STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157562	A. BUILDING 00 B. WING	09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BACK HOME AGAIN	291 N STATE RD 2 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This revisit was for a Federal recertification survey with survey dates of 6/8/17 - 6/19/17. The survey was fully extended on 6/15/17. A complaint was investigated during this survey. Complaint #: IN00232243: Federal deficiencies related to the allegations were cited. Unrelated deficiencies were also cited. Facility #: IN003800 Medicare #: 157562 Medicaid #: 200839250 Revisit Survey Dates: 9/12/17 - 9/15/17 Census: 55 active patients During this survey, 5 conditions were found corrected. 12 standards were found corrected. 10 standards were recited. 2 additional standards were cited.	G 0000		

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

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G 0102 Bldg. 00	484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. Based on home visit observation, record review and interview, the agency failed to ensure the patient / patient's power of attorney was provided a written notice of the patient rights in advance of furnishing care to the patient for 1 (# 19) of 8 records reviewed. The findings include: 1. A review of clinical record #19 failed to evidence the power of attorney (POA) had received a written notice of the patient's rights in advance of care furnished to patient #19 and the patient started care on 9/13/17 as evidenced by the following: A. A review of a clinical record	G 0102	The agency will immediately ensure all patients receive written notice of patient rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. When it has been determined that a patient has a POA who will be completing the admission paperwork and who needs the written notice of patient rights in advance of furnishing care to the patient, the POA will be contacted via phone for verbal consent for admission of the patient. At that time an email or fax number will be obtained in order to send POA the admission paperwork and notice of patient rights prior to the clinician seeing the patient. All communication will be documented in the patient chart with regards to the steps taken to notify the POA. Record of receipt (sent email confirmation or faxed	10/20/2017

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	document titled "Patient Communication" dated 9/13/17 and signed by Employee N, RN, stated, "Set up admission visit with [patient #19's power of attorney]. [Patient #19's power of attorney] unable to be present for admission as [he / she] is at work. [He / she] gave nurse writer verbal consent to complete admission visit. All admission paperwork will need to be sent to [him / her] for signatures." B. A review of a clinical record document titled "Patient Communication" dated 9/15/17 stated, "Received admission paperwork at office yesterday. Mailing to the POA for signatures today." This was signed by Employee P, Receptionist. C. A review of clinical record #19 evidenced a plan of care with a start of care of 9/13/17 and certification period of 9/13/17 - 11/11/17. 2. A review of a document presented on 9/15/17 evidenced a document titled "General Durable Power of Attorney" stated, "Know all men by these presents that I, [patient #19] ... constituted and appointed, and by these presents do appoint [POAs and family members of patient #19] as my true and lawful co - attorneys."		receipt) will be captured and filed. Staff will be educated on communicating with POA and process to provide the admission paperwork with notice of patient rights and how to record in the patient EMR chart. The Clinical Manager will review/audit all new SOC with POA documentation for compliance of item A. Audits to be completed with 100% of new admissions 10/16/17 for 3 months and then 10% quarterly. Administrator & Clinical Manager (DON) are responsible.	

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	3. During a home visit observation on 9/14/17 at 3:20 PM, Employee S, occupational therapist, was observed to complete an occupational therapist evaluation with patient #19. The patient's home folder was observed to be in the medical records / director of nursing's office area of the assisted living where the patient resides. 4. During an interview on 9/15/17 at 11:55 AM, the administrator indicated the rights were explained to the power of attorney verbally. The power of attorney had not received the written rights yet. 5. During a phone interview on 9/15/17 at 2:20 PM, the POA / family member of patient #19 indicated not being given any written documentation about the patient rights at this time or being informed of the Indiana Department of Health Complaint hotline number. This person indicated the agency had called and discussed the services / costs with him / her but no written information had been received. 6. The undated admission folder titled "Patient Information Booklet" included the following section: "Patient Rights and Responsibilities." This document stated, "The patient has the following			

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	rights ... 2. The HHA [home health agency] must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of care to the patient or during the initial evaluation visit before the initiation of treatment. 3. The HHA must maintain documentation showing that it has complied with the requirements of this section. 4. The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights as permitted by law or when the patient has been judged incompetent." 7. The undated agency policy titled "Section C380 - Home Care Bill of Rights" stated "Policy - Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose - To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding their care. To protect and promote the exercise of clients' rights. To establish, operate, and maintain a grievance/complaint mechanism for use by the			

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	client/representative, which assures response and disposition and is in operation at a minimum during normal business hours. Special Instructions - 1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented."			

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G 0110 Bldg. 00	484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on home visit observation, record review and interview, the agency failed to ensure patients had been provided with the most current description of Indiana state law regarding advance directives in 1 (# 19) of 8 records reviewed. The findings include: 1. A review of Clinical record #19 failed to evidence the most current version of the description of Indiana state law regarding advance directives, "Your Right To Decide", dated July 2013, had been provided to the patients at the start of care. This review occurred on 9/15/17. This lack of the family member / power	G 0110	The agency will immediately ensure all patients receive written information concerning agency policies on advance directives, including a description of applicable State Law, in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. When it has been determined that a patient has a POA who will be completing the admission paperwork and who needs the agency policies on advance directives, including a description of applicable State Law (dated July 2013), in advance of furnishing care to the patient the POA will be contacted via phone for verbal consent for admission of the patient. At that time an	10/20/2017

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	of attorney receiving a copy of the copy of the Indiana advance directive is evidenced by the following: 2. A review of the undated admission handbook titled "Back Home Again Inc Home Health Care Services ... Patient Orientation & Information" included the Indiana State Department of Health Advance Directives Your Right to Decide Revised July 1, 2013. A review of the undated section titled "Patient Rights and Responsibilities" included in the admission handbook stated, "The HHA [home health agency] must provide the patent with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. 3. The HHA must maintain documentation showing that it has complied with the requirements of this section ... The patient has the rights to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient rights as permitted by law or when the patient has been judged incompetent ... The HHA must inform and distribute written information, in advance, concerning its policies on advance directives, including a description of applicable State law."		email or fax number will be obtained in order to send POA the admission paperwork, including advance directives, prior to the clinician seeing the patient. All communication to be documentation in the patient chart with regards to the steps taken to notify the POA. Record of receipt (sent email confirmation or faxed receipt) will be captured and filed. Staff will be educated on communicating with POA and process to provide the admission paperwork with advance directives and how to record in the patient EMR chart. The Clinical Manager will review/audit all new SOC with POA documentation for compliance of item A. Audits to be completed with 100% of new admissions 10/16/17 for 3 months and then 10% quarterly. Administrator Clinical Manager (DON) are responsible.	

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	3. A further review of clinical record #19 evidenced the following: A. A review of a clinical record document titled "Patient Communication" dated 9/13/17 and signed by Employee N, RN, stated, "Set up admission visit with [patient #19's power of attorney]. [Patient #19's power of attorney] unable to be present for admission as [he / she] is at work. [He / she] gave nurse writer verbal consent to complete admission visit. All admission paperwork will need to be sent to [him / her] for signatures." B. A review of a clinical record document titled "Patient Communication" dated 9/15/17 stated, "Received admission paperwork at office yesterday. Mailing to the POA for signatures today." This was signed by Employee P, Receptionist. C. A review of clinical record #19 evidenced a plan of care with a start of care of 9/13/17 and certification period of 9/13/17 - 11/11/17. 4. A review of a document presented on 9/15/17 evidenced a document titled "General Durable Power of Attorney" stated, "Know all men by these presents that I, [patient #19] ... constituted and			

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	appointed, and by these presents do appoint [POAs and family members of patient #19] as my true and lawful co - attorneys." 5. During a home visit observation on 9/14/17 at 3:20 PM, Employee S, occupational therapist, was observed to complete an occupational therapist evaluation with patient #19. The patient's home folder was observed to be in the medical records / director of nursing's office area of the assisted living where the patient resides. 6. During an interview on 9/15/17 at 11:55 AM, the administrator indicated the rights were explained to the power of attorney verbally. The power of attorney had not received the written rights yet. 7. During a phone interview on 9/15/17 at 2:20 PM, the POA / family member of patient #19 indicated not being given any written documentation about the patient rights at this time or being informed of the Indiana Department of Health Complaint hotline number. This person indicated the agency had called and discussed the services / costs with him / her but no written information had been received. 8. The undated agency policy titled			

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	"Section C380 - Home Care Bill of Rights" stated "Policy - Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose - To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding their care. To protect and promote the exercise of clients' rights. To establish, operate, and maintain a grievance/complaint mechanism for use by the client/representative, which assures response and disposition and is in operation at a minimum during normal business hours. Special Instructions - 1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented."			

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G 0116 Bldg. 00	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements. Based on home visit observation, record review and interview, the agency failed to ensure patients were provided the telephone number of the home health hotline established by the Indiana State Department of Health and the hours of its operation for 1 of 8 clinical records reviewed (#19). The findings include:	G 0116	The agency will immediately ensure the patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When it has been determined that a patient has a POA who will be completing the admission paperwork and who needs the State HHA Hotline information with hours of availability in advance of furnishing care to the patient, the POA will be contacted via phone for verbal consent for	10/20/2017

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	1. A review of clinical record #19 failed to evidence the power of attorney (POA) was provided the telephone number of the home health hotline established Indiana State Department of Health and the hours of its operation. This is evidenced by the following: A. A review of a clinical record document titled "Patient Communication" dated 9/13/17 and signed by Employee N, RN, stated, "Set up admission visit with [patient #19's power of attorney]. [Patient #19's power of attorney] unable to be present for admission as [he / she] is at work. [He / she] gave nurse writer verbal consent to complete admission visit. All admission paperwork will need to be sent to [him / her] for signatures." B. A review of a clinical record document titled "Patient Communication" dated 9/15/17 stated, "Received admission paperwork at office yesterday. Mailing to the POA for signatures today." This was signed by Employee P, Receptionist. C. A review of clinical record #19 evidenced a plan of care with a start of care of 9/13/17 and certification period of 9/13/17 - 11/11/17.		admission of the patient. At that time an email or fax number will be obtained in order to send POA the admission paperwork, including the State HHA Hotline Number, prior to the clinician seeing the patient. All communication to be documentation in the patient chart with regards to the steps taken to notify the POA. Record of receipt (sent email confirmation or faxed receipt) will be captured and filed. Staff will be educated on communicating with POA and process to provide the admission paperwork including the State HHA Hotline number and how to record in the patient EMR chart. The Clinical Manager will review/audit all new SOC with POA documentation for compliance of item A. Audits to be completed with 100% of new admissions 10/16/17 for 3 months and then 10% quarterly. Administrator Clinical Manager (DON) are responsible.	

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	2. A review of a document presented on 9/15/17 evidenced a document titled "General Durable Power of Attorney" stated, "Know all men by these presents that I, [patient #19] ... constituted and appointed, and by these presents do appoint [POAs and family members of patient #19] as my true and lawful co - attorneys." 3. During a home visit observation on 9/14/17 at 3:20 PM, Employee S, occupational therapist, was observed to complete an occupational therapist evaluation with patient #19. The patient's home folder was observed to be in the medical records / director of nursing's office area of the assisted living where the patient resides. 4. During an interview on 9/15/17 at 11:55 AM, the administrator indicated the rights were explained to the power of attorney verbally. The power of attorney had not received the written rights yet. 5. During a phone interview on 9/15/17 at 2:20 PM, the POA / family member of patient #19 indicated not being given any written documentation about the patient rights at this time or being informed of the Indiana Department of Health Complaint hotline number. This person			

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	indicated the agency had called and discussed the services / costs with him / her but no written information had been received. 6. The undated admission folder titled "Patient Information Booklet" included the following section: "Patient Rights and Responsibilities." This document stated, "The patient has the following rights ... 2. The HHA [home health agency] must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of care to the patient or during the initial evaluation visit before the initiation of treatment. 3. The HHA must maintain documentation showing that it has complied with the requirements of this section. 4. The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights as permitted by law or when the patient has been judged incompetent ... When the agency accepts the patient for treatment or care, teh HHA must advise the patient in writing of the telephone number of the home health hotline established by the Indiana State Deparmtent of Health [ISDH], the hours of its operation, and that the purpose of the hotline is to receive complaints or			

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	questions about local HHAs. The paitnet also has the right to use this hotline to place a complaint with the ISDH regarding treatment or care furnished by the HHA or to lodge complaints concerning the implementation of the advance directives requirements. The ISDH toll free hotline number is 1 - 800-227-6334 Monday through Friday 8:15 AM - 4:45 PM. The answering machine is available for after hours and weekend calls." 7. The undated agency policy titled "Advance Directive Policy C- 430" stated, "Agency recognizes the importance of clients particiapting in planning their care and of their rights to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157562	A. BUILDING 00 B. WING	09/15/2017

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G 0122 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 0122	Deficiency Corrected 8/18/17	10/16/2017
G 0123 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Based on record review, interview and observation the agency failed to have identifiable lines of authority in 1 of 1 agency. The findings include: 1. The undated agency policy titled "A-120 Administrator Backup" stated "Policy When the Administrator is not available, a designated qualified alternate will assume the Administrator's duties and responsibilities. If the Administrator leaves employment, the designated alternate will assume the responsibilities of the Administrator until a replacement is hired and oriented. The Administrator and designated backup will comply with accepted professional standards and principles that are applicable to professional home care practice. The administrator or designated backup will be available at all times during regular business hours. Purpose To assure a qualified individual is designated to fulfill the responsibilities of the Administrator in the	G 0123	The Agency will immediately ensure that there is organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level. The agency failed to have identifiable lines of authority for the Administrator Backup and Alternate Clinical Supervisor (DON). The agency onboarded a new Alternate Administrator on 9/11/17 and our ISDH resurvey was 9/12/17. The agency failed to clearly outline the transition time frames regarding supervising staff for new staff members as effective with hire. In addition, during the entrance interview with DON and RN Case Manager the question was asked who is the alternate clinical supervisor.	10/20/2017

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	Administrator's absence. "Statement of Responsibility: Administrator" In compliance with established policy, and in the event that the Administrator: [administrator name] is not available, the designated, qualified backup: [employee G], will assume the duties and responsibilities of the Administrator. (Refer to the Administrator job description.) The Administrator and designated backup shall comply with accepted professional standards and principles that apply to professionals providing home care services. During hours of operation, the Administrator or designated backup shall be available at all times. The Administrator or designee will report, in writing, all changes in ownership or management to the Department of Health, Medicare and accreditation bodies...." This policy was signed and dated by employee G and employee M on 6/16/17. 2. During the entrance interview on 9/12/17 at 10:40 a.m., employee G indicated that he/she was not 100 percent sure who the alternate administrator was currently. He/She indicated the alternate administrator was just hired on 9/11/17. 3. Observation of an organizational chart titled "Priority Rehab Home Health Organization Chart" on 9/12/17 hanging in the break room indicated employee G was the alternate administrator. 4. Record review of Indiana State Department of Health pre-survey information on 9/11/17 indicated employee G as the alternate administrator. 5. During an interview on 9/12/17 at 2:00 p.m. the administrator indicated employee R as the new alternate administrator.		DON responded that this was RN Case Manager. DON did not interpret the question as ADON because based on prior jobs up to and including her current one the job title was DON and ADON. The title clinical supervisor was used interchangeably with nurse supervisor and case manager which in her experience has been an office position held by an RN that assists with supervision of field staff, documentation review and QI among other administrative tasks. Information for specific titles for nursing supervisor by ISDH is confusing. The new regulations do not take place until January 2018. The agency will revise the Organizational Chart now that the new ADON has been approved by the ISDH. The agency will also implement use of the term Clinical Supervisor effective 10/20/17. Staff will be educated on the updated Org. Chart with the new ISDH verbiage, lines of authority and who to report to. Written acknowledgement will be obtained from all agency staff. The DON/Clinical Supervisor will audit for receipt of B with all current staff and incorporate into new employee audit tool for future hires. Audits to be completed with 100% of current staff then all future hires. Administrator, Clinical Supervisor (DON) are responsible.	

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	6. The agency failed to have an identifiable alternate clinical supervisor. This was indicated as follows: a. During the entrance interview on 9/12/17 at 10:40 a.m. the clinical supervisor indicated employee Q was the alternate clinical supervisor. b. Record review on 9/11/17 of the pre-survey information sent by the Indiana State Department of Health listed employee I as the alternate nursing supervisor. c. During an interview on 9/15/17 at 2:55 p.m. with employee N, he/she indicated employee Q was the alternate clinical supervisor. d. During an interview on 9/12/17 at 2:00 p.m. the administrator indicated that employee R was the new alternate administrator and alternate clinical supervisor.			
G 0133 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.	G 0133	1)The administrator will have knowledge of the essential functions of the agency: Scheduled patient visits with approximate time frames that the agency staff will visit a patient will be captured throughout the week. The schedules will be received	10/20/2017

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			from the therapy companies and forwarded to the DON/Clinical supervisor. Daily, the RN's will forward their schedule for the day each morning to the DON/Clinical supervisor with anticipated visit times indicated for patients that day. Organizational charts will be maintained by the administrator (or Alternate) and updated within a week of a new managerial position being filled. Management to be notified the week before a pending change occurs. Positions of responsibility to be effective the date of hire. Staff will be educated on the updated Org Chart (that includes the new ISDH verbiage for Clinical Supervisor), lines of authority and who to report to. Written acknowledgement will be obtained from all agency staff. 2) The Administrator will oversee the DON/Clinical Supervisor audits for receipt of A & B. A to be captured each work day. B to be captured with all current staff then incorporated into the new hire onboarding audit tool. Audits to be completed with 100% of current staff then all future hires. 3) The Administrator is responsible.	
G 0137 Bldg. 00	484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator. Based on record review, interview, and observation the agency failed to have a	G 0137	1)The administrator will clearly designate alternate administrator	10/20/2017

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	clear alternate administrator in place at 1 of 1 home health agency. The findings include: 1. The undated agency policy titled "A-120 Administrator Backup" stated "Policy When the Administrator is not available, a designated qualified alternate will assume the Administrator's duties and responsibilities. If the Administrator leaves employment, the designated alternate will assume the responsibilities of the Administrator until a replacement is hired and oriented. The Administrator and designated backup will comply with accepted professional standards and principles that are applicable to professional home care practice. The administrator or designated backup will be available at all times during regular business hours. Purpose To assure a qualified individual is designated to fulfill the responsibilities of the Administrator in the Administrator's absence. "Statement of Responsibility: Administrator" In compliance with established policy, and in the event that the Administrator: [administrator name] is not available, the designated, qualified backup: [employee G], will assume the duties and responsibilities of the Administrator. (Refer to the Administrator job description.) The		in place for the agency: Organizational charts will be maintained by the administrator and updated within a week of a new Alternate Administrator being designated. Agency Management to be notified the week before a pending change occurs. Positions of responsibility to be effective the date of hire. Staff will be educated on the updated Org Chart (that includes the new ISDH verbiage for Clinical Supervisor), lines of authority and who to report to. Written acknowledgement will be obtained from all agency staff. 2) The Administrator will oversee the DON/Clinical Supervisor audits for receipt of A. The Org Chart Acknowledgment to be captured with all current staff then incorporated into the new hire onboarding audit tool. Audits to be completed with 100% of current staff then all future hires. 3) The Administrator is responsible.	

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	Administrator and designated backup shall comply with accepted professional standards and principles that apply to professionals providing home care services. During hours of operation, the Administrator or designated backup shall be available at all times. The Administrator or designee will report, in writing, all changes in ownership or management to the Department of Health, Medicare and accreditation bodies...." This policy was signed and dated by employee G and employee M on 6/16/17. 2. During the entrance interview on 9/12/17 at 10:40 a.m., employee G indicated that he/she was not 100 percent sure who the alternate administrator was currently. He/She indicated the alternate administrator was just hired on 9/11/17. 3. Observation of an organizational chart titled "Priority Rehab Home Health Organization Chart" on 9/12/17 hanging in the break room indicated employee G was the alternate administrator. 4. Record review of Indiana State Department of Health pre-survey information on 9/11/17 indicated employee G as the alternate administrator.			

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	5. During an interview on 9/12/17 at 2:00 p.m. the administrator indicated employee R as the new alternate administrator.			
G 0157 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Based on record review and interview the agency failed to meet the patient's needs in the patient's residence in 2 out of 8 patient charts reviewed. (#14, #18) The findings include: 1. The undated agency policy titled "C-120 Admission Policy" stated "Policy Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Agency in the client's place of residence. ... Purpose To provide guidelines for accepting clients for home health care services to be provided in the client's place of residence that are clear to the home care staff, the medical and lay community, and that abide by state/federal guidelines. Special Instructions Criteria for Client Admission: ... 4. There must be a reasonable expectation that the client's medical, nursing, social or rehabilitation needs can be	G 0157	The agency will only accept patients when the patients' health needs can be adequately met by the home health agency in the patients place of residence. If the established plan of care is ineffective and not met within the agencies parameters a referral will be made to an alternate provider. All staff to receive reeducation on meeting the patients' health needs when experiencing shortness of breath. All agency staff to receive education on dyspnea for clinical evaluation during patient visits and documentation of all measures taken to ensure patients safety while performing the visit. The DON/Clinical Supervisor will receive acknowledgement of	10/27/2017

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	adequately met in the client's home. 5. Reasonable expectation shall consider: ... c. The benefits of care at home as compared to care in a hospital, extended care facility or alternate setting. ... 6. There is indication that the delivery, monitoring and coordination of home health care services will enable the client to remain within the home environment. ... 10. Agency services must be appropriate and available to meet the specific needs and requests of the client and caregiver." 2. The undated agency policy titled "C-140 Client Admission Process" stated "Policy ... Services will not be initiated until an initial assessment has been completed and identified client needs can be met by the agency. The agency determines that client needs can be met by the agency. Purpose ... To determine whether the client's health care needs for services are appropriate by evaluating the client's physical, psychological, social, spiritual, and cultural status. ... Special Instructions ... d. The client's needs can safely and adequately be met at home. This includes the ongoing availability of personnel and equipment and a plan to meet medical emergencies. ... f. The Agency is capable of providing the needed care or service at the level of intensity the client's condition requires. ... j. The services and care must conform with current professional standards of practice for the respective discipline and should be reasonable and necessary to the treatment of a medical doctor. ... 10. The admission professional will: ... e. Assess and document the client's vulnerability status and risk of hospitalization. Identify specific safety measures relating to the vulnerability area. Safety measures will be documented in the record and on the care plan as applicable. f. Review the plan for services, treatment, and care with the		completed Dyspnea inservice from each clinical staff. The DON/Clinical Supervisor will include audit of item A in 100% of patient records beginning 10/16/17 for one month then 10% quarterly. Administrator and Clinical Supervisor (DON) are responsible.	

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	client/caregiver and obtain input when possible. Inform the client/caregiver of any reasonable risk and/or alternative associated with any procedure provided in the home...." 3. Review of clinical record #14 on 9/14/17 evidenced a document titled "Physician Order For Start-Of-Care" dated 8/3/17 and signed by the physician on 8/10/17, that stated "...Agency to have Registered Nurse or Licensed Therapist perform assessment and evaluation of the client for admission to home health services...." The majority of services were performed in a therapy gym located on the first floor of the building. 4. Review of clinical record #14 on 9/14/17, start of care 8/7/17, evidenced a document titled "F2F [face to face] Encounter" This document was signed by physician C and dated 9/1/17. The document stated "... Medical Condition The encounter with the patient was directly related to the following medical condition, which is the primary reason for home health care: Hx [history] Falls with injury Clinical Findings In Support of Patient's Eligibility Provide a summary of clinical findings that support the patient's eligibility for home health services, including specific need for intermittent skilled nursing and/or therapy services. The Face-to-Face visit findings must be related to the primary reason for home health admission. Due to history of falls with injury ... physical therapy is recommended to increase strength and decrease gait instability. Statement of Homebound Status I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this patient is confined to the home (i.e., there exists a normal inability to leave home and leaving home requires considerable and taxing effort and is medically contraindicated or requires the assistance of supportive devices, supportive			

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	transportation, or another person) due to: Considerable effort for patient to leave home due to history of falls, unsteady gait, leaving home is a taxing effort...." 5. The agency failed to meet the needs of patient #14, start of care 8/7/17, in his/her place of residence was evidenced as follows: a. During record review on 9/14/17 a document was evidenced titled "PT [physical therapy] Evaluation" dated 8/7/17 and digitally signed by employee T. The document had an area subtitled "Homebound?" with "Yes" check marked, other areas check marked were "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", and "Severe SOB [shortness of breath] or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt [patient] had to take several rest breaks due to LE [lower extremity] fatigue to walk from room down to therapy gym and dining hall." b. Record review on 9/14/17 a document was evidenced titled "PT Visit" dated 8/14/17 and digitally signed by employee T. The document had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", "Severe SOB or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt had to take several rest breaks due to LE fatigue to walk from room down to therapy gym and dining hall." c. Record review on 9/14/17 a document was evidenced titled "PT Visit" dated 8/16/17 and digitally signed by employee T. The document			

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	157562	A. BUILDING 00 B. WING	09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BACK HOME AGAIN	291 N STATE RD 2 VALPARAISO, IN 46383

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	had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", "Severe SOB or SOB upon exertion". Review of this document evidenced an area subtitled "Gait Training" with an area that stated "Impact of Intervention(s) on Functional Performance/Patient Response to Treatment: Pt walks with wide BOS [base of support] and moves slowly due to fear of falling. Pt's endurance better today, requiring no rest breaks to walk from room to therapy gym and back to his room..." d. Record review on 9/14/17 a document was evidenced titled "PT Visit" dated 8/23/17 and digitally signed by employee A. The document had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", "Severe SOB or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt had to take several rest breaks due to LE fatigue to walk from room down to therapy gym and dining hall." 6. During record review of clinical record #14 on 9/14/17 a document was evidenced titled "OASIS-C2 Start of Care" dated 8/7/17 and digitally signed by employee B, RN [registered nurse]. This document had an area subtitled "(M1400) When is the patient dyspneic or noticeably Short of Breath?" which had an area marked that stated "1 - When walking more than 20 feet, climbing stairs". 7. During an interview on 9/15/17 at 10:10 a.m. the administrator (employee M) and clinical supervisor (employee G) indicated that the			

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	157562	A. BUILDING 00 B. WING	09/15/2017

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	therapy gym was in the building, and that this was his/her home. 8. The agency failed to meet the needs of patient #18, start of care 7/13/17, in his/her place of residence was evidenced as follows: a. Record review on 9/14/17 evidenced a document titled "PT visit" dated 8/7/17 and digitally signed by employee T. The document had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", and Severe SOB or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt becomes SOB easily, requiring frequent rest breaks to walk down to therapy gym."			
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. 5. A review of clinical record #15 evidenced a Home Health Certification and Plan of Care with a start of care of 7/27/17 and a certification period of 7/27/17 - 9/24/17. The orders on this document included home health aide visits two times a week for 8 weeks	G 0158	Patient care will follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Home health aide care plans completed by the designating clinician will schedule the frequency in the patients visit schedule to ensure all visits are	10/27/2017

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BACK HOME AGAIN	291 N STATE RD 2 VALPARAISO, IN 46383

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	effective 7/31/17. This clinical document was signed by the physician on 8/10/17. The review of the record evidenced a lack of a home health aide visit. The record evidenced a home health aide visit on 8/22/17 and no other home health aide visits the week of 8/20/17 - 8/26/17. During an interview on 9/15/17 at 2:30 PM, Employee Q, Registered Nurse, indicated a home health aide visit was lacking the week of 8/20/17 - 8/26/17.		attempted to be completed as ordered. The plan of care will be followed as ordered and completely documented in all clinical notes. Admitting clinicians to receive reeducation on content of plan of care including the frequency that each intervention is to be completed. When no frequency is indicated it is to be completed each visit until the discipline is discharged. All field staff will receive education on visit frequency and appropriate as well as complete documentation of missed visits. Documentation to include attempts made to reschedule the visit with the patient. Signature logs of patient visits to be uploaded regularly to patient EMR chart to validate visits completed. The DON/Clinical Supervisor will reeducate current staff on A, B & C as well as include A, B & C in new employee orientation. Clinical Staff that had received previous education on POC will be counselled and documentation retained in HR chart. DON/Clinical Supervisor will include audit of item A in 100% of patient records beginning 10/16/17 for one month then 10% quarterly. Administrator and Clinical Supervisor (DON) are responsible.	
G 0159	484.18(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157562	A. BUILDING 00 B. WING	09/15/2017

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Bldg. 00	PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on observation, record review and interview, the agency failed to ensure the plan of care was complete for 1 of 8 records reviewed (# 17). The findings include: 1. A review of Clinical record #17, start of care 7/31/17, failed to evidence the Home Health Certification and Plan of Care for the certification period of 7/31/17 - 9/28/17 included a complete medication order for Vitamin B 12 with an order for the skilled nurse to administer the Vitamin B 12 injection. The plan of care failed to list the type of injection this was to be: an intramuscular injection. The patient expressed concerns about not receiving the Vitamin B 12 injections as ordered at a home visit observation (see below #4). Skilled nurse visit documents dated 8/7/17, 8/18/17, 8/24/17, 9/6/17 and a missed	G 0159	The medical plan of care shall be developed in consultation with all home health agency staff & the physician to include all services to be provided, cover all pertinent diagnosis, and include key elements specific to the patient. Employee B, RN, failed to clarify/incorporate orders for B12 injections for patient and document follow up for patient receiving monthly B12 injections. This employee is no longer active with the company. They did receive reeducation prior to leaving regarding POC. Employee U, RN, obtained orders for B12 and subsequently completed needed B12 injection. Agency staff to be reminded to have routine stock items (needles) available for patient visits. DON/Clinical Supervisor to receive reeducation on POC content to ensure there are no oversight's on POC. 2) 100% of all new patient POC will be audited for A at admission and recertification for accuracy	10/27/2017

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	visit document completed by the RN on 8/18/17 and 8/31/17 failed to show documentation of Vitamin B 12 administered by the nurse or communication about the Vitamin B 12 injection. An OASIS start of care document dated 7/31/17 signed by Employee B, RN, evidenced the patient was alert and oriented. This is further evidenced by the following: A. A review of the OASIS C2 Start of Care for patient #17 dated 7/31/17 signed by Employee B, RN, stated, " SN [skilled nurse] for education on disease processes and monthly IM injections." The patient is alert and oriented. B. A review of the Home Health Certification and Plan of Care document evidenced a start of care on 7/31/17 and certification period for this plan of care 7/31/17 - 9/28/17. This document the patient's medications included Cyanocobalamin Injection 1000 mcg (micrograms) / ml (milliliter) 1 ml monthly - last injection 7/24/17. Cyanocobalamin is Vitamin B 12. The skilled nurse does not have an order to administer the injection. C. A review of an RN (Registered Nurse) Skilled Nursing Visit document dated 9/6/17 evidenced a visit completed		for one month beginning with certifications 10/16/17 then 10% quarterly.QA to audit POC for compliance content for item C on 100% of new POC with certifications 10/16/17 then 10% quarterly. Item B to be included in new nurse hire orientation. 3) Administrator and Clinical Supervisor (DON) are responsible.	

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	by Employee U, RN, on this date. The nurse documented, "Patient states [he / she] is due for Vitamin B 12 injection. MD notified." Under the skilled intervention this nurse documented, "Patient states last Vitamin B 12 was 8/14/17." D. A review of a patient case conference signed by Employee U on 9/7/17 evidenced under a section titled "Problems needing interventions / Plans" this nurse's notes "DC [discharge] and B 12." E. A review of a physician's order evidenced the nurse was to administer cyanocobalamin 1000 mcg / ml 1 ml intramuscular week of 9/10/17. F. A review of a patient communication note dated 9/12/17 signed by Employee U stated, "SN [skilled nurse] attempted to perform visit for monthly Vitamin B 12 injection. Patient did not have syringe. SN will order syringe from pharmacy." G. A review of a skilled nurse visit with discharge summary 9/13/17 evidenced Employee U administered the Vitamin B 12 into the patient's left dorsogluteal (left buttock muscle area) or			

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	intramuscularly. 2. During an interview on 9/15/17 at 3:40 PM, the director of nursing indicated that this was a documentation delay and that there was a new order for the Vitamin B 12 to be given the week of 9/10/17. 3. The undated agency policy titled "Section C-580 Plan of Care" stated "Policy Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/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 client 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 reflect the client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. 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			

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	physician shall be required for each client 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. b. Mental status. c. Type, frequency, and duration of all visits/services. d. Specific procedures and modalities for therapy services ...h. Rehabilitation potential. i. Functional limitations and precautions. j. Activities permitted or restrictions. k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures." 4. During an interview on 9/13/17 at 2:40 PM, patient #17 stated that the nurse comes to apartment one time per month to administer B12 injection. Patient states that he / she has not received her shot for "5 or 6 weeks" because he / she doesn't have needles. Stated that the nurse is trying to get some needles.			

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G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview the skilled nurse failed to follow the plan of care established by the physician in 3 of 8 clinical records reviewed. (#13, #14, #16) The findings include: 1. The undated agency policy titled "C-580 Plan Of Care" stated "Policy Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/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 client 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 reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. To assure that the plan meets state/federal	G 0170	The skilled nurse will follow the plan of care established by the physician. The plan of care will be followed as ordered and completely documented in all clinical notes. Admitting clinicians to receive reeducation on content of plan of care including the frequency that each intervention is to be completed. When no frequency is indicated it is to be completed each visit until the discipline is discharged. The DON/Clinical Supervisor will receive reeducation on POC content with frequencies to be indicated for each intervention. 2) 100% of all new patient POC will be audited for A at admission and recertification for accuracy for one month beginning with certifications 10/16/17 then 10% quarterly by QA. Clinical staff that had received previous education on POC will be counseled and documentation retained in HR chart. New staff that receive reeducation will receive counseling if POC content is not remediated. DON/Clinical supervisor will receive counseling if correct POC content is not captured and requires remediation. 3) Administrator and Clinical Supervisor (DON) are responsible.	10/27/2017

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	guidelines, and all applicable laws and regulations. Special Instructions 1. An individualized Plan of Care signed by a physician shall be required for each client 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. b. Mental status. c. Type, frequency, and duration of all visits/services. d. Specific procedures and modalities for therapy services. e. Diagnostic tests, including laboratory and x-rays. f. Surgical procedure(s). g. Prognosis. h. Rehabilitation potential. 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. o. Instructions to client/caregiver, as applicable. p. Treatment goals. q. Instructions for timely discharge or referral. r. Discharge plans. s. Name and address of client's physician. t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care...." 2. Review of clinical record #13 on 9/14/17 evidenced an agency document			

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	titled "Home Health Certification and Plan Of Care" for certification period 08/07/17 - 10/5/17 signed and dated 7/26/17 by physician. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following incomplete physician orders: a. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct the patient caregiver on measures to recognize cardiac dysfunction and relieve complications, SN to instruct the patient/caregiver on signs/symptoms of UTI to report to MD/SN, SN to instruct patient on turning/repositioning every 2 hours, SN to instruct patient to increase activity to alleviate constipation, SN to assess patient for diet compliance, and SN to assess patient's compliance with home exercise program. b. The skilled nurse visit note dated 08/9/17 failed to ensure the patient was instructed on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning. c. The skilled nurse visit note dated 7/27/17 and 8/9/17 failed to ensure the			

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	patient was instructed on wound care. d. The skilled nurse visit note dated 8/9/17 failed to ensure the patient was instructed on proper use of nebulizer/inhaler, and assess return demonstration. 3. Review of clinical record #14 on 9/14/17 evidenced an agency document titled "Home Health Certification and Plan Of Care" for certification period 07/24/17 - 9/21/17 signed and dated 8/17/17 by physician C. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following incomplete physician orders: a. During record review on 9/14/17 the document titled "Home Health Certification and Plan of Care" had an area subtitled "21. Order for Discipline and Treatments (Specify Amount/Frequency/Duration) SN [skilled nurse]: 1W9 [once weekly for 9 weeks..."]. Review of the clinical record evidenced the following missed skilled nurse visits: 8/25/17, 8/30/17, 9/7/17. These visits failed to be rescheduled with the client for a different time and/or day. The skilled nurse failed to follow the physician ordered plan of care. During			

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	an interview on 9/15/17 at 10:10 a.m. the clinical supervisor indicated that the skilled nurse could have rescheduled the visit and that he/she would like to see more documentation on the skilled nurse missed visit notes. During an interview on 9/13/17 at 12:00 p.m. patient #14 indicated his/her first skilled nurse visit was on 9/11/17. b. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct Patient/Caregiver that patient should elevate feet when sitting, SN to instruct the Patient/Caregiver on methods to promote oral intake, SN to instruct patient to change positions slowly, SN to instruct the Patient/Caregiver to remove clutter from patient's path such as clothes, books, shoes electrical cords, or other items that may cause patient to trip, SN to instruct the Patient/Caregiver on importance of adequate lighting in patient area, and SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. c. The skilled nurse visit note dated 08/16/17 failed to ensure the			

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	patient/caregiver was instructed on all aspects of diabetic management to include disease process, foot assessments, signs and symptoms of hypo/hyperglycemia, glucometer use and preparation and administration of diabetic medications ordered by the physician. d. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed to inspect patient's feet daily and report any skin or nail problems to the SN. e. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed that patient should never walk barefoot. f. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed to protect patient's feet from extreme heat or cold. g. The skilled nurse visit note dated 8/16/17 failed to ensure the patient /caregiver was instructed to never try to cut off corns, calluses, or any other lesions from lower extremities. h. The skilled nurse visit note dated 8/16/17 failed to ensure the patient was instructed to wear proper footwear when ambulating.			

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	4. Review of clinical record #16 on 9/14/17 evidenced an agency document titled "Home Health Certification and Plan Of Care" for certification period 08/31/17 - 10/29/17. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following uncompleted physician orders: a. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct patient on importance of receiving influenza and pneumococcal vaccines, SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs, SN to instruct patient/caregiver on turning/repositioning every 2 hours, SN to instruct the patient/caregiver on methods to reduce friction and shear, SN to perform inspection of patient's lower extremities every visit and report any alteration in skin integrity to physician, SN to instruct patient on bladder training program, including timed voiding, SN to instruct the patient/caregiver on signs/symptoms of UTI [urinary tract infection] to report to MD/SN, SN to instruct the patient/caregiver on signs and			

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	symptoms of constipation to report to SN or physician, SN to instruct patient to wear proper footwear when ambulating, SN to instruct patient to change positions slowly, SN to instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility, and SN to instruct the patient/caregiver on medication side effects to report to SN or physician. b. The skilled nurse visit note dated 9/5/17 and 9/8/17 failed to ensure the patient/caregiver was instructed on inspecting patient's feet daily and to report any skin or nail problems to SN. c. The skilled nurse visit note dated 9/5/17 failed to ensure the patient was instructed on measures to detect and alleviate edema. d. The skilled nurse visit note dated 9/5/17 failed to ensure the patient was instructed to use prescribed assistive device when ambulating.			
G 0172 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.			

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	Based on observation, record review and interview, the Registered Nurse failed to re-evaluate a patient's nursing needs in relation to a unobserved fall with injury reported by a physical therapist in 1 of 8 records reviewed with Registered Nurse (patient #15 and Employee B, RN). The findings include: 1. A review of clinical record #15 failed to evidence the nurse reevaluated the patient's head abrasion after a reported fall was reported by the physical therapist on 8/15/17. This lack of a registered nurse re-evaluation is evidenced by the following: A. A review of a patient communication note signed by Employee T dated 8/15/17 stated, "Description of fall: unobserved. Pt [patient] reports falling out of bed Sunday night, hitting [his / her] head on the floor. [He / she] says [he/she] was sleeping and then woke up to [himself / herself] falling. Doesn't remember many other details. [He / she] was able to get up and back in bed right after fall." The physician was notified. B. A review of a skilled nurse visit document dated 8/16/17 time in 10:30 AM time out 11 AM evidenced the	G 0172	1) The agency will immediately reevaluate the patients' nursing needs with assessments each visit. A. All RN's will re-evaluate patient needs with each visit and complete a full assessment when indicated. The RN mentioned in this standard (B) is no longer active with this agency. B. All RN's will receive reeducation and training on case management, and coordination of care including documentation and communication. 2) The DON/Clinical Supervisor will continue to complete supervisory visits with field RN's quarterly to ensure complete appropriate assessments are completed on each visit. This will be ongoing. will be audited: 100% of all RN notes to be audited beginning 10/16/17 for one month and then 10% quarterly. RN's that fail to complete full assessments when indicated after receiving reeducation will be counselled. 3) The Administrator and Clinical Supervisor (DON) are responsible.	10/20/2017

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	patient had buttock wounds with wound care treatment completed by the nurse. The nurse did not include any documentation about the head abrasion documented on the therapy communication note. C. A review of a skilled nurse visit document dated 8/16/17 time in of 11:01 AM time out 11:10 AM with a signature of Employee B, RN failed to include an assessment of the head abrasion or any documentation that the patient had experienced a fall. D. During an interview on 9/13/17 at 3:15 PM, the director of nursing indicated that there is no documentation of a re - evaluation by the nurse. 2. The undated agency policy titled "C-200 - Skilled Nursing Services" stated " Policy Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders). In determining whether a service requires the skills of a Nurse, the inherent complexity of the service, condition of the client, and accepted standards of medical and nursing practice will be considered. Purpose To abide by			

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	157562	A. BUILDING 00 B. WING	09/15/2017

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	state/federal guidelines and offer guidelines to the agency staff, physicians, and community for the appropriate utilization of professionally skilled nursing services. Special Instructions 1. The registered nurse: ... b. Regularly reevaluates the client needs, and coordinates the necessary services."			
G 0335 Bldg. 00	484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on record review and interview the skilled nurse failed to ensure a complete comprehensive assessment in 1 of 8 patient records reviewed. (#14) The findings include: 1. The undated agency policy titled "C-145 Comprehensive Client Assessment" stated "Policy A thorough, well-organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients in a timely	G 0335	1)The agency will immediately complete an accurate & comprehensive initial assessment of all patients admitted for a home health episode that includes appropriate elements of the History and Physical obtained to incorporate into the patient's initial assessment. A. The RN (B) that completed the assessment for this survey is no longer active with the agency. RN's that have been counseled and do not incorporate needed elements into the Oasis/POC will be subject to disciplinary action. The DON/Clinical Supervisor reviewing and approving the Oasis/POC will be counseled.	10/20/2017

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	manner, but no later than five (5) calendar days after the start of care. All skilled Medicare and Medicaid clients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals, and the care treatment and services provided, but will be done at least once in every sixty (60) day period. Purpose To determine the appropriate care, treatment and services to meet client initial needs and his/her changing needs. To collect data about the client's health history, (physical, functional and psychological) and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individuals response to care. To increase clarity in measurement. To measure processes of care in the agency. To identify clients medical, nursing, rehabilitative, social and discharge planning needs. ... Special Instructions ... 3. In addition to general health status/system assessment, the agency comprehensive assessment tool with OASIS will include: a. Clinical		B. The agency did contract with an external QA (associated with the new EMR system) to evaluate all components of the Oasis elements as well as the initial therapy evaluations to monitor for discrepancies and contraindications. The agency will review survey findings to ensure all appropriate H&P is incorporated in the Oasis/POC. C. Supporting clinical staff (PT/OT/ST) to receive education on patient H &P and incorporating elements into their POC as well as communicating with the team if discrepancies are noted. 2)DON/Clinical Supervisor will be counseled for Oasis/POC content by Administrators to ensure compliance for A & B. Internal QA to audit 100% of SOC/ROC/DC Oasis/POC for one month beginning 10/16/17 then 10% quarterly prior to locking and approving the Oasis/POC for submission to CMS. Errors identified to be reported to Administrator for further counselling/revision. Clinical staff that fail to identify pertinent diagnosis that caught by final QA will be counseled. 3) The Administrator and Clinical Supervisor (DON) are responsible.	

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	record items b. Demographics and client history c. Living arrangement. ... f. Supportive assistance. ... k. Depression screening l. Fall risk Assessments m. Neuro/emotional/behavioral status. ... Assessment Strategies Interview Interaction ... MD [medical doctor] or Facility information ... 11. Client needs are assessed and care guidelines established based on the assessment data ... 13. Reassessments are conducted based on client needs, physician orders, professional judgment and/or OASIS or other regulatory requirement. The physician will be notified of the assessment findings and collaborate on any changes made to the plan of care." 2. The skilled nurse failed to include patient #14's history and current alcohol abuse in the comprehensive assessment. Patient #14's alcohol history, current abuse and lack of inclusion in the skilled nurse comprehensive assessment is evidenced as follows: a. During review of clinical record #14 on 9/14/17 a document was evidenced from the office of physician C with a fax date listed at top of document as 7/26/17. An area on this document subtitled "Subjective" stated "... HPI [history of present illness] Comments: ... He/She does have a history of chronic			

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	depression. He/She has struggled with alcohol dependency. He/She reports He/She has been using some alcohol on a minimal basis...." b. Review of clinical record #14 on 9/14/17 evidenced a document titled "OASIS-C2 Start of Care" dated 8/7/17. An area on the document subtitled "Past Medical History (Mark all that apply)" failed to evidence "Substance Abuse (specify)" as being marked. Another area also on the same document subtitled "(M1036 Risk Factors, present or past, likely to affect current health status and/or outcome: (Mark all that apply)" failed to evidence "3 - Alcohol dependency" as being marked. No other documentation or comment was evidenced on the OASIS document in reference to patient's current or history of alcohol dependency. c. Review of clinical record #14 on 9/14/17 evidenced a document titled "Patient Communication" dated 8/14/17 that stated "... Description of fall: unobserved Pt [patient] states he/she fell Sunday morning. He/She was getting up to use the restroom when he/she felt himself/herself get dizzy and he/she lost all strength in his/her legs, causing himself/herself to fall to his/her R [right]. He/She hit his/her head on bed frame,			

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	and landed on R shoulder. He/She was on the ground for approximately 2 hours before he/she had enough strength to pull himself/herself back up to his/her bed. Pt states he/she has had these episodes every few months for the past couple of years. Nature of injury: Pt has an abrasion on the R side of his/her head from fall, increased pain in R shoulder after fall (from 1-2/10 to 3-4/10), and his/her L [left] ring finger is bruised but he/she has no pain and has full ROM [range of motion]. ... Post Incident Treatment: Pt did not seek treatment after fall, therapist was first one notified the next day after his/her fall. No apparent serious injury, pt already had dr [doctor] appt [appointment] scheduled for this Thursday 8/17." d. Review of clinical record #14 on 9/14/17 evidenced a document from the office of physician C with a date of 8/17/17 that stated "... Diagnoses ... History of alcohol abuse ... Subjective: ... Unfortunately, he/she has struggled with alcohol abuse. He/She started drinking again. He/She attributes his electrolyte abnormalities to his/her alcohol use. The anniversary of his/her husband's/wife's death was a few days ago. This triggered excessive alcohol use. ... He/She has participated in alcohol rehabilitation both inpatient and			

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	outpatient at [Place D]. He/She declines a referral today. Unfortunately, he/she fell 4 days ago (8/13) out of bed and admittedly was intoxicated. He/She bruised his/her right shoulder. He/She is having some increased pain and decreased range of motion of both shoulders that have been longstanding. He/She also has bruising of his/her left fourth finger. ... He/She reportedly has erosion of his/her esophagus related to his/her alcohol use ... Plan: ... 10. History of alcohol abuse Lengthy discussion today. He/She declines a referral to [Place D]. He/She was encouraged to attend AA [alcoholics anonymous] meetings and maintain abstinence. He/She is fortunate to have family support..." There was no other evidence in the skilled nurse, PT [physical therapy], OT [occupational therapy] or ST [speech therapy] notes that his/her current issues with alcohol abuse were addressed.			
N 0000 Bldg. 00	This revisit was for a state licensure survey with survey dates of 6/8/17 - 6/19/17. A complaint was investigated during this survey. Complaint #: IN00232243.	N 0000		

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	Facility #: IN003800 Medicare #: 157562 Medicaid #: 200839250 Revisit Survey Dates: 9/12/17 - 9/15/17 Census: 55 active patients During this survey, 7 deficiencies were found corrected. 9 deficiencies were recited. 2 new deficiencies were added.			
N 0440 Bldg. 00	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview the administrator failed to organize and direct the agency's ongoing functions in 1 of 1 agency. The findings include: 1. The undated agency job description titled "C-105 Position: Administrator" stated "... Position Summary Plans, develops, and directs the programs, services, activities, and employees of the Agency. ... Essential Functions 1. Identifies and implements the organizational	N 0440	The administrator will have knowledge of the essential functions of the agency: Scheduled patient visits with approximate time frames that the agency staff will visit a patient will be captured throughout the week. The schedules will be received from the therapy companies and forwarded the DON/Clinical Supervisor with anticipated visit times indicated for patients that	10/20/2017

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	structure. 2. Plans, organizes, and directs the Agency's ongoing functions. 3. Directs and coordinates the overall development and administration of the Agency consistent with the Agency mission and available resources, and with the involvement of the Agency staff and participation of the Professional Advisory Board. ... 7. Assures compliance with federal/state regulations governing home health care services. ... 15. Directs daily business activities of the Agency and assures development of systems that support recruitment, hiring and the ongoing professional development of Agency staff...." 2. The administrator failed to have knowledge of the times the agency staff were to visit clients throughout the week as follows: a. During an interview on 9/12/17 with administrator he/she indicated they had phone calls out to their employees to schedule patient visits the following day. The administrator at end of day only had a few employees return his/her phone call and only had a few times for visits written on an employee roster. b. Record review of an untitled employee roster with schedules of employees from 9/12/17 - 9/19/17 listed the days the patient visits were scheduled, but did not list the times they were scheduled to be visited, with the exception of 2 incomplete employee visit times that were written in by the administrator. c. During an interview in the morning on 9/13/17 with the administrator he/she was still awaiting calls from the therapists and nurse to secure visit times with patient. 3. The administrator failed to delineate clear lines of authority and keep his/her staff aware of all		day. Organizational charts will be maintained by the Administrator (or Alternate) and updated within a week of a new managerial position being filled. Management to be notified the week before a pending change occurs. Positions of responsibility to be effective the date of hire. Staff will be educated on the updated Org Chart (that includes the new ISDH verbiage for Clinical Supervisor), lines of authority and who to report to. Written acknowledgement will be obtained from all agency staff. The Administrator will oversee the DON/Clinical Supervisor audits for receipt of A & B. A to be captured each work day. B to be captured with all current staff then incorporated into the new hire onboarding audit tool. Audits to be completed with 100% of current staff then all future hires. The Administrator is responsible.	

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	changes with the agency as follows: a. During the entrance interview on 9/12/17 at 10:40 a.m. the clinical supervisor indicated employee Q was the alternate clinical supervisor. b. Record review on 9/11/17 of the pre-survey information sent by the Indiana State Department of Health listed employee I as the alternate nursing supervisor. c. During an interview on 9/15/17 at 2:55 p.m. with employee N, he/she indicated employee Q was the alternate clinical supervisor. d. During an interview on 9/12/17 at 2:00 p.m. the administrator indicated that employee R was the new alternate administrator and alternate clinical supervisor.			
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on record review and interview the administrator failed to organize and direct the agency's ongoing functions in 1 of 1 agency. The findings include: 1. The undated agency job description titled "C-105 Position: Administrator" stated "...	N 0444	The administrator will have knowledge of the essential functions of the agency: Scheduled patient visits with approximate time frames that the agency staff will visit a patient will be captured throughout the week. The schedules will be received	10/20/2017

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	Position Summary Plans, develops, and directs the programs, services, activities, and employees of the Agency. ... Essential Functions 1. Identifies and implements the organizational structure. 2. Plans, organizes, and directs the Agency's ongoing functions. 3. Directs and coordinates the overall development and administration of the Agency consistent with the Agency mission and available resources, and with the involvement of the Agency staff and participation of the Professional Advisory Board. ... 7. Assures compliance with federal/state regulations governing home health care services. ... 15. Directs daily business activities of the Agency and assures development of systems that support recruitment, hiring and the ongoing professional development of Agency staff...." 2. The administrator failed to have knowledge of the times the agency staff were to visit clients throughout the week as follows: a. During an interview on 9/12/17 with administrator he/she indicated they had phone calls out to their employees to schedule patient visits the following day. The administrator at end of day only had a few employees return his/her phone call and only had a few times for visits written on an employee roster. b. Record review of an untitled employee roster with schedules of employees from 9/12/17 - 9/19/17 listed the days the patient visits were scheduled, but did not list the times they were scheduled to be visited, with the exception of 2 incomplete employee visit times that were written in by the administrator. c. During an interview in the morning on 9/13/17 with the administrator he/she was still awaiting calls from the therapists and nurse to		from the therapy companies and forwarded the DON/Clinical Supervisor with anticipated visit times indicated for patients that day. Organizational charts will be maintained by the Administrator (or Alternate) and updated within a week of a new managerial position being filled. Management to be notified the week before a pending change occurs. Positions of responsibility to be effective the date of hire. Staff will be educated on the updated Org Chart (that includes the new ISDH verbiage for Clinical Supervisor), lines of authority and who to report to. Written acknowledgement will be obtained from all agency staff. The Administrator will oversee the DON/Clinical Supervisor audits for receipt of A & B. A to be captured each work day. B to be captured with all current staff then incorporated into the new hire onboarding audit tool. Audits to be completed with 100% of current staff then all future hires. The Administrator is responsible.	

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	secure visit times with patient. 3. The administrator failed to delineate clear lines of authority and keep his/her staff aware of all changes with the agency as follows: a. During the entrance interview on 9/12/17 at 10:40 a.m. the clinical supervisor indicated employee Q was the alternate clinical supervisor. b. Record review on 9/11/17 of the pre-survey information sent by the Indiana State Department of Health listed employee I as the alternate nursing supervisor. c. During an interview on 9/15/17 at 2:55 p.m. with employee N, he/she indicated employee Q was the alternate clinical supervisor. d. During an interview on 9/12/17 at 2:00 p.m. the administrator indicated that employee R was the new alternate administrator and alternate clinical supervisor.			
N 0451 Bldg. 00	410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. Based on record review and interview the administrator failed to ensure an alternate administrator was clearly asssigned and in place at 1 of 1 agency. The findings include:	N 0451	1)The administrator will have clear alternate administrator in place for the agency: Organizational charts will be maintained by the administrator and updated within a week of a new Alternate Administrator being	10/20/2017

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	1. The undated agency policy titled "A-120 Administrator Backup" stated "Policy When the Administrator is not available, a designated qualified alternate will assume the Administrator's duties and responsibilities. If the Administrator leaves employment, the designated alternate will assume the responsibilities of the Administrator until a replacement is hired and oriented. The Administrator and designated backup will comply with accepted professional standards and principles that are applicable to professional home care practice. The administrator or designated backup will be available at all times during regular business hours. Purpose To assure a qualified individual is designated to fulfill the responsibilities of the Administrator in the Administrator's absence. "Statement of Responsibility: Administrator" In compliance with established policy, and in the event that the Administrator: [administrator name] is not available, the designated, qualified backup: [employee G], will assume the duties and responsibilities of the Administrator. (Refer to the Administrator job description.) The Administrator and designated backup shall comply with accepted professional standards and principles that apply to professionals providing home care services. During hours of operation, the Administrator or designated backup shall be available at all times. The Administrator or designee will report, in writing, all changes in ownership or management to the Department of Health, Medicare and accreditation bodies...." This policy was signed and dated by employee G and employee M on 6/16/17. 2. During the entrance interview on 9/12/17 at 10:40 a.m., employee G indicated that he/she was not 100 percent sure who the alternate administrator was currently. He/She indicated the alternate administrator was just hired on 9/11/17.		designated. Agency Management to be notified the week before a pending change occurs. Positions of responsibility to be effective the date of hire. Staff will be educated on the updated Org Chart (that includes the new ISDH verbiage for Clinical Supervisor), lines of authority and who to report to. Written acknowledgement will be obtained from all agency staff. 2) The Administrator will oversee the DON/Clinical Supervisor audits for receipt of A. The Org Chart Acknowledgment to be captured with all current staff then incorporated into the new hire onboarding audit tool. Audits to be completed with 100% of current staff then all future hires. 3) The Administrator is responsible.	

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	3. Observation of an organizational chart titled "Priority Rehab Home Health Organization Chart" on 9/12/17 hanging in the break room indicated employee G was the alternate administrator. 4. Record review of Indiana State Department of Health pre-survey information on 9/11/17 indicated employee G as the alternate administrator. 5. During an interview on 9/12/17 at 2:00 p.m. the administrator indicated employee R as the new alternate administrator.			
N 0494 Bldg. 00	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. Based on home visit observation, record review and interview, the agency failed to	N 0494	The agency will ensure all patients receive written notice of patient rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.	10/20/2017

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	157562	A. BUILDING 00 B. WING	09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BACK HOME AGAIN	291 N STATE RD 2 VALPARAISO, IN 46383

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	ensure the patient / patient's power of attorney was provided a written notice of the patient rights in advance of furnishing care to the patient for 1 (# 19) of 8 records reviewed. The findings include: 1. A review of clinical record #19 failed to evidence the power of attorney (POA) had received a written notice of the patient's rights in advance of care furnished to patient #19 and the patient started care on 9/13/17 as evidenced by the following: A. A review of a clinical record document titled "Patient Communication" dated 9/13/17 and signed by Employee N, RN, stated, "Set up admission visit with [patient #19's power of attorney]. [Patient #19's power of attorney] unable to be present for admission as [he / she] is at work. [He / she] gave nurse writer verbal consent to complete admission visit. All admission paperwork will need to be sent to [him / her] for signatures." B. A review of a clinical record document titled "Patient Communication" dated 9/15/17 stated, "Received admission paperwork at office yesterday. Mailing to the POA for		When it has been determined that a patient has a POA who will be completing the admission paperwork and who needs the written notice of patient rights in advance of furnishing care to the patient, the POA will be contacted via phone for verbal consent for admission of the patient. At that time an email or fax number will be obtained in order to send POA the admission paperwork and notice of patient rights prior to the clinician seeing the patient. All communication will be documented in the patient chart with regards to the steps taken to notify the POA. Record of receipt (sent email confirmation or faxed receipt) will be captured and filed. Staff will be educated on communicating with POA and process to provide the admission paperwork with notice of patient rights and how to record in the patient EMR chart. The Clinical Manager will review/audit all new SOC with POA documentation for compliance of item A. Audits to be completed with 100% of new admissions 10/16/17 for 3 months and then 10% quarterly. Administrator Clinical Manager (DON) are responsible.	

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	signatures today." This was signed by Employee P, Receptionist. C. A review of clinical record #19 evidenced a plan of care with a start of care of 9/13/17 and certification period of 9/13/17 - 11/11/17. 2. A review of a document presented on 9/15/17 evidenced a document titled "General Durable Power of Attorney" stated, "Know all men by these presents that I, [patient #19] ... constituted and appointed, and by these presents do appoint [POAs and family members of patient #19] as my true and lawful co - attorneys." 3. During a home visit observation on 9/14/17 at 3:20 PM, Employee S, occupational therapist, was observed to complete an occupational therapist evaluation with patient #19. The patient's home folder was observed to be in the medical records / director of nursing's office area of the assisted living where the patient resides. 4. During an interview on 9/15/17 at 11:55 AM, the administrator indicated the rights were explained to the power of attorney verbally. The power of attorney had not received the written rights yet.			

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	5. During a phone interview on 9/15/17 at 2:20 PM, the POA / family member of patient #19 indicated not being given any written documentation about the patient rights at this time or being informed of the Indiana Department of Health Complaint hotline number. This person indicated the agency had called and discussed the services / costs with him / her but no written information had been received. 6. The undated admission folder titled "Patient Information Booklet" included the following section: "Patient Rights and Responsibilities." This document stated, "The patient has the following rights ... 2. The HHA [home health agency] must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of care to the patient or during the initial evaluation visit before the initiation of treatment. 3. The HHA must maintain documentation showing that it has complied with the requirements of this section. 4. The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights as permitted by law or when the patient has been judged incompetent."			

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	7. The undated agency policy titled "Section C380 - Home Care Bill of Rights" stated "Policy - Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose - To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding their care. To protect and promote the exercise of clients' rights. To establish, operate, and maintain a grievance/complaint mechanism for use by the client/representative, which assures response and disposition and is in operation at a minimum during normal business hours. Special Instructions - 1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented."			

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N 0502 Bldg. 00	410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on home visit observation, record review and interview, the agency failed to ensure patients were provided the telephone number of the home health hotline established by the Indiana State Department of Health and the hours of its operation for 1 of 8 clinical records reviewed (#19). The findings include: 1. A review of clinical record #19 failed to evidence the power of attorney (POA) was provided the telephone number of the home health hotline established Indiana State Department of Health and the hours of its operation. This is evidenced by the following: A. A review of a clinical record document titled "Patient Communication" dated 9/13/17 and signed by Employee N, RN, stated, "Set	N 0502	The agency will immediately ensure the patient has the right to place a complaint with the department regarding treatment or care furnished by the home health agency and receive information about advance directives. When it has been determined that a patient has a POA who will be completing the admission paperwork and needs the State HHA Hotline information with hours of availability in advance of furnishing care to the patient, the POA will be contacted via phone for verbal consent for admission of the patient. At that time an email or fax number will be obtained in order to send POA the admission paperwork, including the State HHA Hotline Number and the agency policies on advance directives, including a description of applicable State Law [July 2013], prior to the clinician seeing the patient. All communication to be documented in the patient chart with regards to the steps taken to notify the POA.	10/20/2017

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	up admission visit with [patient #19's power of attorney]. [Patient #19's power of attorney] unable to be present for admission as [he / she] is at work. [He / she] gave nurse writer verbal consent to complete admission visit. All admission paperwork will need to be sent to [him / her] for signatures." B. A review of a clinical record document titled "Patient Communication" dated 9/15/17 stated, "Received admission paperwork at office yesterday. Mailing to the POA for signatures today." This was signed by Employee P, Receptionist. C. A review of clinical record #19 evidenced a plan of care with a start of care of 9/13/17 and certification period of 9/13/17 - 11/11/17. 2. A review of a document presented on 9/15/17 evidenced a document titled "General Durable Power of Attorney" stated, "Know all men by these presents that I, [patient #19] ... constituted and appointed, and by these presents do appoint [POAs and family members of patient #19] as my true and lawful co - attorneys." 3. During a home visit observation on 9/14/17 at 3:20 PM, Employee S,		Record of receipt (sent email confirmation or faxed receipt) will be captured and filed. Staff will be educated on communicating with POA and process to provide the admission paperwork including the State HHA Hotline number as well as advance directives and how to record in the patient EMR chart. The Clinical Manager will review/audit all new SOC with POA documentation for compliance of item A & B. Audits to be completed with 100% of new admissions 10/16/17 for 3 months and then 10% quarterly. Administrator Clinical Manager (DON) are responsible.	

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	occupational therapist, was observed to complete an occupational therapist evaluation with patient #19. The patient's home folder was observed to be in the medical records / director of nursing's office area of the assisted living where the patient resides. 4. During an interview on 9/15/17 at 11:55 AM, the administrator indicated the rights were explained to the power of attorney verbally. The power of attorney had not received the written rights yet. 5. During a phone interview on 9/15/17 at 2:20 PM, the POA / family member of patient #19 indicated not being given any written documentation about the patient rights at this time or being informed of the Indiana Department of Health Complaint hotline number. This person indicated the agency had called and discussed the services / costs with him / her but no written information had been received. 6. The undated admission folder titled "Patient Information Booklet" included the following section: "Patient Rights and Responsibilities." This document stated, "The patient has the following rights ... 2. The HHA [home health agency] must provide the patient with a written notice of the patient's rights in			

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	advance of furnishing care to the patient or during the initial evaluation visit before the initiation of care to the patient or during the initial evaluation visit before the initiation of treatment. 3. The HHA must maintain documentation showing that it has complied with the requirements of this section. 4. The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights as permitted by law or when the patient has been judged incompetent ... When the agency accepts the patient for treatment or care, teh HHA must advise the patient in writing of the telephone number of the home health hotline established by the Indiana State Deparmtent of Health [ISDH], the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The paitnet also has the right to use this hotline to place a complaint with the ISDH regarding treatment or care furnished by the HHA or to lodge complaints concerning the implementation of the advance directives requirements. The ISDH toll free hotline number is 1 - 800-227-6334 Monday through Friday 8:15 AM - 4:45 PM. The answering machine is available for after hours and weekend calls."			

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	7. The undated agency policy titled "Advance Directive Policy C- 430" stated, "Agency recognizes the importance of clients particiapting in planning their care and of their rights to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."			
N 0518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on home visit observation, record review and interview, the agency failed to ensure patients had been provided with the most current description of Indiana state law regarding advance directives in 1 (# 19) of 8 records reviewed. The findings include: 1. A review of Clinical record #19 failed to evidence the most current version of	N 0518	The agency will immediately ensure the patient has written information in advance concerning advance directives prior to care furnished by the home health agency. When it has been determined that a patient has a POA who will be completing the admission paperwork, the POA will be contacted via phone for verbal consent for admission of the patient and to obtain an email or fax number in order to send POA the admission paperwork,	10/20/2017

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	the description of Indiana state law regarding advance directives, "Your Right To Decide", dated July 2013, had been provided to the patients at the start of care. This review occurred on 9/15/17. This lack of the family member / power of attorney receiving a copy of the copy of the Indiana advance directive is evidenced by the following: 2. A review of the undated admission handbook titled "Back Home Again Inc Home Health Care Services ... Patient Orientation & Information" included the Indiana State Department of Health Advance Directives Your Right to Decide Revised July 1, 2013. A review of the undated section titled "Patient Rights and Responsibilities" included in the admission handbook stated, "The HHA [home health agency] must provide the patent with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. 3. The HHA must maintain documentation showing that it has complied with the requirements of this section ... The patient has the rights to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient rights as permitted by law or when the patient		including the agency policies on advance directives, and a description of applicable State Law (July 2013), prior to the clinician seeing the patient. All communication to be documented in the patient chart with regards to the steps taken to notify the POA. Record of receipt (sent email confirmation or faxed receipt) will be captured and filed. Staff will be educated on communicating with POA and process to provide the admission paperwork including the advance directives and how to record in the patient EMR chart. The Clinical Manager will review/audit all new SOC with POA documentation for compliance of item A & B. Audits to be completed with 100% of new admissions 10/16/17 for 3 months and then 10% quarterly. Administrator Clinical Manager (DON) are responsible.	

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	has been judged incompetent ... The HHA must inform and distribute written information, in advance, concerning its policies on advance directives, including a description of applicable State law." 3. A further review of clinical record #19 evidenced the following: A. A review of a clinical record document titled "Patient Communication" dated 9/13/17 and signed by Employee N, RN, stated, "Set up admission visit with [patient #19's power of attorney]. [Patient #19's power of attorney] unable to be present for admission as [he / she] is at work. [He / she] gave nurse writer verbal consent to complete admission visit. All admission paperwork will need to be sent to [him / her] for signatures." B. A review of a clinical record document titled "Patient Communication" dated 9/15/17 stated, "Received admission paperwork at office yesterday. Mailing to the POA for signatures today." This was signed by Employee P, Receptionist. C. A review of clinical record #19 evidenced a plan of care with a start of care of 9/13/17 and certification period of 9/13/17 - 11/11/17.			

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	4. A review of a document presented on 9/15/17 evidenced a document titled "General Durable Power of Attorney" stated, "Know all men by these presents that I, [patient #19] ... constituted and appointed, and by these presents do appoint [POAs and family members of patient #19] as my true and lawful co - attorneys." 5. During a home visit observation on 9/14/17 at 3:20 PM, Employee S, occupational therapist, was observed to complete an occupational therapist evaluation with patient #19. The patient's home folder was observed to be in the medical records / director of nursing's office area of the assisted living where the patient resides. 6. During an interview on 9/15/17 at 11:55 AM, the administrator indicated the rights were explained to the power of attorney verbally. The power of attorney had not received the written rights yet. 7. During a phone interview on 9/15/17 at 2:20 PM, the POA / family member of patient #19 indicated not being given any written documentation about the patient rights at this time or being informed of the Indiana Department of Health Complaint hotline number. This person			

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	indicated the agency had called and discussed the services / costs with him / her but no written information had been received. 8. The undated agency policy titled "Section C380 - Home Care Bill of Rights" stated "Policy - Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose - To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding their care. To protect and promote the exercise of clients' rights. To establish, operate, and maintain a grievance/complaint mechanism for use by the client/representative, which assures response and disposition and is in operation at a minimum during normal business hours. Special Instructions - 1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason			

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	the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented."			
N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on record review and interview the agency failed to meet the patient's needs in the patient's residence in 2 out of 8 patient charts reviewed. (#14, #18) The findings include: 1. The undated agency policy titled "C-120 Admission Policy" stated "Policy Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Agency in the client's place of residence. ... Purpose To provide guidelines for accepting clients for home health care services to be provided in the client's place of residence that are clear to the home care staff, the medical and lay community, and that abide by state/federal guidelines. Special Instructions Criteria for Client Admission: ... 4. There must be a reasonable expectation that the client's medical, nursing, social or rehabilitation needs can be adequately met in the client's home. 5. Reasonable expectation shall consider: ... c. The	N 0520	The agency will only accept patients when the patients' health needs can be adequately met by the home health agency in the patients place of residence. If the established plan of care is ineffective and not met within the agencies parameters a referral will be made to an alternate provider. All staff to receive reeducation on meeting the patients' health needs when experiencing shortness of breath. All agency staff to receive education on dyspnea for clinical evaluation during patient visits and documentation of all measures taken to ensure patients safety while performing the visit. The DON/Clinical Supervisor will receive acknowledgement of completed Dyspnea inservice from each clinical staff. The	10/27/2017

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	157562	A. BUILDING 00 B. WING	09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BACK HOME AGAIN	291 N STATE RD 2 VALPARAISO, IN 46383

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	benefits of care at home as compared to care in a hospital, extended care facility or alternate setting. ... 6. There is indication that the delivery, monitoring and coordination of home health care services will enable the client to remain within the home environment. ... 10. Agency services must be appropriate and available to meet the specific needs and requests of the client and caregiver." 2. The undated agency policy titled "C-140 Client Admission Process" stated "Policy ... Services will not be initiated until an initial assessment has been completed and identified client needs can be met by the agency. The agency determines that client needs can be met by the agency. Purpose ... To determine whether the client's health care needs for services are appropriate by evaluating the client's physical, psychological, social, spiritual, and cultural status. ... Special Instructions ... d. The client's needs can safely and adequately be met at home. This includes the ongoing availability of personnel and equipment and a plan to meet medical emergencies. ... f. The Agency is capable of providing the needed care or service at the level of intensity the client's condition requires. ... j. The services and care must conform with current professional standards of practice for the respective discipline and should be reasonable and necessary to the treatment of a medical doctor. ... 10. The admission professional will: ... e. Assess and document the client's vulnerability status and risk of hospitalization. Identify specific safety measures relating to the vulnerability area. Safety measures will be documented in the record and on the care plan as applicable. f. Review the plan for services, treatment, and care with the client/caregiver and obtain input when possible. Inform the client/caregiver of any reasonable risk		DON/Clinical Supervisor will include audit of item A in 100% of patient records beginning 10/16/17 for one month then 10% quarterly. Administrator and Clinical Supervisor (DON) are responsible.	

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	and/or alternative associated with any procedure provided in the home...." 3. Review of clinical record #14 on 9/14/17 evidenced a document titled "Physician Order For Start-Of-Care" dated 8/3/17 and signed by the physician on 8/10/17, that stated "...Agency to have Registered Nurse or Licensed Therapist perform assessment and evaluation of the client for admission to home health services...." The majority of services were performed in a therapy gym located on the first floor of the building. 4. Review of clinical record #14 on 9/14/17, start of care 8/7/17, evidenced a document titled "F2F [face to face] Encounter" This document was signed by physician C and dated 9/1/17. The document stated "... Medical Condition The encounter with the patient was directly related to the following medical condition, which is the primary reason for home health care: Hx [history] Falls with injury Clinical Findings In Support of Patient's Eligibility Provide a summary of clinical findings that support the patient's eligibility for home health services, including specific need for intermittent skilled nursing and/or therapy services. The Face-to-Face visit findings must be related to the primary reason for home health admission. Due to history of falls with injury ... physical therapy is recommended to increase strength and decrease gait instability. Statement of Homebound Status I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this patient is confined to the home (i.e., there exists a normal inability to leave home and leaving home requires considerable and taxing effort and is medically contraindicated or requires the assistance of supportive devices, supportive transportation, or another person) due to: Considerable effort for patient to leave home due			

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	157562	A. BUILDING 00 B. WING	09/15/2017

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	to history of falls, unsteady gait, leaving home is a taxing effort...." 5. The agency failed to meet the needs of patient #14, start of care 8/7/17, in his/her place of residence was evidenced as follows: a. During record review on 9/14/17 a document was evidenced titled "PT [physical therapy] Evaluation" dated 8/7/17 and digitally signed by employee T. The document had an area subtitled "Homebound?" with "Yes" check marked, other areas check marked were "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", and "Severe SOB [shortness of breath] or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt [patient] had to take several rest breaks due to LE [lower extremity] fatigue to walk from room down to therapy gym and dining hall." b. Record review on 9/14/17 a document was evidenced titled "PT Visit" dated 8/14/17 and digitally signed by employee T. The document had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", "Severe SOB or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt had to take several rest breaks due to LE fatigue to walk from room down to therapy gym and dining hall." c. Record review on 9/14/17 a document was evidenced titled "PT Visit" dated 8/16/17 and digitally signed by employee T. The document had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness",			

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	"Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", "Severe SOB or SOB upon exertion". Review of this document evidenced an area subtitled "Gait Training" with an area that stated "Impact of Intervention(s) on Functional Performance/Patient Response to Treatment: Pt walks with wide BOS [base of support] and moves slowly due to fear of falling. Pt's endurance better today, requiring no rest breaks to walk from room to therapy gym and back to his room..." d. Record review on 9/14/17 a document was evidenced titled "PT Visit" dated 8/23/17 and digitally signed by employee A. The document had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", "Severe SOB or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt had to take several rest breaks due to LE fatigue to walk from room down to therapy gym and dining hall." 6. During record review of clinical record #14 on 9/14/17 a document was evidenced titled "OASIS-C2 Start of Care" dated 8/7/17 and digitally signed by employee B, RN [registered nurse]. This document had an area subtitled "(M1400) When is the patient dyspneic or noticeably Short of Breath?" which had an area marked that stated "1 - When walking more than 20 feet, climbing stairs". 7. During an interview on 9/15/17 at 10:10 a.m. the administrator (employee M) and clinical supervisor (employee G) indicated that the therapy gym was in the building, and that this was his/her home.			

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	8. The agency failed to meet the needs of patient #18, start of care 7/13/17, in his/her place of residence was evidenced as follows: a. Record review on 9/14/17 evidenced a document titled "PT visit" dated 8/7/17 and digitally signed by employee T. The document had an area subtitled "Homebound?" with "Yes" check marked, along with "Residual Weakness", "Requires max assistance/taxing effort to leave home", "Unable to safely leave home unattended", and Severe SOB or SOB upon exertion". This subtitled area also had a section "Other:" with a statement that read "Pt becomes SOB easily, requiring frequent rest breaks to walk down to therapy gym."			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview the skilled nurse failed to follow the plan of care established by the physician in 3 of 8 clinical records reviewed. (#13, #14, #16) The findings include: 1. The undated agency policy titled "C-580 Plan Of Care" stated "Policy Home care services are furnished under the supervision and direction of the	N 0522	Patient care will follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Home health aide care plans completed by the designating clinician will schedule the frequency in the patients visit schedule to ensure all visits are attempted to be completed as ordered. The plan of care will be followed as ordered and completely documented in all clinical notes.	10/27/2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/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 client 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 reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. 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 client 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. b. Mental status. c. Type, frequency, and duration of all visits/services. d. Specific procedures and modalities for therapy services. e. Diagnostic tests, including laboratory and x-rays. f. Surgical procedure(s). g. Prognosis. h. Rehabilitation potential. i. Functional		Admitting clinicians to receive reeducation on content of plan of care including the frequency that each intervention is to be completed. When no frequency is indicated it is to be completed each visit until the discipline is discharged. All field staff will receive education on visit frequency and appropriate as well as complete documentation of missed visits. Documentation to include attempts made to reschedule the visit with the patient. Signature logs of patient visits to be uploaded regularly to patient EMR chart to validate visits completed. The DON/Clinical Supervisor will reeducate current staff on A, B & C as well as include A, B & C in new employee orientation. Clinical Staff that had received previous education on POC will be counselled and documentation retained in HR chart. DON/Clinical Supervisor will include audit of item A in 100% of patient records beginning 10/16/17 for one month then 10% quarterly. Administrator and Clinical Supervisor (DON) are responsible.	

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	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. o. Instructions to client/caregiver, as applicable. p. Treatment goals. q. Instructions for timely discharge or referral. r. Discharge plans. s. Name and address of client's physician. t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care...." 2. Review of clinical record #13 on 9/14/17 evidenced an agency document titled "Home Health Certification and Plan Of Care" for certification period 08/07/17 - 10/5/17 signed and dated 7/26/17 by physician. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following incomplete physician orders: a. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct the patient caregiver on measures to recognize cardiac dysfunction and relieve complications, SN to instruct the			

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	157562	A. BUILDING 00 B. WING	09/15/2017

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	patient/caregiver on signs/symptoms of UTI to report to MD/SN, SN to instruct patient on turning/repositioning every 2 hours, SN to instruct patient to increase activity to alleviate constipation, SN to assess patient for diet compliance, and SN to assess patient's compliance with home exercise program. b. The skilled nurse visit note dated 08/9/17 failed to ensure the patient was instructed on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning. c. The skilled nurse visit note dated 7/27/17 and 8/9/17 failed to ensure the patient was instructed on wound care. d. The skilled nurse visit note dated 8/9/17 failed to ensure the patient was instructed on proper use of nebulizer/inhaler, and assess return demonstration. 3. Review of clinical record #14 on 9/14/17 evidenced an agency document titled "Home Health Certification and Plan Of Care" for certification period 07/24/17 - 9/21/17 signed and dated 8/17/17 by physician C. Review of this document evidenced skilled nurse visits			

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	had not followed the plan of care. This is evidenced by the following incomplete physician orders: a. During record review on 9/14/17 the document titled "Home Health Certification and Plan of Care" had an area subtitled "21. Order for Discipline and Treatments (Specify Amount/Frequency/Duration) SN [skilled nurse]: 1W9 [once weekly for 9 weeks..."]. Review of the clinical record evidenced the following missed skilled nurse visits: 8/25/17, 8/30/17, 9/7/17. These visits failed to be rescheduled with the client for a different time and/or day. The skilled nurse failed to follow the physician ordered plan of care. During an interview on 9/15/17 at 10:10 a.m. the clinical supervisor indicated that the skilled nurse could have rescheduled the visit and that he/she would like to see more documentation on the skilled nurse missed visit notes. During an interview on 9/13/17 at 12:00 p.m. patient #14 indicated his/her first skilled nurse visit was on 9/11/17. b. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct Patient/Caregiver that patient should elevate feet when sitting, SN to			

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	instruct the Patient/Caregiver on methods to promote oral intake, SN to instruct patient to change positions slowly, SN to instruct the Patient/Caregiver to remove clutter from patient's path such as clothes, books, shoes electrical cords, or other items that may cause patient to trip, SN to instruct the Patient/Caregiver on importance of adequate lighting in patient area, and SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. c. The skilled nurse visit note dated 08/16/17 failed to ensure the patient/caregiver was instructed on all aspects of diabetic management to include disease process, foot assessments, signs and symptoms of hypo/hyperglycemia, glucometer use and preparation and administration of diabetic medications ordered by the physician. d. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed to inspect patient's feet daily and report any skin or nail problems to the SN. e. The skilled nurse visit note dated 8/16/17 failed to ensure the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	patient/caregiver was instructed that patient should never walk barefoot. f. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed to protect patient's feet from extreme heat or cold. g. The skilled nurse visit note dated 8/16/17 failed to ensure the patient /caregiver was instructed to never try to cut off corns, calluses, or any other lesions from lower extremities. h. The skilled nurse visit note dated 8/16/17 failed to ensure the patient was instructed to wear proper footwear when ambulating. 4. Review of clinical record #16 on 9/14/17 evidenced an agency document titled "Home Health Certification and Plan Of Care" for certification period 08/31/17 - 10/29/17. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following uncompleted physician orders: a. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct patient on importance of			

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	157562	A. BUILDING 00 B. WING	09/15/2017

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	receiving influenza and pneumococcal vaccines, SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs, SN to instruct patient/caregiver on turning/repositioning every 2 hours, SN to instruct the patient/caregiver on methods to reduce friction and shear, SN to perform inspection of patient's lower extremities every visit and report any alteration in skin integrity to physician, SN to instruct patient on bladder training program, including timed voiding, SN to instruct the patient/caregiver on signs/symptoms of UTI [urinary tract infection] to report to MD/SN, SN to instruct the patient/caregiver on signs and symptoms of constipation to report to SN or physician, SN to instruct patient to wear proper footwear when ambulating, SN to instruct patient to change positions slowly, SN to instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility, and SN to instruct the patient/caregiver on medication side effects to report to SN or physician. b. The skilled nurse visit note dated 9/5/17 and 9/8/17 failed to ensure the patient/caregiver was instructed on			

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	inspecting patient's feet daily and to report any skin or nail problems to SN. c. The skilled nurse visit note dated 9/5/17 failed to ensure the patient was instructed on measures to detect and alleviate edema. d. The skilled nurse visit note dated 9/5/17 failed to ensure the patient was instructed to use prescribed assistive device when ambulating. 5. A review of clinical record #15 evidenced a Home Health Certification and Plan of Care with a start of care of 7/27/17 and a certification period of 7/27/17 - 9/24/17. The orders on this document included home health aide visits two times a week for 8 weeks effective 7/31/17. This clinical document was signed by the physician on 8/10/17. The review of the record evidenced a lack of a home health aide visit. The record evidenced a home health aide visit on 8/22/17 and no other home health aide visits the week of 8/20/17 - 8/26/17. During an interview on 9/15/17 at 2:30 PM, Employee Q, Registered Nurse, indicated a home health aide visit was lacking the week of 8/20/17 - 8/26/17.			
N 0524	410 IAC 17-13-1(a)(1)			

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BACK HOME AGAIN	291 N STATE RD 2 VALPARAISO, IN 46383

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Bldg. 00	Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview the skilled nurse failed to ensure all pertinent diagnoses were included on the plan of care for 1 of 8 patient records reviewed (#14). The findings include: 1. The undated agency policy titled "C-145 Comprehensive Client Assessment" stated "Policy A thorough, well-organized, comprehensive and accurate assessment, consistent with the	N 0524	The agency will immediately complete an accurate & comprehensive initial assessment of all patients admitted for a home health episode that includes appropriate elements of the History and Physical obtained to incorporate into the patients' initial assessment and plan of care. The medical plan of care shall be developed in consultation with all home health agency staff¿& the physician to¿include all services to be provided, cover all pertinent diagnosis, and include key elements specific to	10/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157562	A. BUILDING 00 B. WING	09/15/2017

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	client's immediate needs will be completed for all clients in a timely manner, but no later than five (5) calendar days after the start of care. All skilled Medicare and Medicaid clients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals, and the care treatment and services provided, but will be done at least once in every sixty (60) day period. Purpose To determine the appropriate care, treatment and services to meet client initial needs and his/her changing needs. To collect data about the client's health history, (physical, functional and psychological) and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individuals response to care. To increase clarity in measurement. To measure processes of care in the agency. To identify clients medical, nursing, rehabilitative, social and discharge planning needs. ... Special Instructions ... 3. In addition to general health status/system assessment, the		the patient.¿¿¿ A. The RN (B) that completed the assessment for this survey is no longer active with the agency. RN's that have been counselled and do not incorporate needed elements into the Oasis/POC will be counselled. The DON/Clinical Supervisor reviewing and approving the Oasis/POC will be counselled. B. The agency did contract with an external QA (associated with the new EMR system) to evaluate all components of the Oasis elements as well as the initial therapy evaluations to monitor for discrepancies and contraindications. The agency will review survey findings to ensure all appropriate H&P is incorporated in the Oasis/POC. C. Supporting clinical staff (PT/OT/ST) to receive education on patient H &P and incorporating elements into their POC as well as communicating with the team if discrepancies are noted. D. Employee B, RN, failed to¿clarify/incorporate orders for B12 injections for patient and document follow up for patient¿receiving monthly B12 injections.¿This employee is no longer active with the company. They did receive reeducation prior to leaving regarding POC. Employee U, RN, obtained orders for B12 and subsequently completed needed B12 injection.¿¿	

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	agency comprehensive assessment tool with OASIS will include: a. Clinical record items b. Demographics and client history c. Living arrangement. ... f. Supportive assistance. ... k. Depression screening l. Fall risk Assessments m. Neuro/emotional/behavioral status. ... Assessment Strategies Interview Interaction ... MD [medical doctor] or Facility information ... 11. Client needs are assessed and care guidelines established based on the assessment data ... 13. Reassessments are conducted based on client needs, physician orders, professional judgment and/or OASIS or other regulatory requirement. The physician will be notified of the assessment findings and collaborate on any changes made to the plan of care." 2. The skilled nurse failed to include patient #14's history and current alcohol abuse in the comprehensive assessment. Patient #14's alcohol history, current abuse and lack of inclusion in the skilled nurse comprehensive assessment is evidenced as follows: a. During review of clinical record #14 on 9/14/17 a document was evidenced from the office of physician C with a fax date listed at top of document as 7/26/17. An area on this document subtitled "Subjective" stated "... HPI		Agency staff to be reminded to have routine stock items (needles) available for patient visits.¿¿ DON/Clinical Supervisor to receive reeducation on POC content to ensure there are no oversight's on POC.¿¿¿ 2) DON/Clinical Supervisor will be counselled for Oasis/POC content by Administrators to ensure compliance for A, B, C & D. Internal QA to audit 100% of SOC/ROC/DC Oasis/POC for one month beginning 10/16/17 then 10% quarterly prior to locking and approving the Oasis/POC for submission to CMS. Errors identified to be reported to Administrator for further counselling/revision. Clinical staff that fail to identify pertinent diagnosis that caught by final QA will be counselled. Item E to be included in new nurse hire orientation. 3) The Administrator and Clinical Supervisor (DON) are responsible.	

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	[history of present illness] Comments: ... He/She does have a history of chronic depression. He/She has struggled with alcohol dependency. He/She reports He/She has been using some alcohol on a minimal basis...." b. Review of clinical record #14 on 9/14/17 evidenced a document titled "OASIS-C2 Start of Care" dated 8/7/17. An area on the document subtitled "Past Medical History (Mark all that apply)" failed to evidence "Substance Abuse (specify)" as being marked. Another area also on the same document subtitled "(M1036 Risk Factors, present or past, likely to affect current health status and/or outcome: (Mark all that apply)" failed to evidence "3 - Alcohol dependency" as being marked. No other documentation or comment was evidenced on the OASIS document in reference to patient's current or history of alcohol dependency. c. Review of clinical record #14 on 9/14/17 evidenced a document titled "Patient Communication" dated 8/14/17 that stated "... Description of fall: unobserved Pt [patient] states he/she fell Sunday morning. He/She was getting up to use the restroom when he/she felt himself/herself get dizzy and he/she lost all strength in his/her legs, causing			

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	himself/herself to fall to his/her R [right]. He/She hit his/her head on bed frame, and landed on R shoulder. He/She was on the ground for approximately 2 hours before he/she had enough strength to pull himself/herself back up to his/her bed. Pt states he/she has had these episodes every few months for the past couple of years. Nature of injury: Pt has an abrasion on the R side of his/her head from fall, increased pain in R shoulder after fall (from 1-2/10 to 3-4/10), and his/her L [left] ring finger is bruised but he/she has no pain and has full ROM [range of motion]. ... Post Incident Treatment: Pt did not seek treatment after fall, therapist was first one notified the next day after his/her fall. No apparent serious injury, pt already had dr [doctor] appt [appointment] scheduled for this Thursday 8/17." d. Review of clinical record #14 on 9/14/17 evidenced a document from the office of physician C with a date of 8/17/17 that stated "... Diagnoses ... History of alcohol abuse ... Subjective: ... Unfortunately, he/she has struggled with alcohol abuse. He/She started drinking again. He/She attributes his electrolyte abnormalities to his/her alcohol use. The anniversary of his/her husband's/wife's death was a few days ago. This triggered excessive alcohol			

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	use. ... He/She has participated in alcohol rehabilitation both inpatient and outpatient at [Place D]. He/She declines a referral today. Unfortunately, he/she fell 4 days ago (8/13) out of bed and admittedly was intoxicated. He/She bruised his/her right shoulder. He/She is having some increased pain and decreased range of motion of both shoulders that have been longstanding. He/She also has bruising of his/her left fourth finger. ... He/She reportedly has erosion of his/her esophagus related to his/her alcohol use ... Plan: ... 10. History of alcohol abuse Lengthy discussion today. He/She declines a referral to [Place D]. He/She was encouraged to attend AA [alcoholics anonymous] meetings and maintain abstinence. He/She is fortunate to have family support..." There was no other evidence in the skilled nurse, PT [physical therapy], OT [occupational therapy] or ST [speech therapy] notes that his/her current issues with alcohol abuse were addressed.. Based on observation, record review and interview, the agency failed to ensure the plan of care was complete for 1 of 8 records reviewed (# 17).			

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	The findings include: 1. A review of Clinical record #17, start of care 7/31/17, failed to evidence the Home Health Certification and Plan of Care for the certification period of 7/31/17 - 9/28/17 included a complete medication order for Vitamin B 12 with an order for the skilled nurse to administer the Vitamin B 12 injection. The plan of care failed to list the type of injection this was to be: an intramuscular injection. The patient expressed concerns about not receiving the Vitamin B 12 injections as ordered at a home visit observation (see below #4). Skilled nurse visit documents dated 8/7/17, 8/18/17, 8/24/17, 9/6/17 and a missed visit document completed by the RN on 8/18/17 and 8/31/17 failed to show documentation of Vitamin B 12 administered by the nurse or communication about the Vitamin B 12 injection. An OASIS start of care document dated 7/31/17 signed by Employee B, RN, evidenced the patient was alert and oriented. This is further evidenced by the following: A. A review of the OASIS C2 Start of Care for patient #17 dated 7/31/17 signed by Employee B, RN, stated, " SN [skilled nurse] for education on disease processes and monthly IM injections."			

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	The patient is alert and oriented. B. A review of the Home Health Certification and Plan of Care document evidenced a start of care on 7/31/17 and certification period for this plan of care 7/31/17 - 9/28/17. This document the patient's medications included Cyanocobalamin Injection 1000 mcg (micrograms) / ml (milliliter) 1 ml monthly - last injection 7/24/17. Cyanocobalamin is Vitamin B 12. The skilled nurse does not have an order to administer the injection. C. A review of an RN (Registered Nurse) Skilled Nursing Visit document dated 9/6/17 evidenced a visit completed by Employee U, RN, on this date. The nurse documented, "Patient states [he / she] is due for Vitamin B 12 injection. MD notified." Under the skilled intervention this nurse documented, "Patient states last Vitamin B 12 was 8/14/17." D. A review of a patient case conference signed by Employee U on 9/7/17 evidenced under a section titled "Problems needing interventions / Plans" this nurse's notes "DC [discharge] and B 12."			

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	E. A review of a physician's order evidenced the nurse was to administer cyanocobalamin 1000 mcg / ml 1 ml intramuscular week of 9/10/17. F. A review of a patient communication note dated 9/12/17 signed by Employee U stated, "SN [skilled nurse] attempted to perform visit for monthly Vitamin B 12 injection. Patient did not have syringe. SN will order syringe from pharmacy." G. A review of a skilled nurse visit with discharge summary 9/13/17 evidenced Employee U administered the Vitamin B 12 into the patient's left dorsogluteal (left buttock muscle area) or intramuscularly. 2. During an interview on 9/15/17 at 3:40 PM, the director of nursing indicated that this was a documentation delay and that there was a new order for the Vitamin B 12 to be given the week of 9/10/17. 3. The undated agency policy titled "Section C-580 Plan of Care" stated "Policy Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the			

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	client/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 client 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 reflect the client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. 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 client 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. b. Mental status. c. Type, frequency, and duration of all visits/services. d. Specific procedures and modalities for therapy services ...h. Rehabilitation potential. i. Functional limitations and precautions. j. Activities permitted or restrictions. k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures."			

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	4. During an interview on 9/13/17 at 2:40 PM, patient #17 stated that the nurse comes to apartment one time per month to administer B12 injection. Patient states that he / she has not received her shot for "5 or 6 weeks" because he / she doesn't have needles. Stated that the nurse is trying to get some needles.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, record review and interview, the Registered Nurse failed to re-evaluate a patient's nursing needs in relation to a unobserved fall with injury reported by a physical therapist in 1 of 8 records reviewed with Registered Nurse (patient #15 and Employee B, RN). The findings include: 1. A review of clinical record #15 failed to evidence the nurse reevaluated the patient's head abrasion after a reported fall was reported by the physical therapist	N 0541	1) The agency will immediately reevaluate the patients' nursing needs with assessments each visit. A. All RN's will receive reevaluating patient needs with each visit and complete a full assessment when indicated. The RN mentioned in this standard (B) is no longer active with this agency. B. All RN's will receive reeducation and training on case management, and coordination of care including documentation and communication. 2) The DON/Clinical Supervisor will continue to complete supervisory visits with field RN's	10/20/2017

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	on 8/15/17. This lack of a registered nurse re-evaluation is evidenced by the following: A. A review of a patient communication note signed by Employee T dated 8/15/17 stated, "Description of fall: unobserved. Pt [patient] reports falling out of bed Sunday night, hitting [his / her] head on the floor. [He / she] says [he/she] was sleeping and then woke up to [himself / herself] falling. Doesn't remember many other details. [He / she] was able to get up and back in bed right after fall." The physician was notified. B. A review of a skilled nurse visit document dated 8/16/17 time in 10:30 AM time out 11 AM evidenced the patient had buttock wounds with wound care treatment completed by the nurse. The nurse did not include any documentation about the head abrasion documented on the therapy communication note. C. A review of a skilled nurse visit document dated 8/16/17 time in of 11:01 AM time out 11:10 AM with a signature of Employee B, RN failed to include an assessment of the head abrasion or any documentation that the patient had experienced a fall.		quarterly to ensure complete appropriate assessments are completed on each visit. This will be ongoing. will be audited: 100% of all RN notes to be audited beginning 10/16/17 for one month and then 10% quarterly. RN's that fail to complete full assessments when indicated after receiving reeducation will be counselled. 3) The Administrator and Clinical Supervisor (DON) are responsible.	

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	D. During an interview on 9/13/17 at 3:15 PM, the director of nursing indicated that there is no documentation of a re - evaluation by the nurse. 2. The undated agency policy titled "C-200 - Skilled Nursing Services" stated " Policy Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders). In determining whether a service requires the skills of a Nurse, the inherent complexity of the service, condition of the client, and accepted standards of medical and nursing practice will be considered. Purpose To abide by state/federal guidelines and offer guidelines to the agency staff, physicians, and community for the appropriate utilization of professionally skilled nursing services. Special Instructions 1. The registered nurse: ... b. Regularly reevaluates the client needs, and coordinates the necessary services."			
N 0547 Bldg. 00	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician,			

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	chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview the skilled nurse failed to follow the plan of care established by the physician in 3 of 8 clinical records reviewed. (#13, #14, #16) The findings include: 1. The undated agency policy titled "C-580 Plan Of Care" stated "Policy Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/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 client 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 reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. To assure that the plan meets state/federal guidelines, and all applicable laws and	N 0547	Patient care will follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. The plan of care will be followed as ordered and completely documented in all clinical notes. Admitting clinicians to receive reeducation on content of plan of care including the frequency that each intervention is to be completed. When no frequency is indicated it is to be completed each visit until the discipline is discharged. All field staff will receive education on visit frequency and appropriate as well as complete documentation of missed visits. Documentation to include attempts made to reschedule the visit with the patient. Signature logs of patient visits to be uploaded regularly to patient EMR chart to validate visits completed. The DON/Clinical Supervisor will reeducate current staff on A & B as well as include A & B in new employee orientation. Clinical Staff that had received previous education on POC will be counselled and documentation retained in HR chart. DON/Clinical Supervisor will include audit of item A in 100% of patient records beginning 10/16/17 for one month then 10% quarterly.	10/27/2017

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	regulations. Special Instructions 1. An individualized Plan of Care signed by a physician shall be required for each client 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. b. Mental status. c. Type, frequency, and duration of all visits/services. d. Specific procedures and modalities for therapy services. e. Diagnostic tests, including laboratory and x-rays. f. Surgical procedure(s). g. Prognosis. h. Rehabilitation potential. 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. o. Instructions to client/caregiver, as applicable. p. Treatment goals. q. Instructions for timely discharge or referral. r. Discharge plans. s. Name and address of client's physician. t. Other appropriate items. u. All of the above items must always be addressed on the Plan of Care...." 2. Review of clinical record #13 on 9/14/17 evidenced an agency document titled "Home Health Certification and		Administrator and Clinical Supervisor (DON) are responsible.	

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	157562	A. BUILDING 00 B. WING	09/15/2017

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	Plan Of Care" for certification period 08/07/17 - 10/5/17 signed and dated 7/26/17 by physician. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following incomplete physician orders: a. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct the patient caregiver on measures to recognize cardiac dysfunction and relieve complications, SN to instruct the patient/caregiver on signs/symptoms of UTI to report to MD/SN, SN to instruct patient on turning/repositioning every 2 hours, SN to instruct patient to increase activity to alleviate constipation, SN to assess patient for diet compliance, and SN to assess patient's compliance with home exercise program. b. The skilled nurse visit note dated 08/9/17 failed to ensure the patient was instructed on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning. c. The skilled nurse visit note dated 7/27/17 and 8/9/17 failed to ensure the patient was instructed on wound care.			

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d. The skilled nurse visit note dated 8/9/17 failed to ensure the patient was instructed on proper use of nebulizer/inhaler, and assess return demonstration.

3. Review of clinical record #14 on 9/14/17 evidenced an agency document titled "Home Health Certification and Plan Of Care" for certification period 07/24/17 - 9/21/17 signed and dated 8/17/17 by physician C. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following incomplete physician orders:

a. During record review on 9/14/17 the document titled "Home Health Certification and Plan of Care" had an area subtitled "21. Order for Discipline and Treatments (Specify Amount/Frequency/Duration) SN [skilled nurse]: 1W9 [once weekly for 9 weeks..."]. Review of the clinical record evidenced the following missed skilled nurse visits: 8/25/17, 8/30/17, 9/7/17. These visits failed to be rescheduled with the client for a different time and/or day. The skilled nurse failed to follow the physician ordered plan of care. During an interview on 9/15/17 at 10:10 a.m. the

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	clinical supervisor indicated that the skilled nurse could have rescheduled the visit and that he/she would like to see more documentation on the skilled nurse missed visit notes. During an interview on 9/13/17 at 12:00 p.m. patient #14 indicated his/her first skilled nurse visit was on 9/11/17. b. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct Patient/Caregiver that patient should elevate feet when sitting, SN to instruct the Patient/Caregiver on methods to promote oral intake, SN to instruct patient to change positions slowly, SN to instruct the Patient/Caregiver to remove clutter from patient's path such as clothes, books, shoes electrical cords, or other items that may cause patient to trip, SN to instruct the Patient/Caregiver on importance of adequate lighting in patient area, and SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. c. The skilled nurse visit note dated 08/16/17 failed to ensure the patient/caregiver was instructed on all			

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	aspects of diabetic management to include disease process, foot assessments, signs and symptoms of hypo/hyperglycemia, glucometer use and preparation and administration of diabetic medications ordered by the physician. d. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed to inspect patient's feet daily and report any skin or nail problems to the SN. e. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed that patient should never walk barefoot. f. The skilled nurse visit note dated 8/16/17 failed to ensure the patient/caregiver was instructed to protect patient's feet from extreme heat or cold. g. The skilled nurse visit note dated 8/16/17 failed to ensure the patient /caregiver was instructed to never try to cut off corns, calluses, or any other lesions from lower extremities. h. The skilled nurse visit note dated 8/16/17 failed to ensure the patient was instructed to wear proper footwear when ambulating.			

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	4. Review of clinical record #16 on 9/14/17 evidenced an agency document titled "Home Health Certification and Plan Of Care" for certification period 08/31/17 - 10/29/17. Review of this document evidenced skilled nurse visits had not followed the plan of care. This is evidenced by the following uncompleted physician orders: a. All the SN visit notes in this certification period failed to ensure the following physician orders were completed. The orders include: SN to instruct patient on importance of receiving influenza and pneumococcal vaccines, SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs, SN to instruct patient/caregiver on turning/repositioning every 2 hours, SN to instruct the patient/caregiver on methods to reduce friction and shear, SN to perform inspection of patient's lower extremities every visit and report any alteration in skin integrity to physician, SN to instruct patient on bladder training program, including timed voiding, SN to instruct the patient/caregiver on signs/symptoms of UTI [urinary tract infection] to report to MD/SN, SN to instruct the patient/caregiver on signs and symptoms of constipation to report to SN			

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	or physician, SN to instruct patient to wear proper footwear when ambulating, SN to instruct patient to change positions slowly, SN to instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility, and SN to instruct the patient/caregiver on medication side effects to report to SN or physician. b. The skilled nurse visit note dated 9/5/17 and 9/8/17 failed to ensure the patient/caregiver was instructed on inspecting patient's feet daily and to report any skin or nail problems to SN. c. The skilled nurse visit note dated 9/5/17 failed to ensure the patient was instructed on measures to detect and alleviate edema. d. The skilled nurse visit note dated 9/5/17 failed to ensure the patient was instructed to use prescribed assistive device when ambulating.			