

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012068</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/19/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADIEL HOME HEALTH SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>608 W 81ST AVE</b> <b>MERRILLVILLE, IN 46410</b>
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N 000	<p>Initial Comments survey</p> <p>This visit was a state re-licensure, focused infection control, and complaint survey with 1 complaint. The survey visit took place 4/13/2021 to 4/19/2021.</p> <p>Facility ID: 012068</p> <p>Complaint: IN00213510 - substantiated with related and unrelated findings.</p>	N 000		
N 470	<p>410 IAC 17-12-1(m) Home health agency administration/management</p> <p>Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>This RULE is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all employees followed standard / universal precautions and infection control practices, in 2 of 7 patient records reviewed (#1, #2)</p> <p>The findings include:</p> <p>1. Record review on 4/19/2021, evidenced an undated agency policy titled, "INFECTION CONTROL", numbered N-140, which stated, "APPLIES TO ... Registered Nurses ... Licensed Practical / Vocational Nurses ... Therapists ... SPECIAL CONSIDERATIONS Standard precautions apply to blood and other potentially infectious fluids including: ... Semen and vaginal secretions ... Saliva ... Body fluids ... REQUIRED INFECTION PROCEDURES ... Remove gloves and wash hands after each</p>	N 470	<p>410 IAC 17-12-1</p> <p>Inservice and review with all direct patient care staff the policies of infection control. This would involve documentation of standards met, and practice in handling procedures and precautions. Inservices to include: Bag technique, hand washing, changing gloves, steps in performing procedures. This will be completed within 30 days o with performance check off stations to ensure all required standards have been met.</p> <p>The administrator and clinical supervisor are responsible for this task to prevent recurrence.</p>	

Indiana State Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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N 470	<p>Continued From page 1</p> <p>contact. Refer to the Hand Washing procedure ... Disinfect equipment and discard non disposables. ..."</p> <p>2. Record review on 4/19/2021, evidenced an undated agency policy titled, "STANDARD INFECTION CONTROL PROCEDURES FOR HOME CARE", numbered N-100, which stated, "Standard precautions were developed by the Centers for Disease Control and Prevention to provide the widest possible protection against transmission of infection ... PURPOSE..... To provide protection against the transmission of infection .... APPLIES TO ..... Registered Nurses ... Licensed Practical / Vocational Nurses ... Therapists ... PROCEDURE ... 1. Wash hands before and after client care and after removing gloves.....Gloves should be worn for any known or anticipated contact with blood, body fluids, tissue, mucous membrane and non-intact skin. Change gloves and wash hands between client contacts...."</p> <p>3. Record review on 4/19/2021, evidenced an undated agency policy titled, "NURSING BAG", numbered N-120, which stated, "PURPOSE ... To maintain supplies in clean environment ... APPLIES TO ... Registered Nurses..... Licensed Practical / Vocational Nurses ... Therapists ... GUIDELINES The inside of the bag and its contents are considered clean. Therefore: Hand washing must occur before entering the bag for any reason. All items removed from the bag should be cleaned before returning to the bag... "</p> <p>4. Review of an undated agency procedure titled "Tracheostomy Care," stated "... Procedure ...</p> <p>5. Apply gloves ... 6.....remove the oxygen source..... "</p>	N 470		

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N 470	<p>Continued From page 2</p> <p>5. Review of an undated agency procedure titled "Aseptic Technique in the Home," stated "... To prevent introduction of microorganisms onto a designated field ... Applies to ... Registered Nurses.....2. Create a sterile field and arrange sterile supplies ... 4. Open sterile items and use inside of wrapping to create a sterile field. ... "</p> <p>6. Review of an undated agency policy titled "Urinary Catheter Insertion - Straight or Indwelling Catheter," stated "... Applies to.....Registered Nurses ... Procedure ... 10.....Do not touch contaminated surfaces with gloves. ... "</p> <p>7. During a home health visit on 4/14/21 at 10:19 a.m. for patient #1, primary diagnosis: Anoxic Brain Damage (A complete lack of oxygen being provided to the brain which results in the death of brain cells), start of care 4/13/2020, (Registered Nurse) RN C was observed adjusting the oxygen mask located directly over the tracheostomy ( A surgically implanted tube into the trachea to more easily provide oxygen into the lungs) without the use of gloves. The clinician failed to apply gloves prior to adjusting the oxygen mask located directly over the tracheostomy, which had the potential to be contaminated with body fluids.</p> <p>During an interview on 4/16/21 at 2:34 p.m., the Administrator indicated gloves should be worn when working with items such as a trach (tracheostomy) or foley.</p>	N 470		

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N 470	<p>Continued From page 3</p> <p>8. Personnel record review on 4/15/2021, for employee G, PT [physical therapist] evidenced an agency document titled, "NURSING BAG TECHNIQUE COMPETENCY EVALUATION", dated 10/14/20, signed by the administrator as evaluator. This document stated, "PERFORMANCE CRITERIA 1. Bag is placed on clean surface 2. Barrier is utilized as appropriate 3. Bag is placed out of reach of children and animals 4. Antiseptic no rinse gel or towelettes is available for Handwashing if necessary 5. Washes hands before entering the bag 6. Equipment used is cleaned prior to returning to bag if appropriate 7. Clean and dirty supplies are maintained separately 7. Clean and dirty supplies are maintained separately 8. Supplies are maintained in the bag and checked for expiration on a regular basis...."</p> <p>9. During a home visit on 4/14/2021 at 11:15 a.m., for patient #2, start of care 4/14/2020, certification period 2/18/2021 to 4/18/2021, and primary diagnosis of Chronic lymphocytic leukemia, at 11:20 a.m., employee G, PT [physical therapist] was observed placing the bag on barrier on the patient's floor, removed gloves from the bag, and applied the gloves. Employee G, PT failed to wash their hands before entering the bag and prior to the application of gloves. At 11:23 a.m., the PT assisted the patient to sit up at</p>	N 470		

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N 470	<p>Continued From page 4</p> <p>the side of the bed, then transferred the patient to a wheelchair. At 11:25 a.m., the PT assisted the patient to exercise their arms. At 11:28 a.m., the PT removed a pulse oximeter from the bag and placed it on the patient's middle finger on the right hand. The PT failed to remove gloves and wash hands before the bag was entered. At 11:30 a.m., the PT removed an automatic blood pressure cuff from the bag and placed it on the patient's left wrist. Employee G failed to remove gloves and wash hands before entering bag. At 11:40 a.m., the PT and person A assisted patient to transfer back to bed.</p> <p>During an interview on 4/16/2021 at 2:27 p.m., the administrator indicated clinicians should wash hands before entering bag each time. When informed of the findings, the administrator indicated the clinician was probably nervous.</p>	N 470		
N 522	<p>410 IAC 17-13-1(a) Patient Care</p> <p>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:</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to follow a written medical plan of care in 4 of 7 clinical records reviewed (#2, #3, #4, #6,).</p> <p>The findings include:</p> <p>1. Record review on 4/19/2021, evidenced an undated agency policy titled, "PLAN OF CARE", numbered C-580, which stated, "POLICY Home</p>	N 522	<p>410 IAC 17-13-1 (a)</p> <p>Agency will educate skilled staff on individualizing patient plan of care to ensure coordination of services and quality of care necessary to meet the patient's needs. Staff will review 100% of SN and HHA plans of car, and make corrections as appropriate with subsequent orders. The clinical manager is responsible for this task. Further process to prevent recurrence:</p> <p>25% weekly audits of all patient charts to ensure there is evidence of plan of care which includes: all diagnoses, the patient's mental, psychosocial and cognitive stats. Types of services, supplies and equipment. Frequency and duration of visits to be made. All medications and treatments, safety measures to protect against injury. A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors, patient specific interventions and education.</p>	

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N 522	<p>Continued From page 5</p> <p>care services are furnished under the supervision and direction of the patient's physician, The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... To assure that the plan meets state / federal guidelines, and all applicable laws and regulations. SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each patient receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es), principle and secondary, including dates of onset ... C. Type, frequency, and duration of all visits / services. d. Specific procedures and modalities for therapy services ... i. Functional limitations and precautions. j. Activities permitted or restrictions. k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures. m. Medical supplies and equipment required. n. Any safety measures to protect against injury ... t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care ... 4. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and durations ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. .. "</p> <p>2. Record review on 4/19/2021, evidenced an</p>	N 522	See previous page	

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N 522	<p>Continued From page 6</p> <p>undated agency policy titled, "HOME HEALTH AIDE CARE PLAN", numbered C-751, which stated, "POLICY A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan. The Care Plan will be available to all persons involved in patient care, including contracted providers. PURPOSE To provide a means of assigning duties to the Home Health Aide that are clear to the Nurse, Home Health Aide, and to the patient / caregiver being served...."</p> <p>3. Record review on 4/19/2021, evidenced an undated agency policy titled, "FALL PREVENTION PROGRAM", numbered C-146, which stated, "POLICY All patients are assessed at the time of admission to determine their risk for falls. Patients identified to be at risk will be given information on safety precautions that may be helpful in preventing falls. Referrals will be made to other disciplines as appropriate to decrease risk factors. PURPOSE To identify patients believed to be at risk for falls. To implement teaching and / or other interventions that will assist the patient to decrease risk of falls ... SPECIAL INSTRUCTIONS ... 4. Nurse / Therapist will document teaching provided and recommendations given to family ... 6. Risk factors will be incorporated into the Plan of Care and assessed on each visit. ..."</p> <p>4. Record review on 4/19/2021, evidenced an undated agency policy titled, "SKILLED NURSING SERVICES", numbered C-200, which stated, "POLICY Skilled nursing services will be provided ..... in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered</p>	N 522		

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N 522	<p>Continued From page 7</p> <p>nurse: ... b. Regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs...."</p> <p>5. Record review on 4/19/2021, evidenced an undated agency policy titled, "HOME HEALTH AIDE SERVICES", numbered C-220, which stated, "POLICY Home Health Aide services will be provided.....under direct supervision of an agency Registered Nurse / Therapist in accordance with a medically approved Plan of Care ... SPECIAL INSTRUCTIONS .... b. Assisting with patient transfers, ambulation and protecting the patient from falls ... c. Cleaning perineal area around catheter ... e. Maintaining a safe environment for the patient. ... "</p> <p>6. Clinical record review on 4/16/2021 for patient #2, with start of care 4/14/2020, certification period 2/18/2021 to 4/18/2021, and primary diagnosis of Chronic lymphocytic leukemia, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/8/2021. This plan of care had a subcategory titled, "Safety Measures", which stated, "Keep Pathway Clear ..... Anticoagulant Precautions. Safety in ADL's. [activities of daily living] Instructed on safety measures. Fall Precautions..... Standard Precautions / Infection Control...." The plan of care had a subcategory titled, "Orders and Treatments", which stated, "... HHA [home health aide]: 1w1 [once a week for one week], 2w8 [twice a week for 8 weeks] for</p>	N 522		

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N 522	<p>Continued From page 8</p> <p>safety and assistance with adl's ... Assessment Summary: ... Home Health aide will do personal care needs and safety measures. "</p> <p>Review on 4/16/2021, of patient #2's electronic medical record (Kinnser) evidenced skilled nurse visit notes dated 2/24/2021, 3/3/2021, 3/10/2021, 3/17/2021, and 3/24/2021. These skilled nurse visit notes failed to evidence fall precautions. Skilled nurse visit notes dated 2/24/2021, 3/3/2021, 3/10/2021, 3/17/2021, 3/24/2021, 3/31/2021, and 4/7/2021, failed to evidence anticoagulant precautions.</p> <p>Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 2/18/2021, signed by employee C, RN [registered nurse]. This care plan failed to evidence fall precautions and anticoagulant precautions. Review on 4/16/2021, of patient #2's electronic medical record (Kinnser), evidenced HHA [home health aide] visit notes dated 2/18/2021, 2/22/2021, 2/25/2021, 3/1/2021, 3/4/2021, 3/8/2021, 3/11/2021, 3/15/2021, 3/18/2021, 3/22/2021, 3/25/2021, 3/29/2021, 4/1/2021, 4/5/2021, and 4/8/2021. These home health aide visit notes failed to evidence fall precautions and anticoagulant precautions.</p> <p>During an interview on 4/16/2021 at 2:23 p.m., the administrator indicated all disciplines should be aware of and enforce fall prevention and anticoagulant precautions, and documentation of this should be in each visit's notes. The administrator indicated safety should be assessed each visit by all disciplines.</p> <p>7. Clinical record review for patient #3, start of care 3/11/2021, certification period 3/11/2021 to 5/9/2021, primary diagnosis of memory deficit</p>	N 522		

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N 522	<p>Continued From page 9</p> <p>following cerebral infarction [stroke], evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/29/2021. This plan of care had a subcategory titled, "Safety Measures", which stated, "Keep Pathway Clear ... Safety in ADLs. Instructed on safety measures ... Fall Precautions ... Standard Precautions / Infection Control...." The plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... HHA: 1w1, 2w8 for safety and assistance with adl's ... Assessment Summary: ... Home Health aide will do personal care needs and safety needs... "</p> <p>Review on 4/16/2021, of patient #3's electronic medical record (Kinnser), evidenced skilled nurse visit notes dated 3/18/2021, 3/25/2021, and 3/30/2021, which failed to evidence fall precautions.</p> <p>Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 3/12/2021, signed by employee C, RN. This care plan failed to evidence fall precautions and anticoagulant precautions. Review on 4/16/2021, of patient #3's electronic medical record (Kinnser), evidenced HHA visit notes dated 3/12/2021, 3/16/2021, 3/18/2021, 3/23/2021, 3/26/2021, 3/30/2021, 4/2/2021 and 4/6/2021, which failed to evidence fall and safety precautions.</p> <p>During an interview on 4/16/2021 at 2:23 p.m., the administrator indicated all disciplines should be aware of and enforce fall prevention and anticoagulant precautions, and documentation of this should be in each visit's notes. The administrator indicated safety should be assessed each visit by all disciplines.</p>	N 522		

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N 522	<p>Continued From page 10</p> <p>8. Clinical record review on 4/19/2021 for patient #4, start of care 10/4/2017, certification period 3/17/2021 to 5/15/2021, primary diagnosis of hereditary motor and sensory neuropathy, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician. The plan of care had a subcategory titled, "Safety Measures", which stated, "Keep Pathway Clear ... Safety in ADLs ... Instructed on safety measures ... Fall Precautions ... Standard Precautions / Infection Control...." The plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... HHA: 1w1, 2w8 for safety and assistance with adl's ... Home Health Aide will do personal care needs and safety needs...."</p> <p>Review on 4/19/2021, of patient #4's electronic medical record (Kinnser), evidenced a skilled nurse visit note dated 3/25/2019, signed by employee C, RN, which failed to evidence fall and safety precautions.</p> <p>Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 3/16/2021, signed by employee C, RN. This care plan failed to evidence fall and safety precautions.</p> <p>Review on 4/19/2021, of patient #4's electronic medical record (Kinnser), evidenced HHA visit notes dated 3/18/2021, 3/22/2021, 3/25/2021, 3/29/2021, 4/1/2021, 4/5/2021, 4/8/2021, and 4/12/2021, which failed to evidence fall and safety precautions.</p> <p>During an interview on 4/16/2021 at 2:23 p.m., the administrator indicated all disciplines should be aware of and enforce fall prevention and anticoagulant precautions, and documentation of</p>	N 522		

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N 522	<p>Continued From page 11</p> <p>this should be in each visit's notes. The administrator indicated safety should be assessed each visit by all disciplines.</p> <p>9. Clinical record review on 4/19/2021, for patient #6, start of care 7/7/2016, certification period 7/7/2016 to 9/4/2016, primary diagnosis of atherosclerotic heart disease [a thickening and hardening of the walls of the coronary arteries], evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 8/1/2016. The plan of care contained a subcategory titled, "Safety Measures", which stated, "Infection Control Precautions, O2 [oxygen] Precautions, Fall Precautions ... Bleeding Precautions, Anticoagulant Precautions ... Standard Precautions...." The plan of care contained a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, " ... SN [skilled nurse] ... for skilled services and assessments per plan of care. HHA ... for safety and assistance with adl's per aide care plan ... SN to teach ... Safe Ambulation / Transfers, Home Safety / Fall Prevention. .."</p> <p>Review on 4/19/2021, of patient #6's electronic medical record (HealthcareFirst.com), evidenced a group of documents titled, "Skilled Nursing Visit Notes". The notes dated 7/14/2016, 7/21/2016, 8/4/2016, 8/18/2016, 8/25/2016, and 9/1/2016, failed to evidence assessment of or teaching about oxygen precautions, fall precautions, bleeding precautions, anticoagulant precautions, and standard precautions.</p> <p>Clinical record review evidenced an agency document titled, "HHA Care Plan B", dated 7/11/2016, signed by person C, RN. In the first,</p>	N 522		

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N 522	<p>Continued From page 12</p> <p>untitled, subcategory of this care plan, the following were indicated with a check-mark: Standard Precautions, Safety Check, Report to RN Red or Broken Skin, Bleeding Precautions, and Fall Precautions.</p> <p>Review on 4/19/2021, of patient #6's electronic medical record (HealthcareFirst.com), evidenced a group of documents titled, "HHA Vist Note B". The notes dated 7/8/2016, 7/11/2016, 7/14/2016, 7/18/2016, 7/21/2016, 7/25/2016, 7/28/2016, 8/1/2016, 8/5/2016, 8/9/2021, 8/12/2016, 8/15/2016, 8/18/2016, 8/22/2016, 8/25/2016, 8/29/2016, and 9/1/2016, failed to evidence Standard Precautions, Safety Check, Bleeding Precautions, and Fall Precautions.</p> <p>During an interview on 4/16/2021 at 2:23 p.m., the administrator indicated all disciplines should be aware of and enforce fall prevention and anticoagulant precautions, and documentation of this should be in each visit's notes. The administrator indicated safety should be assessed each visit by all disciplines.</p>	N 522		
N 524	<p>410 IAC 17-13-1(a)(1) Patient Care</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p>	N 524	<p>410 IAC 17-13-1(a) (1)</p> <p>Agency will educate skilled staff on individualizing patient plan of care to ensure coordination of services and quality of care necessary to meet the patient's needs. Staff will review 100% of plans of care and make corrections as appropriate with subsequent orders.</p> <p>The clinical manager is responsible for this task. Further process to prevent recurrence: Patient POC will have detailed listing of medications with careful consideration of special needs and procedures for routing of medication.</p>	

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N 524	<p>Continued From page 13</p> <ul style="list-style-type: none"> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> <p>This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure a complete, individualized plan of care was established for 5 of 7 clinical records reviewed (#1, #2, #3, #4, #6).</p> <p>The findings include:</p> <p>1. Record review on 4/19/2021, evidenced an undated agency policy titled, "PLAN OF CARE", numbered C-580, which stated, "POLICY Home care services are furnished under the supervision and direction of the patient's physician, The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... To assure that the plan meets state / federal</p>	N 524	<p>Continued</p> <p>25% weekly audits of all patient charts to ensure there is evidence of plan of care which includes: all diagnoses, the patient's mental, psychosocial and cognitive stats. Types of services, supplies and equipment. Frequency and duration of visits to be made. All medications and treatments, safety measures to protect against injury. A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors, patient specific interventions and education. Measurable outcomes and goals identified by and the patient. Any additional items the HHA or physician may choose to include. After threshold of 100% is met a 10% quarterly audit will be performed to ensure compliance.</p> <p>There will be a poc Addendum addressing specific procedures and modalities to be used and the amount, frequency and duration. Staff shall promptly alert physician of any changes that alter plans of care.</p> <p>This would include clients clinical record, 1, 2, 3.</p> <p>For patients 4-6 Nurses were inserviced regarding medications orders, frequency, amount, routes, and ensuring accuracy of all medication orders.</p> <p>The administrator is responsible for this correction to prevent recurrence.</p>	

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N 524	<p>Continued From page 14</p> <p>guidelines, and all applicable laws and regulations. SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each patient receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es), principle and secondary, including dates of onset ... C. Type, frequency, and duration of all visits / services. d. Specific procedures and modalities for therapy services ... i. Functional limitations and precautions. j. Activities permitted or restrictions. k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures. m. Medical supplies and equipment required. n. Any safety measures to protect against injury ... t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care ... 4. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and durations ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. . . "</p> <p>2. Record review on 4/19/2021, evidenced an undated agency policy titled, "COORDINATION OF PATIENT SERVICES", numbered C-360, which stated, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans ... PURPOSE To ensure services are coordinated between members of the interdisciplinary team. To ensure appropriate, quality care is being provided to patients. To establish effective interchange, reporting, and</p>	N 524		

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N 524	<p>Continued From page 15</p> <p>coordination of patient care does occur. To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care ... 3. After the initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure: A.. Clarification of the plan of care orders..."</p> <p>3. Record review on 4/19/2021, evidenced an undated agency policy titled, "THERAPY SERVICES", numbered C-240, which stated, "POLICY Therapists shall participate in developing operational policies and procedures pertinent to their discipline ... PURPOSE ..... To provide optimum quality care to patients. To provide guidelines for therapy services and care coordination with other disciplines. To comply with state / federal guidelines. SPECIAL INSTRUCTIONS 1. Referrals to the agency for therapy services (Physical or Occupational) may include, but are not limited to: ... d. Overall development of an individualized therapy program under the direction of the physician...."</p> <p>4. Record review on 4/19/2021, evidenced an undated agency policy titled, "MEDICATION ORDERS", numbered C-706, which stated, " ... PURPOSE ..... To assess that medication orders are written clearly and transcribed accurately. To minimize errors and misinterpretation of written or verbal medication orders. SPECIAL INSTRUCTIONS 1. All medication orders, including herbal preparations, must contain dosage, route and frequency ... 4. Orders for PRN [as needed] Medications must include name, dose, reason for use and any specific time constraints for administration ... 6. Agency staff will verify with the physician any incomplete,</p>	N 524	Nurses were inserviced regarding medications orders, frequency, amount, routes, and ensuring accuracy of all medication orders.	

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N 524	<p>Continued From page 16</p> <p>illegible or unclear medication orders...."</p> <p>5. Clinical record review on 4/16/2021 for patient #2, start of care 4/14/2020, certification period 2/18/2021 to 4/18/2021, and primary diagnosis of Chronic lymphocytic leukemia, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/8/2021. This plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... PT [physical therapy]: eval [evaluate]...." Review of the plan of care failed to evidence frequency and duration of physical therapy visits, and a physical therapy plan of care. Review of the patient's electronic record (Kinnser), failed to evidence a PT plan of care.</p> <p>During an interview on 4/16/2021 at 2:18 p.m., the administrator indicated when physical therapy is ordered for a patient, the physical therapist should evaluate the patient and create a plan of care to be signed by the physician. The administrator indicated the plan of care failed to evidence a frequency and duration of physical therapy visits, and a physical therapy plan of care. When informed of the findings, the administrator provided no further documentation.</p> <p>Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/8/2021. This plan of care evidenced a subcategory titled, "Medications", which stated, " ... Lotrisone External 1-0.05% [a topical anti-fungal medication] 1 apply small amount to the affected area BID [twice a day]...." The medication order failed to evidence where, on the body, the medication was to be used.</p> <p>During an interview on 4/16/2021 at 2:20 p.m.,</p>	N 524		

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N 524	<p>Continued From page 17</p> <p>the administrator indicated orders for topical medications should include location of where the medication is to be used. When informed of the findings, the administrator indicated the order for the medication was not complete.</p> <p>Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/8/2021. This plan of care evidenced a subcategory titled, "SN [skilled nurse] interventions", which stated, "... SN to instruct caregiver on prevention of wandering episodes such as remind patient to use bathroom every 2 hours. ..."</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 [Outcome and Assessment Information Set] [a standardized Medicare assessment used in home health] Recertification, dated 2/14/2021, signed by employee C, RN [registered nurse]. This assessment had a subcategory titled, "ADL [activities of daily living] / IADLs [instrumental activities of daily living]", which stated, "... (M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. ..." Answer choice 5 was indicated, which stated, "Bedfast, unable to transfer and is unable to turn and position self." This subcategory also stated, "... (M 1860) Ambulation / Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces...." Answer choice 6 was indicated, which stated, "Bedfast, unable to ambulate or be up in a chair."</p> <p>Clinical record review evidenced an agency document titled, "PT [physical therapy]</p>	N 524		

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N 524	<p>Continued From page 18</p> <p>Evaluation", dated 2/18/2021, signed by employee G, PT. This assessment had a subcategory titled, "Clinical Statement of Assessment Findings and Recommendations", which stated, " ... Pt [patient] becomes confused and wants to stay in bed most of the time. Pt is dependent with care, unable to use right shoulder. Pt needs maximum assist ... Pt able to ambulate with ... maximum assist of 2...."</p> <p>During an interview on 4/16/2021 at 2:25 p.m., the administrator indicated patient #2 was bedbound, and not at risk for wandering.</p> <p>6. Clinical record review for patient #3, start of care 3/11/2021, certification period 3/11/2021 to 5/9/2021, primary diagnosis of memory deficit following cerebral infarction [stroke], evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/29/2021. This plan of care had a subcategory titled, "Medications", which stated, "Lisinopril [a blood pressure medication] Oral 10 MG [milligram] 1 Tab(s) Twice a Day (C) Lisinopril Oral 10 MG 1 Tab(s) daily (C) Aspirin Low Strength Oral 81 MG 1 Tab(s) daily (N) Novolog Mix 70/30 [an insulin] Subcutaneous (70 - 30) 100 unit/mL [milliliter] Sliding scale as directed by dr. [doctor] (N)...."</p> <p>During an interview on 4/16/2021 at 2:53 p.m., the administrator indicated the plan of care should contain all medications a patient is currently taking. When informed of the findings, the administrator reviewed the plan of care and stated, "It didn't get discontinued, so it's on there again". The administrator indicated the plan of care failed to evidence a current, clear Lisinopril order. When asked to explain the patient's current insulin orders, the administrator reviewed</p>	N 524	<p>Nurses were inserviced regarding medications orders, frequency, amount, routes, and ensuring accuracy of all medication orders.</p>	

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N 524	<p>Continued From page 19</p> <p>the plan of care and stated, "Where is the sliding scale?" The administrator indicated the plan of care failed to evidence the sliding scale for insulin dosage.</p> <p>Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/29/2021. This plan of care had a subcategory titled, "SN [skilled nurse] Interventions", which stated, " ... Patient will verbalize understanding of proper use of pain medication by end of episode SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit SN to report to physician ... pain medications not effective, patient unable to tolerate pain medications...." Review of the medication list on the plan of care and the medication profile failed to evidence any pain medications.</p> <p>During an interview on 4/16/2021 at 3:05 p.m., the administrator indicated the patient only took aspirin once daily as ordered as a blood thinner, and did not use it as a pain medication. The administrator indicated the plan of care failed to evidence the patient took any pain medication.</p> <p>7. Clinical record review on 4/19/2021 for patient #4, start of care 10/4/2017, certification period 3/17/2021 to 5/15/2021, primary diagnosis of hereditary motor and sensory neuropathy, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician. The plan of care had a subcategory titled, "Medications", which stated, " ... Clobetasol Propionate External [a medication used to treat a variety of skin conditions and comes in cream, gel, spray, and shampoo forms] 0.05% 1 BID [twice a day]...." The plan of care</p>	N 524		

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N 524	<p>Continued From page 20</p> <p>failed to evidence the form the medication was in and where it was used.</p> <p>During an interview on 4/16/2021 at 2:20 p.m., the administrator indicated orders for topical medications should include location of where the medication is used.</p> <p>When informed of the findings on 4/19/2021 at 2:02 p.m., the administrator indicated the plan of care failed to evidence the form of the medication and where, on the body, it was used.</p> <p>8. Clinical record review on 4/19/2021 for patient #6, start of care 7/7/2016, certification period 7/7/2016 to 9/4/2016, primary diagnosis of atherosclerotic heart disease [a thickening and hardening of the walls of the coronary arteries], evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 8/1/2016. The plan of care contained a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, " ... Sn [skilled nurse] needed for skilled assessments of cardiovascular and respiratory status as change can occur rapidly with little to no warning ... SN [skilled nurse] 1W9 [once a week for 9 weeks] for skilled services and assessments per plan of care ... SN to Assess, as needed: Skilled Observe / Assess Body Systems Related to Dx [diagnoses], VS [vital signs], and Meds, Ambulation and Locomotion, Abuse / Neglect, Nutrition / Hydration / Elimination Status, Medication ... SN to Teach, as needed: Medications / Medication Dosage Regimen, Diet, Disease Process ... SN to Perform, as needed: Skilled Nursing Assessment and Teaching, Care Coordination, Management and Evaluation of Patient Care Plan...." Review of the plan of care failed to</p>	N 524		

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N 524	<p>Continued From page 21</p> <p>evidence skilled nursing tasks to be performed at each visit.</p> <p>During an interview on 4/19/2021 at 2:27 p.m., the administrator indicated skilled nursing assessments and teaching should be done at each nursing visit. When informed of the findings, the administrator stated about the plan of care, "It doesn't say that".</p> <p>9. Clinical record review on 4/15/21 for patient #1, primary diagnosis: Anoxic Brain Damage (A complete lack of oxygen being provided to the brain which results in the death of brain cells), start of care 4/13/2020, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/7/2021 - 4/7/2021, and signed by the primary care physician. This document had a subsection titled "Medications." This subsection indicated the patient was to take D-mannose (used to treat and prevent urinary tract infections) and Glycopyrrolate (reduces drooling and treats peptic ulcers in the stomach) orally (by mouth). This document failed to include Doxycycline (antibiotic) in the medication list; what wound site to apply the medications, Duoderm (dressing used to protect wounds and promote healing) and Medihoney (topical medication for the management of wounds and burns) to; and where to apply the medications Venelex (ointment</p>	N 524		

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N 524	<p>Continued From page 22</p> <p>to protectively cover pressure wounds) and Scopolamine (decreases saliva and treats nausea and vomiting). This document failed to indicate how many cc (Cubic Centimeter: measurement for volume) and how many feedings a day the patient was to receive of the enteral (involving or passing through the intestine) nutrition Jevity 1.5 formula. Clinical record review failed to evidence the home health agency included in the medical plan of care that the proper medication routes were via the PEG (Percutaneous Endoscopic Gastrostomy feeding tube placed through the abdominal wall and into the stomach for medications and nutrition) tube for D-mannose and Glycopyrrolate: include doxycycline in the medical plan of care; include where the wound site was to apply the Duoderm and Medihoney; include where Venelex and Scopolamine were to be applied; and include how many cc and feedings/day the patient was to receive of Jevity 1.5 formula.</p> <p>During a home visit on 4/14/2021 at 10:10 a.m., (Registered Nurse) RN C, indicated the patient was now on Doxycycline.</p> <p>During an interview on 4/16/21 at 2:41 p.m., the Administrator indicated that to her knowledge the patient is not taking Doxycycline. Person I, Office Personnel indicated Doxycycline is not part of the plan of care.</p> <p>During an interview on 4/16/21 at 2:34 p.m., the Administrator indicated the patient cannot take anything orally and the routes for D-mannose and Glycopyrrolate were incorrect. The Administrator indicated the plan of care did not state where the medications Duoderm and Medihoney are located. The Administrator also indicated the plan of care did not state where the medications</p>	N 524		

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N 524	Continued From page 23  Venelex and Scopolamine were to be applied. The administrator indicated the medical plan of care should include how many cc and feedings/day the Jevity 1.5 formula should be given.	N 524		
N 527	410 IAC 17-13-1(a)(2) Patient Care  Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.  This RULE is not met as evidenced by: Based on record review and interview, the agency failed to promptly alert the physician to any changes in the patient's condition in 2 of 7 clinical records reviewed (#3, #6).  The findings include:  1. Record review on 4/15/2021, evidenced an undated agency policy titled, "SKILLED NURSING SERVICES", numbered C-200, which stated, " ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... b. Regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs ... h. Supervises and	N 527	410 IAC 17-13-1 (a) (2)  As follows, the medical plan of care shall: (C) Be developed in consultation with the homehealth agency staff. (D) Include all services to be provided if a skilledservice is being provided. (D) Cover all pertinent diagnoses. (E) Include the following: (v) Mental status. (vi) Types of services and equipment required. (vii) Frequency and duration of visits. Prognosis.  (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect againstinjury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length oftreatment. (xiii) Any other appropriate items.  Inservice to staff as to promptly alert physician as to any changes in the patient condition. Audit 100% of clients to ensure compliance.. A plan of care addendum was initiated for any clients found to be deficient. A 10% audit will be performed to ensure continued compliance. Th QA staff was educated to assess for this deficiency for future changes in patient condition.	

			<p>The administrator is responsible for this to prevent recurrence.</p>	
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N 527	<p>Continued From page 24</p> <p>teaches other nursing personnel and home health aides as appropriate...."</p> <p>2. Record review on 4/15/2021, evidenced an undated agency policy titled, "COORDINATION OF PATIENT SERVICES", numbered C-360, which stated, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care ... PURPOSE.....To ensure appropriate, quality care is being provided to patients. To establish effective interchange, reporting, and coordination of patient care does occur .....To provide the attending physician with an ongoing assessment of the patient...."</p> <p>3. Clinical record review for patient #3, start of care 3/11/2021, certification period 3/11/2021 to 5/9/2021, primary diagnosis of memory deficit following cerebral infarction [stroke], evidenced an agency document titled, "OASIS-D1 [Outcome and Assessment Information Set] [a standardized Medicare assessment used in home health] Start of Care, dated 3/11/2021, signed by employee C, RN [registered nurse]. This assessment had a subcategory titled, "Digestive", which indicated the patient's last BM [bowel movement] was "WNL [within normal limits]".</p> <p>Review on 4/16/2021, of patient #3's electronic medical record (Kinnser), evidenced skilled nursing visit notes dated 3/18/2021, 3/25/2021, and 3/30/2021, each signed by employee C, RN. Each note stated, " ..... Last BM [bowel movement], [check-mark] Fresh Blood ...." The nursing visit notes had a section titled, "Coordination Plan", each note stated, " ... Physician Contacted Re: [blank]....."</p>	N 527	Cont.	

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N 527	<p>Continued From page 25</p> <p>During an interview on 4/16/2021 at 3:08 p.m., the administrator indicated the nurse should notify the physician with any change in condition, and document this communication in the nurse's visit note. The administrator indicated the assessments in the nursing notes dated 3/18/2021, 3/25/2021, and 3/30/2021, indicate a change from the assessment at start of care on 3/11/2021, and the nurse's documentation failed to evidence the physician was notified.</p> <p>4. Clinical record review on 4/19/2021, for patient #6, start of care 7/7/2016, certification period 7/7/2016 to 9/4/2016, primary diagnosis of atherosclerotic heart disease [a thickening and hardening of the walls of the coronary arteries], evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 8/1/2016. The plan of care contained a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, " ... SN [skilled nurse] needed for monitoring of therapeutic drug levels ... SN to Perform, as needed: ... PT / INR [a blood test that measures the time it takes a clot to form, used to determine dosage of the blood thinner, Coumadin] to be completed by 7/8/2016, and then Q [each] month and / or as ordered. ... "</p> <p>Clinical record review evidenced an agency document, identified by the administrator as a physician order sheet, signed by person C, RN and physician F. This document stated, " ... Begin Date: 08/05/2016 ... INR results 3.6. Hold Coumadin tonight, take 3 mg [milligram] Coumadin tomorrow, then return to regular dose. Repeat PT / INR in 1 week... "</p> <p>During an interview on 4/19/2021 at 2:34 p.m.,</p>	N 527		

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N 527	<p>Continued From page 26</p> <p>the administrator indicated the "Begin Date" on a physician order form indicated the date the order was received by the clinician.</p> <p>Clinical record review evidenced a document identified by the administrator as a lab result sheet from lab E. The result sheet stated, " ... Collection Date: 8/5/2016 11:31 AM ... INR 2.9... "</p> <p>Clinical record review failed to evidence the physician was notified of the correct INR result from 8/5/2016.</p> <p>During an interview on 4/19/2021 at 2:34 p.m., the administrator indicated the INR result from 8/5/2016, on the lab result sheet should match the INR on the physician order sheet from 8/5/2016. When informed of the findings, the administrator stated, "It's not matching .....I don't have an answer."</p>	N 527		
N 533	<p>410 IAC 17-13-2 Nursing Plan of Care</p> <p>Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.</p> <p>(b) The nursing plan of care must contain the following:</p> <ol style="list-style-type: none"> <li>(1) A plan of care and appropriate patient identifying information.</li> <li>(2) The name of the patient's physician.</li> <li>(3) Services to be provided.</li> <li>(4) The frequency and duration of visits.</li> <li>(5) Medications, diet, and activities.</li> </ol>	N 533	<p>410 IAC 17-13-2</p> <p>Applies to numbers 1 and 3. The SN will be inserviced on how to prepare a proper and complete aide care plan that specified the care and services necessary to meet the patient's need.</p> <p>The staff reviewed 100% of aide care plans and corrected all care plans that were deficient. The staff will be inserviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs.</p> <p>Audit 10% of all active patients to ensure the plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%. Once threshold is met, will continue to audit 10% of all patient records quarterly.</p> <p>The clinical manager is responsible for correction to</p>	

			<p>prevent recurrence.</p> <p>Number 2. Supervisory visits will be performed every 14 days as per the regulation. This will be inserviced to complete and assure compliance. This will be audited by QA to ensure supervisory regulation.</p> <p>Number 4 &amp; 5,6 &amp;7: We reviewed 100% of care plans and ensured medical conditions specialty care was included in Aide care plans. Such as fall precautions and anticoagulation safety measures. All nurses were inserviced regarding such precautions in the plan of care. Inservice and audits will be done to assure compliance.</p>	
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N 533	<p>Continued From page 27</p> <p>(6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the registered nurse failed to ensure the nursing plan of care contained all services to be provided by the home health aide in 4 of 5 active patient clinical records reviewed (#2, #3, #4, #7).</p> <p>The findings include:</p> <p>1. Record review on 4/16/2021 evidenced an undated agency policy titled, "CARE PLANS", numbered C-660, which stated, "POLICY Each patient will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the patient and family, as indicated, and is based on services needed to achieve specific measurable goals. PURPOSE ... To provide updated, coordinated document that reflects the current home care services. SPECIAL INSTRUCTIONS 1. Following the initial assessment, a Care Plan shall be developed with the patient and / or caregiver. The interventions shall correspond to the problems identified, services needed and the patient goals for the episode of care ... The Care Plan shall include, but not be limited to: ... A list of specific interventions with plans for implementation. ..."</p>	N 533		

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N 533	<p>Continued From page 28</p> <p>2. Record review on 4/16/2021 evidenced an undated agency policy titled, "HOME HEALTH AIDE SUPERVISION", numbered C-340, which stated, "POLICY Agency shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse / Therapist when personal care services are ordered by the physician ... SPECIAL INSTRUCTIONS 1. The Nursing Supervisor or designated Registered Nurse / Therapist will give the Home Health Aide direction for patient care by way of the Care Plan... "</p> <p>3. Record review on 4/16/2021 evidenced an undated agency policy titled, "HOME HEALTH AIDE SERVICES", numbered C-220, which stated, "POLICY Home Health Aide services will be provided to appropriate patients ..... under the direct supervision of an agency Registered Nurse / Therapist in accordance with a medically approved Plan of Care. The duties of a home health aide include the provision of hands-on personal care, performance of simple procedures as an extension of therapy or nursing services ... SPECIAL INSTRUCTIONS 1. Home Health Aide services may include: a. Providing personal care services including bathing , dressing, feeding, weighing, back rubs, skin care and shampoos as directed by the care plan and licensed professional. b. Assisting with patient transfers, ambulation and protecting the patient from falls. c. Cleaning perineal area around catheter. d. Obtaining patient temperature, pulse, respiration, and blood pressure. e. Maintaining a safe environment for the patient ... 2. The nurse or therapist assesses the need for personal care services and includes the services in the physician plan of care (orders). A specific plan is developed documenting the Aide services to be provided. 3. The Aide will follow the care plan</p>	N 533		

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N 533	<p>Continued From page 29</p> <p>and will not initiate new services or discontinue services without contacting the supervising Nurse / therapist..."</p> <p>4. Clinical record review on 4/16/2021 for patient #2 with start of care 4/14/2020, certification period 2/18/2021 to 4/18/2021, and primary diagnosis of Chronic lymphocytic leukemia, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/8/2021. This plan of care had a subcategory titled, "Safety Measures", which stated, "Keep Pathway Clear ..... Anticoagulant Precautions. Safety in ADL's. Instructed on safety measures. Fall Precautions .....Standard Precautions / Infection Control...." The plan of care had a subcategory titled, "Orders and Treatments", which stated, "..... HHA [home health aide]: 1w1 [once a week for one week], 2w8 [twice a week for 8 weeks] for safety and assistance with adl's [activities of daily living] ... Assessment Summary: .....Home Health aide will do personal care needs and safety measures...."</p> <p>Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 2/18/2021, signed by employee C, RN [registered nurse]. This care plan failed to evidence fall precautions and anticoagulant precautions.</p> <p>Review on 4/16/2021 of patient #2's electronic medical record (Kinnser) evidenced HHA [home health aide] visit notes dated 2/18/2021, 2/22/2021, 2/25/2021, 3/1/2021, 3/4/2021, 3/8/2021, 3/11/2021, 3/15/2021, 3/18/2021, 3/22/2021, 3/25/2021, 3/29/2021, 4/1/2021, 4/5/2021, and 4/8/2021 failed to evidence fall precautions and anticoagulant precautions.</p> <p>During an interview on 4/16/2021 at 2:23 p.m.,</p>	N 533		

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N 533	<p>Continued From page 30</p> <p>the administrator indicated all disciplines should be aware of and enforce fall prevention and anticoagulant precautions, and documentation of this should be in each visit's notes. The administrator indicated safety should be assessed each visit by all disciplines.</p> <p>During an interview on 4/16/2021 at 3:15 p.m., the administrator indicated the nurse created the care plan based on assessed patient needs. The administrator indicated the nurse failed to include the patient's safety needs in the aide care plan.</p> <p>5. Clinical record review for patient #3, start of care 3/11/2021, certification period 3/11/2021 to 5/9/2021, primary diagnosis of memory deficit following cerebral infarction [stroke], evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/29/2021. This plan of care had a subcategory titled, "Safety Measures", which stated, "Keep Pathway Clear ... Safety in ADLs [activities of daily living]. Instructed on safety measures ... Fall Precautions ... Standard Precautions / Infection Control...." The plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... HHA [home health aide]: 1w1 [once a week for one week], 2w8 [twice a week for 8 weeks] for safety and assistance with adl's [activities of daily living] ... Assessment Summary: ... Home Health aide will do personal care needs and safety needs ... Foley catheter care...."</p> <p>Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 2/18/2021, signed by employee C, RN [registered nurse]. This care plan failed to evidence fall precautions and anticoagulant precautions.</p>	N 533		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012068</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/19/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADIEL HOME HEALTH SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>608 W 81ST AVE</b> <b>MERRILLVILLE, IN 46410</b>
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N 533	<p>Continued From page 31</p> <p>Review on 4/16/2021 of patient #3's electronic medical record (Kinnser) evidenced HHA [home health aide] visit notes dated 2/18/2021, 2/22/2021, 2/25/2021, 3/1/2021, 3/4/2021, 3/8/2021, 3/11/2021, 3/15/2021, 3/18/2021, 3/22/2021, 3/25/2021, 3/29/2021, 4/1/2021, 4/5/2021, and 4/8/2021 failed to evidence fall precautions and anticoagulant precautions.</p> <p>During an interview on 4/16/2021 at 2:23 p.m., the administrator indicated all disciplines should be aware of and enforce fall prevention and anticoagulant precautions, and documentation of this should be in each visit's notes. The administrator indicated safety should be assessed each visit by all disciplines.</p> <p>During an interview on 4/16/2021 at 3:15 p.m., the administrator indicated the nurse created the care plan based on assessed patient needs. The administrator indicated the nurse failed to include the patient's safety needs in the aide care plan.</p> <p>Review of the Aide Care Plan evidenced a list of tasks and their frequencies. Only the tasks checking the patient's pulse, respirations, and temperature were indicated to be performed "q [each] visit". The tasks back rub / massage, shampoo hair, and shower or bed bath were indicated to be performed "as needed". The skilled nurse failed to list the indications for when the home health aide was to perform the "as needed" tasks. The following tasks were not indicated to be performed by the Aide: Catheter Care, Incontinent Care, Assist in Ambulation, Assist in Transfer, Assist to Dress, Pericare.</p> <p>On 4/16/2021 at 3:17 p.m., when informed of the findings, the administrator reviewed the Aide Care Plan and stated, "Then you don't need an aide".</p>	N 533		

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N 533	<p>Continued From page 32</p> <p>The administrator indicated the nurse failed to include personal care to be performed at each visit including Catheter Care, Incontinent Care, Assist in Ambulation, Assist in Transfer, Assist to Dress, Pericare.</p> <p>6. Clinical record review on 4/19/2021 for patient #4, start of care 10/4/2017, certification period 3/17/2021 to 5/15/2021, primary diagnosis of hereditary motor and sensory neuropathy, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician. The plan of care had a subcategory titled, "Safety Measures", which stated, "Keep Pathway Clear ... Safety in ADLs [activities of daily living] ... Instructed on safety measures ... Fall Precautions ... Standard Precautions / Infection Control...." The plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... HHA [home health aide]: 1w1 [once a week for one week], 2w8 [twice a week for 8 weeks] for safety and assistance with adl's [activities of daily living] ... Home Health Aide will do personal care needs and safety needs. .."</p> <p>Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 3/16/2021, signed by employee C, RN [registered nurse]. This care plan failed to evidence fall and safety precautions.</p> <p>Review on 4/19/2021 of patient #4's electronic medical record (Kinnser) evidenced HHA [home health aide] visit notes dated 3/18/2021, 3/22/2021, 3/25/2021, 3/29/2021, 4/1/2021, 4/5/2021, 4/8/2021, and 4/12/2021 failed to evidence fall and safety precautions.</p> <p>During an interview on 4/16/2021 at 2:23 p.m.,</p>	N 533		

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N 533	<p>Continued From page 33</p> <p>the administrator indicated all disciplines should be aware of and enforce fall prevention and anticoagulant precautions, and documentation of this should be in each visit's notes. The administrator indicated safety should be assessed each visit by all disciplines.</p> <p>During an interview on 4/19/2021 at 2:10 p.m., the administrator indicated the nurse failed to include fall and safety precautions in the home health aide care plan.</p> <p>7. Clinical record review on 4/19/21 for patient #7, primary diagnosis: Infection following a procedure, other surgical site, start of care 3/5/2021, evidenced an agency document titled "Aide Care Plan," dated 3/5/2021, signed by RN C. This document failed to include the Tub/Shower Bench as part of the DME [durable medical equipment].</p> <p>During an interview on 4/19/2021 at 2:21 p.m., the Administrator indicated the tub/shower bench should be there in the Aide Care Plan for patient #7.</p>	N 533		
N 537	<p>410 IAC 17-14-1(a) Scope of Services</p> <p>Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to follow a written medical</p>	N 537	<p>410 IAC 17-14-1(a)</p> <p>The staff will be inserviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs. 100% of all active clinical records were reviewed for this deficiency. Tracking logs were created to make sure that no special procedures are missed.</p>	

			<p>Audit 100% of all active patients to ensure the plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%. Once threshold is met, will continue to audit 10% of all patient records quarterly.</p>	
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N 537	<p>Continued From page 34</p> <p>plan of care established and periodically reviewed by the physician in 1 of 4 active clinical records reviewed. (#1)</p> <p>The findings include:</p> <p>Review of an undated agency policy titled "Position: Registered Nurse" stated "... Essential Functions/Areas of Accountability ... Assumes responsibility and accountability for the practice of professional nursing in accordance with the State Nurse Practice Act and standards for home health nursing ... Initiates the plan of care and necessary revisions ... Develops and/or follows an individualized Plan of Care...."</p> <p>Clinical record review on 4/15/21 for patient #1, primary diagnosis: Anoxic Brain Damage (A complete lack of oxygen being provided to the brain which results in the death of brain cells) start of care 4/13/2020, evidenced an agency document titled "SNV [Skilled Nursing Visit]," dated 3/2/2021, signed by RN (Registered Nurse) C. This document had a subsection titled "GU [Genitourinary: pertaining to the genital and urinary system]." This subsection indicated the foley catheter (Thin, sterile tube inserted into the bladder to drain urine) was last changed on 3/2/2021.</p> <p>A record review on 4/15/21 evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/7/2021 - 4/7/2021, and signed by the primary care physician. This document had a subsection titled "Orders and Treatments." This subsection stated "... SN [Skilled Nurse] to change foley catheter with 16 FR [French: gauge system used to measure size of catheter] 10 cc [Cubic centimeter: unit of measurement to measure</p>	N 537	<p>The 485 must contain current and updated orders to insure updated care is given.</p> <p>The administrator is responsible for this task in order to prevent recurrence.</p>	

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N 537	<p>Continued From page 35</p> <p>volume] catheter EVERY MONTH and prn [as needed] for dislodgement per sterile [Free from bacteria or other living organisms] technique...."</p> <p>A record review on 4/15/21, evidenced an untitled agency recertification comprehensive assessment, dated 4/6/2021, signed by RN C. This document had a subsection titled "Elimination Status." This subsection indicated the foley catheter was last changed on 4/6/2021. Clinical record review failed to evidence the clinician changed the foley catheter every month as ordered in the medical plan of care.</p> <p>During an interview on 4/16/2021 at 2:46 p.m., the Administrator indicated the plan of care stated the foley catheter should be replaced at least once a month.</p> <p>During an interview on 4/16/2021 at 2:47 p.m., Employee I, Office Personnel, indicated it was changed next (after 3/2/2021) on 4/6/2021.</p>	N 537		
N 542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services</p> <p>Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the registered nurse revised the plan of care as necessary in 1 of 3 active patient records receiving only skilled nursing and home health aide services (#4).</p>	N 542	<p>410 IAC 17-14-10(a)(1)(C)</p> <p>Inservice will be given to review updated orders. A plan of care must be initiated, changed with order, updated to ensure proper and appropriate care is given. A plan of care addendum will be initiated, signed by physician and applied to the care.</p> <p>The 485 must contain current and updated orders to insure updated care is given.</p> <p>The administrator is responsible for this task in order to prevent recurrence.</p>	

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N 542	<p>Continued From page 36</p> <p>The findings include:</p> <p>Record review on 4/19/2021 evidenced an undated agency policy titled, "PLAN OF CARE", numbered C-580, which stated, "POLICY Home care services are furnished under the supervision and direction of the patient's physician, The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... To assure that the plan meets state / federal guidelines, and all applicable laws and regulations. SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each patient receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es), principle and secondary, including dates of onset ... C. Type, frequency, and duration of all visits / services. d. Specific procedures and modalities for therapy services ... i. Functional limitations and precautions. j. Activities permitted or restrictions. k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures. m. Medical supplies and equipment required. n. Any safety measures to protect against injury ... t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care ... 4. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency,</p>	N 542	<p>Cont.</p> <p>Audit 100% of all active patients to ensure the plan of care and addendum of plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%. Once threshold is met, will continue to audit 10%oa all patient records quarterly.</p> <p>The clinical record was updated and all clinical staff were inserviced to ensure that all new and changed medication orders are updated.</p>	

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N 542	<p>Continued From page 37</p> <p>and durations ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. ... "</p> <p>Record review on 4/19/2021 evidenced an undated agency policy titled, "SKILLED NURSING SERVICES", numbered C-200, which stated, "POLICY Skilled nursing services will be provided ..... in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... b. Regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs...."</p> <p>Clinical record review on 4/19/2021 for patient #4, start of care 10/4/2017, certification period 3/17/2021 to 5/15/2021, primary diagnosis of hereditary motor and sensory neuropathy, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician. The plan of care had a subcategory titled, "Medications", which stated, " ... Norvasc [a blood pressure medication] Oral 5 MG [milligram] 1 Tab(s) daily (N)... "</p> <p>Clinical record review evidenced an agency document titled, "Physician Order", dated 3/25/2021, signed by employee C, RN, which stated, " ... Orders: Discontinued Medication: Norvasc Oral Tablet 5 MG..." Clinical record review failed to evidence the nurse updated the plan of care with the order to discontinue the</p>	N 542		

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N 542	Continued From page 38  Norvasc.  During an interview on 4/19/2021 at 1:54 p.m., the administrator indicated the skilled nurse should update the plan of care when a new or changed medication order was received.	N 542		
N 543	410 IAC 17-14-1(a)(1)(D) Scope of Services  Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.  This RULE is not met as evidenced by: Based on record review, and interview, the agency failed to ensure the skilled nurse initiated appropriate preventative and rehabilitative nursing measures in 1 of 2 clinical records of patients with Foley catheters and a home visit (#3).  Record review on 4/16/2021, evidenced an undated agency policy titled, "INFECTION PREVENTION / CONTROL", numbered B-403, which stated, "POLICY Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC) ... PURPOSE To ensure employee and patient safety. To reduce the risk of transmission of microbes from both recognized and unrecognized sources of infection ... SPECIAL INSTRUCTIONS ... Protocol for addressing patient care issues and prevention of infection related to infusion therapy, urinary tract care, respiratory tract care, and wound care to include the following preventative activities in	N 543	410 IAC 17-14-1 (a)(1) (D)  Inservice staff on the requirement to initiate appropriate preventive and rehabilitative nursing procedures. Infection control policies will be reviewed to ensure safety of employee and patient to reduce the risk of transmission of microbes. Protocol for addressing patient care issues will be reviewed to continue to ensure and prevent any infections. Aseptic technique for special techniques or equipment with care. Infection control records will be reviewed at 100% to ensure proper techniques are used and to screen for preventable infections.  Document urine return and characteristics, teaching provided and the patient's tolerance of the procedure.  The clinical supervisor is responsible for this audit and will continue for the results/prevention of infections.	

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N 543	<p>Continued From page 39</p> <p>addition to standard precautions as applicable: ... Demonstrate aseptic technique in the care of technical equipment such as ... indwelling urinary catheter ... Perform pericare in a thorough and appropriate manner per agency guidelines ... Types of care that may place patients at risk for infection: ... Urethral or suprapubic catheterization...."</p> <p>Record review on 4/16/2021, evidenced an undated agency policy titled, "URINARY CATHETER INSERTION - STRAIGHT OR INDWELLING CATHETER", numbered D-100, which stated, " ... PROCEDURE ... 9. Open catheter kit or individual sterile supplies. Don sterile gloves and organize supplies on sterile field ... DOCUMENTATION GUIDELINES 1. Document in the clinical record: ... c. Urine return and characteristics, color, and odor, if any. d. Amount of urine prior to residual catheterization. e. Any difficulties or discomfort. f. Teaching provided and client / caregiver response. g. The client's tolerance of the procedure. "</p> <p>Record review on 4/19/2021, evidenced an undated agency policy titled, "SKILLED NURSING SERVICES", numbered C-200, which stated, "POLICY Skilled nursing services will be provided ..... in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... b. Regularly reevaluates the patient needs, and coordinates the necessary services ... d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs...."</p>	N 543		

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N 543	<p>Continued From page 40</p> <p>Clinical record review on 4/16/2021 for patient #3, start of care 3/11/2021, certification period 3/11/2021 to 5/9/2021, primary diagnosis of memory deficit following cerebral infarction [stroke], evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/29/2021. The plan of care had a subcategory titled, "SN [skilled nurse] Interventions", which stated, " ... SN to change Foley catheter ... every 30 days beginning on 3/10/2021..."</p> <p>Clinical record review evidenced a skilled nursing visit note, dated 4/9/2021, signed by employee C, RN. This visit note had a section titled, "GU [genito-urinary] [relating to the genital and urinary systems]", which stated, " ... Catheter: Foley Last Changed: 04/09/2021 ... Urine: [no assessment] ... Comments: [blank]...." Review of the skilled nurse's note failed to evidence documentation of urine return and characteristics, teaching provided, and the patient's tolerance of the procedure, as indicated in the agency's policy for urinary catheter insertion.</p> <p>During an interview on 4/16/2021 at 3:08 p.m., the administrator indicated sterile equipment and sterile technique should be used when inserting a Foley catheter. When informed of the findings, the administrator indicated the nurse's note failed to indicate sterile equipment and technique were used. The administrator also indicated the nurse's note also failed to evidence an assessment of the urine, teaching provided, and the patient's tolerance of the procedure.</p>	N 543		
N 553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services</p> <p>Rule 14 Sec. 1(a) (2) For purposes of practice in</p>	N 553		

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N 553	<p>Continued From page 41</p> <p>the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies.</p> <p>This RULE is not met as evidenced by: Based on record review, the home health agency failed to ensure the licensed practical nurse provided services in accordance with agency policies in 1 of 1 clinical records reviewed of patient's receiving licensed practical nurse services (#7).</p> <p>The findings include:</p> <p>Review of an untitled agency policy titled "Position: Licensed Practical/Vocational Nurse" stated "... Performs skilled nursing functions in accordance with the federal, state, and local laws and within guidelines of his/her professional organization and agency ... Scope of clinical practice includes ... monitoring and reporting findings ... Performs other related duties and responsibilities as deemed necessary. ... "</p> <p>Clinical record review on 4/19/21 for patient #7, primary diagnosis: Infection following a procedure, other surgical site, start of care 3/5/2021, evidenced an agency document titled "LPN [Licensed Practical Nurse] /LVN [Licensed Vocational Nurse] - Skilled Nursing Visit," dated 4/1/2021, signed by LPN D. This document had a subsection titled "Digestive Nutrition." This subsection failed to indicate when the last BM (bowel movement) occurred. Clinical record review failed to evidence the clinician obtained the last BM per agency policy.</p>	N 553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services Inservice to RN and LPN that care to be given by LPN will be supervised will be complete, accurate and thorough to ensure the top level of care in accordance with policies and standard practice of care. All body systems are to be reviewed and charted to provide quality care. 100% of all active clinical charts were reviewed for this deficiency. A clinical record review will be ongoing to QA the weekly charts. The clinical supervisor is responsible for the inservice to prevent further recurrence.</p>	

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N 563 N 563	<p>Continued From page 42</p> <p>410 IAC 17-14-1(c)(2) Scope of Services</p> <p>Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months;</p> <p>This RULE is not met as evidenced by: Based on observation, record review, and interview, the physical therapist failed to review the plan of care as often as the severity of the patient's condition requires, in 1 of 2 active patient records receiving physical therapy (#2).</p> <p>The findings include:</p> <p>Record review on 4/19/2021 evidenced an undated agency policy titled, "PLAN OF CARE", numbered C-580, which stated, "POLICY Home care services are furnished under the supervision and direction of the patient's physician, The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... To assure that the plan meets state / federal guidelines, and all applicable laws and regulations. SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each patient receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: a.</p>	N 563 N 563	<p>410 IAC 17-14-1 (c) (2)</p> <p>Inservice care personnel that vital signs should be obtained at the beginning of care to ensure a baseline of vitals is achieved in order to assess ability of patient to perform assigned exercises and strengthening performances. 100% of all active clinical charts were reviewed for this deficiency. The physician and/or supervising nurse will be notified of any vitals out of parameter.</p> <p>The clinical supervisor is responsible for this education/knowledge to be shared in order to prevent recurrence.</p>	

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N 563	<p>Continued From page 43</p> <p>All pertinent diagnosis(es), principle and secondary, including dates of onset ... C. Type, frequency, and duration of all visits / services. d. Specific procedures and modalities for therapy services ... i. Functional limitations and precautions. j. Activities permitted or restrictions. k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures. m. Medical supplies and equipment required. n. Any safety measures to protect against injury ... t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care ... 4. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and durations ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. .. "</p> <p>Record review on 4/19/2021 evidenced an undated agency policy titled, "COORDINATION OF PATIENT SERVICES", numbered C-360, which stated, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans ... PURPOSE To ensure services are coordinated between members of the interdisciplinary team. To ensure appropriate, quality care is being provided to patients. To establish effective interchange, reporting, and coordination of patient care does occur. To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care .....3. After the initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical</p>	N 563		

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N 563	<p>Continued From page 44</p> <p>manager to ensure: A.. Clarification of the plan of care orders..."</p> <p>Record review on 4/19/2021 evidenced an undated agency policy titled, "THERAPY SERVICES", numbered C-240, which stated, "POLICY Therapists shall participate in developing operational policies and procedures pertinent to their discipline ... PURPOSE ..... To provide optimum quality care to patients. To provide guidelines for therapy services and care coordination with other disciplines. To comply with state / federal guidelines. SPECIAL INSTRUCTIONS 1. Referrals to the agency for therapy services (Physical or Occupational) may include, but are not limited to: ... d. Overall development of an individualized therapy program under the direction of the physician...."</p> <p>Clinical record review on 4/16/2021 for patient #2, with start of care 4/14/2020, certification period 2/18/2021 to 4/18/2021, and primary diagnosis of Chronic lymphocytic leukemia, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/8/2021. This plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... Notify physician of:..... Pulse greater than (&gt;) 100 or less than (&lt;) 58...."</p> <p>During a home visit on 4/14/2021 at 11:15 a.m., for patient #2, employee G, PT [physical therapist], was observed asking patient if she was having pain at 11:21 a.m. At 11:22 a.m., the PT was observed lowering the head of the patient's hospital bed. The PT was observed assisting the patient to sit up at the side of the bed at 11:23 a.m. At 11:24 a.m., the PT and person A, family member to patient #2, assisted to transfer the patient to a wheelchair. At 11:25 a.m., employee</p>	N 563		

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N 563	<p>Continued From page 45</p> <p>G assisted patient to exercise arms. At 11:28 a.m., the PT removed a pulse oximeter from the bag and placed it on the patient's middle finger on the right hand. A pulse rate reading of 42 was observed on the pulse oximeter. Person A stated, "It's been low, but not that low". At 11:30 a.m., the PT was observed to place an automatic blood pressure cuff on the patient's left wrist. The PT stated, "Blood pressure is good". At 11:38 a.m., the PT indicated the patient's pulse rate was 43. At 11:40 a.m., the PT and person A assisted the patient to return to bed.</p> <p>The physical therapist failed to assess the patient before beginning treatment and failed to notify the case manager or the patient's primary care physician of the low pulse rate.</p> <p>During an interview on 4/16/2021 at 2:28 p.m., the administrator indicated vital signs should be checked at the beginning of each therapy visit, before beginning any treatment. When informed of the findings, the administrator stated, "Oh", and offered nothing further.</p>	N 563		
N 565	<p>410 IAC 17-14-1(c)(4) Scope of Services</p> <p>Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary);</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the physical therapist helped develop and revise the plan of care, in 1 of 2 active patient records receiving physical therapy (#2).</p>	N 565	<p>Home care services are furnished under the supervision and direction of the patient's physician, The Plan of Care / Plan of care Addendum is based on a comprehensive assessment and information provided by the patient / family and health team members.</p> <p>Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty days</p> <p>The staff was inserviced to prevent this deficiency.</p>	

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N 565	<p>Continued From page 46</p> <p>The findings include:</p> <p>Record review on 4/19/2021 evidenced an undated agency policy titled, "PLAN OF CARE", numbered C-580, which stated, "POLICY Home care services are furnished under the supervision and direction of the patient's physician, The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... To assure that the plan meets state / federal guidelines, and all applicable laws and regulations. SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each patient receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es), principle and secondary, including dates of onset ... C. Type, frequency, and duration of all visits / services. d. Specific procedures and modalities for therapy services ... i. Functional limitations and precautions. j. Activities permitted or restrictions. k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures. m. Medical supplies and equipment required. n. Any safety measures to protect against injury ... t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care ... 4. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency,</p>	N 565	<p>The agency will include therapy. frequency and duration, as well as orders and treatments or an addendum will be created to reflect that. 100% of all clinical records were reviewed for this deficiency.</p> <p>A clinical record review will be ongoing to QA the weekly charts. The clinical supervisor is responsible for the inservice to prevent further recurrence.</p>	

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N 565	<p>Continued From page 47</p> <p>and durations ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. ... "</p> <p>Record review on 4/19/2021, evidenced an undated agency policy titled, "COORDINATION OF PATIENT SERVICES", numbered C-360, which stated, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans ... PURPOSE To ensure services are coordinated between members of the interdisciplinary team. To ensure appropriate, quality care is being provided to patients. To establish effective interchange, reporting, and coordination of patient care does occur. To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care .....3. After the initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure: A.. Clarification of the plan of care orders.."</p> <p>Record review on 4/19/2021, evidenced an undated agency policy titled, "THERAPY SERVICES", numbered C-240, which stated, "POLICY Therapists shall participate in developing operational policies and procedures pertinent to their discipline ... PURPOSE ..... To provide optimum quality care to patients. To provide guidelines for therapy services and care coordination with other disciplines. To comply with state / federal guidelines. SPECIAL INSTRUCTIONS 1. Referrals to the agency for therapy services (Physical or Occupational) may</p>	N 565		

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N 565	<p>Continued From page 48</p> <p>include, but are not limited to: ... d. Overall development of an individualized therapy program under the direction of the physician...."</p> <p>Clinical record review on 4/16/2021, for patient #2 with start of care 4/14/2020, certification period 2/18/2021 to 4/18/2021, and primary diagnosis of Chronic lymphocytic leukemia, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/8/2021. This plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... PT [physical therapy]: eval [evaluate]...." Review of the plan of care failed to evidence frequency and duration of physical therapy visits, and a physical therapy plan of care. Review of the patient's electronic record (Kinnser), failed to evidence a PT plan of care.</p> <p>During an interview on 4/16/2021 at 2:19 p.m., the administrator indicated when physical therapy is ordered for a patient, the physical therapist should evaluate the patient and create a plan of care to be signed by the physician. The administrator indicated the plan of care failed to evidence a frequency and duration of physical therapy visits, and a physical therapy plan of care. When informed of the findings, the administrator provided no further documentation.</p>	N 565		
N 584	<p>410 IAC 17-14-1(g) Scope of Services</p> <p>Rule 14 Sec. 1(g) Home health aides shall be supervised by a health care professional to ensure competent provision of care. Supervision of services must be within the scope of practice of the health care professional providing the supervision.</p>	N 584	<p>410 IAC 17-14-1(g) Scope of Services</p> <p>Inservice the home health aides to ensure competent provision of care. 100% of all active patient charts will be reviewed for this deficiency. The supervising nurse is responsible for ensuring competent provision of care.</p>	

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N 584	<p>Continued From page 49</p> <p>This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the supervisory health care professional ensured competent provision of care was provided by the home health aide in 2 of 7 clinical records reviewed. (#1, #7)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of an undated agency policy titled "Position: Home Health Aide," stated "... Provides personal care services under the direction of the Registered Nurse or Therapist...."</li> <li>2. Review of an undated agency policy titled "Home Health Aide Supervision," stated "... Agency shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse ... Purpose ... To observe the aide in providing care to patients, and to assess competency in basic skills as well as delegated nursing tasks ... 1. The nursing Supervisor or designated Registered Nurse/Therapist will give the Home Health Aide direction for patient care by way of the Care Plan ... 8. The aide visit record is reviewed by the supervising nurse/therapist to assure services are being provided according to the care plan...."</li> <li>3. Review of an undated agency polity titled "Home Health Aide Services," stated "...Home Health Aide services will be provided to appropriate patients..... under the direct supervision of an agency Registered Nurse/Therapist in accordance with a medically approved Plan of Care ... 1. Home Health Aide services may include ... d. Obtaining patient temperature, pulse, respiration, and blood</li> </ol>	N 584	<p>Cont.</p> <p>The supervising nurse is to give clear and concise assignments and direction for care. The vitals obtained by the home health aide, are to be accurate and written in the file. The supervising nurse is to review the vitals and note patterns for the patient.</p> <p>Each patient should have accurate and actual vitals without a WNL notation. The clinical supervisor is responsible for the teaching and overseeing the vitals to assure this area to prevent recurrence.</p>	

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N 584	<p>Continued From page 50</p> <p>pressure... "</p> <p>4. Clinical record review on 4/15/21 for patient #1, primary diagnosis: Anoxic Brain Damage (A complete lack of oxygen being provided to the brain which results in the death of brain cells), start of care 4/13/2020, evidenced an agency document titled "Aide Care Plan," dated 2/7/2021, signed by (Registered Nurse) RN C. This document indicated the home health aide was to obtain the pulse, respiration, and temperature every visit.</p> <p>A record review on 4/15/21 for patient #1, evidenced agency documents titled "HHA [Home Health Aide] Visit," dated 2/8/21, 2/15/21, 2/18/21, 2/22/21, 2/25/21, 3/1/21, 3/4/21, 3/8/21, 3/11/21, 3/22/21, 3/25/21, 4/1/21, and signed by Home Health Aide J. All these documents indicated the patient's pulse was 73 and respirations were 23.</p> <p>A record review on 4/15/21 for patient #1, evidenced agency documents titled "SNV [Skilled Nursing Visit] w/ [with] Aide Supervision," dated 2/10/21, 2/17/21, 2/24/21, 3/2/21, 3/10/21, 3/17/21, 3/24/21, 3/31/21, and signed by RN C. These documents had a subsection titled "Visit Assessment." These subsections stated "... Follows client plan of care as instructed ... Excellent ...." Clinical record review failed to evidence the clinician ensured the home health aide was obtaining the pulse and respirations each visit, as ordered in the Aide Care Plan.</p> <p>During an interview on 4/16/21 at 2:44 p.m., the Administrator indicated the home health aide should be obtaining the pulse, respirations, and temperature. She also indicated she does not think the home health aide is actually getting the vitals.</p>	N 584		

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NAME OF PROVIDER OR SUPPLIER  <b>ADIEL HOME HEALTH SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>608 W 81ST AVE</b> <b>MERRILLVILLE, IN 46410</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 584	<p>Continued From page 51</p> <p>5. Clinical record review on 4/19/21 for patient #7, primary diagnosis: Infection following a procedure, other surgical site, start of care 3/5/2021, evidenced an agency document titled "Aide Care Plan," dated 3/5/2021, signed by RN C. This document indicated the home health aide was to obtain the pulse, respiration, and temperature every visit.</p> <p>A record review on 4/19/21 for patient #7, evidenced agency documents titled "HHA Visit," dated 3/11/21, 3/15/21, 3/17/21, 3/22/21, and signed by Home Health Aide J. All these documents indicated the patient's pulse was 72 and respirations were 23.</p> <p>A record review on 4/19/21 for patient #7, evidenced an agency document titled "SNV w/ Aide Supervision," dated 3/23/21, signed by RN F. This document had a subsection titled "Visit Assessment." This subsection stated "... Follows client plan of care as instructed ... Excellent....." Clinical record review failed to evidence the clinician ensured the home health aide was obtaining the pulse and respirations each visit, as ordered in the Aide Care Plan.</p>	N 584		
N 610	<p>410 IAC 17-15-1(a)(7) Clinical Records</p> <p>Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home</p>	N 610	410 IAC 17-15-1(a)(7) Clinical Records	

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N 610	<p>Continued From page 52</p> <p>health agency failed to ensure all entries were clear, complete, and appropriately authenticated and dated in 5 of 5 active clinical records reviewed. (#1, #2, #3, #4, #7)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of an undated agency policy titled "Position: Registered Nurse" stated "... Essential Functions/Areas of Accountability ... Documents legibly and according to Agency documentation guidelines and standards ... Follows Agency guidelines for completion of forms, reflecting the orders and care plan. ..."</li> <li>2. Review of an undated agency policy titled "Electronic Signature" stated "... An electronic signature will authenticate certain clinical record documents generated in the computerized medical record system. The documents affected by this policy include visit notes, charting sessions, verbal orders, and summaries..."</li> <li>3. Review of an undated agency policy titled "Home Health Aide Care Plan" stated "... A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan ... Purpose.....To provide documentation that the supervising Nurse oriented the assigned Aide to the patient's care before initiating the care...."</li> <li>4. Clinical record review on 4/15/21 for patient #1, primary diagnosis: Anoxic Brain Damage (A complete lack of oxygen being provided to the brain which results in the death of brain cells), start of care 4/13/2020, evidenced an agency document titled "SNV [Skilled Nursing Visit] w/</li> </ol>	N 610	<p>410 IAC 17-15-1 (a) (7)</p> <p>Inservice with staff the requirement to write legibly, clear, and complete and dated information as charted on all patients. The information needed for complete information should be of utmost accurate, quality information to ensure continuity of care. 100% of all clinical records were reviewed to prevent this deficiency from recurring.</p> <p>Ongoing QA on all patients will be performed on a weekly basis to ensure the above information.</p> <p>The clinical supervisor will be responsible to ensure this deficiency does not reocure.</p>	

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N 610	<p>Continued From page 53</p> <p>[with] Aide Supervision," dated 2/10/2021, 2/17/2021, 2/24/2021, 3/2/2021, 3/10/2021, 3/17/2021, 3/24/2021, 3/31/2021, and signed by (Registered Nurse) RN C. These documents had a subsection titled "Respiratory," that indicated the lung sounds were diminished. These subsections also indicated the lungs were WNL (within normal limits). Clinical record review failed to evidence the clinician appropriately documented that the lungs were not WNL as indicated by the diminished lung sounds.</p> <p>A record review on 4/15/21, evidenced an untitled agency recertification comprehensive assessment , dated 4/6/21, signed by RN C. This document had a subsection titled "Respiratory Status." This subsection indicated the lung sounds were diminished. This subsection also indicated the lungs were WNL. Clinical record review failed to evidence the clinician appropriately documented that the lungs were not WNL as indicated by the diminished lung sounds</p> <p>During an interview on 4/16/2021 at 2:44 p.m., the Administrator indicated the documentation in the "SNV w/ Aide Supervision" and comprehensive assessment should not state WNL for patient #1.</p> <p>5. Clinical record review on 4/19/21 for patient #7, primary diagnosis: Infection following a procedure, other surgical site, start of care 3/5/2021 , evidenced an agency document titled "LPN [Licensed Practical Nurse]/LVN [Licensed Vocational Nursing] - Skilled Nursing Visit," dated 3/11/2021 and 3/18/2021, signed by LPN D. Clinical record review failed to evidence the clinician included their discipline as LPN in their signature.</p>	N 610		

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N 610	<p>Continued From page 54</p> <p>A record review on 4/19/21 for patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 3/5/2021 - 5/3/2021, and signed by the primary care physician. This document stated "... DME [Durable Medical Equipment] &amp; Supplies ... Tub/Shower Bench ...." This document had a subsection titled "Goals and Outcomes." This subsection stated "... Patient will maintain heart healthy diet..... "</p> <p>A record review on 4/19/21 for patient #7, evidenced agency documents titled "SNV w/ Aide Supervision," dated 3/23/2021 and 4/8/2021, signed by RN F. These documents had a subsection titled "Digestive Nutrition." These subsections stated "... Diet: no concentrated sweets ...." Clinical record review failed to evidence the clinician documented the correct diet from the plan of care as heart healthy.</p> <p>During an interview on 4/19/2021 at 2:16 p.m., the Administrator indicated the clinician (LPN) did not put her discipline in her signature, but it should be there.</p> <p>During an interview on 4/19/2021 at 2:24 p.m., person I, Office Personnel, indicated the plan of care stated the diet was heart healthy and the SNV on 3/11/21 and 3/18/21, for patient #7, said no concentrated sweets for both dates and should instead have said heart healthy.</p>	N 610		



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N 610	<p>Continued From page 56</p> <p>communicate to the physician how and why the care was canceled.</p> <p>7. Clinical record review on 4/16/2021 for patient #3, start of care 3/11/2021, certification period 3/11/2021 to 5/9/2021, primary diagnosis of memory deficit following cerebral infarction [stroke], evidenced a skilled nurse's note dated 4/9/2021 and signed by employee C, RN [registered nurse]. This note had a section titled, "Comments", which stated, "Set up daily meds for the week. Purpose of Plavix [a medication to help prevent blood clots], dosage schedule, and side effects."</p> <p>Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/29/2021. This plan of care had a subcategory titled, "Medications", which failed to evidence Plavix.</p> <p>Review of the patient's electronic medical record (Kinnsler) on 4/16/2021 evidenced a medication profile, which failed to evidence Plavix.</p> <p>During an interview on 4/16/2021 at 2:53 p.m., the administrator indicated the plan of care and medication profile should contain all medications a patient is currently taking, and the plan of care did not indicate the patient was taking Plavix.</p> <p>8. Clinical record review on 4/19/2021 for patient #4, start of care 10/4/2017, certification period 3/17/2021 to 5/15/2021, primary diagnosis of hereditary motor and sensory neuropathy, evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care had a section titled, "Attending Physician's</p>	N 610		

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N 610	<p>Continued From page 57</p> <p>Signature and Date Signed", signed by physician B, failed to evidence a date signed.</p> <p>During an interview on 4/19/2021 at 2:15 p.m., the administrator indicated the plan of care should be signed and dated by the physician. Office staff employee I reviewed the plan of care in the patient's electronic record (Kinnser), and stated "He didn't date it". The administrator indicated the agency failed to ensure the plan of care was dated.</p>	N 610		