include a review of supplemental orders and when those are necessary. The in-service will provide re-education that when a patient or caregiver notifies the agency that they are working hours that do not follow the plan of care, the registered nurse will obtain a verbal and signed physician order to authorize the change to the plan of care. This order will be maintained in the clinical record.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met. The Administrator or designee will be responsible for monitoring these corrective actions to ensure | |

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| | A. Review of an agency form titled "Nursing Supervisory Note" dated 11/2/17, included care coordination (such as level of services, advance directives, plan of care reviewed and appropriate, changes to the treatment, other agencies in the home), chart (current plan of care in the chart and reviewed, home chart reviewed, emergency plan reviewed, grievance and branch numbers available, current medication profile in chart and updated, medication reconciliation complete, and goals reviewed), Patient / caregiver (verbalizing satisfaction with services, involved and agreed with plan of care, any changes in patient caregiver involvement, patient / caregiver education provided if necessary), environment (patient area / room clean and organized, DME and supplies match plan of care, oxygen safety observed, medications stored appropriately), assessment (vital signs obtained including oxygen saturations), and pain assessments.<br><br>B. Review of a home health aide visit note dated 11/25/17, the home health aide note indicated "I call they office 2 C if I could stay he stayed home to day he didn't fill good [sic]." The time in indicated 7:00 AM and the time out indicated 11:00 AM. Review of the clinical record, the record | | that this deficiency is corrected and will not recur.<br>The Administrator will in-service all agency by 1/16/18 on the requirement for Registered Nurse to make an aide supervisory visit at least every 30 days, whether aide is present or not, to observe the care aide is providing, to assess relationship between aide and patient and to determine if goals are being met.<br>The Administrator/designee will ensure orientation of newly hired agency staff includes education on following the plan of care, review of supplemental orders and when those are necessary. Orientation will include education that when a patient or caregiver notifies the agency that they are working hours that do not follow the plan of care, the registered nurse will obtain a verbal and signed physician order to authorize the change to the plan of care. This order will be maintained in the clinical record. | |

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| | failed to contain a verbal order for the home health aide to stay an additional 2 hours. The home health aide failed to follow the plan of care.<br><br>3. The clinical record for patient #11 was reviewed on 12/1/17. The clinical record contained a plan of care for the certification period of 11/10/17 to 1/8/18, with orders for the Registered Nurse "to perform supervisory visits per state regulations ... RN to monitor vital signs and pulse oximetry at this time."<br><br>A. Review of an agency form titled "Nursing Supervisory Note" dated 11/2/17 and 11/7/17, included care coordination (such as level of services, advance directives, plan of care reviewed and appropriate, changes to the treatment, other agencies in the home), chart (current plan of care in the chart and reviewed, home chart reviewed, emergency plan reviewed, grievance and branch numbers available, current medication profile in chart and updated, medication reconciliation complete, and goals reviewed), Patient / caregiver (verbalizing satisfaction with services, involved and agreed with plan of care, any changes in patient caregiver involvement, patient / caregiver education provided if necessary), environment (patient area / room | | | |

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| | clean and organized, DME and supplies match plan of care, oxygen safety observed, medications stored appropriately), assessment (vital signs obtained including oxygen saturations), and pain assessments.<br><br>4. The findings were reviewed with the Director of Clinical Services, Administrator, and Alternate Administrator on 12/1/17 at 4:30 PM, and indicated the case manager / registered nurse should have been observing care provided by the home health aide during joint visits and that an order should have been obtained for the additional time.<br><br>5. An agency policy titled "Plan of Treatment" revised on 3/21/12, indicated " ... Medical care shall follow a written medical plan of care established and periodically reviewed by the physician .... "<br><br>6. An agency policy titled "Supplemental Physician Orders" revised on 3/21/12, indicated "A signed physician order must be obtained any time an order is taken which modifies the existing orders on the Plan of Care .... " | | | |
| N 0524 | 410 IAC 17-13-1(a)(1)<br>Patient Care | | | |

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| Bldg. 00 | Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:<br>(A) Be developed in consultation with the home health agency staff.<br>(B) Include all services to be provided if a skilled service is being provided.<br>(B) Cover all pertinent diagnoses.<br>(C) Include the following:<br>(i) Mental status.<br>(ii) Types of services and equipment required.<br>(iii) Frequency and duration of visits.<br>(iv) Prognosis.<br>(v) Rehabilitation potential.<br>(vi) Functional limitations.<br>(vii) Activities permitted.<br>(viii) Nutritional requirements.<br>(ix) Medications and treatments.<br>(x) Any safety measures to protect against injury.<br>(xi) Instructions for timely discharge or referral.<br>(xii) Therapy modalities specifying length of treatment.<br>(xiii) Any other appropriate items.<br><br>Based on record review and interview, the agency failed to ensure that the development of the plans of care were supported by the comprehensive assessment and failed to include a duration of services to be provided in 3 out of 3 records reviewed. (#9, 11 and 12)<br><br>Findings include: | N 0524 | N 524<br>The Administrator will provide an in-service to all internal employees including Clinical Managers by 1/16/18. The in-service will include the following: The clinicians will be educated that the duration of services needs to be included on the verbal order when and also on the plan of care.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance | 02/16/2018 |

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| | 1. The clinical record of #9, SOC (start of care) of 4/10/17, was reviewed on 12/1/17. The clinical record included a plan of care for the certification period of 10/7/17 to 12/5/17, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 hours a week, not to exceed 6 hours per week through the certification period to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were sequelae of other cerebrovascular (stroke) with secondary diagnoses of end stage renal disease, essential hypertension, athlersclerotic heart disease, hyperlipidemia and anemia.<br><br>C. The patient's medications included Lipitor (treat high cholesterol), metoprolol (treat high blood pressure), Seroquel (treatment of schizophrenia, bipolar and depression), pantoprazole (treat high levels of stomach acid) Isosorbide (treat high blood pressure and chest pain), Carbidopa-Levodopa (treat high blood | | with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.<br>The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.<br>The Administrator/designee will provide an in-service to all internal employees including Clinical Managers by 1/16/18. The in-service will review coordination of care with other healthcare providers. Clinical Managers will conduct coordination of care at a minimum of once per month to ensure no duplication of services. Clinical Managers will be in-serviced to contact other providers providing care to client and document services, dates, and times they are in the home. The in-service will also review with Clinical Managers to follow up and document physician appointments to ensure possible changes in orders or condition of patient are documented and staff in the home is educated. | |

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| | pressure), Iron (anemia supplement), Epogen (anemia treatment during dialysis), Hectorol (high parathyroid treatment during dialysis), and Venofer (anemia treatment during dialysis).<br><br>D. Safety measures included but were not limited to respiratory precautions.<br><br>E. Nutritional requirements indicated the patient was on a low nutritional status, renal diet, low sodium, and fluid restrictions.<br><br>F. Functional limitations included but were not limited to paralysis.<br><br>G. The plan of care indicated the patient had dialysis 3 times a week.<br><br>H. The patient goals included no falls and no weight loss over the next 60 days.<br><br>I. Page 2 of the same plan of care included a 60 day summary dated 10/5/17, indicating the patient's dialysis site located on the right side of the chest was intact, continued to need "help hands on help", continued to be unsteady on his feet which continued to make him a high fall risk, had a fistula that was placed in the right arm and had a vascular appointment in November, continued to have dialysis three times a | | The Administrator/designee will ensure orientation of newly hired internal staff, including Clinical Managers, includes: review coordination of care with other healthcare providers, Clinical Managers should conduct coordination of care at a minimum of once per month to ensure no duplication of services, Clinical Managers are to contact other providers providing care to client and document services, dates, and times they are in the home and Clinical Managers are to follow up and document physician appointments to ensure possible changes in orders or condition of patient are documented and staff in the home is educated. To begin immediately and be on-going.<br><br>The Administrator/designee will in-service Clinical Managers on ensuring the plan of care is supported by the documentation in the comprehensive assessment. Clinical Managers to include, when applicable, the following: if patient has dialysis access site – where is the site, who is responsible to monitor the access site; names of physicians that may give orders; duration of aide services; fluid restriction amount for a 24 hour period; does patient have paralysis or weakness specific to one side of body; fall interventions; description of pain; onset of pain; diet | |

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| | week on Tuesday, Thursday, and Saturday, ex spouse continued to prepare the patient's medication, benefited from medication reminders, continued to live with ex spouse (patient #11) who was also a patient of the agency, had a family member that checked on the patient often, no willing caregivers.<br><br>J. Review of the comprehensive nursing assessment dated 10/5/17, indicated the patient was on a renal diet with 1000 milliliters fluid restriction under the feeding tube section. Neurological assessment indicated the patient was alert to person, place and time, unequal hand grasps, left sided weakness, normal cardiovascular assessment but had a blood pressure of 183/54, musculoskeletal assessment indicated the patient had limited range of motion, ambulation with a cane, had some tremors, shortness of breath with exertion, smokers, PICC line to the right chest for dialysis, intact and last changed on 10/3/17 with name of dialysis and location in the comments section. No further documentation to elaborate the findings.<br><br>K. Review of the fall risk assessment dated 10/5/17, indicated the patient had visual impairment, pain affecting level of function, impaired functional mobility, scored a total of 6, in which a score of 4 or more | | restrictions; weight loss interventions and name of other agencies providing health care services including when services are being provided. To be done by 1/16/18.<br><br>The Administrator/designee will ensure orientation of newly hired Clinical Managers includes: ensuring the plan of care is supported by the documentation in the comprehensive assessment. Clinical Managers are to include, when applicable, the following: if patient has dialysis access site – where is the site, who is responsible to monitor the access site; names of physicians that may give orders; duration of aide services; fluid restriction amount for a 24 hour period; does patient have paralysis or weakness specific to one side of body; fall interventions; description of pain; onset of pain; diet restrictions; weight loss interventions and name of other agencies providing health care services including when services are being provided. To begin immediately and be on-going. | |

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| | was considered at risk for falling.<br><br>L. Review of the nutritional risk assessment dated 10/5/17, indicated the patient scored a 30, in which a score 30 to 55 points was considered a medium nutritional risk with recommendations to provide education, appropriate dietary instructions, consult with dieticians as needed, consult with physician and discuss need for dietary supplements and to continue to monitoring and provided instructions as indicated. The comment section indicated the patient was not to have potassium, green vegetables, a renal diet with 1000 milliliter fluid restriction. The form also indicated the meals were not only prepared by the spouse and the home health aide, but also received prepared and delivered meals from a community service.<br><br>M. An agency document titled "Nursing Supervisory Note" dated 9/1/17, indicated the patient had an appointment with a surgeon on 9/8/17. The clinical record failed to evidenced documentation of coordination with the surgeon's office in regards to follow up / possible change in orders or patient condition and failed to include the services being provided by the shared agency along with dates and times. | | | |

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| | N. An agency document titled "Nursing Supervisory Note" dated 9/25/17, indicated the patient had an appointment with a Nurse Practitioner for "[physician name" and the patient was receiving services from another home health agency.<br><br>O. An agency document titled "Nursing Supervisory Note" dated 10/5/17, indicated the patient had a vascular lab appointment on 11/7/17, dialysis on Tuesday, Thursday, and Saturday, and was receiving services from another home health agency.<br><br>P. An agency document titled "Patient Care Coordination" dated 10/5/17 and 11/2/17, indicated the patient continued to have another agency come into the home to help care for the patient's instrumental activities of daily living and that the agency was aware of the services being provided by Adaptive.<br><br>The plan of care failed to be supported by the comprehensive assessment, failed to include the person / facility responsible for the patient's dialysis access, failed to correctly identify the dialysis accesses to observe, physician responsible for the management of the patient's hypertension / dialysis, failed to include the names of physicians that orders may be accepted | | | |

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| | from, failed to include a duration of services to be provided by the home health aide, failed to include the amount of fluids restricted in a 24 hour period, failed to correctly identify if the patient had paralysis or left sided weakness, and failed to include interventions for the prevention of falls and weight loss as well as diet restrictions. The plan of care also failed to include the name of the shared agency, the services being provided and when those services would be provided.<br><br>2. The clinical record of patient #11, SOC 3/15/17, was reviewed on 12/1/17. The clinical record included a plan of care for the certification period of 11/10/17 to 1/8/18, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were chronic obstructive pulmonary disease (COPD) with secondary diagnoses of type | | | |

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| | 2 diabetes, polyarthritis, hypertension and hyperlipidemia.<br><br>C. The medication section indicated the patient was taking Gabapentin 600 mg (medication used for diabetic neuropathy - numbness / tingling pain in patient extremities) three times a day, Metformin (treatment for diabetes) Tradjenta (treatment for diabetes), Hydroxyzine as needed (treatment for anxiety/sleep), Cymbalta (treatment for depression), Seroquel (treatment for depression), Metoprolol (treatment for high blood pressure), Amlodipine (treatment for high blood pressure), Nexium (treatment for stomach acidity), Proair (treatment for COPD), Qvar (treatment for COPD), Xalatan (treatment of glaucoma), Alphagan (treatment for glaucoma), Muro (treatment for corneal edema), Polyvinyl (treatment for eye redness and eye lubrication), Zofran (treatment for nausea), iron supplement, and low dose aspirin. No pain medication(s) were identified.<br><br>D. Functional limitations indicated endurance and ambulation, and goal that the patient would not experience any falls over the next 60 days.<br><br>E. Page 3 of the same plan of care | | | |

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| | indicated in the 60 day summary dated 11/7/17, indicating the patient would tried to be independent as much as he / she can, continued to set up his / her own medications but would benefit from medication reminders. The patient was able to demonstrate obtaining his / her own blood sugar, lived with ex spouse who was also a patient of the agency (patient #9) and was unable to care for the patient.<br><br>F. Review of the comprehensive nursing assessment dated 11/7/17, indicated the patient was continent, no ears / nose / throat / mouth / head, neurological, genitourinary, cardiovascular, integumentary impairments, the patient had shortness of breath during exertion, clear breath sounds but productive cough, full range of motion but had some weakness and walks with a cane, a diabetic with a current reading of 214, pain assessment indicated the patient had lower back pain that was chronic - took "gabapentin / prn (as needed) pain, and the narrative indicated the patient complained of chronic pain ranging from a 6 to a 10 (on a scale of 1 - 10 with 10 being the worst pain). The pain assessment failed to include a description of pain the patient was having (stabbing, throbbing, sharp). No further documentation to elaborate the findings. | | | |

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| | G. Review of a fall risk assessment dated 11/7/17, indicated the patient had visual impairment and pain affecting level of function, scored a total of 4, in which a score of 4 or more was considered at risk for falling.<br><br>The plan of care failed to be supported by the comprehensive assessment, failed to include a duration of services to be provided by the home health aide, and failed to include interventions for the prevention of falls.<br><br>3. The clinical record of patient #12, SOC 9/28/17, was reviewed on 11/30/17. The clinical record included a plan of care for the certification period of 9/28/17 to 11/26/17, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care (no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were age related physical debility with secondary | | | |

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| | diagnoses of unspecified dementia without behaviors, chronic obstructive pulmonary disease, unspecified systolic congestive heart, essential hypertension, diverticulitis with perforation, anemia, hypothyroidism, and mixed incontinence.<br><br>C. Medications included Calcium, Ferrous Sulfate, Synthroid (for Trazodone (for sleep and / or behaviors), Amlodipine (for hypertension), Hydralazine (for hypertension), Tylenol (for pain or fever) and Ensure Supplements (nutrition supplements).<br><br>D. Page 2 of the same plan of care indicated the patient was hard of hearing, the patient had good days and bad, the patient looked to the family member for answers to questions, used a cane in the home, gait and balance was unsteady, high fall risk, fell a month ago without injury, gets short of breath easily while exerting self such as getting dressed and walking more that 20 to 40 feet. The patient had chronic pain in his / her right hip that does not get greater than 6 on a scale of 1 - 10 and took Tylenol as needed. The daughter would set up the patient's medication box and the patient would benefit from medication reminders. The family member reported the patient needed assistance 3 days a week with a | | | |

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| | shower, needs direct assistance with transfer in / out of the shower, direct assistance with washing, assistance with a "sink bath" when the patient declines a shower, assistance with incontinent / peri care, wears depends and needs help with clean up, needs stand by assistance with walking due to frequent falls, need assistance with light housekeeping and meal prep. The plan of care continued to say the patient lived with family members, one works while the other was disabled and therefore, the patient did not have willing or able caregivers in the home.<br><br>E. Review of the comprehensive nursing initial and admitting assessment dated 9/28/17, indicated the patient had right hip pain, intensity 4 - 10, duration was chronic, onset was blank, relief measures was prn (as needed) tylenol, regular diet, feeds self, incontinent and diaper was checked, patient was alert to self, had dementia, cardiovascular assessment within normal limits, musculoskeletal assessment indicated the patient had limited range of motion to the right shoulder, assist with a cane, shortness of breath with exertion, fair integumentary status (skin), and the nursing narrative indicated the patient a diagnoses of dementia, COPD, debility, incontinence, HTN, diverticulitis, CHF, "has balance endurance fell in August", hard time upon | | | |

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| | assessment, no unusual findings. No further documentation to elaborate the findings.<br><br>The plan of care failed to be supported by the comprehensive assessment and failed to include a duration of services to be provided by the home health aide.<br><br>4. The findings of patient #12 was reviewed with the Director of Nursing, Administrator, and Alternate Administrator on 11/30/17 at 3:45 PM, and all administrative staff acknowledged and agreed the comprehensive assessment did not support the plan of care. The findings of patient #9 and #11 was reviewed with the same administrative staff on 12/1/17 at 4:30 PM, all acknowledged and agreed the comprehensive assessments did not support the plan of care.<br><br>5. An agency policy titled "Comprehensive Client Assessment" revised on 5/1/15, indicated " ... Purpose ... To collect data about the client's health history, (physical, functional and psychological) and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individual's response to care .... " | | | |

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| | 6. An agency policy titled "Plan of Treatment" revised on 3/21/12, indicated " ... the medical plan of care shall ... included the following ... frequency and duration of visits, nutritional requirements ... any safety measures to protect against injury ... any other appropriate items .... " | | | |
| N 0541<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(B)<br>Scope of Services<br>Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br>(B) Regularly reevaluate the patient's nursing needs.<br><br>Based on record review and interview, the Registered Nurse failed to accurately identify a patient's dialysis access and failed to include all possible dialysis access sites in 1 out of 1 record reviewed of a patient with dialysis in a sample of 3. (#9)<br><br>Findings include:<br><br>1. The clinical record of patient #12, start of care 4/10/17, was reviewed on 12/1/17. | N 0541 | N541<br>The Administrator/designee will provide an in-service to all internal employees including Clinical Managers by 1/16/18. The in-service will include educating Clinical Managers on how to implement appropriate infection, and checking for bruit and thrill. Clinical Managers will also educate Home Health Aides, on site maintenance and what to report to clinicians. These interventions will be added to the clients plan of care. Aide care plan will include signs/issues to report | 02/16/2018 |

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| | A. The clinical record contained a plans of care dated 8/8/17 to 10/6/17 and 10/7/17 to 12/5/17, which indicated the patient had a diagnosis of End Stage Renal Disease and was receiving dialysis 3 times a week.<br><br>B. Review of the comprehensive nursing assessments dated 10/5/17 and 11/2/17, indicated the patient had a PICC line (peripherally inserted central catheter) to the right chest wall..<br><br>C. According to Cleveland Clinic website (www.myclevelandclinic.org), a PICC line was defined as "A thin, soft, flexible tube -- an intravenous (IV) line. Treatments, such as IV medications, can be be given through a PICC. Blood for laboratory tests can also be withdrawn from a PICC ... A PICC can also spare your veins and blood vessels from the irritating effects of IV medications .... "<br><br>2. The findings were reviewed with the Director of Clinical Services, Administrator, and Alternate Administrator on 12/1/17 at 4:30 PM, and the Director of Clinical Services indicated she was aware that the former employee identified and documented the dialysis inaccurately, but at the time of | | to Clinical Managers. Administrator/designee will ensure orientation of newly hired Clinical Managers will include: educating Clinical Managers to implement appropriate interventions related to maintenance and protection of clients dialysis access site such as bleeding precautions, signs and symptoms of infection, and checking for bruit and thrill. Clinical Managers will also educate Home Health Aides on site maintenance interventions related to maintenance and protection of clients dialysis access site such as bleeding precautions, signs and symptoms of and what to report to Clinical Managers. These interventions will be added to the clients plan of care. Aide care plan will include signs/issues to report to registered nurse. To begin immediately and be on-going.<br><br>Clinical Managers will also be educated to attempt to coordinate care with client's dialysis center and these attempts will be documented on the care coordination sheet. Administrator/designee to complete by 1/16/18.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance | |

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| | recognition, she was in orientation and did question the former employee. | | with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | |
| N 0542<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(C)<br>Scope of Services<br>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:<br>(C) Initiate the plan of care and necessary revisions.<br><br>Based on record review and interview, the Registered Nurse failed to ensure that the development of the plans of care were supported by the comprehensive assessment and failed to include a duration of services to be provided in 3 out of 3 records reviewed. (#9, 11 and 12)<br><br>Findings include:<br><br>1. The clinical record of #9, SOC (start of care) of 4/10/17, was reviewed on 12/1/17. | N 0542 | N542<br>The Administrator/designee will provide an in-service to all internal employees by 1/16/18. The in-service will include the following: The clinicians will be educated that the duration of services needs to be included on the verbal order when and also on the plan of care.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month | 02/16/2018 |

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| | The clinical record included a plan of care for the certification period of 10/7/17 to 12/5/17, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 hours a week, not to exceed 6 hours per week through the certification period to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were sequelae of other cerebrovascular (stroke) with secondary diagnoses of end stage renal disease, essential hypertension, athlersclerotic heart disease, hyperlipidemia and anemia.<br><br>C. The patient's medications included Lipitor (treat high cholesterol), metoprolol (treat high blood pressure), Seroquel (treatment of schizophrenia, bipolar and depression), pantoprazole (treat high levels of stomach acid) Isosorbide (treat high blood pressure and chest pain), Carbidopa-Levodopa (treat high blood pressure), Iron (anemia supplement), Epogen (anemia treatment during dialysis), | | period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met.<br>The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.<br>The Administrator/designee will provide an in-service to all internal employees, which refers to Clinical Managers by 1/16/18.<br>The in-service will review coordination of care with other healthcare providers. Clinical Managers should conduct coordination of care at a minimum of once per month to ensure no duplication of services. Clinical Managers will be in-serviced to contact other providers providing care to client and document services, dates, and times they are in the home. The in-service will also review with Clinical Managers to follow up and document physician appointments to ensure possible changes in orders or condition of patient are documented and staff in the home is educated.<br>The Administrator/designee will ensure orientation of newly hired internal staff, including Clinical Managers, includes: review coordination of care with other healthcare providers, Clinical Managers should conduct | |

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| | Hectorol (high parathyroid treatment during dialysis), and Venofer (anemia treatment during dialysis).<br><br>D. Safety measures included but not limited to respiratory precautions.<br><br>E. Nutritional requirements indicated the patient was on a low nutritional status, renal diet, low sodium, and fluid restrictions.<br><br>F. Functional limitations included but not limited to paralysis.<br><br>G. Plan of care indicated the patient had dialysis 3 times a week.<br><br>H. The patient goals included no falls and no weight loss over the next 60 days.<br><br>I. Page 2 of the same plan of care included a 60 day summary dated 10/5/17, indicating the patient's dialysis site located on the right side of the chest was intact, continued to need "help hands on help", continued to be unsteady on his feet which continued to make him a high fall risk, had a fistula that was placed in the right arm and had a vascular appointment in November, continued to have dialysis three times a week on Tuesday, Thursday, and Saturday, ex spouse continued to prepare the patient's | | coordination of care at a minimum of once per month to ensure no duplication of services, Clinical Managers are to contact other providers providing care to client and document services, dates, and times they are in the home and Clinical Managers are to follow up and document physician appointments to ensure possible changes in orders or condition of patient are documented and external staff, the hourly caregivers working in the home are educated. To begin immediately and be on-going.<br>The Administrator/designee will in-service Clinical Managers on ensuring the plan of care is supported by the documentation in the comprehensive assessment. Clinical Managers to include, when applicable, the following: if patient has dialysis access site – where is the site, who is responsible to monitor the access site; names of physicians that may give orders; duration of aide services; fluid restriction amount for a 24 hour period; does patient have paralysis or weakness specific to one side of body; fall interventions; description of pain; onset of pain; diet restrictions; weight loss interventions and name of other agencies providing health care services including when services are being provided. To be done by 1/16/18.<br>The Administrator/designee will | |

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| | medication, benefited from medication reminders, continued to live with ex spouse (patient #11) who was also a patient of the agency, had a family member that checked on the patient often, no willing caregivers.<br><br>J. Review of the comprehensive nursing assessment dated 10/5/17, indicated the patient was on a renal diet with 1000 milliliters fluid restriction under the feeding tube section. Neurological assessment indicated the patient was alert to person, place and time, unequal hand grasps, left sided weakness, normal cardiovascular assessment but had a blood pressure of 183/54, musculoskeletal assessment indicated the patient had limited range of motion, ambulation with a cane, had some tremors, shortness of breath with exertion, smokers, PICC line to the right chest for dialysis, intact and last changed on 10/3/17 with name of dialysis and location in the comments section. No further documentation to elaborate the findings.<br><br>K. Review of the fall risk assessment dated 10/5/17, indicated the patient had visual impairment, pain affecting level of function, impaired functional mobility, scored a total of 6, in which a score of 4 or more was considered at risk for falling. | | ensure orientation of newly hired Clinical Managers includes: ensuring the plan of care is supported by the documentation in the comprehensive assessment. Clinical Managers to include, when applicable, the following: if patient has dialysis access site – where is the site, who is responsible to monitor the access site; names of physicians that may give orders; duration of aide services; fluid restriction amount for a 24 hour period; does patient have paralysis or weakness specific to one side of body; fall interventions; description of pain; onset of pain; diet restrictions; weight loss interventions and name of other agencies providing health care services including when services are being provided. To begin immediately and be on-going. | |

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| | L. Review of the nutritional risk assessment dated 10/5/17, indicated the patient scored a 30, in which a score 30 to 55 points was considered a medium nutritional risk with recommendations to provide education, appropriate dietary instructions, consult with dieticians as needed, consult with physician and discuss need for dietary supplements and to continue to monitoring and provided instructions as indicated. The comment section indicated the patient was not to have potassium, green vegetables, a renal diet with 1000 milliliter fluid restriction. The form also indicated the meals were not only prepared by the spouse and the home health aide, but also received prepared and delivered meals from a community service.<br><br>M. An agency document titled "Nursing Supervisory Note" dated 9/1/17, indicated the patient had an appointment with a surgeon on 9/8/17. The clinical record failed to evidenced documentation of coordination with the surgeon's office in regards to follow up / possible change in orders or patient condition and failed to include the services being provided by the shared agency along with dates and times.<br><br>N. An agency document titled "Nursing Supervisory Note" dated 9/25/17, indicated | | | |

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| | the patient had an appointment with a Nurse Practitioner for "[physician name" and the patient was receiving services from another home health agency.<br><br>O. An agency document titled "Nursing Supervisory Note" dated 10/5/17, indicated the patient had a vascular lab appointment on 11/7/17, dialysis on Tuesday, Thursday, and Saturday, and was receiving services from another home health agency.<br><br>P. An agency document titled "Patient Care Coordination" dated 10/5/17 and 11/2/17, indicated the patient continued to have another agency come into the home to help care for the patient's instrumental activities of daily living and that the agency was aware of the services being provided by Adaptive.<br><br>The plan of care failed to be supported by the comprehensive assessment, failed to include the person / facility responsible for the patient's dialysis access, failed to correctly identify the dialysis accesses to observe, physician responsible for the management of the patient's hypertension / dialysis, failed to include the names of physicians that orders may be accepted from, failed to include a duration of services to be provided by the home health aide, | | | |

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| | failed to include the amount of fluids restricted in a 24 hour period, failed to correctly identify if the patient had paralysis or left sided weakness, and failed to include interventions for the prevention of falls and weight loss as well as diet restrictions. The plan of care also failed to include the name of the shared agency, the services being provided and when those services would be provided.<br><br>2. The clinical record of patient #11, SOC 3/15/17, was reviewed on 12/1/17. The clinical record included a plan of care for the certification period of 11/10/17 to 1/8/18, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were chronic obstructive pulmonary disease (COPD) with secondary diagnoses of type 2 diabetes, polyarthritis, hypertension and hyperlipidemia. | | | |

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| | C. The medication section indicated the patient was taking Gabapentin 600 mg (medication used for diabetic neuropathy - numbness / tingling pain in patient extremities) three times a day, Metformin (treatment for diabetes) Tradjenta (treatment for diabetes), Hydroxyzine as needed (treatment for anxiety/sleep), Cymbalta (treatment for depression), Seroquel (treatment for depression), Metoprolol (treatment for high blood pressure), Amlodipine (treatment for high blood pressure), Nexium (treatment for stomach acidity), Proair (treatment for COPD), Qvar (treatment for COPD), Xalatan (treatment of glaucoma), Alphagan (treatment for glaucoma), Muro (treatment for corneal edema), Polyvinyl (treatment for eye redness and eye lubrication), Zofran (treatment for nausea), iron supplement, and low dose aspirin. No pain medication(s) were identified.<br><br>D. Functional limitations indicated endurance and ambulation, and goal that the patient would not experience any falls over the next 60 days.<br><br>E. Page 3 of the same plan of care indicated in the 60 day summary dated 11/7/17, indicating the patient would tried to | | | |

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| | be independent as much as he / she can, continued to set up his / her own medications but would benefit from medication reminders. The patient was able to demonstrate obtaining his / her own blood sugar, lived with ex spouse who was also a patient of the agency (patient #9) and was unable to care for the patient.<br><br>F. Review of the comprehensive nursing assessment dated 11/7/17, indicated the patient was continent, no ears / nose / throat / mouth / head, neurological, genitourinary, cardiovascular, integumentary impairments, the patient had shortness of breath during exertion, clear breath sounds but productive cough, full range of motion but had some weakness and walks with a cane, a diabetic with a current reading of 214, pain assessment indicated the patient had lower back pain that was chronic - took "gabapentin / prn (as needed) pain, and the narrative indicated the patient complained of chronic pain ranging from a 6 to a 10 (on a scale of 1 - 10 with 10 being the worst pain). The pain assessment failed to include a description of pain the patient was having (stabbing, throbbing, sharp). No further documentation to elaborate the findings.<br><br>G. Review of a fall risk assessment dated 11/7/17, indicated the patient had | | | |

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| ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC | 9840 WESTPOINT DRIVE, SUITE 400<br>INDIANAPOLIS, IN 46256 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
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| | visual impairment and pain affecting level of function, scored a total of 4, in which a score of 4 or more was considered at risk for falling.<br><br>The plan of care failed to be supported by the comprehensive assessment, failed to include a duration of services to be provided by the home health aide, and failed to include interventions for the prevention of falls.<br><br>3. The clinical record of patient #12, SOC 9/28/17, was reviewed on 11/30/17. The clinical record included a plan of care for the certification period of 9/28/17 to 11/26/17, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care (no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were age related physical debility with secondary diagnoses of unspecified dementia without behaviors, chronic obstructive pulmonary | | | |

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| | disease, unspecified systolic congestive heart, essential hypertension, diverticulitis with perforation, anemia, hypothyroidism, and mixed incontinence. Medications included Calcium, Ferrous Sulfate, Synthroid (for Trazodone (for sleep and / or behaviors), Amlodipine (for hypertension), Hydralazine (for hypertension), Tylenol (for pain or fever) and Ensure Supplements (nutrition supplements).<br><br>C. Page 2 of the same plan of care indicated the patient was hard of hearing, the patient had good days and bad, the patient looked to the family member for answers to questions, used a cane in the home, gait and balance was unsteady, high fall risk, fell a month ago without injury, gets short of breath easily while exerting self such as getting dressed and walking more that 20 to 40 feet. The patient had chronic pain in his / her right hip that does not get greater than 6 on a scale of 1 - 10 and took Tylenol as needed. The daughter would set up the patient's medication box and the patient would benefit from medication reminders. The family member reported the patient needed assistance 3 days a week with a shower, needs direct assistance with transfer in / out of the shower, direct assistance with washing, assistance with a "sink bath" when | | | |

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| | the patient declines a shower, assistance with incontinent / peri care, wears depends and needs help with clean up, needs stand by assistance with walking due to frequent falls, need assistance with light housekeeping and meal prep. The plan of care continued to say the patient lived with family members, one works while the other was disabled and therefore, the patient did not have willing or able caregivers in the home.<br><br>D. Review of the comprehensive nursing initial and admitting assessment dated 9/28/17, indicated the patient had right hip pain, intensity 4 - 10, duration was chronic, onset was blank, relief measures was prn (as needed) tylenol, regular diet, feeds self, incontinent and diaper was checked, patient was alert to self, had dementia, cardiovascular assessment within normal limits, musculoskeletal assessment indicated the patient had limited range of motion to the right shoulder, assist with a cane, shortness of breath with exertion, fair integumentary status (skin), and the nursing narrative indicated the patient a diagnoses of dementia, COPD, debility, incontinence, HTN, diverticulitis, CHF, "has balance endurance fell in August", hard time upon assessment, no unusual findings. No further documentation to elaborate the findings. | | | |

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| | The plan of care failed to be supported by the comprehensive assessment and failed to include a duration of services to be provided by the home health aide.<br><br>4. The findings of patient #12 was reviewed with the Director of Nursing, Administrator, and Alternate Administrator on 11/30/17 at 3:45 PM, and all administrative staff acknowledged and agreed the comprehensive assessment did not support the plan of care. The findings of patient #9 and #11 was reviewed with the same administrative staff on 12/1/17 at 4:30 PM, all acknowledged and agreed the comprehensive assessments did not support the plan of care.<br><br>5. An agency policy titled "Comprehensive Client Assessment" revised on 5/1/15, indicated " ... Purpose ... To collect data about the client's health history, (physical, functional and psychological) and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individual's response to care .... "<br><br>6. An agency policy titled "Plan of Treatment" revised on 3/21/12, indicated " ... the medical plan of care shall ... included | | | |

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| | the following ... frequency and duration of visits, nutritional requirements ... any safety measures to protect against injury ... any other appropriate items .... " | | | |
| N 0543<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(D)<br>Scope of Services<br>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:<br>(D) Initiate appropriate preventive and rehabilitative nursing procedures.<br><br>Based on record review and interview, the Registered Nurse failed to ensure that appropriate preventative nursing measures were put into place with patient identified as a fall and nutritional risk in 3 out of 3 records reviewed. (#9, 11 and 12)<br><br>Findings include:<br><br>1. The clinical record of #9, SOC (start of care) of 4/10/17, was reviewed on 12/1/17. The clinical record included a plan of care for the certification period of 10/7/17 to 12/5/17, with the following orders / information: | N 0543 | N543<br>The Administrator/designee will provide an in-service to all internal employees, including Clinical Managers by 1/16/18. The in-service will review interventions for fall and nutritional risk assessments. The in-service will instruct Clinical Managers that there clearly needs to be documented education taking place between the Clinical Managers and the Home Health Aides working in the home and client in regards to implementing this information in to the care for the patient, as well as care coordination with other providers and family to support nutrition risk intervention.<br>Administrator/designee will ensure | 02/16/2018 |

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| | A. Home health aide 2 hours a day, 2 to 3 hours a week, not to exceed 6 hours per week through the certification period to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were sequelae of other cerebrovascular (stroke) with secondary diagnoses of end stage renal disease, essential hypertension, athlersclerotic heart disease, hyperlipidemia and anemia.<br><br>C. Safety measures included but not limited to respiratory precautions.<br><br>D. Nutritional requirements indicated the patient was on a low nutritional status, renal diet, low sodium, and fluid restrictions.<br><br>E. Functional limitations included but not limited to paralysis.<br><br>F. The patient goals included no falls and no weight loss over the next 60 days.<br><br>G. Page 2 of the same plan of care | | orientation of newly hired Clinical Managers includes: having interventions for fall and nutritional risk assessments that indicate issues in those areas; that there clearly needs to be documented education taking place between the Clinical Managers and the Home Health Aide and client in regards to implementing this information in to the care for the patient, as well as care coordination with other providers and family to support nutrition risk intervention. To begin immediately and be on-going.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | |

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| | included a 60 day summary dated 10/5/17, indicating the patient's dialysis site located on the right side of the chest was intact, continued to need "help hands on help", continued to be unsteady on his feet which continued to make him a high fall risk, had a fistula that was placed in the right arm, continued to have dialysis three times a week on Tuesday, Thursday, and Saturday.<br><br>H. Review of the comprehensive nursing assessment dated 10/5/17, indicated the patient was on a renal diet with 1000 milliliters fluid restriction under the feeding tube section. Neurological assessment indicated the patient was alert to person, place and time, unequal hand grasps, left sided weakness, normal cardiovascular assessment but had a blood pressure of 183/54, musculoskeletal assessment indicated the patient had limited range of motion, ambulation with a cane, had some tremors, shortness of breath with exertion, smoker.<br><br>I. Review of the fall risk assessment dated 10/5/17, indicated the patient had visual impairment, pain affecting level of function, impaired functional mobility, scored a total of 6, in which a score of 4 or more was considered at risk for falling. | | | |

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| | J. Review of the nutritional risk assessment dated 10/5/17, indicated the patient scored a 30, in which a score 30 to 55 points was considered a medium nutritional risk with recommendations to provide education, appropriate dietary instructions, consult with dieticians as needed, consult with physician and discuss need for dietary supplements and to continue to monitoring and provided instructions as indicated. The comment section indicated.<br><br>The plan of care failed to include interventions for the prevention of falls and weight loss.<br><br>2. The clinical record of patient #11, SOC 3/15/17, was reviewed on 12/1/17. The clinical record included a plan of care for the certification period of 11/10/17 to 1/8/18, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only. | | | |

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| | B. The principle diagnoses were chronic obstructive pulmonary disease (COPD) with secondary diagnoses of type 2 diabetes, polyarthritis, hypertension and hyperlipidemia.<br><br>C. Functional limitations indicated endurance and ambulation, and goal that the patient would not experience any falls over the next 60 days.<br><br>D. Page 3 of the same plan of care indicated in the 60 day summary dated 11/7/17, indicating the patient would tried to be independent as much as he / she can.<br><br>E. Review of the comprehensive nursing assessment dated 11/7/17, indicated the patient had shortness of breath during exertion, clear breath sounds but productive cough, full range of motion but had some weakness and walks with a cane, pain assessment indicated the patient had lower back pain that was chronic.<br><br>F. Review of a fall risk assessment dated 11/7/17, indicated the patient had visual impairment and pain affecting level of function, scored a total of 4, in which a score of 4 or more was considered at risk for falling. | | | |

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| | The plan of care failed to include interventions for the prevention of falls.<br><br>3. The clinical record of patient #12, SOC 9/28/17, was reviewed on 11/30/17. The clinical record included a plan of care for the certification period of 9/28/17 to 11/26/17, with the following orders / information:<br><br>A. Home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care (no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only.<br><br>B. The principle diagnoses were age related physical debility with secondary diagnoses of unspecified dementia without behaviors, chronic obstructive pulmonary disease, unspecified systolic congestive heart, essential hypertension, diverticulitis with perforation, anemia, hypothyroidism, and mixed incontinence.<br><br>C. Page 2 of the same plan of care indicated the patient was hard of hearing, the patient had good days and bad, the patient | | | |

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| | looked to the family member for answers to questions, used a cane in the home, gait and balance was unsteady, high fall risk, fell a month ago without injury, gets short of breath easily while exerting self such as getting dressed and walking more that 20 to 40 feet. The patient had chronic pain in his / her right hip that does not get greater than 6 on a scale of 1 - 10 and took Tylenol as needed.<br><br>D. Review of the comprehensive nursing initial and admitting assessment dated 9/28/17, indicated the patient had right hip pain, intensity 4 - 10, duration was chronic, onset was blank, relief measures was prn (as needed) tylenol, incontinent, patient had dementia, musculoskeletal assessment indicated the patient had limited range of motion to the right shoulder, assist with a cane, shortness of breath with exertion, and the nursing narrative indicated the patient a diagnoses of dementia, COPD, debility, incontinence, HTN, diverticulitis, CHF, "has balance endurance fell in August" [SIC] hard time upon assessment.<br><br>The plan of care failed to include interventions for the prevention of falls.<br><br>4. The findings of patient #12 was reviewed with the Director of Nursing, Administrator, | | | |

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| | and Alternate Administrator on 11/30/17 at 3:45 PM, and all administrative staff acknowledged and agreed that the plan of care should have included interventions for the prevention of falls. The findings of patient #9 and #11 was reviewed with the same administrative staff on 12/1/17 at 4:30 PM, all acknowledged and agreed that the plans of care should have included interventions for the prevention of falls and weight loss due to nutritional risks.<br><br>5. An agency policy titled "Plan of Treatment" revised on 3/21/12, indicated " ... the medical plan of care shall ... included the following ... frequency and duration of visits, nutritional requirements ... any safety measures to protect against injury ... any other appropriate items .... " | | | |
| N 0546<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(G)<br>Scope of Services<br>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:<br>(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 | | | |

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| | programs, and supervise and teach other nursing personnel.<br><br>Based on record review and interview, the Registered Nurse failed to evidence that a patient was educated on a new medication order upon a return home from the hospital in 1 out of 1 record reviewed of a patient resumed after hospitalization in a sample of 3. (#9)<br><br>Finding included:<br><br>1. The clinical record of patient #9 was reviewed on 12/1/17. The clinical record contained an order dated 11/6/17, which indicated services to resume on 11/2/17 from a hospitalization and the patient was started on Meclizine 12.5 mg tablets by mouth up to 3 x a day as needed for dizziness. Review of the comprehensive nursing assessment dated 11/2/17, the assessment failed to indicate if the patient was educated on the new medication.<br><br>2. The Director of Clinical Services was interviewed on 12/1/17 at 4:30 PM, acknowledged the documentation errors and agreed that the patient should have been educated on the new medication, patient response to the education, and documentation of the education. | N 0546 | **N546**<br>**The Administrator/designee will provide an in-service to all internal staff including Clinical Managers employees by 1/16/18. The in-service will include educating Clinical Managers that whenever they obtain knowledge of a new medication, they will provide education to the patient, document this education as well as patient response to education.**<br>**The Administrator /designee will ensure orientation of newly hired Clinical Managers includes: whenever they obtain knowledge of a new medication, they will provide education to the patient, document this education as well as patient response to education. To begin immediately and be on-going.**<br>**100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Then quarterly will be audited by Administrator or designee.**<br>**The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.**<br>**Update: The agency will ensure the admitting nurse reviews the plan of care to ensure its accuracy. The Director of Nursing and Compliance/designee will also review all plan of care to ensure accuracy. Once 100% accuracy is achieved Director of Nursing and** | 02/16/2018 |

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| | | | **Compliance/designee will audit 25% of plans of care quarterly.**<br>**The agency will ensure that patients needs will be met by coordinating care with the patients physician and with all other companies providing care to the patient. The Director of Nursing and Compliance/designee will instruct Clinical Managers on how to coordinate care and document in patient's chart. The agency will work to prevent the reoccurrence of missed visits by providing caregivers that are able to meet the clients needs. Director of Nursing and Compliance/designee will monitor missed visits to ensure visits are made up when possible.** | |
| N 0547<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(H)<br>Scope of Services<br>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:<br>(H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written).<br><br>Based on record review and interview, the agency failed to ensure the Registered Nurse put verbal orders in writing after an admission assessment in 1 out of 1 record reviewed of a patient admitted to services in a sample of 3. (#12) | N 0547 | N547<br>The Administrator/designee will provide an in-service to all internal employees including Clinical Managers by 1/16/18. The in-service will include education that Clinical Managers will obtain a separate written verbal order that follows the verbal order that was taken during a phone call with the | 02/16/2018 |

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| | Findings include:<br><br>1. The clinical record of #12, SOC (start of care) 9/28/17, was reviewed on 11/30/17. Review of the admitting comprehensive assessment dated 9/28/17, indicated that the physician was notified and new orders were received "To start service w/ (with) personal care and light housekeeping for the next 60 days." The clinical record failed to evidence a written verbal order.<br><br>2. The Director of Clinical Services, Administrator and Alternate Administrator were interviewed on 11/30/17 at 3:45 PM. The Alternate Administrator indicated the plan of care was used as physician order. | | physician's office after the comprehensive assessment. This verbal order will include the findings of the comprehensive assessment, and orders for hours. The written verbal order will be separate from the plan of care and will be maintained in the clinical record.<br>The Administrator/designee will ensure orientation of newly hired Clinical Managers includes: Clinical Managers will obtain a separate written verbal order that follows the verbal order that was taken during a phone call with the physician's office after the comprehensive assessment. This verbal order will include the findings of the comprehensive assessment, and orders for hours. The written verbal order will be separate from the plan of care and will be maintained in the clinical record. To begin immediately and be on-going.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met. The Administrator or designee will | |

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| | | | be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | |
| N 0563<br><br>Bldg. 00 | 410 IAC 17-14-1(c)(2)<br>Scope of Services<br>Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:<br>(2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months;<br><br>Based on record review and interview, the agency failed to ensure that the comprehensive 60 day reassessments were accurate, consistent and contained adequate amount of information to support the plan of care in 2 out of 2 records reviewed in a sample of 3. (#9 and 11)<br><br>Findings include:<br><br>1. The clinical record of #9, SOC (start of care) of 4/10/17, was reviewed on 12/1/17.<br><br>A. Review of the comprehensive nursing assessment dated 10/5/17, indicated the patient was on a renal diet with 1000 milliliters fluid restriction under the feeding tube section. Neurological assessment indicated the patient was alert to person, place and time, unequal hand grasps, left sided weakness, normal cardiovascular | N 0563 | N 563<br>**The Administrator/designee will provide an in-service to all internal employees including Clinical Managers by 1/16/18 which will include instructing Clinical Managers that the comprehensive assessment must be accurate, consistent and contain adequate information to support the plan of care such as, where applicable, information regarding patients functional status to support the need of assistance with activities of daily living and instrumental activities of daily living, accurately identify the patient's catheter access site for dialysis, the person / facility responsible for the management of the patient's dialysis permacatheter site, an assessment of the fistula, consistent assessment of the patient's vision between the** | 02/16/2018 |

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| | assessment but had a blood pressure of 183/54, musculoskeletal assessment indicated the patient had limited range of motion, ambulation with a can, had some tremors, shortness of breath with exertion, smokers, PICC line to the right chest for dialysis, intact and last changed on 10/3/17 with name of dialysis and location in the comments section. Skin assessment indicated no skin impairments. Ears/Nose/Throat/Mouth/Head assessment did not indicate impairments. No further documentation to elaborate the findings.<br><br>B. Review of the fall risk assessment dated 10/5/17, indicated the patient had visual impairment, pain affecting level of function, impaired functional mobility scored a 6, in which a score of 4 or more was considered at risk for falling.<br><br>C. Review of the nutritional risk assessment dated 10/5/17, indicated the patient scored a 30, in which a score 30 to 55 points was considered a medium nutritional risk with recommendations to provide education, appropriate dietary instructions, consult with dieticians as needed, consult with physician and discuss need for dietary supplements and to continue to monitoring and provided instructions as indicated. The assessment | | **comprehensive assessment and the fall risk assessment, consistent assessment of the patient's diet between the plan of care and the nutritional assessment, and consistent with the comprehensive assessment indicating weakness and limited mobility versus the plan of care indicating paralysis, identify the patient's hypertension, depression, iron deficiency, stroke and the medications used for the treatment of hypertension, depression, iron deficiency, and stroke, accurately identify visual impairment / glaucoma, identification of the patient's hypertension, COPD, depression, description of pain and accurate identification of pain medication(s) used to treat the back pain, neuropathy, adequate diabetic assessment that include a diabetic foot exam and history of blood sugars since last nursing visit and report abnormal findings, and the medications used for the treatment of hypertension, COPD, depression, neuropathy, and diabetes.**<br><br>**The Administrator/designee will ensure orientation of newly hired Clinical Managers will include instructing Clinical Managers that the** | |

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| | indicated the patient had a skin impairment. The comment section indicated "no potassium, no green veggies, renal, fluid restriction 1,000 ml [milliliters]."<br><br>D. Review of the plan of care for the certification period of 10/7/17 to 12/5/17, with orders for home health aide 2 hours a day, 2 to 3 hours a week, not to exceed 6 hours per week through the certification period to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only. The principle diagnosis was sequel of other cerebrovascular (stroke) with secondary diagnoses of end stage renal disease, essential hypertension, athlersclerotic heart disease, hyperlipidemia and anemia. The patient's medications included Lipitor (treat high cholesterol), metoprolol (treat high blood pressure), Seroquel (treatment of schizophrenia, bipolar and depression), pantoprazole (treat high levels of stomach acid), Isosorbide (treat high blood pressure and chest pain), Carbidopa-Levodopa (treat high blood pressure), Iron (anemia supplement), Epogen (anemia treatment during dialysis), Hectorol (high parathyroid treatment during dialysis), and Venofer (anemia treatment | | **comprehensive assessment must be accurate, consistent and contain adequate information to support the plan of care such as, where applicable, information regarding patients functional status to support the need of assistance with activities of daily living and instrumental activities of daily living, accurately identify the patient's catheter access site for dialysis, the person / facility responsible for the management of the patient's dialysis permacatheter site, an assessment of the fistula, consistent assessment of the patient's vision between the comprehensive assessment and the fall risk assessment, consistent assessment of the patient's diet between the plan of care and the nutritional assessment, and consistent with the comprehensive assessment indicating weakness and limited mobility versus the plan of care indicating paralysis, identify the patient's hypertension, depression, iron deficiency, stroke and the medications used for the treatment of hypertension, depression, iron deficiency, and stroke, , accurately identify visual impairment / glaucoma, identification of the patient's** | |

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| | during dialysis). Safety measures included but not limited to respiratory precautions. Nutritional requirements indicated the patient was on a low nutritional status, renal diet, low sodium, and fluid restrictions. Functional limitations included but not limited to paralysis. Plan of care indicated the patient had dialysis 3 times a week. The patient goals included no falls and no weight loss over the next 60 days.<br><br>E. Page 2 of the same plan of care included a 60 day summary dated 10/5/17, which indicated that the patient's dialysis site located on the right side of the chest was intact, continued to need "help hands on help", continued to be unsteady on his feet which continued to make him a high fall risk, had a fistula that was placed in the right arm and had a vascular appointment in November, continued to have dialysis three times a week on Tuesday, Thursday, and Saturday, ex spouse (patient #11) continued to prepare the patient's medication, benefited from medication reminders, continued to live with ex spouse who was also a patient of the agency, had a family member that checked on the patient often, no willing caregivers.<br><br>The comprehensive assessment failed to be accurate, consistent and contained adequate | | **hypertension, COPD, depression, description of pain and accurate identification of pain medication(s) used to treat the back pain, neuropathy, adequate diabetic assessment that include a diabetic foot exam and history of blood sugars since last nursing visit and report abnormal findings, and the medications used for the treatment of hypertension, COPD, depression, neuropathy, and diabetes.**<br><br>**Update: The agency will ensure the admitting nurse reviews the plan of care to ensure its accuracy. The Director of nursing and Compliance/designee will also review all plans of care to ensure accuracy. Once 100% accuracy is achieved Director of Nursing and Compliance/designee will audit 25% of plans of care quarterly.**<br><br>**The agency will ensure that patients needs will be met by coordinating care with the patients physician and with all other companies providing care to the patient. The Director of Nursing and Compliance/designee will instruct Clinical Managers on how to coordinate care and document in patient's chart. The agency will work to prevent the reoccurrence of missed visits by providing caregivers that are able to meet the clients needs. Director of Nursing and Compliance/designee will monitor missed visits to ensure visits are made up when possible.** | |

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| | of information to support the plan of care such as adequate information in regards to the patients functional status to support the need of assistance with activities of daily living and instrumental activities of daily living, inaccurately identified the patient's catheter access site for dialysis, the person / facility responsible for the management of the patient's dialysis permacatheter site, an assessment of the fistula in the patient's right arm, inconsistent assessment of the patient's vision between the comprehensive assessment and the fall risk assessment, inconsistent assessment of the patient's diet between the plan of care and the nutritional assessment, and inconsistent with the comprehensive assessment indicating weakness and limited mobility versus the plan of care indicating paralysis. The assessment failed to identify the patient hypertension, depression, iron deficiency, stroke and the medications used for the treatment of hypertension, depression, iron deficiency, and stroke.<br><br>2. The clinical record of patient #11, SOC 3/15/17, was reviewed on 12/1/17.<br><br>A. Review of the comprehensive nursing assessment dated 11/7/17, indicated the patient was continent, no ears / nose / throat / mouth / head, neurological, | | **To begin immediately and be on-going.**<br>**100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Then quarterly will be audited by Administrator or designee.**<br>**The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.** | |

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| | genitourinary, cardiovascular, integumentary impairments, the patient had shortness of breath during exertion, clear breath sounds but productive cough, full range of motion but had some weakness and walks with a cane, a diabetic with a current reading of 214, pain assessment indicated the patient had lower back pain that was chronic - took "gabapentin / prn (as needed) pain", and the narrative indicated the patient complained of chronic pain ranging from a 6 to a 10 (on a scale of 1 - 10 with 10 being the worst pain). The pain assessment failed to include a description of pain the patient was having (stabbing, throbbing, sharp). No further documentation to elaborate the findings.<br><br>B. Review of a fall risk assessment dated 11/7/17, indicated the patient had visual impairment and pain affecting level of function, scored a total of 4, in which a score of 4 or more was considered at risk for falling.<br><br>C. The clinical record included a plan of care for the certification period of 11/10/17 to 1/8/18, with orders for home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail | | | |

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| | care ( no clipping), incontinence care, meal prep, light housekeeping, transfers and medication reminders only. The principle diagnosis was Chronic obstructive pulmonary disease (COPD) with secondary diagnoses of type 2 diabetes, polyarthritis, hypertension and hyperlipidemia. The medication section indicated the patient was taking Gabapentin 600 mg (medication used for diabetic neuropathy - numbness / tingling pain in patient extremities) three times a day, Metformin (treatment for diabetes) Tradjenta (treatment for diabetes), Hydroxyzine as needed (treatment for anxiety/sleep), Cymbalta (treatment for depression), Seroquel (treatment for depression), Metoprolol (treatment for high blood pressure), Amlodipine (treatment for high blood pressure), Nexium (treatment for stomach acidity), Proair (treatment for COPD), Qvar (treatment for COPD), Xalatan (treatment of glaucoma), Alphagan (treatment for glaucoma), Muro (treatment for corneal edema), Polyvinyl (treatment for eye redness and eye lubrication), Zofran (treatment for nausea), iron supplement, and low dose aspirin. No pain medications were included. Functional limitations indicated endurance and ambulation, and goal that the patient would not experience any falls over the next 60 days. | | | |

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| | D. Page 3 of the same plan of care indicated in the 60 day summary dated 11/7/17, indicating the patient would tried to be independent as much as he / she can, continued to set up his / her own medications but would benefit from medication reminders. The patient was able to demonstrate obtaining his / her own blood sugar, lived with ex spouse who was also a patient of the agency (patient #9) and was unable to care for the patient.<br><br>The comprehensive assessment failed to contain adequate amount of information to support the plan of care, such as adequate information in regards to the patients functional status to support the need of assistance with activities of daily living and instrumental activities of daily living, accurately identifying visual impairment / glaucoma, identification of the patient's hypertension, COPD, depression, description of pain and accurate identification of pain medication(s) used to treat the back pain, neuropathy, adequate diabetic assessment that included a diabetic foot exam and history of blood sugars since last nursing visit and report abnormal findings, and the medications used for the treatment of hypertension, COPD, depression, neuropathy, and diabetes. | | | |

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| N 0606<br><br>Bldg. 00 | 410 IAC 17-14-1(n)<br>Scope of Services<br>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.<br><br>Based on record review and interview, the agency failed to ensure the Registered Nurse conducted a supervisory visit that included observance of care and assessing the relationship between the patient and the home health aide in 2 out of 3 records reviewed (#9 and 11) and failed to conduct a supervisory visit every 30 days in 1 out of 3 records reviewed. (#11)<br><br>Findings include:<br><br>1. The clinical record for patient #9 was reviewed on 12/1/17. The clinical record contained a plan of care for the certification period of 10/7/17 to 12/5/17, with orders for the Registered Nurse "to perform supervisory visits per state regulations ... RN to monitor vital signs and pulse oximetry at this time." | N 0606 | N606<br>The agency's supervisory note will be updated as of 1/2/18 to include observation of Home Health Aide providing direct care to the patient at a minimum of every 60 days.<br>We do have a sup not dated 10/5/17 which we will upload as a supporting document for patient #11.<br>The agency's supervisory note will be updated as of 1/2/18 to include observation of Home Health Aide providing direct care to the patient at a minimum of at least every 30 days.<br><br>100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met.<br>The Administrator or designee will | 02/16/2018 |

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| | A. Review of an agency form titled "Nursing Supervisory Note" dated 11/2/17, included care coordination (such as level of services, advance directives, plan of care reviewed and appropriate, changes to the treatment, other agencies in the home), chart (current plan of care in the chart and reviewed, home chart reviewed, emergency plan reviewed, grievance and branch numbers available, current medication profile in chart and updated, medication reconciliation complete, and goals reviewed), Patient / caregiver (verbalizing satisfaction with services, involved and agreed with plan of care, any changes in caregiver involvement, patient / caregiver education provided if necessary), environment (patient area / room clean and organized, DME and supplies match plan of care, oxygen safety observed, medications stored appropriately), assessment (vital signs obtained including oxygen saturations), and pain assessments. The form was signed by the home health aide. The supervisory visit failed to include observance of care and the assessment of the relationship between the patient and the home health aide.<br><br>2. The clinical record for patient #11 was reviewed on 12/1/17. The clinical record contained a plan of care for the certification period of 11/10/17 to 1/8/18, with orders | | be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.<br>Administrator/designee will in-service all agency by 1/16/18 on the requirement for Clinical Managers to make an aide supervisory visit at least every 30 days, whether aide is present or not, to observe the care aide is providing, to assess relationship between aide and patient and to determine if goals are being met. | |

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| | for the Registered Nurse "to perform supervisory visits per state regulations ... RN to monitor vital signs and pulse oximetry at this time."<br><br>A. The clinical record failed to evidence a Nursing Supervisory visit note between 9/7/17 to 11/2/17.<br><br>B. Review of an agency form titled "Nursing Supervisory Note" dated 11/2/17 and 11/7/17, included care coordination (such as level of services, advance directives, plan of care reviewed and appropriate, changes to the treatment, other agencies in the home), chart (current plan of care in the chart and reviewed, home chart reviewed, emergency plan reviewed, grievance and branch numbers available, current medication profile in chart and updated, medication reconciliation complete, and goals reviewed), Patient / caregiver (verbalizing satisfaction with services, involved and agreed with plan of care, any changes in caregiver involvement, patient / caregiver education provided if necessary), environment (patient area / room clean and organized, DME and supplies match plan of care, oxygen safety observed, medications stored appropriately), assessment (vital signs obtained including oxygen saturations), and pain assessments. The form was signed by | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 12/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC | 9840 WESTPOINT DRIVE, SUITE 400<br>INDIANAPOLIS, IN 46256 |

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|---|---|---|---|---|
| | the home health aide. The supervisory visit failed to include observance of care and the assessment of the relationship between the patient and the home health aide.<br><br>3. The findings were reviewed with the Director of Clinical Services, Administrator, and Alternate Administrator on 12/1/17 at 4:30 PM, and indicated the case manager / registered nurse should have been observing care provided by the home health aide during joint visits. | | | |