STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K070	A. BUILDING 00 B. WING	06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TMG HOME HEALTH CARE INC	108 N MAIN STREET STE 305 SOUTH BEND, IN 46601

(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
G000000	This visit was a Home Health federal recertification survey. This was a partially extended survey. Survey Dates: June 12, 13, 16, and 17, 2014 Facility Number: 011556 Medicaid Number: 201022100 Surveyor: Tonya Tucker, RN, PHNS Total Census (unduplicated last 12 months) = 24 Quality Review: Joyce Elder, MSN, BSN, RN June 19, 2014	G000000		
G000158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on policy review, clinical record and document review, and interview, the agency failed to ensure home health aide	G000158	G-0158: Finding # 1: Correction: 06/20/2014; A. Immediately following the exit of the surveyor on 06/20/2014 all	06/24/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	visits were made in accordance with the plan of care in 2 of 10 records reviewed creating the potential to affect all patients of the agency that receive home health aide services. (#1 and #6) Findings include: 1. The agency policy with a revision date of 5/15/14 titled "Subject: Cancellation; Missed visits; late or changed visit times" states, "Policy: When a client/CG [caregiver] calls and cancels a visit, the employee who received the call must complete the visit cancellation form. Missed visits by staff members are to be made up as soon as possible unless the client refuses service at a later time/day/date. ... ." 2. Clinical record #1, start of care 4/18/15, contained a physicians plan of care for certification period 4/18 to 6/16/14 which states, "HH [home health] AIDE visits 3hr [hour] visits 3w8 [3 times per week for 8 weeks]; 1w1 [1 time per week for 1 week] starting wk [week] of 4/20/14 ... ON HOLD TILL PA [prior authorization] APPROVED ... ." A. The record evidenced a document dated 5/19/14 titled "Prior Authorization Inquiry" stating, "Status Approved ... Start Date 05/05/2014 ... ." The record		home health Aides were notified via phone that a mandatory in-service will be held Saturday 06/21/2014 at 3:00 PM and Sunday 06/22/2014 @ 3:00 PM and they must attend one. Aides agreed by signature when picking up their check on Friday 06/20/2014. Anyone who failed to meet this requirement received proper disciplinary action. Agency policy was also revised to reflect this change. B. Administrator, Alternate Administrator, or her designee will educate all staff members on missed visits, cancelled visits, calling the office when a client cancels or if they have missed a scheduled visit, and completing the proper form for a missed/cancelled visit. Administrator advised staff to follow the policy that was instituted on 06/20/2014.C. If/when staff member calls off work, the Office Manager or her designee receiving the call will contact additional staff via phone for a replacement to prevent missed visits and provide patient care as ordered by the physician's ordered POC. If no staff is available to pick up an additional client or the client/CG wishes to cancel, the newly implemented form "Missed/Cancelled visit form" will be completed at that time and must be faxed to the PCP for documentation and notification of change in service.	

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	evidenced a home health aide visit was conducted on 5/2/14 and 5/6/14 and not again until 5/30/14. B. On 6/17/14 at 11:18 AM, employee A (administrator/director of nursing) indicated agency staff inquired about approval for payment of home health aide services on 5/19/14 at which time they realized it had been approved to start on 5/5/14. The employee indicated there a home health aide visit made on 5/6/14 and not again until 5/30/14. 3. Clinical record #6, start of care 4/25/14, contained a physicians plan of care for certification period 4/25 to 6/23/14 which states, "HH AIDE 3hr visits 3w8; 1w1; starting wk of 4/27/14 ... ON HOLD TILL PA APPROVED ... ." A. The record evidenced a physician's verbal order received by employee A dated 4/30/14 which states, "Proposed dates of service 5/12/14 - 11/8/14 ... ." B. The record evidenced a document dated 5/28/14 stating, "Status Approved ... Start Date 5/12/14 ... ." The record evidenced the first home health aide visit was conducted on 6/3/14. C. On 6/13/14 at 11:28 AM,		D. In-service also provided education on reading and following the POC. Each POC must indicate services provided type of service, length, frequency, and duration of services. All required information will be available on the POC-485/487 and will be accessible in the client's medical file/chart. Chart Audits to be completed on 10% of all charts monthly by Administrator or her designee to monitor corrective actions are being completed and deficiency does not recur. G-0158: Finding #2 and #3:Correction: 06/20/2014 A. The Primary Nurse caring for the clients in Clinical Record #1 and #6, was notified on 06/20/2014 that they did not want and could not receive services on Monday, Wednesday, and Friday due to physical Therapy appointments for clinical record # 1.. TMG had already scheduled services to be provided on M-W-F having staff availability for these days. This presented TMG with staffing difficulties when the client requested a change in days, all staff was assigned according to client needs. Additional staff will be hired to prevent this from recurring.B. Administrator educated all Office Personnel on missed visits, cancelled visits, and completing the proper form. All staff was advised to review/follow the new instituted policy. Educated office	

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	employee A indicated agency staff inquired about approval for payment of home health aide services on 5/28/14. The employee indicated the payment authorization was approved to start on 5/12/14 but the first home health aide visit was not conducted until 6/3/14.		staff on contacting additional staff via phone call for placement to prevent missed visits and provide patient care as ordered by physician/POC. A copy of policy was distributed to staff members.C. When obtaining Prior Authorization for services Administrator or her designee will check the status every Monday and Thursday and/or on any additional day. This is to prevent missed visits due to Medicaid authorizing visits prior to the date TMG received authorization. All Inquiries will be printed at the time was checked and filed in the chart. This is to provide documentation of the inquiry; Approved, Denied, Suspended, in Review. A New Policy will be written by 06/27/2014 to correct this and prevent the deficiency from recurring. Administrator or designee will audit 10 % of all charts monthly to monitor	
G000159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on agency policy review, clinical record review, and interview, the agency	G000159	G- 159 FINDING The SOC date for clinical record #5,	06/24/2014

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	failed to ensure the plan of care included accurate information in 1 of 10 clinical records reviewed. (#5) Findings include: 1. The undated agency policy titled "Clinical records/medical record retention" states, "POLICY A clinical record will be maintained for every client receiving home health services. ... Clinical records are legal documents containing accurate, and organized information ... PURPOSE To maintain an accurate record of the services provided by the agency for each client. ... ." 2. Clinical record #5 evidenced a document signed by the registered nurse, dated 5/6/11, and titled "Adult Nursing Assessment" which states, "REASON FOR ASSESSMENT: Start of Care ... ." A. The record evidenced a home health certification and plan of care for certification period 3/20 to 5/18/14 that states, "Start of Care Date 03/20/2014." B. On 6/12/14 at 1:25 PM, employee A (administrator / director of nursing) indicated the patient was admitted to the agency on May 6, 2011, with home health aide services only. The employee		was changed to the date the patient was admitted into skilled services. Starting skilled services requires the OASIS Assessment to be entered into HAVEN. A new SOC date was indicated on the POC/485 along with a new certification period. Correction: On 06/20/2014 the Administrator Deleted the HAVEN ASSESSMENT on the SOC and Re-certification OASIS ASSESSMENTS for clinical record #5. This was completed to correct the deficiency (G-159) and to change the SOC date back to original date that NON-SKILLED services started (05/06/2011) Upon Re-entering the admission assessment into HAVEN, the system would not allow the assessment to be entered on the date (05/06/2011), not even with accepting the warning then continuing. When attempting to "complete" the assessment and export it, HAVEN will not allow this to occur. The Administrator called HAVEN for assistance in this, it was determined that entering the original SOC date of 05/06/2011 was impossible. It does not accept dates from an extended time frame. Example SOC entered 05/06/2011 and the initial assessment date 03/20/2014. Rich, the assistant from HAVEN, then placed a three way call to Joyce Elder,MSN,BSN,RN, QUALITY REVIEW. After determining that OASIS-C, entry for HAVEN had a changed in March 2014, Again, this	

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	indicated skilled nursing services were ordered in March, 2014 and was under the impression the start of care date needed to be changed to the date the new service was added.		will not allow the original SOC date to be used. Joyce Elder,MSN,BSN,RN stated this will be addressed with Kelley,BSN,RN PHNSS-Program Director ISDH/Acute Care Division. OASIS re-entered with new SOC date. The Administrator will follow up on this discrepancy with Joyce Elder,MSN,BSN,RN and Kelley,BSN,RN PHNSS-Program Director ISDH/Acute Care Division one week after this plan of correction is submitted. A new policy to be instituted when a decision on this matter has been approved.	
G000224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on agency policy review, clinical record review, and interview, the agency failed to ensure the home health aide plan of care was updated at least every 60 days as required by agency policy in 1 of 8 clinical records reviewed of patients receiving home health aide services with the potential to affect all patients receiving home health aide services. (#7) Findings include:	G000224	G-224 Correction: On 06/20/2014 The Administrator has instructed the Registered Nurses verbally on following/reviewing P&P.. The Administrator instructed Nursing staff on updating the Aide Care Plan at least every 60 days and as needed. Registered Nurses were given a copy of (42 CFR 484.36 - Condition of participation) (ASSIGNMENT & DUTIES OF HOME HEALTH AIDE). The Administrator has a checklist for the nurse to	06/20/2014

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	1. The policy with a revision date of January 20, 2014, titled "Medical Plan of Care" states, "The total medical plan of care shall be reviewed by the attending physician ... and home health agency personnel as often as the severity of the patient's condition requires, but at least once every sixty (60) days. ... ." 2. Clinical record #7, start of care 1/14/14, contained a physician's plan of care for certification period 5/14 to 7/12/14. The record evidenced an aide care plan with the last review/update by the registered nurse as 2/14/14. 3. On 6/13/14 at 11:55 AM, employee A (administrator/director of nursing) indicated the aide care plan should have been reviewed by the registered nurse in April, 2014.		complete for an admission, recertification, and resumption and nurses are to utilize this form. This will assist in providing assurance the required information/duties have been completed. The Administrator will audit 10% of incoming forms monthly to monitor if corrective actions are being completed and to prevent deficiency from recurring. During the home health Aide staff meeting held on 06/21/2014 and 06/22/2014, all staff members were instructed to call the Primary Nurse when a change/update is needed for a client. If unable to contact the Primary Nurse call the office and report to the Administrator or her designee. Administrator or designee is to complete chart audits on 10% of all charts monthly to monitor if corrective actions are being completed and to prevent deficiency from recurring.	
G000225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on policy review, clinical record review, and interview, the agency failed to ensure the home health aide provided services that were ordered by the	G000225	G-225: Correction: 06/20/2014; A. Immediately following the exit of the surveyor on 06/20/2014 all home health Aides were notified via phone call, a mandatory staff meeting will beheld Saturday 06/21/2014 at 3:00 PM and	06/21/2014

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	physician in the plan of care in 2 of 8 patient records reviewed of patients receiving home health aide services creating the potential to affect all patients receiving home health aide services. (#1 and #6) Findings include: 1. The agency policy titled "Home Health Aide Documentation" with a revision date as 5/15/14 states, "Policy: Home Health Aides are to document care/services provided on the visit record and be in concurrence with the Care Plan. Purpose: 1. Provides documentation of care/services provided during the home health aide visit. 2. Provides documentation of the home health aide's observations during the visit and evidence of client's progress or demise. ... ." 2. Clinical record #1, start of care 4/18/14, included a plan of care established by the physician for certification period 4/18 to 6/16/14 with orders for home health aide services and states, "for personal care to assist with shower or bed bath; hair care; shampoo; skin care; foot care; check pressure areas and notify nurse regarding problem skin area. Assist with medication reminders; assist with mobility; perform PROM		Sunday 06/22/2014 @ 3:00 PM they must attend one. Aides agreed by signature when picking up their check on 06/20/2014. Anyone who failed to meet this requirement received proper disciplinary action. G-225 B. During the In-service on 06/21/2014 and 06/22/2014, staff members were re-educated on following the POC per physician orders and following Agency policy. All staff instructed on care provided must be concurrent with the Care Plan and staff is to monitor for changes every visit, the RN may update at any time and they are responsible for following this POC. Staff also in-serviced on correct visit note to complete,time, date, client signature, and staff credentials must all be completed before turning in. All visit notes to be turned in on Friday of current week,visit note is a legal document and per policy must be filed in the chart within 14 days of the visit. Administrator or designee is to audit 10% of all charts monthly to monitor if corrective actions are being completed and to prevent deficiency from recurring.	

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	[passive range of motion] to BLE [bilateral lower extremities]. Assist with nutrition, light housekeeping in patient bedroom; bathroom; kitchen; living room; change bed linen. ... ." A. The record evidenced an aide visit dated 6/3/14 with task of "light housekeeping / bedroom / bathroom / kitchen / changed bed linen" being the only task completed at the visit. B. On 6/12/14 at 2:25 PM, employee A (administrator / director of nursing) indicated the home health aides are educated on following the care plan and proper documentation and was not aware the tasks ordered were not completed at this visit. 3. Clinical record #6, start of care 4/25/14, included a plan of care established by the physician for certification period 4/25 to 6/23/14 with orders for home health aide services and states, "for personal care to assist with shower or bed bath; hair care; shampoo; skin care; foot care; nail care; oral care; check pressure areas and notify nurse regarding problem skin area. Assist with medication reminders; assist with mobility; perform PROM to BLE. Assist with nutrition, light meal preparation, set-up meals and fluids. Wash			

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	clothes/towels; perform light housekeeping in patient bedroom; bathroom; kitchen; living room; change bed linen. ... ." A. The record evidenced an aide visit dated 6/3/14 with task of "light housekeeping / bedroom / bathroom / kitchen / changed bed linen" being the only task completed at the visit. B. On 6/13/14 at 11:18 AM, employee A indicated being unaware the aide did not perform all tasks as ordered on the plan of care.			
N000000	This visit was a Home Health state licensure survey. Survey Dates: June 12, 13, 16, and 17, 2014 Facility Number: 011556 Medicaid Number: 201022100 Surveyor: Tonya Tucker, RN, PHNS Total Census (unduplicated last 12	N000000		

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	months) = 24 Quality Review: Joyce Elder, MSN, BSN, RN June 19, 2014			
N000522	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 policy review, clinical record and document review, and interview, the agency failed to ensure home health aide visits were made in accordance with the plan of care in 2 of 10 records reviewed creating the potential to affect all patients of the agency that receive home health aide services. (#1 and #6) Findings include: 1. The agency policy with a revision date of 5/15/14 titled "Subject: Cancellation; Missed visits; late or changed visit times" states, "Policy: When a client/CG [caregiver] calls and cancels a visit, the employee who received the call must complete the visit cancellation form. Missed visits by staff members are to be made up as soon as possible unless the	N000522	N-522: Finding # 1: Correction: 06/20/2014; A. Immediately following the exit of the surveyor on 06/20/2014 all home health Aides were notified via phone call, a mandatory staff meeting will be held Saturday 06/21/2014 at 3:00 PM and Sunday 06/22/2014 @ 3:00 PM they must attend one. Aides agreed by signature when picking up their check on 06/20/2014. Anyone who failed to meet this requirement received proper disciplinary action. Agency policy was also revised to reflect this change. B. Administrator, Alternate Administrator, or her designee will educate all staff members on missed visits, cancelled visits, calling the office when a client cancels or if they have missed a scheduled visit, and completing the proper form for missed/cancelled visits. Administrator advised staff	06/20/2014

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	client refuses service at a later time/day/date. ... ." 2. Clinical record #1, start of care 4/18/15, contained a physicians plan of care for certification period 4/18 to 6/16/14 which states, "HH [home health] AIDE visits 3hr [hour] visits 3w8 [3 times per week for 8 weeks]; 1w1 [1 time per week for 1 week] starting wk [week] of 4/20/14 ... ON HOLD TILL PA [prior authorization] APPROVED ... ." A. The record evidenced a document dated 5/19/14 titled "Prior Authorization Inquiry" stating, "Status Approved ... Start Date 05/05/2014 ... ." The record evidenced a home health aide visit was conducted on 5/2/14 and 5/6/14 and not again until 5/30/14. B. On 6/17/14 at 11:18 AM, employee A (administrator/director of nursing) indicated agency staff inquired about approval for payment of home health aide services on 5/19/14 at which time they realized it had been approved to start on 5/5/14. The employee indicated there a home health aide visit made on 5/6/14 and not again until 5/30/14. 3. Clinical record #6, start of care 4/25/14, contained a physicians plan of care for certification period 4/25 to		to follow the new policy that was instituted on 06/20/2014. C. If/when staff member calls off work, the Office Manager or her designee who receive the call will contact additional staff via phone call for a replacement to prevent missed visits and provide patient care as ordered by the physician/POC. If no staff is available to pick up additional client or the client/CG wishes to cancel the implemented form "Missed/Cancelled"visit form will be complete at that time. Each POC must indicate services provided type of service, length, frequency, and duration of services. All information will be available on the POC-485/487 and will be accessible in the client's medical file/chart. POC will be faxed to PCP for documentation of notification, and his records. Chart Audits to be completed on 10% of all charts monthly by Administrator or her designee to monitor corrective actions are being completed and deficiency does not recur. N-522: Finding #2 and #3: Correction: 06/20/2014 A. It was advised that clients for Clinical Record #1 and #6 had told the Primary nurse they did not want and could not receive visits on Monday, Wednesday, and Friday due to physical Therapy appointments for clinical record # 1.. TMG had already scheduled services for M-W-F having staff availability for these	

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	15K070	A. BUILDING 00 B. WING	06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TMG HOME HEALTH CARE INC	108 N MAIN STREET STE 305 SOUTH BEND, IN 46601

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	6/23/14 which states, "HH AIDE 3hr visits 3w8; 1w1; starting wk of 4/27/14 ... ON HOLD TILL PA APPROVED ... ." A. The record evidenced a physician's verbal order received by employee A dated 4/30/14 which states, "Proposed dates of service 5/12/14 - 11/8/14 ... ." B. The record evidenced a document dated 5/28/14 stating, "Status Approved ... Start Date 5/12/14 ... ." The record evidenced the first home health aide visit was conducted on 6/3/14. C. On 6/13/14 at 11:28 AM, employee A indicated agency staff inquired about approval for payment of home health aide services on 5/28/14. The employee indicated the payment authorization was approved to start on 5/12/14 but the first home health aide visit was not conducted until 6/3/14.		days. This presented TMG with staffing difficulties when the client requested a change in days, all staff was assigned according to client needs. B. Administrator educated Office Personnel on missed visits, cancelled visits, and completing the proper form for missed/cancelled visits. All staff was advised to review/follow the new instituted policy.Educated office staff on contacting additional staff via phone call for are placement to prevent missed visits and provide patient care as ordered by the physician/POC. A copy of policy was distributed to staff members C. When obtaining Prior Authorization for services Administrator or her designee will check status every Monday and Thursday and/or on any additional day. This is to prevent missed visits due to Medicaid authorizing visits prior to date authorization was received. All Inquiries will be printed at that time it was checked to note status of the inquiry; Approved, Denied, Suspended,in Review. A New Policy will be written by 06/27/2014 to correct this and prevent deficiency from recurring.	
N000524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a			

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	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 agency policy review, clinical record review, and interview, the agency failed to ensure the plan of care included accurate information in 1 of 10 clinical records reviewed. (#5) Findings include: 1. The undated agency policy titled "Clinical records/medical record retention" states, "POLICY A clinical record will be maintained for every client receiving home health services. ... Clinical records are legal documents containing accurate, and organized information ... PURPOSE To maintain an accurate record of the services provided by the agency for each client. ...	N000524	N-524 FINDING The SOC date for clinical record #5, was changed to the date the patient was admitted into skilled services. Starting skilled services requires the OASIS Assessment to be entered into HAVEN. A new SOC date was indicated on the POC/485 along with a new certification period. Correction: On 06/20/2014 the Administrator Deleted the HAVEN ASSESSMENT on the SOC and Re-certification OASIS ASSESSMENTS for clinical record #5. This was completed to correct the deficiency (G-159) and to change the SOC date back to original date that NON-SKILLED services started (05/06/2011) Upon Re-entering the admission assessment into HAVEN,	06/24/2014

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	." 2. Clinical record #5 evidenced a document signed by the registered nurse, dated 5/6/11, and titled "Adult Nursing Assessment" which states, "REASON FOR ASSESSMENT: Start of Care ... ." A. The record evidenced a home health certification and plan of care for certification period 3/20 to 5/18/14 that states, "Start of Care Date 03/20/2014." B. On 6/12/14 at 1:25 PM, employee A (administrator / director of nursing) indicated the patient was admitted to the agency on May 6, 2011, with home health aide services only. The employee indicated skilled nursing services were ordered in March, 2014 and was under the impression the start of care date needed to be changed to the date the new service was added.		the system would not allow the assessment to be entered on the date (05/06/2011), not even with accepting the warning then continuing. When attempting to "complete" the assessment and export it, HAVEN will not allow this to occur. The Administrator called HAVEN for assistance in this, it was determined that entering the original SOC date of 05/06/2011 was impossible. It does not accept dates from an extended time frame. Example SOC entered 05/06/2011 and the initial assessment date 03/20/2014. Rich, the assistant from HAVEN, then placed a three way call to Joyce Elder,MSN,BSN,RN, QUALITY REVIEW. After determining that OASIS-C, entry for HAVEN had a changed in March 2014, Again, this will not allow the original SOC date to be used. Joyce Elder,MSN,BSN,RN stated this will be addressed with Kelley,BSN,RN PHNSS-Program Director ISDH/Acute Care Division. OASIS re-entered with new SOC date. The Administrator will follow up on this discrepancy with Joyce Elder,MSN,BSN,RN and Kelley,BSN,RN PHNSS-Program Director ISDH/Acute Care Division one week after this plan of correction is submitted. A new policy is to be instituted when a decision on this matter has been approved.	
N000550	410 IAC 17-14-1(a)(1)(K)			

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	Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on agency policy review, clinical record review, and interview, the agency failed to ensure the home health aide plan of care was updated at least every 60 days as required by agency policy in 1 of 8 clinical records reviewed of patients receiving home health aide services with the potential to affect all patients receiving home health aide services. (#7) Findings include: 1. The policy with a revision date as January 20, 2014 titled "Medical Plan of Care" states, "The total medical plan of care shall be reviewed by the attending physician ... and home health agency personnel as often as the severity of the patient's condition requires, but at least once every sixty (60) days. ... ." 2. Clinical record #7, start of care 1/14/14, contained a physician's plan of care for certification period 5/14 to 7/12/14. The record evidenced an aide care plan with the last review / update by the registered nurse as 2/14/14.	N000550	N-550 Correction: The Registered Nurses have been instructed verbally on following/reviewing P&P and updating the POC at least every 60 days as required by agency policy. A copy of policy was given to all Registered Nurses. Nurses also instructed to use the checklist available to ensure all requirements are completed. A copy of the checklist was given to all Registered Nurses. During the home health Aide staff meeting held on 06/21/2014 and 06/22/2014, all staff members were instructed to call the Primary Nurse when a change/update is needed for a client. If unable to contact the Primary Nurse call the office and report to the Administrator or her designee. Administrator or designee is to complete chart audits on 10% of all charts monthly to monitor if corrective actions are being completed and to prevent deficiency from recurring.	06/20/2014

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	3. On 6/13/14 at 11:55 AM, employee A (administrator / director of nursing) indicated the aide care plan should have been reviewed by the registered nurse in April, 2014.			