STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157632	A. BUILDING 00 B. WING	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIANT AT HOME LTD	341 LOGAN ST STE L110 NOBLESVILLE, IN 46060

(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		G 0000		

This was a home health agency federal complaint investigation.

Complaint #: IN00176059: Unsubstantiated: lack of sufficient evidence.

Unrelated deficiencies are cited.

Survey dates: 7-22 and 7-23-15

Facility number: 012546

Medicaid #: 201027880

Current Census:
Skilled: 79
Home Health Aide only: 27
Total: 106

QA;LD, R.N.

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

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

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G 0143 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on policy review, clinical record review, and interview, the agency failed to ensure all personnel furnishing services maintained liaison and documented coordination of care while services were being provided for 1 of 4 clinical records reviewed (2). Findings include: 1. Policy, "Care/Service Coordination", last reviewed/revised 1-14-14, states, "Purpose: To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Policy: Timely and ongoing communication is the responsibility of each team member and will be appropriate to the needs and abilities of the patient ... It will be the responsibility of the primary clinician to facilitate communication about changes in the patient's status among all assigned disciplines ... Documentation of all communication will be included in the clinical record on a communication note, case conference summary, or clinical note ... When the patient requires more than	G 0143	The deficiency was corrected by the addition of 60 day summary notes in the electronic chart for all assigned caregivers on each case to be completed. This note will appear on the to do list of all caregivers who are electronic. Those caregivers that are not electronic will be required to report to the office every 60 days to complete the paper version of this form. This will be tracked and monitored by the scheduling coordinator at both locations. Case manager is then responsible for the aggregation of this data to incorporate the notes from the additional discipline into her summary document. The Skilled Nurse 60 day summary with this aggregated data is what will be faxed to the MD office for their records By implementing this new protocol should see no recurring events Responsibilities: Nursing Supervisor for the loading of the documents in the electronic chart on Start of Care or Recertification. Employees not electronic will be tracked by the Scheduling Coordinator for completion. Additional Response from 9/4/15 coorespondance: Within the system there is a communication	08/28/2015

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	one service from the organization, the Case Manager will be responsible for cooperative care planning in order to assure goals, actions, and the interrelationship of services is not duplicated .. All organization personnel involved in the patient care/service, including those providing contracted services, will have access to the plan of care/service and all other relevant patient information to ensure coordination and continuity." 2. Clinical record (CR) 2, start of care 5-20-15, contained a physician's plan of care for certification period 5-20 to 7-18-15 with orders for skilled nursing 2 times a week for 9 weeks; home health aide 2 times a week for 9 weeks; physical therapy 2 times a week for 8 weeks; and occupational therapy 2 times a week for 6 weeks. The CR evidenced all the disciplines made visits during the certification period. The CR evidenced a case conference note dated 7-15-15 which failed to identify occupational therapy services had been provided and failed to document the participation of any other disciplines. Employee D, registered nurse, signed the case conference. The CR failed to evidence any other documentation of coordination of care/ communication between the disciplines during the certification period.		note available which ties into the E-mail system of Axxess. Employees communicate daily through this system regarding issues of our patients and these communications are tagged to the patients chart. Within the QA performed quarterly, their is already a audit item for communications. We will review these during chart audit performed quarterly. Responsibility will lie on the Clinical Director. This deficiency was corrected by 8/28/15.	

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	3. On 7-23-15 at 3:00 PM, Administrator indicated the clinical record lacked documentation of coordination of care/communication between the disciplines for CR 2.			
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 clinical record review, policy review, and interview, the agency failed to ensure patient needs were addressed and being met by the agency for 2 of 4 clinical records reviewed (1 and 2). Findings included: 1. Policy, "Availability of Services", last reviewed revised 1-14-14, states, "Purpose ... to define the availability of services to the community ... The start of care assessment visit must be performed either within 48 hours of the referral,	G 0157	This error occurred because as an agency we were not changing the Episode Start date to reflect the 1st billable visit. Often we get referrals that require time to submit to Indiana Medicaid or Medicaid waiver for approval which can take up to 2-3 weeks. Effective 8/28/15 all patients who are delayed in first billable visit due to delay in authorization from payer source, will have their episode adjusted to the first billable date of service when the auth is received. Delay in evaluation by ancillary caregivers was addressed via a E-mail notification sent on 8/28/15. Internal administrative staff also	08/28/2015

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	within 48 hours of the patient's return home, on the start of care date ordered by the physician ... Additional discipline initial assessments will be provided within 7 business days of the start of care or the physician's order." 2. Clinical record 1 (CR), start of care (SOC) 4-15-15, contained a physician's plan of care (POC) for certification period (CP) 4-15 to 6-13-15, with order for home health aide (HHA) services 2 hours per day, 2 days per week for 9 weeks per Medicaid waiver and 3 hours per day, 3 days a week, for 9 weeks per Medicaid prior authorization. The CR evidenced the first visit by a HHA was on 4-28-15, 13 days after the POC order for HHA services. The CR failed to evidence the physician, the patient, or the caregiver were notified of the 13 day delay in providing HHA services. 3. Clinical record (CR) 2, SOC 5-20-15, contained a physician's POC for CP 5-20 to 7-18-15 with order for occupational therapy (OT) evaluation. The CR evidenced the OT evaluation was dated 6-5-15, 13 business days, 16 calendar days, after the physician order. The CR failed to evidence a reason for the delay of the evaluation, and failed to evidence the physician had been notified of the delay in providing the OT evaluation.		educated to locate a new caregiver if their schedule does not allow for them to schedule the evaluation within 7 days of order received. Education of the internal administrative staff and clinical staff occurred on 8/28/15. This protocol will be in place effective immediately. This will prevent recurring issues Responsibility for compliance will be assigned to the Clinical Director to include education and ongoing compliance monitoring Additional Response from 9/4/15 coorespondance: This is being monitored at the billing end of our systems to ensure the first invoice sent matches the first billable visit date. This is performed by the Administrator. The Nursing Supervisor is responsible for ensuring the episode date ranges are reviewed when authorizations are obtained for adjustment in the system of the episodic dates. This will be monitored using both methods. This deficiency was corrected on 8/28/15. Additional response from 9/11/15 coorespondance: SOC within 48 hours and initial assessment for additional disciplines within 7 days of SOC. When we admit patient and wait for authorization prior to staffing. (Example: Medicaid or Medicaid waiver) We will perform the SOC documentation and submit for authorization. Once authorization received we will write an correction order to move	

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	4. On 7-23-15 at 3:00 PM, Employee A, the administrator, indicated the delay of 13 days providing HHA services to CR 1 was not acceptable agency practice, and the delay in obtaining an OT evaluation for CR 2 was not per agency policy.		the episodoic dates to coorespond with the first billable date under the authorized payer. This order will include all disciplines. If the SOC or the evaluation visit cannot be performed within the 48 SOC or 7 days evaluation policy, a call will be placed to the MD, to notify and new order will be written to move the SOC date to the date patient actually agreed to be seen and schedules with Reliant At Home. This will be monitored by the Nursing Supervisor, and is also in the QI quarterly audit form for compliance monitoring.	

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G 0159 Bldg. 00	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 policy review, clinical record review, and interview, the agency failed to ensure the plan of care (POC) correctly identified the start of care (SOC) date and certification period (CP) for 2 of 4 clinical records reviewed (1 and 2); failed to ensure every patient had only 1, and only 1, plan of care addressing all the patients needs for 1 of 1 dual eligible clinical records reviewed (4); failed to ensure the discharge plan established was non-contradictory and realistic for 1 of 4 clinical records reviewed (4); and failed to ensure the plan of care established goals for every service provided for 1 of 4 clinical records reviewed (4). Findings include: 1. Policy, "Care Planning Process", last reviewed/revised 1-14-14, states, "A written plan of care will be initiated	G 0159	This error occurred because as an agency we were not changing the Episode Start date to reflect the 1st billable visit. Often we get referrals that require time to submit to Indiana Medicaid or Medicaid waiver for approval which can take up to 2-3 weeks. Effective 8/28/15 all patients who are delayed in first billable visit due to delay in authorization from payer source, will have their episode adjusted to the first billable date of service when the auth is received. Education of the internal administrative staff and clinical staff occurred on 8/28/15. This protocol will be in place effective immediately. This will prevent recurring issues Responsibility for compliance will be assigned to the Nursing Supervisor to include education and ongoing compliance monitoring Additional Response from 9/4/15 coorespondance: Two chart system was originally established to prevent incorrect payer submission for services	08/28/2015

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	within five (5) days of start of care ... Plan of Care: The clinical plan of care includes: ... Other appropriate items ... " 2. Policy, "Initial & Comprehensive Assessment", last reviewed/revised 1-14-14, states, "A comprehensive patient assessment will be completed within five (5) calendar days of the patient's start of care." 3. Policy, "Reassessment/Recertification", last reviewed/revised 1-14-14, states, "The comprehensive assessment must be updated and revised every 60 days beginning with the start of care." 4. Policy, "Care Planning Process", last reviewed/revised 1-14-14, states, "Services provided will be based on the prioritized needs of the patient. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to determine if goals have been achieved." 5. Clinical record (CR) 1, start of care (defined as 1st billable visit) 4-15-15, contained a plan of care (POC) for the certification period (CP) 4-15 to 6-13-15, Medicaid payor. The first billable visit, with care furnished, was by a home		performed on our patients. For those patients receiving services from more than one payer source the two chart system will be integrated into one chart by 10/1/15. During recertification cycles we will merge the charts into one, thus it will take several weeks to prevent discharge and readmit to make this conversion. This convertion will be the responsibility of the Administrator, with the Nursing Supervisor being educated on what is required in POC creation. New notes will also need to be created to separate out the payer charges within the chart to prevent incorrect billing. Education will be completed by 9/15/15. Full conversion by 10/1/15. Additional Response from 9/18/15 coorespondance: Goals were not being written for all disciplines caring for the patient. In the incident cited the Home Health Aide goals were not established and discharge plans were contradictory. This is the responsibility of the Nursing Supervisor to review the POC before MD signature to ensure accuracy. The review of the document will continue to be performed by the Nursing Supervisor, and goals and discharge are already on the clinical chart audit. To add a subset on the quarterly review document to look for goals for all disciplines and that discharge plans are not contradictory. This	

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	health aide (HHA) on 4-28-15, 13 days after the date identified on the POC as the start of care (SOC). The SOC should have been 4-28-15, and the CPs should have been 4-28 to 6-26-15 and 6-27 to 8-25-15. 6. CR 2, SOC 5-20-15, contained a POC for the CP from 5-20 to 7-18-15, Medicare payor. The first billable visit, with care furnished, was by a registered nurse on 5-22-15, 2 days after the date identified on the POC as the SOC. The SOC should have been 5-22-15 and the CPs should have been 5-22 to 7-20-15 and 7-21 to 9-19-15. 7. CR 4, was maintained in the electronic clinical record system, Axxess, with 2 separate physician's plans of care. A. CR 4, SOC 5-29-15, contained a physician's POC for the CP 5-29 to 7-27-15, signed by the attending physician on 6-4-15, with orders for HHA services up to 12 hours per week, 4 days a week, Medicaid prior authorization, to assist with bathing, shampoo, grooming, dressing, oral care, hair care, skin care, ambulation, meal set-up (field identifier 21). Diagnoses included principal diagnosis of CHF (congenital heart failure); other pertinent diagnoses of hypertension and atrial fibrillation (field identifiers 11 and 13); DME listed:		will be completed by 9/24/15.	

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	walker and incontinence supplies (field identifier 14); nutritional requirement: regular diet, supplement boost (field identifier 16); functional limitations: bowel/ bladder incontinence, hearing, ambulation (field identifier 18A); activities permitted: up as tolerated, independent at home, walker (field identifier 18B); goals/rehabilitation potential/discharge plans: The patient will be free from falls during the episode. The patient will be free from injury during the episode. Rehab. Potential: Fair for stated goals. Patient's condition is not expected to improve over time. Discharge Plan: Patient to be discharged to the care of caregiver. Discharge when caregiver willing and able to manage all aspects of patient's care (field identifier 22). The clinical record evidenced HHA visits were made during the episode. The POC failed to evidence goal(s) were established for HHA services. B. CR 4, SOC, 6-24-15, contained a physician's POC for the CP 6-24 to 8-22-15, Medicare payor, signed by attending physician on 6-25-15, with orders for skilled nursing (SN) 2 times a week for 1 week; 3 times a week for 2 weeks; 2 times a week for 6 weeks; SN for wound care. SN for medication management and education. SN visits monthly for supervision of HHA. HHA 3 times a			

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	week for 9 weeks to assist with bathing, shampoo, grooming, dressing, oral care, hair care, skin care, ambulation, meal set-up (field identifier 21). Diagnoses included principal diagnosis of CHF (congenital heart failure); other pertinent diagnoses of pressure ulcer of buttocks, hypertension, malaise and fatigue, and atrial fibrillation (field identifiers 11 and 13); DME listed: grab bars, tub/shower bench, walker, dressing supplies, exam gloves, and incontinence supplies (field identifier 14); nutritional requirement: regular, low cholesterol, supplement boost (field identifier 16); functional limitations: bowel/ bladder incontinence, hearing, endurance, ambulation (field identifier 18A); activities permitted: walker (field identifier 18B); goals/rehabilitation potential/discharge plans: Patient will verbalize understanding of proper use of pain medication by the end of the episode Patient/CG [caregiver] will verbalize knowledge of paint medication regimen and pain relief measures by the end of the episode. Wound(s) will heal without complication by the end of the episode. Wound(s) will be free from signs and symptoms of infection during the 60 day episode. Wound(s) will decrease in size by 100% by the end of the episode. Patient skin integrity will remain intact during this episode. The			

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	patient/caregiver will verbalize and demonstrate edema relieving measures the episode. The patient will be free from falls during the episode. The patient will be free from injury during the episode. The patient will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by [blank]. Rehab. Potential: Good for stated goals. Discharge Plan: Patient to be discharged to the care of caregiver. Patient to be discharged to self-care. Discharge when caregiver willing and able to manage all aspects of patient's care. Discharge when goals met. Discharge when wound(s) healed (field identifier 22). The clinical record evidenced SN and HHA visits were made during the episode. The POC failed to evidence goals were established for HHA services. The CR evidenced discharge plans which were contradictory, Patient to be discharged to care of caregiver. Patient to be discharged to self-care. Discharge when caregiver willing and able to manage all aspects of patient's care." 8. On 7-23-15 at 3:00 PM, the administrator, Employee A, indicated not being aware the first billable visit defined the start of care for CR 1 and CR 2. The administrator indicated CR 4 has 2 separate clinical records and 2 plans of			

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	care because the patient is dual eligible for Medicare SN for wound care and also Medicaid for HHA services. CR 4 started with HHA services from Medicaid, and later skilled nursing services under Medicare were added for wound care, medication management, and education. The plans of care are not identical, apart from the patient claim identification number, because the patient has two payors with separate billing. Administratively, Employee A indicated, it is simpler to track the services, frequencies, orders, etc. with 2 different clinical records and plans of care. The administrator indicated not being aware of the requirement to have 1 plan of care to address all the care provided by the agency to meet the patients' needs. The administrator indicated the agency has one other patient with dual eligibility for Medicare and Medicaid on service and there are 2 clinical records and 2 separate plans of care for each payor source, which are not identical apart from the patient claim identification number. Administrator indicated the discharge plan for CR 4 for the Medicare payer services, SOC 6-24-15 had contradictory goals of discharging patient to self-care and also discharging patient when caregiver willing and able to manage all aspects of patient's care. Administrator indicated the POC did not establish			

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	goal(s) in relation to HHA services. Administrator indicated it was not realistic to expect CR 4 to be able to resume independent self-care as patient was not expected to improve over time.			
G 0173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse (RN) revised and updated the plan of care to	G 0173	Education of the Nursing Supervisor that during admission of patients that are ordered only non skilled care, that during the assessment if clinical issues are found, to contact the ordering	08/28/2015

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RELIANT AT HOME LTD	341 LOGAN ST STE L110 NOBLESVILLE, IN 46060

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	address all the needs identified in the comprehensive assessment for 1 of 4 clinical records reviewed (1). Findings include: 1. Policy, "Care Planning Process", last reviewed/revised 1-14-14, states, "Plan of Care: The clinical plan of care includes: ... Pertinent primary and secondary diagnosis ... A physical assessment, including ... skin ... and other relevant data related to pertinent physical findings." 2. Clinical record 1 (CR), start of care (SOC) 4-15-15, contained a physician's plan of care (POC) for certification period (CP) 4-15 to 6-13-15. Comprehensive assessment, dated 4-15-15, evidenced under Other Diagnosis: ... Pressure Ulcer, stage 2 ... peripheral vascular disease ... diabetes mellitus type 2 ... Under Integumentary: Braden score 15, at risk for skin breakdown, Wound 1 right BKA [below knee amputation], date of onset 1-1-15, pressure ulcer, stage 2, length 2.0 cm, width 0.5 cm, depth 0.2 cm , surrounding tissue pink, drainage none, no odor ... patient leaves open to air, leaves off prosthesis ... No orders to do dressing change, is Medicaid episode." The CR failed to evidence the registered nurse		physician to notify and ensure that documentation is performed stating physicians response. This is to ensure that the MD is aware of these issues and to verify if any treatment is required. In this situation the MD was aware of the wound care status, and did not have any orders for us. Patient was being seen by MD and wound care clinic. Education performed on 8/28/15 via E-mail to notify the nurses of Reliant At Home of this requirement. Nursing Supervisor will be responsible for auditing the start of care documentation to ensure there is 100% compliance. Responsible: Nursing Supervisor, Start of Care Clinicians	

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	(RN), Employee D, assessed the pressure ulcer for granulation, slough, eschar, and tunneling; and failed to evidence the RN updated the POC to notify the physician of the stage 2 pressure ulcer and the need to revise the plan of care. 3. On 7-23-15 at 3:00 PM, Employee A, administrator, indicated the comprehensive assessment lacked a complete assessment of CR 1 pressure ulcer. Administrator indicated the RN should have reported the assessment of the pressure ulcer to the attending physician and initiated modification of the plan of care to address care of the pressure ulcer.			
G 0230 Bldg. 00	484.36(d)(3) SUPERVISION If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently			

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	than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care. Based on policy review, clinical record review and interview, the agency failed to ensure the registered nurse (RN) appropriately supervised the home health aide (HHA) as required by agency policy and implemented corrective actions for care not documented as provided for 1 of 1 clinical records reviewed receiving home health aide (HHA) only services (1). Findings include: 1. Policy, "Home Health Aide Supervisory Visits", last reviewed/revised 1-14-14, states, "Nursing personnel or therapists, as appropriate, must be available to the home health aide for consultation at all times during the aide's working hours. The registered nurse or therapist must conduct supervisory visits to the patient's residence at regular intervals ... The frequency of supervisory visits will be based upon the needs of the patient after the plan of care is established. They must be conducted at least every two (2) weeks ... The registered nurse and / or appropriate therapist will be responsible for:	G 0230	The charts showed no evidence that the Skilled Nurse or Physical Therapist Assigned to the case was reviewing the Home Health Aide Care plan and conforming to this plan. This was addressed by the following protocols. 1. Note type of HHA supervisory visit exchanged for Note Type of SNV with supervisory visit. HHA supervisory note has the requirements of our policy unlike the note being used. Examples of these note types can be located in the attachments of this response. 2. Supervising clinician with the assistance of the scheduling coordinator are responsible for reviewing the notes and comparing it to the care plan and make the necessary corrections during the supervisory visit to ensure HHA compliance. 3. Nursing Supervisor will be responsible for the entry of the correct note type effective immediately. 4. Monitoring: HHA care plan is already tracked on the QA and is an indicator. This will be reviewed quarterly during out audit and reported for compliance. Education of requirements sent to clinical staff on 8/28/15 by the Nursing Supervisor These protocols will prevent this from recurring in the	08/28/2015

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	supervision of all services provided for in the plan of care." 2. Clinical record (CR) 1, start of care 4-15-15, included a physician's plan of care (POC)for the certification period 4-15- to 6-13-15 with orders for home health aide (HHA) services 2 hours each day, 2 days each week, for 9 weeks. HHA to assist with ADL(activities of daily living)/IADLs (instrument activities of daily living) of hygiene/bathing, dressing, grooming, meal prep, and light housekeeping. A. HHA plan of care, dated 4-15-15, signed by Employee D, RN, included the following care: Every visit - assist with shower with chair, shampoo hair, hair care/comb hair, oral care, skin care, peri care, nail care, shave, assist with dressing, assist with bedpan/urinal, assist with BSC (bedside commode), turn and position, assist with transfer, make bed, light housekeeping, meal set up, assist with feeding; Every week-change linen. B. On 4-28-15 and 4-30-15, Employee G, HHA, failed to evidence bathing assistance, oral hygiene, turn and reposition, skin care, assist with dressing, peri care, making of bed, and meal preparation had been provided. On 5-5-15 and 5-7-15, Employee G, HHA, visit note failed to evidence bathing assistance, shave, oral hygiene,		future. Responsibility: Nursing Supervisor, Scheduling Coordinator and supervising clinician.	

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	turn and reposition, skin care, assist with dressing, peri care, and meal preparation had been provided. On 5-11-15 and 5-14-15, Employee G, HHA, failed to evidence bathing assistance, oral hygiene, turn and reposition, assist with dressing, peri care, and meal preparation had been provided. On 5-19-15, Employee G, HHA, visit note failed to evidence bathing assistance, oral hygiene, turn and reposition, skin care, peri care, making of bed, and meal preparation had been provided. On 5-21-15, Employee G, HHA, visit note failed to evidence oral hygiene, turn and reposition, making of bed, and meal preparation had been provided. On 5-25-15, Employee G, HHA, visit note failed to evidence oral hygiene and turn and reposition had been provided. On 5-27-15, Employee G, HHA, visit note failed to evidence turn and reposition care had been provided. On 6-2-15, Employee G, HHA, visit note failed to evidence oral hygiene, turn and reposition, and meal preparation had been provided. On 6-4-15, Employee G, HHA, visit note failed to evidence oral hygiene, turn and reposition, and meal preparation had been provided. On 6-8-15, Employee G, HHA, visit			

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	note failed to evidence turn and reposition, and meal preparation had been provided. On 6-10-15, Employee G, HHA, visit note failed to evidence turn and reposition, and meal preparation had been provided. C. The CR evidenced a supervisory visit on 5-13-15, by Employee D, RN, which failed to evidence the RN took appropriate corrective action regarding Employee G, HHA, failure to document services were provided as per HHA plan of care. Supervisory visit dated 6-11-15, #2 "Follows client's plan of care", evidenced Employee D, RN, checked "Yes". 3. The administrator, Employee A, indicated on 7-23-15 at 3:00 PM the HHA had not completed the services as per the HHA plan of care and the RN should have taken corrective measures to ensure the HHA followed the HHA care plan. The administrator, Employee A, was unable to locate an agency policy for supervisory visits of patients receiving only HHA services. Administrator indicated the agency policy title and contents do not distinguish between skilled and unskilled patients, therefore this policy applies.			

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G 0334 Bldg. 00	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on policy review, clinical record review, and interview, the agency failed to ensure the comprehensive assessment (CA) was performed within 5 days after the start of care (SOC) for 2 of 4 clinical records reviewed (1 and 2). Findings include:	G 0334	This error occurred because as an agency we were not changing the Episode Start date to reflect the 1st billable visit. Often we get referrals that require time to submit to Indiana Medicaid or Medicaid waiver for approval which can take up to 2-3 weeks. Effective 8/28/15 all patients who are delayed in first billable visit due to delay in authorization from	08/28/2015

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	1. Agency policy, "Initial and Comprehensive Assessment", last reviewed/revised 1-14-14, states, "A comprehensive patient assessment will be completed within five (5) calendar days of the patient's start of care." 2. Clinical record (CR) 1, referral date 4-14-15, start of care (SOC) 4-15-15, (defined as 1st billable visit), contained a plan of care (POC) for the certification period (CP) 4-15 to 6-13-15, and 6-14 to 8-12-15, under Medicaid waiver services, with orders for home health aide (HHA). The first billable visit, with care furnished, was by a HHA on 4-28-15, 13 days after the date identified by the agency as the SOC on the POC. The comprehensive assessment (CA) was dated 4-15-15, 13 days prior to the start of care. The SOC should have been 4-28-15, with CP #1 from 4-28- to 6-26-15, and CP #2 from 6-27 to 8-25-15. The CA should have been performed between 4-28 and 5-2-15. 3. CR 2, referral date 5-19-15, SOC 5-20-15 (defined as 1st billable visit), contained a POC for the CP 5-20 to 7-18-15, under Medicare, with orders for skilled nursing, home health aide, physical therapy, and occupational therapy. The first billable visit, with care		payer source, will have their episode adjusted to the first billable date of service when the auth is received. Education of the internal administrative staff and clinical staff occurred on 8/28/15. This protocol will be in place effective immediately. This will prevent recurring issues Responsibility for compliance will be assigned to the Nursing Supervisor to include education and ongoing compliance monitoring Monitoring: This is monitored at two levels. Administrator during the billing process and the Nursing Supervisor when the authorization is obtained. No invoices will be cut or submitted until episode dates are reviewed. Once first episode is correct, this issue does not repeat itself.	

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	furnished, was on 5-22-15 by skilled nursing, 2 days after the date identified by the agency as the SOC on the POC. The CA was dated 5-20-15, 2 days prior to the start of care. The SOC should have been 5-22-15, with CP #1 from 5-22 to 7-20-15 and CP #2 from 7-21 to 11-19-15. The CA should have been performed between 5-22 and 5-26-15. 4. On 7-23-15 at 3:00 PM, Employee A, the administrator, indicated the agency has used the date of the CA as the SOC although no billable visit occurs at the CA.			

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N 0000 Bldg. 00	This was a home health agency state complaint investigation. Complaint #: IN00176059: Unsubstantiated: lack of sufficient evidence. Unrelated deficiencies are cited. Survey dates: 7-22 and 7-23-15 Facility number: 012546 Medicaid #: 201027880 Current Census: Skilled: 79 Home Health Aide only: 27 Total: 106 QA; LD, R.N.	N 0000		
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing			

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	services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on policy review, clinical record review, and interview, the agency failed to ensure all personnel furnishing services maintained liaison and documented coordination of care while services were being provided for 1 of 4 clinical records reviewed (2). Findings include: 1. Policy, "Care/Service Coordination", last reviewed/revised 1-14-14, states, "Purpose: To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Policy: Timely and ongoing communication is the responsibility of each team member and will be appropriate to the needs and abilities of the patient ... It will be the responsibility of the primary clinician to facilitate communication about changes in the patient's status among all assigned disciplines ... Documentation of all communication will be included in the clinical record on a communication note, case conference summary, or clinical note	N 0484	The deficiency was corrected by the addition of 60 day summary notes in the electronic chart for all assigned caregivers on each case to be completed. This note will appear on the to do list of all caregivers who are electronic. Those caregivers that are not electronic will be required to report to the office every 60 days to complete the paper version of this form. This will be tracked and monitored by the scheduling coordinator at both locations. Case manager is then responsible for the aggregation of this data to incorporate the notes from the additional discipline into her summary document. The Skilled Nurse 60 day summary with this aggregated data is what will be faxed to the MD office for their records By implementing this new protocol should see no recurring events Responsibilities: Nursing Supervisor for the loading of the documents in the electronic chart on Start of Care or Recertification. Employees not electronic willbe tracked by the Scheduling Coordinator for completion. Additional Response from 9/4/15 coorespondance: Within the	08/28/2015

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	... When the patient requires more than one service from the organization, the Case Manager will be responsible for cooperative care planning in order to assure goals, actions, and the interrelationship of services is not duplicated .. All organization personnel involved in the patient care/service, including those providing contracted services, will have access to the plan of care/service and all other relevant patient information to ensure coordination and continuity." 2. Clinical record (CR) 2, start of care 5-20-15, contained a physician's plan of care for certification period 5-20 to 7-18-15 with orders for skilled nursing 2 times a week for 9 weeks; home health aide 2 times a week for 9 weeks; physical therapy 2 times a week for 8 weeks; and occupational therapy 2 times a week for 6 weeks. The CR evidenced all the disciplines made visits during the certification period. The CR evidenced a case conference note dated 7-15-15 which failed to identify occupational therapy services had been provided and failed to document the participation of any other disciplines. Employee D, registered nurse, signed the case conference. The CR failed to evidence any other documentation of coordination of care/ communication between the		system there is a communication note available which ties into the E-mail system of Axxess. Employees communicate daily through this system regarding issues of our patients and these communications are tagged to the patients chart. Within the QA performed quarterly, their is already a audit item for communications. We will review these during chart audit performed quarterly. Responsibility will lie on the Nursing Supervisor. This deficiency was corrected by 8/28/15.	

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	disciplines during the certification period. 3. On 7-23-15 at 3:00 PM, Administrator indicated the clinical record lacked documentation of coordination of care/communication between the disciplines for CR 2.			
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 clinical record review, policy review, and interview, the agency failed to ensure patient needs were addressed and being met by the agency for 2 of 4 clinical records reviewed (1 and 2). Findings included:	N 0520	This error occurred because as an agency we were not changing the Episode Start date to reflect the 1st billable visit. Often we get referrals that require time to submit to Indiana Medicaid or Medicaid waiver for approval which can take up to 2-3 weeks. Effective 8/28/15 all patients who are delayed in first billable visit	08/28/2015

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	1. Policy, "Availability of Services", last reviewed revised 1-14-14, states, "Purpose ... to define the availability of services to the community ... The start of care assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, on the start of care date ordered by the physician ... Additional discipline initial assessments will be provided within 7 business days of the start of care or the physician's order." 2. Clinical record 1 (CR), start of care (SOC) 4-15-15, contained a physician's plan of care (POC) for certification period (CP) 4-15 to 6-13-15, with order for home health aide (HHA) services 2 hours per day, 2 days per week for 9 weeks per Medicaid waiver and 3 hours per day, 3 days a week, for 9 weeks per Medicaid prior authorization. The CR evidenced the first visit by a HHA was on 4-28-15, 13 days after the POC order for HHA services. The CR failed to evidence the physician, the patient, or the caregiver were notified of the 13 day delay in providing HHA services. 3. CR 2, SOC 5-20-15, contained a physician's POC for CP 5-20 to 7-18-15 with order for occupational therapy (OT) evaluation. The CR evidenced the OT		due to delay in authorization from payer source, will have their episode adjusted to the first billable date of service when the auth is received. Delay in evaluation by ancillary caregivers was addressed via a E-mail notification sent on 8/28/15. Internal administrative staff also educated to locate a new caregiver if their schedule does not allow for them to schedule the evaluation within 7 days of order received. Education of the internal administrative staff and clinical staff occurred on 8/28/15. This protocol will be in place effective immediately. This will prevent recurring issues Responsibility for compliance will be assigned to the Nursing Supervisor to include education and ongoing compliance monitoring Additional Response from 9/4/15 coorespondance: This is being monitored at the billing end of our systems to ensure the first invoice sent matches the first billable visit date. This is performed by the Administrator. The Nursing Supervisor is responsible for ensuring the episode date ranges are reviewed when authorizations are obtained for adjustment in the system of the episodic dates. This will be monitored using both methods. This deficiency was corrected on 8/28/15. Additional response from 9/11/15	

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RELIANT AT HOME LTD	341 LOGAN ST STE L110 NOBLESVILLE, IN 46060

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	evaluation was dated 6-5-15, 13 business days, 16 calendar days, after the physician order. The CR failed to evidence a reason for the delay of the evaluation, and failed to evidence the physician had been notified of the delay in providing the OT evaluation. 4. On 7-23-15 at 3:00 PM, Employee A, the administrator, indicated the delay of 13 days providing HHA services to CR 1 was not acceptable agency practice, and the delay in obtaining an OT evaluation for CR 2 was not per agency policy.		coorespondance: SOC within 48 hours and initial assessment for additional disciplines within 7 days of SOC. When we admit patient and wait for authorization prior to staffing. (Example: Medicaid or Medicaid waiver) We will perform the SOC documentation and submit for authorization. Once authorization received we will write an correction order to move the episodoic dates to coorespond with the first billable date under the authorized payer. This order will include all disciplines. If the SOC or the evaluation visit cannot be performed within the 48 SOC or 7 days evaluation policy, a call will be placed to the MD, to notify and new order will be written to move the SOC date to	

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			the date patient actually agreed to be seen and schedules with Reliant At Home. This will be monitored by the Nursing Supervisor, and is also in the QI quarterly audit form for compliance monitoring.	
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on policy review, clinical record	N 0524	This error occurred because as an agency we were not changing	08/28/2015

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	review, and interview, the agency failed to ensure the plan of care (POC) correctly identified the start of care (SOC) date and certification period (CP) for 2 of 4 clinical records reviewed (1 and 2); failed to ensure every patient had only 1, and only 1, plan of care addressing all the patients needs for 1 of 1 dual eligible clinical records reviewed (4); failed to ensure the discharge plan established was non-contradictory and realistic for 1 of 4 clinical records reviewed (4); and failed to ensure the plan of care established goals for every service provided for 1 of 4 clinical records reviewed (4). Findings include: 1. Policy, "Care Planning Process", last reviewed/revised 1-14-14, states, "A written plan of care will be initiated within five (5) days of start of care ... Plan of Care: The clinical plan of care includes: ... Other appropriate items ... " 2. Policy, "Initial & Comprehensive Assessment", last reviewed/revised 1-14-14, states, "A comprehensive patient assessment will be completed within five (5) calendar days of the patient's start of care." 3. Policy, "Reassessment/Recertification", last		the Episode Start date to reflect the 1st billable visit. Often we get referrals that require time to submit to Indiana Medicaid or Medicaid waiver for approval which can take up to 2-3 weeks. Effective 8/28/15 all patients who are delayed in first billable visit due to delay in authorization from payer source, will have their episode adjusted to the first billable date of service when the auth is received. Delay in evaluation by ancillary caregivers was addressed via a E-mail notification sent on 8/28/15. Internal administrative staff also educated to locate a new caregiver if their schedule does not allow for them to schedule the evaluation within 7 days of order received. Education of the internal administrative staff and clinical staff occurred on 8/28/15. This protocol will be in place effective immediately. This will prevent recurring issues Responsibility for compliance will be assigned to the Nursing Supervisor to include education and ongoing compliance monitoring Additional Response from 9/4/15 coorespondance: Two chart system was originally established to prevent incorrect payer submission for services performed on our patients. For those patients receiving services from more than one payer source the two chart system will be integrated into one chart by 10/1/15. During recertification	

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	reviewed/revised 1-14-14, states, "The comprehensive assessment must be updated and revised every 60 days beginning with the start of care." 4. Policy, "Care Planning Process", last reviewed/revised 1-14-14, states, "Services provided will be based on the prioritized needs of the patient. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to determine if goals have been achieved." 5. Clinical record (CR) 1, start of care (defined as 1st billable visit) 4-15-15, contained a plan of care (POC) for the certification period (CP) 4-15 to 6-13-15, Medicaid payor. The first billable visit, with care furnished, was by a home health aide (HHA) on 4-28-15, 13 days after the date identified on the POC as the start of care (SOC). The SOC should have been 4-28-15, and the CPs should have been 4-28 to 6-26-15 and 6-27 to 8-25-15. 6. CR 2, SOC 5-20-15, contained a POC for the CP from 5-20 to 7-18-15, Medicare payor. The first billable visit, with care furnished, was by a registered nurse on 5-22-15, 2 days after the date identified on the POC as the SOC. The		cycles we will merge the charts into one, thus it will take several weeks to prevent discharge and readmit to make this conversion. This convertion will be the responsibility of the Administrator, with the Nursing Supervisor educated on what is required in POC creation. New notes will also need to be created to separate out the payer charges within the chart to prevent incorrect billing. Education will be completed by 9/15/15. Full conversion by 10/1/15. Additional Response from 9/18/15 coorespondance: Goals were not being written for all disciplines caring for the patient. In the incident cited the Home Health Aide goals were not established and discharge plans were contradictory. This is the responsibility of the Nursing Supervisor to review the POC before MD signature to ensure accuracy. The review of the document will continue to be performed by the Nursing Supervisor, and goals	

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	SOC should have been 5-22-15 and the CPs should have been 5-22 to 7-20-15 and 7-21 to 9-19-15. 7. CR 4, was maintained in the electronic clinical record system, Axxess, with 2 separate physician's plans of care. A. CR 4, SOC 5-29-15, contained a physician's POC for the CP 5-29 to 7-27-15, signed by the attending physician on 6-4-15, with orders for HHA services up to 12 hours per week, 4 days a week, Medicaid prior authorization, to assist with bathing, shampoo, grooming, dressing, oral care, hair care, skin care, ambulation, meal set-up (field identifier 21). Diagnoses included principal diagnosis of CHF (congenital heart failure); other pertinent diagnoses of hypertension and atrial fibrillation (field identifiers 11 and 13); DME listed: walker and incontinence supplies (field identifier 14); nutritional requirement: regular diet, supplement boost (field identifier 16); functional limitations: bowel/ bladder incontinence, hearing, ambulation (field identifier 18A); activities permitted: up as tolerated, independent at home, walker (field identifier 18B); goals/rehabilitation potential/discharge plans: The patient will be free from falls during the episode. The patient will be free from injury during the episode. Rehab. Potential:		and discharge are already on the clinical chart audit. To add a subset on the quarterly review document to look for goals for all disciplines and that discharge plans are not contradictory. This will be completed by 9/24/15.	

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	Fair for stated goals. Patient's condition is not expected to improve over time. Discharge Plan: Patient to be discharged to the care of caregiver. Discharge when caregiver willing and able to manage all aspects of patient's care (field identifier 22). The clinical record evidenced HHA visits were made during the episode. The POC failed to evidence goal(s) were established for HHA services. B. CR 4, SOC, 6-24-15, contained a physician's POC for the CP 6-24 to 8-22-15, Medicare payor, signed by attending physician on 6-25-15, with orders for skilled nursing (SN) 2 times a week for 1 week; 3 times a week for 2 weeks; 2 times a week for 6 weeks; SN for wound care. SN for medication management and education. SN visits monthly for supervision of HHA. HHA 3 times a week for 9 weeks to assist with bathing, shampoo, grooming, dressing, oral care, hair care, skin care, ambulation, meal set-up (field identifier 21). Diagnoses included principal diagnosis of CHF (congenital heart failure); other pertinent diagnoses of pressure ulcer of buttocks, hypertension, malaise and fatigue, and atrial fibrillation (field identifiers 11 and 13); DME listed: grab bars, tub/shower bench, walker, dressing supplies, exam gloves, and incontinence supplies (field identifier 14); nutritional requirement:			

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	regular, low cholesterol, supplement boost (field identifier 16); functional limitations: bowel/ bladder incontinence, hearing, endurance, ambulation (field identifier 18A); activities permitted: walker (field identifier 18B); goals/rehabilitation potential/discharge plans: Patient will verbalize understanding of proper use of pain medication by the end of the episode Patient/CG [caregiver] will verbalize knowledge of paint medication regimen and pain relief measures by the end of the episode. Wound(s) will heal without complication by the end of the episode. Wound(s) will be free from signs and symptoms of infection during the 60 day episode. Wound(s) will decrease in size by 100% by the end of the episode. Patient skin integrity will remain intact during this episode. The patient/caregiver will verbalize and demonstrate edema relieving measures the episode. The patient will be free from falls during the episode. The patient will be free from injury during the episode. The patient will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by [blank]. Rehab. Potential: Good for stated goals. Discharge Plan: Patient to be discharged to the care of caregiver. Patient to be discharged to self-care. Discharge when caregiver			

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	willing and able to manage all aspects of patient's care. Discharge when goals met. Discharge when wound(s) healed (field identifier 22). The clinical record evidenced SN and HHA visits were made during the episode. The POC failed to evidence goals were established for HHA services. The CR evidenced discharge plans which were contradictory, Patient to be discharged to care of caregiver. Patient to be discharged to self-care. Discharge when caregiver willing and able to manage all aspects of patient's care." 8. On 7-23-15 at 3:00 PM, the administrator, Employee A, indicated not being aware the first billable visit defined the start of care for CR 1 and CR 2. The administrator indicated CR 4 has 2 separate clinical records and 2 plans of care because the patient is dual eligible for Medicare SN for wound care and also Medicaid for HHA services. CR 4 started with HHA services from Medicaid, and later skilled nursing services under Medicare were added for wound care, medication management, and education. The plans of care are not identical, apart from the patient claim identification number, because the patient has two payors with separate billing. Administratively, Employee A indicated, it is simpler to track the services,			

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	frequencies, orders, etc. with 2 different clinical records and plans of care. The administrator indicated not being aware of the requirement to have 1 plan of care to address all the care provided by the agency to meet the patients' needs. The administrator indicated the agency has one other patient with dual eligibility for Medicare and Medicaid on service and there are 2 clinical records and 2 separate plans of care for each payor source, which are not identical apart from the patient claim identification number. Administrator indicated the discharge plan for CR 4 for the Medicare payer services, SOC 6-24-15 had contradictory goals of discharging patient to self-care and also discharging patient when caregiver willing and able to manage all aspects of patient's care. Administrator indicated the POC did not establish goal(s) in relation to HHA services. Administrator indicated it was not realistic to expect CR 4 to be able to resume independent self-care as patient was not expected to improve over time.			

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N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on policy review, job description review, clinical record review, and interview, the agency failed to ensure the registered nurse (RN) revised the plan of care to address all the needs identified in the comprehensive assessment for 1 of 4 clinical records reviewed (1). Findings include: 1. Policy, "Care Planning Process", last reviewed/revised 1-14-14, states, "Plan of Care: The clinical plan of care includes:	N 0542	Education of the Clinical Nurses that during admission of patients that are ordered only nonskilled care, that during the assessment if clinical issues are found, to contact the ordering physician to notify and ensure that documentation is performed stating physicians response. This is to ensure that the MD is aware of these issues and to verify if any treatment is required. In this situation the MD was aware of the wound care status, and did not have any orders for us. Patient was being seen by MD and wound care clinic. Education performed on 8/28/15 via E-mail	08/28/2015

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	... Pertinent primary and secondary diagnosis ... A physical assessment, including ... skin ... and other relevant data related to pertinent physical findings." 2. Job description of Registered Nurse, last reviewed/revised 1-14-14, states, "Provides a complete physical assessment and history of current and previous illness(es) ... initiates the plan of care and makes necessary revisions as patient status and needs change ... communicates with the physician regarding the patient's needs." 3. Clinical record 1 (CR), start of care (SOC) 4-15-15, contained a physician's plan of care (POC) for certification period (CP) 4-15 to 6-13-15. Comprehensive assessment, dated 4-15-15, evidenced under Other Diagnosis: ... Pressure Ulcer, stage 2 ... peripheral vascular disease ... diabetes mellitus type 2 ... Under Integumentary: Braden score 15, at risk for skin breakdown, Wound 1 right BKA [below knee amputation], date of onset 1-1-15, pressure ulcer, stage 2, length 2.0 cm, width 0.5 cm, depth 0.2 cm , surrounding tissue pink, drainage none, no odor ... patient leaves open to air, leaves off prosthesis ... No orders to do dressing change, is Medicaid episode." The CR		to notify the nurses of Reliant At Home of this requirement. Nursing Supervisor will be responsible for auditing the start of care documentation to ensure there is 100% compliance. Responsible: Nursing Supervisor, Start of Care Clinicians Additional Response from 9/4/15 coorespondance: Two chart system was originally established to prevent incorrect payer submission for services performed on our patients. For those patients receiving services from more than one payer source the two chart system will be integrated into one chart by 10/1/15. During recertification cycles we will merge the charts into one, thus it will take several weeks to prevent discharge and readmit to make this conversion. This convertion will be the responsibility of the Administrator, with the Nursing Supervisor being educated on what is required in POC creation. New notes will also need to be created to separate out the payer charges within the chart to prevent incorrect billing. Education will be completed by 9/15/15. Full conversion by 10/1/15.	

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	failed to evidence the registered nurse (RN), Employee D, assessed the pressure ulcer for granulation, slough, eschar, and tunneling; and failed to evidence the RN updated the POC to notify the physician of the stage 2 pressure ulcer and the need to revise the plan of care. 4. On 7-23-15 at 3:00 PM, Employee A, administrator, indicated the comprehensive assessment lacked a complete assessment of CR 1 pressure ulcer. Administrator indicated the RN should have reported the assessment of the pressure ulcer to the attending physician and initiated modification of the plan of care to address care of the pressure ulcer.			
N 0602 Bldg. 00	410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only cases). Based on review of 410 IAC 17-9-15 and	N 0602	Full data on our protocol was not entered into the interview. The	08/21/2015

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	interview, the agency failed to ensure home health aides were only assigned to their patient by a registered nurse in 1 of 1 agency. Findings include: 1. 410 IAC 17-9-15 states "The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only cases)." 2. During the entrance conference 7-22-15 at 10:05 A.M., the office manager, indicated the scheduler, Employee H, and the office manager, Employee B, not a registered nurse, contact the HHAs to inquire if the HHA will accept patients when a referral is received. Employee B indicated Employee H, scheduler, assigned all the HHAs to patients for the Bloomington branch and the Noblesville parent agency. 3. On 7-22-15 at 1:25 PM, Employee A, administrator, indicated Employee H, scheduler in the Bloomington branch, not a registered nurse, assigned home health aides (HHA) to patients for the parent agency in Noblesville and the branch office in Bloomington.		Scheduler and the Office Manager perform these functions under the supervision and instruction of the Nursing Supervisor which is a Registered Nurse. Each day at 10:30 am we hold a conference call which includes all locations and the sales team. Staffing of new admission and resumptions, readmission are discussed daily with verbal acknowledgement of who will be assigned to the case. The office staff is then instructed by the Registered Nurse (Clinical Director) to make the necessary calls to start or resume services. Believe this deficiency to be incorrect. Responsibility: Nursing Supervisor	

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N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on policy review, clinical record review and interview, the agency failed to ensure the registered nurse (RN) appropriately supervised the home health aide (HHA) as required by agency policy and implemented corrective actions for care not documented as provided for 1 of 1 clinical records reviewed receiving home health aide (HHA) only services (1). Findings include: 1. Policy, "Home Health Aide Supervisory Visits", last reviewed/revised 1-14-14, states, "Nursing personnel or therapists, as appropriate, must be available to the home health aide for consultation at all times during the aide's	N 0606	The charts showed no evidence that the Skilled Nurse or Physical Therapist Assigned to the case was reviewing the Home Health Aide Care plan and conforming to this plan. This was addressed by the following protocols. 1. Note type of HHA supervisory visit exchanged for Note Type of SNV with supervisory visit. HHA supervisory note has the requirements of our policy unlike the note being used. Examples of these note types can be located in the attachments of this response. 2. Supervising clinician with the assistance of the scheduling coordinator are responsible for reviewing the notes and comparing it to the care plan and make the necessary corrections during the supervisory visit to ensure HHA compliance. 3. Nursing Supervisor will be responsible for	08/28/2015

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RELIANT AT HOME LTD	341 LOGAN ST STE L110 NOBLESVILLE, IN 46060

(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
	working hours. The registered nurse or therapist must conduct supervisory visits to the patient's residence at regular intervals ... The frequency of supervisory visits will be based upon the needs of the patient after the plan of care is established. They must be conducted at least every two (2) weeks ... The registered nurse and / or appropriate therapist will be responsible for: supervision of all services provided for in the plan of care." 2. Clinical record (CR) 1, start of care 4-15-15, included a physician's plan of care (POC)for the certification period 4-15- to 6-13-15 with orders for home health aide (HHA) services 2 hours each day, 2 days each week, for 9 weeks. HHA to assist with ADL(activities of daily living)/IADLs (instrument activities of daily living) of hygiene/bathing, dressing, grooming, meal prep, and light housekeeping. A. HHA plan of care, dated 4-15-15, signed by Employee D, RN, included the following care: Every visit - assist with shower with chair, shampoo hair, hair care/comb hair, oral care, skin care, peri care, nail care, shave, assist with dressing, assist with bedpan/urinal, assist with BSC (bedside commode), turn and position, assist with transfer, make bed, light housekeeping, meal set up, assist		the entry of the correct note type effective immediately. 4. Monitoring: HHA care plan is already tracked on the QA and is an indicator. This will be reviewed quarterly during out audit and reported for compliance. Education of requirements sent to clinical staff on 8/28/15 by the Nursing Supervisor These protocols will prevent this from recurring in the future. Responsibility: Nursing Supervisor, Scheduling Coordinator and supervising clinician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	with feeding; Every week-change linen. B. On 4-28-15 and 4-30-15, Employee G, HHA, failed to evidence bathing assistance, oral hygiene, turn and reposition, skin care, assist with dressing, peri care, making of bed, and meal preparation had been provided. On 5-5-15 and 5-7-15, Employee G, HHA, visit note failed to evidence bathing assistance, shave, oral hygiene, turn and reposition, skin care, assist with dressing, peri care, and meal preparation had been provided. On 5-11-15 and 5-14-15, Employee G, HHA, failed to evidence bathing assistance, oral hygiene, turn and reposition, assist with dressing, peri care, and meal preparation had been provided. On 5-19-15, Employee G, HHA, visit note failed to evidence bathing assistance, oral hygiene, turn and reposition, skin care, peri care, making of bed, and meal preparation had been provided. On 5-21-15, Employee G, HHA, visit note failed to evidence oral hygiene, turn and reposition, making of bed, and meal preparation had been provided. On 5-25-15, Employee G, HHA, visit note failed to evidence oral hygiene and turn and reposition had been provided. On 5-27-15, Employee G, HHA, visit note failed to evidence turn and			

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	reposition care had been provided. On 6-2-15, Employee G, HHA, visit note failed to evidence oral hygiene, turn and reposition, and meal preparation had been provided. On 6-4-15, Employee G, HHA, visit note failed to evidence oral hygiene, turn and reposition, and meal preparation had been provided. On 6-8-15, Employee G, HHA, visit note failed to evidence turn and reposition, and meal preparation had been provided. On 6-10-15, Employee G, HHA, visit note failed to evidence turn and reposition, and meal preparation had been provided. C. The CR evidenced a supervisory visit on 5-13-15, by Employee D, RN, which failed to evidence the RN took appropriate corrective action regarding Employee G, HHA, failure to document services were provided as per HHA plan of care. Supervisory visit dated 6-11-15, #2 "Follows client's plan of care", evidenced Employee D, RN, checked "Yes". 3. The administrator, Employee A, indicated on 7-23-15 at 3:00 PM the HHA had not completed the services as per the HHA plan of care and the RN should have taken corrective measures to ensure the HHA followed the HHA care			

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	plan. The administrator, Employee A, was unable to locate an agency policy for supervisory visits of patients receiving only HHA services. Administrator indicated the agency policy title and contents do not distinguish between skilled and unskilled patients, therefore this policy applies.			