STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K167	A. BUILDING 00 B. WING	09/13/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00		G 0000		

This visit was for a Federal Recertification and State Licensure survey of a Medicaid agency. This survey was fully extended.

Survey Dates: September 09, 10, 11, 12, and 13, 2019

Facility #: IN014118
Provider #: 15K167

Census: 90
Skilled: 2
Aide only: 65
Personal Service: 23

Active Census: 44
Skilled: 2
Aide only: 42

These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State findings.

Adaptive Nursing and Healthcare Services, INC, are precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning September 13, 2019 to September 12, 2021 for being out of compliance with Condition of Participation 42 CFR 484.50 Patient Rights; 42 CFR 484.55 Comprehensive assessment of patients; §484.60 Care planning, coordination, and quality of care; §484.65; Quality assessment and performance improvement; and §484.80 Home Health Aide Services; §484.105 Organization and

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	administration of services; and §484.110 Clinical Records. Quality Review Completed: 10/24/19 by SFF			
G 0350 Bldg. 00	Based on record review and interview, the agency failed to have in place a current written contract for the agent, acting on behalf of the agency, to ensure the confidentiality of all patient identifiable information included in the clinical record for 1 of 1 agency. Findings include: During the entrance conference meeting conducted on 09/09/19 at 10:30 AM, with the administrator and office manager, the administrator indicated that administrator of another entity transmited the agency's patient OASIS [outcome and assessment information set] information. The administrator indicated they did not have a contract with the individual. Review of Patient Orientation Handbook, undated, was completed on 09/09/19, section entitled "Privacy" stated "The patient has the right to confidentiality of the clinical records maintained by the home health agency" and "The patient has the right to confidentiality of written, verbal, and electronic information about the health, social and financial circumstances of the patient or about what takes place in their home." Record review of patient #1 evidenced an	G 0350	As per active RN roster that was provided on 9/10/19 Jennifer Miller, HHA employee submitting OASIS data, is an employee of Adaptive Nursing and Healthcare Indianapolis. Personnel file to be uploaded with current roster list that was provided during survey. There has been no HIPAA violation. The deficiency has been corrected by a contract has been signed with the Jennifer Miller to submit OASIS data. See contract attached. All OASIS data submissions were reviewed and had been submitted by agent who is an active employee of Adaptive Nursing Indianapolis. OASIS data submission contract has been created and signed to cover all future OASIS data submissions. Administrator will monitor yearly to ensure OASIS data submission	11/07/2019

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	assessment with OASIS information was collected and transmitted by a non-employee of the agency. An interview with the administrator and office manager was conducted on 09/09/19 at 4:45 PM. The office manager indicated that OASIS information was submitted without having a contract in place for the individual that transmited the OASIS data collected.		contract is up to date and current for all OASIS data submissions to prevent any HIPPA violation.	
G 0372 Bldg. 00	Based on record review and interview, the agency failed to submit OASIS (outcome and assessment information set) within 30 days of assessment completion for 1 of 1 skilled record where OASIS information was collected and transmitted. (# 1). Findings include: Review of the OASIS submission report, the agency failed to evidence any skilled OASIS submissions for the year 2019. The clinical record of patient #1 was reviewed, start of care of 7/15/19. The OASIS certification assessment was submitted for transmission on 8/30/2019. The record failed to evidence that OASIS submission occurred within 30 days of completion. During the entrance conference on 9/09/2019 at 10:30 AM, the administrator indicated an individual, from the Jeffersonville, Indiana sister office, entered and submited the OASIS data and transmits.	G 0372	The Administrator did provide OASIS In-service to reeducate all Clinical Managers on the specifics of the time requirement of OASIS completion has been completed on 10/29/19. Administrator will track all OASIS clients weekly to ensure review and submission of OASIS form within 30 days of visit. Administrator will complete a full audit of all skilled clients by 11/4/19 to ensure compliance with all clients that could have been effected. Administrator will ensure that orientation of newly hired clinical staff will include review of agency OASIS requirements. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/04/2019

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G 0406 Bldg. 00	Based on record review and interview, the agency failed to ensure patient and/ or patient representatives were provided an accurate notice of the Patient Bill of Rights, Authorization, Agreement, and Acknowledgement Forms, and Notice of Privacy Rights before the initiation of treatment and failed to ensure all patients admitted after 6/07/2019 were provided the correct agency contact for all grievances for patients with start of care after 6/07/2019; failed to ensure the current administrator contact information was provided to patients in the patient orientation handbook; failed to ensure the patient's right to have a confidential clinical record; failed to ensure that patients were provided current names, addresses, and telephone numbers for the Indiana Area Agency on Aging by service area; failed to ensure the home health agency arranged a safe and appropriate transfer to another care entity(s) when the needs of the patient exceeded the HHA's capabilities; failed to investigate injuries of an unknown source and misappropriation of patient property by anyone furnishing services on behalf of the HHA (home health agency); failed to document the resolution of complaints made by the patient/ legal representative. These practices impacted 5 (Patients #1, 2, 3, 6, 8) out of 9 sample records an 4 (Patient #25, 26, 27, 28) out of 25 grievance entries reviewed. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure apatient rights were adhered to which could result in the agency not providing quality health care and safety for all 44 current patients.	G 0406	Administrator has updated Patient Orientation Handbook and consent was updated to reflect current and accurate information in 10/2019. Handbook was updated with accurate notice of patient bill of rights, authorization agreement and acknowledgement forms, Notice of privacy rights and current Administrator's name and contact information. All current names, addresses and phone numbers have been updated with this update as well. This will be provided prior to initiation of services. All current clients will receive updated handbook as of 11/8/19. Administrator will ensure with monthly checklist that Patient Orientation Handbook is up to date with all requirements. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's needs exceed the capabilities of the HHA with HHA Not Meeting Patient Needs In-service to be completed on 11/4/19. Administrator will ensure reeducation to all internal staff regarding misappropriation of client property, resolution of complaints, and investigation of injuries with Investigation of Mistreatment, Neglect or Abuse	11/08/2019

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			In-service, completed by 11/4/19. Administrator modified grievance review process to ensure grievances are logged and resolved weekly on 10/24/19. Form included. Administrator will be notified of all incidents/grievances, delegate investigation and ensure follow-up and documentation are completed weekly. See attachments	
G 0410 Bldg. 00	Based on record review and interview, the agency failed to ensure patient and/ or patient representatives were provided an accurate notice of the Patient Bill of Rights, Authorization, Agreement, and Acknowledgement Forms, and Notice of Privacy Rights before the initiation of treatment in 4 of 8 active clinical records reviewed (#1, 2, 4, 6) and 1 of 2 closed records reviewed (#8) and also failed to ensure all patients admitted after 6/07/2019 were provided the correct agency contact for all grievances in 3 of 3 active records reviewed with SOC after 6/07/2019 (Patients 1, 4, and 6) with potential to affect all patients of the agency. The findings include: 1. During the entrance conference on 9/09/2019 at 10:30 AM, employee C was identified as the administrator and employee QQ was identified as the director of nursing. 2. Review of the agency's undated admission	G 0410	**Administrator has updated Patient Orientation Handbook and consent was updated to reflect current and accurate information in 10/2019. Handbook was updated with accurate notice of patient bill of rights, authorization agreement and acknowledgement forms, Notice of privacy rights and current Administrator's name and contact information. All current names, addresses and phone numbers have been updated with this update as well. This will be provided prior to initiation of services. All current clients will receive updated handbook as of 11/8/19.** Administrator will ensure with monthly checklist that Patient Orientation Handbook is up to	11/08/2019

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	packet, on 9/09/2019, indicated the individual to contact at the agency with concerns or grievance was the previous administrator, Employee E. 3. Written notice to the state agency, dated 6/07/2019, indicated employee C was the current administrator and employee QQ was the clinical director. 3. The admission document titled, "Adaptive Nursing and Healthcare Services Admission Consent," stated, "Client fully understands and acknowledges that Adaptive: (a) is a non-medical provider, and (b) is not licensed to perform medical services." This document was dated, at time of admission, in the individual clinical records, 1, 2, 4, 6, and 8, as received. 4. A review of clinical record #1, start of care [SOC] 7/15/2019, evidenced that the patient / patient representative received an inaccurate Patient Rights, Authorization / Agreement / Acknowledgement, and Notice of Privacy Rights documents before the initiation of treatment and given inaccurate administrator contact for concerns and grievances. The patient / patient representative signed these documents on 7/15/2019 with Employee F, Registered Nurse (RN). 5. A review of clinical record #2, SOC of 5/20/19, evidenced that the patient / patient representative received an inaccurate Patient Rights, Authorization / Agreement / Acknowledgement, and Notice of Privacy Rights documents before the initiation of treatment. The patient / patient representative signed these documents on 5/20/2019 with Employee E, a RN. 6. A review of clinical record #4, SOC of 9/04/19,		date with all requirements. **See** attachments	

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	evidenced that the patient / patient representative received an inaccurate Patient Rights, Authorization / Agreement / Acknowledgement, and Notice of Privacy Rights documents before the initiation of treatment and given inaccurate administrator contact for concerns and grievances. The patient / patient representative signed these documents on 9/04/2019 with Employee L, a RN. 7. A review of clinical record # 6, SOC of 7/02/19, evidenced that the patient / patient representative received an inaccurate Patient Rights, Authorization / Agreement / Acknowledgement, and Notice of Privacy Rights documents before the initiation of treatment and given inaccurate administrator contact for concerns and grievances. The patient / patient representative signed these documents on 7/02/2019 with Employee G, a RN. 8. A review of clinical record #8, 01/30/2019, evidenced that the patient / patient representative received an inaccurate Patient Rights, Authorization / Agreement / Acknowledgement, and Notice of Privacy Rights documents before the initiation of treatment. The patient / patient representative signed these documents on 0130/2019 with Employee RR, a RN. 9. On 9/12/2019 at 3:30 PM, the administrator indicated the consents in the electronic medical record system were not updated when the consents for the Personal Service Agency and the Home health agency were merged.			
G 0414 Bldg. 00		G 0414	Administrator has updated Patient	11/08/2019

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	Based on record review and interview, the agency failed to ensure patients / patient representatives admitted after 6/07/2019, received the accurate home health agency administrator's name, business address, and business phone number in order to receive complaints for 3 of 3 active clinical records reviewed with start of care after 6/07/2019 and affected all patients admitted after 6/07/2019. (Patients 1, 4, and 6) Findings include: 1. The agency's, undated, patient information titled, "Patient Orientation Handbook," was reviewed on 09/09/19. The section entitled "Problem Solving Procedure" stated "Any concern or grievance may be made in writing or by a telephone call to the Indy North Parent Office Administrator, [name of employee E]." 2. During survey entrance conference on 09/09/19 at 10:30 AM, employee C indicated she was the administrator on record and that employee E was out on maternity leave. Interview with the administrator and office manager was conducted on 09/09/19 at 4:45 PM. The administrator relayed that the incorrect individual was referenced in the admission document and that they would update the admission packet to reflect the change. 3. A review of clinical record #1, start of care [SOC] 7/15/2019, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints. 4. A review of clinical record #4, SOC of 9/04/19, failed to evidence that the patient / patient		Orientation Handbook and consent was updated to reflect current and accurate information in 10/2019. Handbook was updated with accurate notice of patient bill of rights, authorization agreement and acknowledgement forms, Notice of privacy rights and current Administrator's name and contact information. All current names, addresses and phone numbers have been updated with this update as well. We added an acknowledgement signature page with Administrators information to ensure when updates are received. This will be provided prior to initiation of services. All current clients will receive updated handbook as of 11/8/19. Administrator will ensure with monthly checklist that Patient Orientation Handbook is up to date with all requirements. See attachments	

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	representative received the current administrator's name, business address, and business phone number in order to receive complaints. 5. A review of clinical record # 6, SOC of 7/02/19, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.			
G 0438 Bldg. 00	Based on record review and interview, the agency failed to ensure the patient's right to have a confidential clinical record for 1 of 1 skilled clinical records reviewed. (#1) Findings include: During the entrance conference meeting conducted on 09/09/19 at 10:30 AM, with the administrator and office manager, the administrator indicated that an individual of another home health agency transmitted the agency's OASIS data. When asked, the administrator indicated that they did not have a contract with the individual. Review of Patient Orientation Handbook, undated, was completed on 09/09/19, section entitled "Privacy" stated "The patient has the right to confidentiality of the clinical records maintained by the home health agency" and "The patient has the right to confidentiality of written, verbal, and electronic information about the health, social and financial circumstances of the patient or about what takes place in their home."	G 0438	As per active RN roster that was provided on 9/10/19 Jennifer Miller, HHA employee submitting OASIS data, is an employee of Adaptive Nursing and Healthcare Indianapolis. Personnel file to be uploaded with current roster list that was provided during survey. There has been no HIPAA violation. The deficiency has been corrected by a contract has been signed with the Jennifer Miller to submit OASIS data. See contract attached. All OASIS data submissions were reviewed and had been submitted by agent who is an active employee of Adaptive Nursing Indianapolis. OASIS data submission contract has been created and signed to cover all future OASIS data submissions.	11/07/2019

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	Record review of patient #1 revealed that an assessment with OASIS [Outcome and ASsessment Information Set] data information, collected from the patient, was reviewed and transmitted by a non-employee of the agency. During an interview with the administrator and office manager, conducted on 09/09/19 at 4:45 PM, the office manager indicated that OASIS information was submitted by an individual, without a contract in place. 410 IAC 17-12-3(b)(2)(E)		Administrator will monitor yearly to ensure OASIS data submission contract is up to date and current for all OASIS data submissions to prevent any HIPPA violation. See attachments	
G 0446 Bldg. 00	Based on record review and interview, the agency failed to ensure that patients were provided current names, addresses, and telephone numbers for the Indiana Area Agency on Aging by service area for 1 of 1 agency. The findings include: Review of Patient Orientation Handbook, undated, included Indiana's Area Agencies on Aging by service area (dated 07/03/17). Review of Area Agencies on Aging from in.gov, documented an update on 02/05/19. The update included new contact addresses/ phone numbers for Public Service Area's 7, 8, and 9. An interview was conducted with the administrator and office manager on 09/09/19 at 4:45 p.m.. At that time, both the administrator and office manager concurred that the current admission handbook contained outdated Area on	G 0446	Administrator has updated Patient Orientation Handbook and consent was updated to reflect current and accurate information in 10/2019. Handbook was updated with accurate notice of patient bill of rights, authorization agreement and acknowledgement forms, Notice of privacy rights and current Administrator's name and contact information. All current names, addresses and phone numbers have been updated with this update as well. We added an acknowledgement signature page with Administrators information to ensure when updates are received. This will be provided prior to initiation of services. All current clients will receive updated handbook as of 11/8/19. Administrator will ensure with monthly checklist that Patient	11/08/2019

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	Aging information.		Orientation Handbook is up to date with all requirements. See attachments	
G 0454 Bldg. 00	Based on record review and interview, the agency failed to ensure the home health agency arranged a safe and appropriate transfer to another care entity(s) when the needs of the patient exceeded the HHA's capabilities for 2 of 2 adult skilled records reviewed (#1 and 6). The findings included: The clinical record for patient # 1, with start of care [SOC] 7/15/2019, included a plan of care for the certification period of 7/15/19 to 9/12/19, with orders for skilled nurse services, 8 hours a day, 5 days a week, effective 7/15/19. Review of the electronic medical record for patient #1 failed to evidence skilled nurse visits were provided as ordered. The first skilled nurse visit note, dated 8/13/2019, by employee I, a registered nurse, was the first documentation of skilled nurse services. The clinical record failed to evidence documentation to explain why skilled nurse services were not completed as ordered on the plan of care. During interviews on 9/10/19 at 3:30 PM, the office manager indicated the patient was accepted and the plan of care was established and the nurse for the case was to begin the following day, 7/16/2019, and failed to arrive for her first day of orientation, therefore, the agency did not have a	G 0454	Patient #1 Chart reviewed and documentation has been updated to show communication with primary caregiver that she was okay to wait after skilled nurse did not show up for orientation. Mom reported that she was oaky to wait for new skilled nurse as she had someone providing the services and wanted to give them an appropriate notice that they were no longer needed. All charts have been reviewed to ensure services are being provided as orderd. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's needs exceed the capabilities of the HHA with HHA Not Meeting Patient Needs In-service to be completed on 11/4/19. Administrator will review all client admission charts to ensure 100% compliance. Patient #6 Documentation from interoffice emails showing communication with primary caregiver and her wishes to wait on services until	11/04/2019

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	nurse for the case. Employee A indicated the communication between the agency and the primary care giver was in her agency emails. No information was provided by survey exit. A review of record #6 on 9/10/2019, evidenced an assessment was completed on 7/02/2019, by employee G, a registered nurse. The record included a Home Health Certification and Plan of Care for the certification period of 7/02/2019 to 8/30/2019 with orders for skilled nursing services 8 hours per day 5 days a week throughout the certification period. The record failed to evidence any skilled service was provided as ordered in the physician ordered plan of care. During an interview on 9/10/2019 at 3:20 PM, the administrator indicated there were no visits provided. The record failed to evidence documentation to explain why there were no skilled services provided.		she received a hoyer lift in the home is in chart. All charts have been reviewed to ensure services are being provided as orderd. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's needs exceed the capabilities of the HHA with HHA Not Meeting Patient Needs In-service to be completed on 11/4/19. See attachments Administrator will review all client admission charts to ensure 100% compliance. See attachments	
G 0482 Bldg. 00	Based on record review, the agency failed to investigate injuries of an unknown source and misappropriation of patient property by anyone furnishing services on behalf of the HHA (home health agency) for 2 of 25 grievances reviewed. (#25 and 26) Findings include: 1. Review of policy entitled "Grievance Policy", dated 03/13/19 stated the grievance definition as "A grievance is any formal or informal written or	G 0482	**Administrator will ensure reeducation to all internal staff regarding misappropriation of client property, resolution of complaints, and investigation of injuries with Investigation of Mistreatment, Neglect or Abuse In-service, completed by 11/4/19.** **Administrator modified grievance review process to ensure grievances are logged and resolved weekly on**	11/04/2019

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	verbal expression of dissatisfaction with care or service that is expressed by the client/family that is not solved at the time by staff present. A written complaint is always considered a grievance; as are complaints alleging abuse, neglect, client harm, charges/ billing or non-compliance with state regulations." And "Agency name must document both the existence of the complaint and the resolution." 2. Review of Patient Orientation Handbook, undated, page 17 stated "The Administrator/ Director shall document both the existence of the complaint and the resolution of the complaint, investigate the complaint and report the outcome of the investigation to the patient or their representative." 3. Complaint/ Grievance dated 01/02/18, documented "Patient #25 called the office and reported that she believed the caregiver for and her husband, took a woman's suit from her." This entry was signed by administrator. The agency failed to evidence that the incident was investigated. 4. Activity Tracking Log, Complaint/ Grievance date 04/02/19, indicated indicated Patient #26 had a swollen wrist/ with an unknown origin. The agency failed to evidence that the injury was investigated. 410 IAC 17-12-3(c)(1) 410 IAC 17-12-3(c)(2)		**10/24/19. Form included. Administrator will be notified of all incidents/grievances, delegate investigation and ensure follow-up and documentation are completed weekly.** Administrator will monitor 100% compliance weekly with report from Matrix and place in QAPI binder. Administrator will review all charts to ensure 100% compliance with all documentation and resolution. See attachments	
G 0484 Bldg. 00	Based on record review, the agency failed to	G 0484	Administrator will ensure reeducation to all internal staff	11/04/2019

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	document the resolution of complaints made by the patient / legal representative for 4 of 25 grievances reviewed. (#3, 25, 27. 28) Findings include: Review of agency policy entitled "Grievance Policy", dated 03/13/18, stated "Grievances will be addressed by the manager/administrator or his/her designee and response made to the complainant within seven (7) calendar days of receipt." And "Grievances are considered completed when the complainant has been provided with the investigation/resolution of the grievance. This will be used to determine actions to be taken regarding improvements in organizational process, services, or individual employee performance. Grievances are considered resolved when the client is satisfied with the actions taken on their behalf." Review of Patient Admission Handbook, undated, page 17 stated "The Administrator/Director shall document both the existence of the complaint and the resolution of the complaint, investigate the complaint and report the outcome of the investigation to the patient or their representative." A review of the Activity Tracking Log, Complaint / Grievance for the time period of 1/1/18 through 9/9/19 was completed on 09/09/19. The following complaints logged failed to evidence documentation of a resolution. 1. Complaint/ Grievance dated 01/02/18, included the following intake, "Patient #25 called the office and reported that she believed the caregiver for and her husband, took a woman's suit from her." The complaint was signed by administrator.		regarding misappropriation of client property, resolution of complaints, and investigation of injuries with Investigation of Mistreatment, Neglect or Abuse In-service, completed by 11/4/19. Administrator modified grievance review process to ensure grievances are logged and resolved weekly on 10/24/19. Form included. Administrator will be notified of all incidents/grievances, delegate investigation and ensure follow-up and documentation are completed weekly. Administrator will monitor 100% compliance weekly with report from Matrix and place in QAPI binder. Administrator will review all charts to ensure 100% compliance with all documentation and resolution. Resolution of patient #25 missing suit - documentation was present and is now attached. See attachments	

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	2. Complaint/ Grievance dated 03/14/19, related to patient #3, documented "I received a call from [patient] and she is balling her eyes out. Basically, her aide in the evening and her do not get along. The aides name is [name of aide]. She works at [name] hospital as a MA (medical assistant) and has been doing patient care for a long time so I trust she knows what she is doing. Patient doesn't like her because she bought the wrong kind of Mt. (Mountain) Dew and because [aide name] wouldn't take a box of incontinent supplies down the street to a different house (agency told her not to do this). I asked patient if she is being fed, showered, and kept clean and she said yes, so those are my biggest concerns. I will replace this caregiver per patient request, but it will take us time to interview, hire, and train someone." The complaint was void author, there was no signature. The agency failed to evidence a resolution. 3. Complaint/ Grievance dated 08/13/19, patient #27, documented "Caregiver [sent] text - I can no longer work for patient #27. I refuse to put myself in that environment. Him and Ms. [patient] want to much out of me. I have to hear them argue and see [patient] have screaming episodes plus more. He needs more help than I can give him. If that means I have to resign then I am sorry. $12 isn't worth it. CK." The agency failed to evidence a resolution. 4. Complaint/ Grievance dated 09/05/19, patient #28, documented "Patient #28 is threatening to leave us again because aide isn't able to do 7:15 am - 5:15 PM. She is scheduled for 7:30-5:30 PM. She also said that everything else is great, but she wants us to replace her ASAP if she can't do the schedule she needs. Neither the aide nor the			

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	patient are coming to an agreement with the times. We are pretty much staffing all of her hours at this time and I am not sure what else to do to keep the patient happy." The agency failed to evidence a resolution. 410 IAC 17-12-3(c)(2)			
G 0510 Bldg. 00	Based on observation, record review and interview, the agency failed to evidence a skilled service was provided to establish the start of care [SOC], ensured the comprehensive assessment accurately reflected the patient's current health, psychosocial, functional status, including a correct home safety evaluation, and a correct nutritional risk assessment, ensured included the patient's strengths, goals, and care preferences, including information to demonstrate progress toward goals and measurable outcomes, updated a patient's current medication additions and changes in medications; ensured included the patient's strengths, ensured to include the incorporation of the current Outcome and Assessment Information Set [OASIS] items; ensured an updated comprehensive assessment was completed within the last 5 days of certification period; and ensured to complete an updated comprehensive assessment at discharge. These practices impacted 5 (Patient #1, 2, 4, 6, 7) out of 8 sample records and 1 (Patient #9) out of 1 focused sampled records reviewed. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure patients were assessed accurately and completely which could result in the agency not providing quality health care in a safe	G 0510	**Administrator will ensure reeducation to all internal staff regarding complete and accurate comprehensive assessments with Comprehensive Assessment In-service, completed by 11/4/19.** In-service includes reeducation to accurately reflected the patient's current health,psychosocial, functional status, including acorrect home safety evaluation, and a correctnutritional risk assessment, ensured included thepatient's strengths, goals, and care preferences,including information to demonstrate progresstoward goals and measurable outcomes, updateda patient's current medication additions andchanges in medications; ensured included thepatient's strengths, ensured to include theincorporation of the current Outcome andAssessment Information Set [OASIS] items;ensured an updated comprehensive assessmentwas completed within the last 5 days	11/04/2019

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	environment.		ofcertification period; and ensured to complete anupdated comprehensive assessment atdischarge.Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. See attachment ="" span="">	
G 0528 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient's current health and functional status including a correct home safety evaluation (patient #2); failed to be consistent with the plan of care in regards to the nutritional risk assessment (patient #7); failed to assess of the endocrine system, integumentary status, cardiopulmonary, a complete elimination status with bowel assessment, psychosocial assessment, functional limitations, musculoskeletal, activities permitted, allegory assessment, patient goals, and discharge planning (patient #1) and failed to evidence an accurate and complete assessment of a client's environment, personal care needs, medications, activity level, and the wheelchair status (patient #4) during 1 of 3 home visits and for 4 of 8 sampled records reviewed. Findings include: 1. The "Comprehensive Client Assessment"	G 0528	**Administrator will ensure reeducation to all internal staff regarding complete and accurate comprehensive assessments with Comprehensive Assessment In-service, completed by 11/4/19.** **In-service includes reeducation to accurately reflected the patient's current health,psychosocial, functional status, including acorrect home safety evaluation, and a correctnutritional risk assessment, ensured included thepatient's strengths, goals, and care preferences,including information to demonstrate progresstoward goals and measurable outcomes, updateda patient's current medication additions andchanges in medications;**	11/04/2019

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	policy was provided by Employee C on 9/11/19 at 1:00 p.m. This current policy indicated "POLICY A thorough, well organized comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients in a timely manner, but no later then five (5) calendar days after start of care....PURPOSE To determine the appropriate care, treatment and services to meet client initial needs and his/her changing needs. To collect data about the client's health history, (physical, functional and psychological) and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individual's response to care...SPECIAL INSTRUCTIONS ...2. The Comprehensive Assessment will include a review of all medications the client is using...6. Assessment and documentation are made regarding whether the home environment is suitable for providing home care ...." 2. Review of policy entitled "Admission Criteria", dated 03/20/18, only refers to the home safety evaluation in section #8. which stated "The following forms are signed, by the patient, during the admission process with a copy remaining in the patient's home chart and the original will be maintained in the office clinical record; Home Safety Evaluation." 3. A home observation was completed on 09/11/19 at 6:50 am for patient #2. During the home visit it was observed that there was no alternate exit in case of fire. The home consisted of a renovated attic above an existing home with one entrance/ exit around the side of the home through a staircase. Review of the "Home Environment Safety		**ensured included thepatient's strengths, ensured to include theincorporation of the current Outcome andAssessment Information Set [OASIS] items;ensured an updated comprehensive assessmentwas completed within the last 5 days ofcertification period; and ensured to complete anupdated comprehensive assessment atdischarge.**Administrator will ensure reeducation for home safety concerns with The Home Safety Evaluation In-service on 11/4/19. **Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.** See attachment ="" span="">	

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	Evaluation" form dated 05/20/19, #6 asked if alternate exits were accessible in case of fire, in which the response/ answer was "yes." On 09/11/19 at 12:30 p.m., a copy of a home environment assessment policy was requested. On 09/11/19 at 1 p.m., the administrator indicated that there was no policy for home safety/ environment assessment or policy of any kind related to home environment and that it is included in the Admission Criteria policy. 4. Record review for patient #7, a form titled "Nutritional Risk Assessment" dated 02/15/19, indicated a risk score of 10, low risk (score range 0-25). This score was comprised of "takes 3 or more prescribed or OTC (over the counter) medications per day, frequently has problems with diarrhea or constipation." Plan of care review for certification period 02/17/19-04/17/19, the nutritional requirements stated "Medium nutritional risk." 60-day summary (page 2 of 4) stated "She isn't physically able to provide her own personal care, cook her own meals . . ." and "Patient #7 has no willing or able caregivers outside of agency name . . ." 5. On 9/10/19 from 10:46 a.m. to 1:35 p.m., Client 4's home visit was conducted. Upon entry into the kitchen, an odor was detected. Employee M, who was present in the kitchen, indicated the odor was body odor. Fly tapes were observed hanging above the washer next to the exit door, another next to the stove and a third tape above the kitchen sink. Gnats and flies were observed on these tapes. At this same time Employee M indicated the fly tapes were not present yesterday, but the flies were "pretty bad" yesterday. The refrigerator door was observed with brown dried substances on the outside door,			

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	dishes were stacked in 1 side of the sink with dried food present and the other side of the sink had standing water with brown substances floating in the water. Soiled rags were observed in a pan on the table located in front of the window. The bagless trash can was full of trash, including, but not limited to, disposable gloves, cardboard pasta box, and food wrappers. A floor fan, which was presently turned off, was observed with dark gray to black dust covering the majority of the front screen of this fan. In the living room with lights on, Client 4 was observed eating a bowl of cereal in her bed. She was observed in a hospital gown with several wet and brown, soiled sheets underneath her the length of her shoulders to her upper legs. A Foley catheter with the attached bag containing a small amount of dark, yellow urine in the bag hung at the end of the client's bed. The carpeting in this room was observed with scattered stained areas with a saucer size worn hole in the carpeting near the end of one of the bed's wheels. A Hoyer lift and walker was observed in the corner of the room. As Employee M was observed giving the client her bed bath, the client apologized to staff present and indicated she needed to urinated, and then, Client 4 urinated in the bed. This puddle of urine between her legs was absorbed by the client's female roommate with a towel. When the client was turned to her right side, the mattress from the client's shoulders to her upper legs was odorous and wet with loose, brown soft bowel movement observed in the rectal area. At the time for the rectal care and perineal care, Employee L (RN) indicated she had to leave for a short period. Employee L left at 12:35 p.m. and returned at 12:46 p.m. During the client's bath she complained of			

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	being too hot ,and the fan present in the kitchen was turned on blowing towards the client in her bed. On 9/11/9 from 11:40 a.m. to 12:09 p.m., during an interview Employee L indicated her initial visit consisted of completing the admission forms, client's past medical history, any falls, nutrition, review all medications and document the medications. A verbal order for the start of care would be obtained from the physician, and a Plan of Care would be initiated and would be reviewed by the Supervisor or the Director of Nursing. She indicated Client 4's assessment included her vital signs, checking the client's hand grasps, any swelling in the ankles and feet. She indicated she did a visual check of the skin from head to toes anteriorly, but she was unable to do a posterior check as no one was present to help turn the client to her side. She did indicate she asked the client about the condition of her skin. She indicated Client 4 was found in the same condition related to the soiled sheets and condition of her abdominal fold as at the home visit conducted 9/10/19. She also indicated the house was "very dark" with the curtains pulled, and she did not see the fan or the F/C bag and tubing at the end of the bed. Related to the medications she indicated a concern with the laxatives the client was taking, but she had not discuss this with the client at the home visit. Employee L indicated the environment was a concern due to the possible bugs in the house. When queried Employee L indicated 1 aide would not be able to turn her, and the roommates have indicated they did not want to help with the client's care. Employee L also indicted the client continued to refuse to use the Hoyer lift, which was present in the home, and her electric wheelchair was broken and non-functional.			

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	Client 4's clinical record was reviewed on on 9/10/19 at 3:45 p.m. The client's diagnoses included, but were not limited to, rheumatoid arthritis, Type 2 Diabetes Mellitus, hypertension, and obesity. The Start of Care was 9/4/19. The Plan of Care with the certification period of 9/4/19 through 11/2/19 indicated the HHA (Home Health Aide) was to provide 4 to 5 hours a day for 5 days per week and not to exceed 25 hours per week throughout the 60 day certification period. The "Professional Services Orders" the HHA was to assist with all ADLs (Activities of Daily Living) such as bathing (bed/ tub/ shower), hair care, dressing, nail care, incontinence care, meal prep (preparation), medication reminders, light housekeeping, and transfers. Patient is widowed with no family willing to provide care. She lived in a one story home with 2 room mates (no relatives), who were unable and unwilling to care for the patient during the day time hours. Patient was unable to care for self due to immobility related to arthritis causing severe pain mainly in her left hip and right hand and wrist. Patient was considered bedbound and did not ambulate. Patient had severe incontinence of both bladder and bowel and unable to assist with any personal care. Patient was unable to prepare meals for self or perform light housekeeping. The motorized wheelchair (w/c) was currently not working. The "MEDICAL HISTORY/ PHYSICAL/ FUNCTIONAL ASSESSMENT," dated 9/4/19, indicated this was a new client's assessment. The client's used a wheelchair and her own glucometer. The "Activity Level" was "Transfer bed/ chair." Total assistance was indicated for bathing, hygiene, and dressing. The client was fully dependent for dressing with meals/snacks to "be completely prepared and served to			

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	individual." Housekeeping was to be performed by staff, and personal laundry and linens was to be done "by others." Her "MOBILITY" was "Dependent - requires assistance from bed to chair and vice versa; requires wheelchair for mobility but cannot maneuver without assistance. She was incontinent of bowel and bladder. The rating for this assessment was totaled as "Moderately Dependent.." The "NARRATIVE DOCUMENTATION" indicated the client was bedbound and did not ambulate and had "severe" incontinence of both bladder and bowel. There was no evidence of information regarding the client's weight, her wheelchair was not working, and/or her refusal to use the Hoyer lift. The "HOME ENVIRONMENT SAFETY EVALUATION," dated and electronically signed by Employee L on 9/9/19 at 2:33 p.m., indicated "...13. Kitchen is safe for the provision of care (i.e...hygienic area for food prep, etc.)...15. Overall environment is adequately sanitary for the provision of care." The answer to both of these was a "yes." The "SKILLED NURSE VISIT NOTE," dated and electronically signed by Employee L on 9/10/19 at at 3:03 p.m., indicated the "HOMEBOUND REASON" was the need for assistance with all activities, residual weakness, required assistance to ambulate, unable to safely leave home unassisted, and dependent upon adaptive device(s) with no clarifications included. The client was indicated as incontinent with no further details and no medication changes. The "NARRATIVE NOTES" included, but were not limited to, the Home Health Aide (HHA) was instructed to reposition the patient when possible, the patient was continually incontinent, and medications were reviewed with no changes. This nurse visit also did not provide any evidence the information related to the environment, client's obesity including the difficulty in turning the			

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	client from side to side, the client's refusal of the Hoyer lift, the medications as clarified by the client as taken and additional medications being used as observed during the home visit observation. 6. A review of clinical record #1, with SOC 7/15/2019, was reviewed on 9/09/2019. The record included a Plan of Care [POC] for the certification period 7/15/2019 to 9/12/2019 with orders for skilled nurse 8 hours per day, five days a week. The comprehensive assessment dated 7/15/19 failed to evidence an assessment of the endocrine system, integumentary status, cardiopulmonary, a complete elimination status with bowel assessment, psychosocial assessment, functional limitations, musculoskeletal, activities permitted, allegory assessment, patient goals, and discharge planning. These areas of the assessment were left blank. The document failed to evidence that a nursing service was provided during the assessment, to establish the start of care of 7/15/2019; the area of the assessment document was left blank. The record failed to evidence skilled nursing services were provided until 8/13/2019. The record failed to evidence an updated comprehensive assessment with OASIS items was completed prior to the first skilled nurse visit dated 8/13/19, a period of 29 days passed since a staff member assessed the patient. A review of record #6 on 9/10/2019, evidenced an assessment was completed on 7/02/2019, by employee G, a registered nurse. The record evidenced the patient was 21 years old, and failed to evidence a head to toe comprehensive assessment, that included an assessment of the endocrine system, integumentary status,			

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	cardiopulmonary, a complete elimination status with bowel assessment, psychosocial assessment, functional limitations, musculoskeletal, activities permitted, allegory assessment, patient goals, involvement of the primary care giver, discharge planning, and the collection of OASIS data items. The document failed to evidence that a nursing service was provided during the assessment, to establish the start of care of 7/02/2019. The record included a Home Health Certification and Plan of Care for the certification period of 7/02/2019 to 8/30/2019 with orders for skilled nursing services 8 hours per day 5 days a week throughout the certification period. During an interview on 9/10/2019 at 3:20 PM, the administrator indicated there were no other assessments for the patient found in the clinical record. 410 IAC 17-14-1(a)(1)(B)			
G 0530 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure the patient's care preference for Boost and a sink bath were based on the comprehensive assessment for 1 (patient #2) out of 1 pediatric skilled record reviewed and 1 (patient #7) out of 2 closed records reviewed. Findings include: 1. Home observation was completed on 09/11/19 at 6:50 am, for patient #2. During the home visit,	G 0530	**Administrator will ensure reeducation to all clinical managers regarding patient preference/requests with Comprehensive Assessment In-service, completed by 11/4/19.** Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. See attachment	11/04/2019

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	the patient was given a carton of Boost to drink. Record review of a plan of care for the certification period of 05/20/19 - 07/18/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day" and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Record review of a plan of care for the certification period of 07/19/19 - 09/16/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Review of the Intrake/ Referral form indcated the patient was to have Pediasure. Review of the nutritional section of the comprehensive assessment dated 5/20/19, the nutritional assessment indicated Pediasure. The assessment failed to address the patient's care preferences for boost over the ordered pediasure. Interview with employee K, RN, stated "we use Boost and only use Pediasure when we run out of Boost." Interview with patient caregiver (father) was completed via phone on 09/11/19 at 2:53 p.m.. He indicated that the patient prefers Boost, so she gets Boost during the day. 2. Patient #7 clinical record was reviewed and evidenced in the home health aide visit notes that the sink baths were started on 3/26/19. Review of a communication note from the RN, case manager, dated 03/28/19 states "Client		=”” span=””>	

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	requesting sink bath ...." Review of the recertification reassessment dated 4/17/19, failed to evidence the patient's preference for bathing. Review of plan of care for patient #7, for certification period of 04/18/19-06/16/19, professional services order section (page 2 of 4) stated "HHA (home health aide) to assist with all ADLs (activities of daily living) such as bathing (shower).			
G 0536 Bldg. 00	Based on observation, record review, and interview, the agency failed to update a client's current medication additions and changes in medications for 1 of 3 home visits conducted (Patient #4) and 1 of 2 discharged records reviewed. (Patient #7) Findings include: 1. On 9/9/19 from 10:30 a.m. to 11:05 a.m., the entrance conference was completed with Employee C. During this entrance conference Employee C indicated new medications were documented on a paper copy, which was left in the home, and electronically in the electronic medical record where the information was checked for drug interactions. She also indicated this process should be completed any time there was a medication change. On 9/10/19 from 10:46 a.m. to 1:35 p.m., Client 4's home visit was conducted. During the client's bed bath, Nystatin cream and Nystatin powder were	G 0536	1. For client #4 chart was reviewed and all medications updated with supplemental order sent to MD for validation signature. All files were reviewed and un-validated orders re-sent to MD for validation signature. All Clinical Managers received in-service and re-education to update medication/plan of care with any and all changes and send supplemental order to the MD. All charts will be reviewed by Administrator with following each visit to ensure updates of medication profile and supplemental orders sent to MD for validation signature. 2. For client #7 Client has been discharged, unable to verify medication change and get order at this time. All charts are being reviewed to ensure all medication changes	11/08/2019

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	used in the reddened areas under the abdominal fold and breasts. Also, the client took a dose (30 milliliters) of Peptol Bismol (nausea and upset stomach) for her complaint of nausea. When the client's medications were checked, 3 bottles of Atorvastatin 10 mg with directions to take a 1/2 tab nightly; 1 bottle of Amlodipine Besylate 10 mg take 1 every day and a second bottle of Amlodipine 0.5 mg every day. No information was evident to include the Bepto Bismol, Nystatin cream or Nystatin powder. When Employee L inquired, the client indicated she only took a 1/2 tablet of the Amlodipine and did not clarify the dose for the Atorvastatin. The client's medication list, dated 9/4/19, indicated carbamide peroxide 6.5% otic solution (for ear wax build up), Amlodipine 10 milligrams (mg) once a day (hypertension), hydrochloric 12.5 mg 1 tablet every day (hypertension), ducolax 50 mg-8.6mg 2 tablets (tabs) at bedtime (constipation), lorazepam 0.5 mg 2 times a day (anxiety), Atorvastatin 10 mg once a day (hyperlipidemia), tramadol 50 mg 1 tablet every 4 hours as needed for pain, oxybutynin 10 mg/24 hour, extended release, 10 mg once a day (bladder spasms), gabapentin 300 mg take 1 to 2 times a day (pain), and metformin 500 mg 2 times a day (oral diabetic medication per Drugs.com but indicated on this medication sheet for hyperlipidemia). The "SKILLED NURSE VISIT NOTE," dated and electronically signed by Employee L on 9/10/19 at at 3:03 p.m., failed to evidence any medication changes. The medication list failed to accurately indicate all the medications were taking and their correct doseages. 2. The clinical record of Patient #7, start of care 12/19/18, was reviewed and indicated a primary diagnosis is rheumatoid arthritis with rheumatoid		have supplemental order sent to MD with MD validation signature. All current employees have been in-serviced on updating medication profile with each visit and sending supplemental order for all changes. All charts will be reviewed by Administrator with following each visit to ensure updates of medication profile and supplemental orders sent to MD for validation signature. Administrator will ensure reeducation to all internal staff regarding review of all medications with Comprehensive Assessment In-service, completed by 11/4/19. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. **See attachment** =”” 4=”” 11=”” accurate=”” and=”” complete=”” be=”” to=”” charts=”” current=”” all=”” review=”” will=””>	

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	faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Skilled nurse visit note, dated 03/12/19, medication section, page 2 of 4, indicated that "medication changed since last visit" and "Pt (patient) to call pharmacy for accucheck and new med." Review of the medication profile dated 4/17/19 evidenced calcium (bone health), Humira (rheumatoid arthritis), acetaminophen (pain), ferrous sulfate (anemia), prednisone (arthritis), clonazepam (anxiety), metoprolol (hypertension). The medication profile failed to evidence any medication changes since 12/19/18. 410 IAC 17-14-1(a)(1)(B)			
G 0546 Bldg. 00	Basd on reord review, the agency failed to ensure an updated comprehensive assessment was completed within the last 5 days of certification period for 1 of 1 focused discharged records reviewed. (Patient #9) Findings include: Clinical record 9 was reviewed on 9/13/19. The record included a plan of care for the certification period 7/27/18 to 9/24/18 with orders for skilled nurse visit once a week for oral medication preset and pre-fill of insulin syringes. The record failed to evidence an updated	G 0546	Patient #9 failed to ensure an updated comprehensive assessment was completed within the last 5 days of certification period. Chart has been reviewed. Client has SOC 3/29/18 for cert period 3/29/18 -5/27/18. Recertification OASIS was completed 5/23/18 for cert period 5/28/18 -7/26/18. Recertification OASIS was completed 7/23/8 for cert period 7/27/18 -9/24/18. Client was discharged from services due to switching to a new provider on 9/14/18. Client was discharged 10	11/05/2019

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	comprehensive assessment, which included the collection of OASIS data items. During an interview on 9/10/2019 at 3:20 PM, the administrator indicated there were no other assessments for the patient found in the clinical record.		days before recertification visit due. Client was discharged prior to the 5 day window for recertification. All charts have been reviewed and will continue to be monitored for timely recertifications. All visits are entered into calendar in EMR program for tracking purposes. Each week report is ran to see what visits are due. Cert period end dates previously were monitored monthly to make sure recertifications were completed on time. Going forward they will be reviewed weekly to ensure recertifications are not late. In the event of a missed recertification visit, MD will be notified and order sent to MD for validation. Clinical Managers have been re-educated that all recertifications must be done on time with the 56-60 day window. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. **Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.**	

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G 0550 Bldg. 00	Based on record review and interview, the agency failed to complete an updated comprehensive assessment at discharge for 4 of 4 closed clinical records reviewed. [Patients 6, 7, 8, and 9] Findings include: 1. Review of clinical record for patient #7, physician order dated 05/07/19 stated "discharge client from agency effective 05/07/19 due to client switching to another home health company." No physician authentication. Review of clinical record completed on 09/12/19 did not include a discharge comprehensive assessment. An interview was conducted on 09/12/19 at 5:45 PM with the administrator and office manager. They reviewed the clinical record and agreed that there was no discharge comprehensive assessment. 2. Clinical record # 6 evidenced a start of care of 7/02/2019 and a plan of care for the certification period 7/02/19 to 8/30/2019 with physician orders for skilled nurse services 8 hours a day, five days a week. The record evidenced a discharge date of 8/21/2019. The record failed to evidence a discharge assessment with the incorporation of OASIS data items.	G 0550	See attachment =”” accurate=”” and=”” complete=”” to=”” current=”” be=”” will=”” review=”” all=”” charts=”” 11=”” 5=””> The Administrator will provide OASIS and Comprehensive Assessment In-service to reeducate all Clinical Managers on the discharges completed on 10/29/19 and 11/4/19. Administrator will track all OASIS clients weekly to ensure review and submission of OASIS form within 30 days of visit. Administrator will complete a full audit of all skilled clients by 11/4/19 to ensure compliance with all clients that could have been effected. Administrator will ensure that orientation of newly hired clinical staff will include review of agency OASIS requirements. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/04/2019

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	On 9/10/19 at 3:20 PM, the director of nursing confirmed there was no other discharge assessment available. 3. Clinical record # 8 evidenced a start of care of 01/30/2019 and a plan of care for the certification period 7/29/19 to 9/26/2019 with physician orders for aide services 7-8 hours a day, 5-6- days a week. The record evidenced a discharge date of 8/16/2019. The record failed to evidence an assessment at discharge. 4. Clinical record 9 was reviewed on 9/13/19. The record included a plan of care for the certification period 7/27/18 to 9/24/18 with orders for skilled nurse visit once a week for oral medication preset and pre-fill of insulin syringes. The record evidence documentation that the patient was transferred to another agency on 9/14/2018. The record failed to evidence a discharge assessment with the incorporation of OASIS data items. 410 IAC 17-13-2(2)(b)(9)			
G 0570 Bldg. 00	Based on observation, record review and interview, the agency failed to ensure the patient's medical and nursing needs were met in their place of residence, visits were provided per the plan of care, ensured a physician order was in place prior to providing care, ensured a patient's received services in accordance with the written plan of care, ensured fall precautions were place accurately, ensured that the individualized care	G 0570	The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics pain medications, supplemental orders, physician authentication requirements has been completed by 11/4/19. The Administrator will provide Not	11/05/2019

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	plan included patient-specific interventions with measurable outcomes for aspiration precautions, fall precautions, pain precautions, failed to ensure the skilled nurse put new orders in writing to be sent to the physician for signature, failed to ensure the physician was notfied when it was decided the patient declined to have skilled nursing services as ordered per the plan of care, changes in feeding supplements, and unrelieved pain, and failed to ensure the physician was notfied when it was decided the patient declined to have skilled nursing services as ordered per the plan of care. These practices impacted 4 (#1, 2, 6, 7) out of 8 sampled records reviewed. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure care and services provided which could result in the agency not providing quality health care in a safe environment. In regards to G570 Based on record review and interview, the agency failed to ensure patients medical and nursing needs were met in their place of residence for 2 out of 2 skilled adult records reviewed. (Patient #1, 6) Findngs include: 1. Clinical record # 1, with Start of care 7/15/2019, included a plan of care for the certification period 7/15/2019 to 9/12/2019 with orders for skilled nurse 8 hours a day, 5 days a week. Review of the electronic medical record for patient #1 failed to evidence skilled nurse visits were provided as ordered. The first skilled nurse visit note, dated 8/13/2019, by employee I, a registered nurse, was the first documentation of skilled nurse services. The record failed to evidence skilled		Meeting Patient Needs In-service to reeducate all internal staff of specifics of documenting missed shifts and all communications accurately. New clients will not be admitted unless the agency is able to meet their staffing needs. Once admitted services will begin immediately. All internal employees will be re-educated on this with meeting on 11/15/19. Administrator will monitor all referrals and admissions weekly to ensure services begin immediately. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/5/19. see attachments	

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	nurse services were provided from 7/15/2019 to 8/13/2019. The clinical record failed to evidence documentation to explain why skilled nurse services were not completed as ordered on the plan of care. During interviews on 9/23/19 at 4:30 PM, the office manager indicated the patient was accepted and the plan of care was established and the nurse for the case was to begin the following day, 7/16/2019, and failed to arrive for her first day of orientation, therefore, the agency did not have a nurse for the case. The administrator confirmed that there were no skilled services provided to patient 1 until 8/13/2019. Employee A indicated the communication between the agency and the primary care giver was in her agency emails. No information was provided by survey exit. 2. A review of record #6 with a start of care 7/02/2019, evidenced a Home Health Certification and Plan of Care for the certification period of 7/02/2019 to 8/30/2019, with orders for skilled nursing services 8 hours per day 5 days a week throughput the certification period. The clinical record failed to evidence skilled nursing services were provided as ordered and communication notes to explain why services were not provided. During an interview on 9/10/2019 at 3:20 PM, the office manager, indicated patient #6 did not receive any nurse services due to the primary care giver decided, after meeting multiple nurses, they did not want other individuals in the home. 410 IAC 17-13-1(a)			
G 0572 Bldg. 00				

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	Based on record review and interview, the agency failed to ensure care and services were not provided prior to the physician approving the plan of care (Patient #2), failed to ensure nutritional supplement was provided per the plan of care (Patient #2) and OSHA kit was in place per agency policy and plan of care failed to ensure home health aide visits and skilled nursing visits were provided as ordered per the plan of care (Patient #1, 7), and failed to ensure medications and gastronomy tube feeding were administered per the plan of care (Patient #1), and for 4 of 7 records reviewed. Findings include: 1. A review of policy entitled "Admission Criteria", dated 03/20/18, section 5 stated "No patient is admitted for services without an order from a physician." 2. A review of policy entitled "Clinical Documentation/ Missed Shifts", dated February 14, 2014, section #2 stated "A separate note shall be completed for each visit/shift and signed and dated by the appropriate professional." 3. A home observation was completed on 09/11/19 at 6:50 am, for patient #2. During the home visit, the skilled nurse offered the patient a carton of Boost to drink. During this time, Employee K was interviewed in regards to the Boost being provided versus the Pediasure that was ordered. Employee K stated "we use Boost and only use Pediasure when we run out of Boost." During this visit, surveyor asked employee K, RN to see the OSHA kit. Employee K stated "I have no idea what that is."	G 0572	1. Patient #2 Chart reviewed and processes put in place to prevent any future services being provided without physician order. Clinical Managers will notify scheduling staff when VSOC is received so that services can be scheduled. All employees re-educated with in-service to ensure that MD order obtained prior to any service being provided. Supplemental order has been sent to MD for Boost or Pediasure. All employees have been educated on maintaining accurate supplies and documentation, ensuring that each home has these supplies listed. All nurses to have extra gloves, sanitizer and OSHA kits, and CPR masks to replace those missing supplies provided by Adaptive immediately. RN will send supplemental order for all updated changes to the plan of care to ensure that the plan of care matches what is in the home and being provided to the client. All charts are being reviewed to ensure that services did not begin prior to MD order. All charts are being reviewed by the Administrator after each visit to ensure order received from MD prior to services being provided. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical	11/29/2019

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	A plan of care review for certification period of 05/20/19 - 07/18/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day" and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." The section DME [durable medical supplies]/ Supplies (page 3 of 4) stated "OSHA kit" as one of the supplies in the patient home. The plan of care failed to evidence instruction to use Boost supplement and to use the Pediasure supplement when the patient is out of Boost. The plan of care indicated the registered nurse obtained verbal start of care orders on 10/22/19. Review of the clinical record evidenced two Skilled Nurse Visit notes dated of 05/20/19 and 05/21/19. Review of the physician order on 05/22/19 stated "Admission completed on 05/20/19. Spoke with [NAME] RN at physician's office on 05/22/19 at 9:57 am for VSOC (verbal start of care) for SN (skilled nurse) services." The 5/20/19 to 7/18/19 plan of care evidenced that a verbal start of care date was documented as completed on 05/22/19. The agency provided skilled nursing services prior to obtaining orders from the physician. Further record review evidenced a plan of care for certification period of 07/19/19 - 09/16/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day" and section DME [durable medical supplies]/ Supplies (page 3 of 4) stated "OSHA kit" as one of the supplies in the patient home. The plan of care failed to evidence an order for Boost, the physician order was for Pediasure.		Managers on the specifics patient preferences, supplemental orders, physician authorization requirements has been completed by 11/4/19. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/29/19 Patient #7 Chart reviewed and last date HHA services were provided was 4/19/19. Shift on 4/20/19 was cancelled due to caregiver being sick, client stated she would have granddaughter help her for the day. Shift for 4/21 was unable to staff and client stated she would be good without anyone since it was Easter. Documentation for 4/22, 4/23, & 4/25 states they were unable to find replacement for the usual caregiver. 4/25/19 Client called and stated she no longer needed services and was looking for a new provider. Discharge order was sent to MD on 5/7/19 but had not been signed by MD. All charts have been reviewed for unauthenticated	

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	Supervisory visit note dated 07/17/19, section #15 documented "no OSHA kit in the home". An interview was conducted on 09/11/19 at 10:50 am with employee F, who indicated that the program manager would go out and complete a home assessment prior to accepting each patient to ensure the home environment was appropriate and services were needed. That assessment would then be given to the case manager to obtain an order from the physician to complete the initial comprehensive assessment, which would include putting hands on the patient prior to the start of care order. Once the initial comprehensive assessment was completed, the physician would be called to get an order to admit. Employee F, case manager, indicated that the OSHA kit was a spill kit for infectious fluids and had a CPR mouthpiece as well. Employee F showed the surveyor an example of one, which also contained a red hazard bag. Employee F stated "one is brought to each home on admission." Employee F further stated "This patient does not have one; don't know where it is. I've only seen her once." On 09/11/19 at 12:00 PM, the administrator confirmed that there was only one order from the physician for patient #2 and that it was dated for 05/22/19. During an interview on 09/12/19 at 2:25 PM, the administrator indicated that she saw the supervisory note dated 07/17/19 that stated "No OSHA kit in the home." She agreed that there should be one in the home. 4. Clinical record review for patient #7 was completed on 09/12/19. The plan of care for recertification period 4/18/19 to 6/16/19 included orders for aide services to be provided 5-7 days		supplemental orders and re-sent to MDs for validation signatures. Adminsitrator will review each chart when home visits are done to ensure all changes have supplemental order sent to MD for signature. Adminstrator will check weekly to ensure all sent orders have been authenticated by MD or re-sent to MD for signature. Administrator will review client schedules weekly to ensure that schedule/services provided match the order in the plan of care. If it does not match that there is documentation to support the changes. Patient #1 Chart has been reviewed and order clarification has been sent to MD to ensure plan of care matches the services being provided. All employees have been re-educated and received in-service on all documentation must be reviewed by nurse and uploaded into the office chart to match home chart. Clinical Manager will review all documentation of the home nurse to ensure all orders are being followed and documented accurately. All skilled charts reviewed to ensure the proper documentation and matches the plan of care. Administrator will review all charts	

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	per week. Review of aide visit notes evidenced the last date of care provided by the aide was 04/17/19. The record failed to evidence any further aide visits were provided. A communication note, dated 4/26/19 was reviewed on 9/12/19, which stated "Wanted to update you all on patient #7. She called me yesterday and said she doesn't need our services anymore because she is looking for another company. I told her we can continue to staff until she finds a replacement, but she said no." A communication note, dated 04/29/19 was reviewed on 09/12/19, which stated "We called patient #7 to verify her waiver services and she said that we should not call her anymore and that we need to discharge her as a client because she no longer wants to deal with us." Review of physician order dated 05/07/19 stated "discharge client from agency effective 05/07/19 due to client switching to another home health company;" no physician authentication. An interview was conducted on 09/12/19 at 4:15 PM with the office manager who indicated that the last day of direct, hands on care was 04/19/19. An interview was conducted on 09/12/19 at 5:45 PM with the office manager and administrator. At that time the office manager stated "Caregiver (aide) called off full week of 04/21/19-04/27/19. Patient called and stated not to send anyone as she was mad and wanted to find a new company. We could not discharge without a new company in place." The office manager agreed that there were missed visits. 5. The clinical record for patient # 1, with start of care [SOC] 7/15/2019, included a plan of care for		the week after the clinical manager completes the home supervisory visits to ensure any changes are sent to MD for signature and that the plan of care is being followed. see attachments	

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	the certification period of 7/15/19 to 9/12/19, with orders for skilled nurse services, 8 hours a day, 5 days a week, effective 7/15/19. The plan of care included orders for the skilled nurse to administer medications "ordered by the physician and document on the MAR [medication administration record]." Review of the electronic medical record for patient #1 failed to evidence skilled nurse visits were provided as ordered. The first skilled nurse visit note, dated 8/13/2019, by employee I, a registered nurse, was the first documentation of skilled nurse services. The clinical record failed to evidence documentation to explain why skilled nurse services were not completed as ordered on the plan of care. Review of the electronic medical record evidenced skilled nurse visits were made 3 days a week, on Tuesdays, Wednesdays, and Thursdays, beginning 8/13/2019. The record evidenced skilled nurse visit notes dated August 13, 14, 15, 20, 21, 22, 27, and 28, and September 3, 4, and 5, 2019. The skilled nurse visit notes failed to evidence documentation of the medications and gastronomy tube feeding were administered by the nurse, during the visit. On 9/10/2019 at 2:10 PM, the clinical record was reviewed with the administrator. The administrator confirmed that skilled nurse services were provided 3 times a week and not 5 days a week as on the plan of care. The administrator indicated the record failed to evidence documentation that the physician was updated and the plan of care revised. During interviews on 9/12/19 at 4:30 PM, the office manager indicated the patient was accepted and			

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	the plan of care was established and the nurse for the case was to begin the following day, 7/16/2019, and failed to arrive for her first day of orientation, therefore, the agency did not have a nurse for the case. Employee A indicated the communication between the agency and the primary care giver was in her agency emails. At 5:45 PM, the administrator relayed that the clinical record failed to evidence documentation of the liquid nutrition and the medications that were administered by the nurse during the skilled nurse visit. Employee A indicated the documents were not turned into the agency by the nurse that completed the visits. No information was provided by survey exit on 9/13/19. 410 IAC 17-13-1 (a)			
G 0574 Bldg. 00	Based on record review, the agency failed to ensure that the individualized care plan included patient-specific interventions with measurable outcomes for aspiration precautions (patient #2), fall precautions (patient #7), pain precautions (patient #7) for 2 of 2 clinical records reviewed. Findings include: 1. A review of policy entitled "Plan of Treatment", dated April 10. 2019, stated in section (1)(C)(xiv) "the medical plan of care shall include the following: Patient-specific interventions and education; measurable outcomes and goals identified by the HHA (home health agency) and the patient." 2. Record review of patient #2, plan of care for	G 0574	The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics of patient specific interventions with measurable outcomes in regard to pain precautions, falls and aspiration requirements has been completed by 11/4/19. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review	11/29/2019

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	certification period of 05/20/19-07/18/19 and for certification period of 07/19/19 - 09/16/19 indicate aspiration precautions. The plan of care failed to evidence individualized, measurable interventions with goals/ outcomes. An interview with the administrator was conducted on 09/12/19 at 2:25 pm where the administrator stated "if the nurse would have checked them, then they would be there." She agreed that there were no interventions, no outcomes or goals documented. 3. Review of Patient #7's clinical record indicated a primary diagnosis of rheumatoid arthritis with rheumatoid faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Review of a form titled "Pain Assessment" dated 12/19/18 documented "worst pain level over last 48 hours - 8". Review of the plan of care for start of care date 12/19/18, for the certification period of 12/19/18 to 02/16/19, the professional services order section (page 2 of 4) stated "She has chronic widespread pain" and "She explained that she will be prescribed stronger pain medication when she receives a keypad lock box for her narcotic pain medications due to past experiences of her medications getting stolen from her." The safety measures section (page 3 of 4) stated "fall precautions." The plan of care failed to evidence interventions or individualized measurable goals for fall precautions and the safety measures section failed to evidence pain precautions. Review of the form titled "Pain Assessment"		will be completed weekly. Administrator will review all charts for completion by 11/5/19. see attachments Pt #2 failed to have individualized, measurable interventions with outcomes/goals. Plan of care updated with appropriate interventions and measurable goals/outocomes. All charts being reviewed to ensure appropriate interventions with measurable goals/outcomes. Admisnistrator has provided Comprehensive Assessment in-service to re-educate all clinical managers on importance of appropriate interventions and measurable goals/outcomes. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Patietn #7 has been discharged and are unable to fix this deficiency for this chart. All charts being reviewed to ensure appropriate documentation of pain assessment. All clinical managers re-educated	

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	dated 02/15/19, comment section indicated the patient has obtained a new lock box so she can get her pain medication. Review of the plan of care for certification period of 02/17/19 - 04/17/19, page 2 of 4 stated "She explained that she will be prescribed stronger pain medication when she receives a keypad lock box for per narcotic pain medications due to past experiences of her medications getting stolen from her." Documented pain score was +8/10. Additionally, the plan of care stated "She has recently received a lockbox for her pain medication and will request more from her doctor next visits." The Safety Measures section (page 3 of 4) stated "fall precautions." The plan of care failed to evidence interventions or individualized measurable goals for fall precautions and the safety measures section failed to evidence pain precautions. 4. On 09/11/19 at 12:30 pm a copy of the fall precautions policy was requested. On 09/11/19 at 1 pm, the administrator indicated that the agency did not have a separate fall precautions policy and that falls are included in the comprehensive assessment policy. 5. An interview was conducted with the administrator on 09/11/19 at 2:25 pm. She stated "there are no fall care plans. It means that they have a copy of the fall risk assessment."		with Comprehensive Assessment in-service to be sure to document completely all pain assessments and notify MD of any increased or uncontrolled pain. Clinical Managers have been educated on falls, aspiration and pain interventions to be added to the plan of care as appropriate with measurable goals/outcomes to monitor. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.	
G 0584 Bldg. 00	Based on record review, the agency failed to ensure the skilled nurse put new orders in writing to be sent to the physician for signature in 1 of 4	G 0584	For client #7 Client has been discharged, unable to verify medication change and get order at this time.	11/05/2019

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	closed records reviewed. (Patient #7) Findings include: The clinical record of Patient #7, start of care 12/19/18, was reviewed and indicated a primary diagnosis is rheumatoid arthritis with rheumatoid faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Skilled nurse visit note, dated 03/12/19, medication section, page 2 of 4, indicated that "medication changed since last visit" and "Pt (patient) to call pharmacy for accucheck and new med." Page 3 of 4, interventions/ instructions section stated "fingersticks with accucheck." The clinical record failed to evidence any new physician orders for the accucheck or medication. 410 IAC 17-15-1(a)(7)		All charts are being reviewed to ensure all medication changes have supplemental order sent to MD with MD validation signature. All current employees have been in-serviced on updating medication profile with each visit and sending supplemental order for all changes. All charts will be reviewed by Administrator with following each visit to ensure updates of medication profile and supplemental orders sent to MD for validation signature. Administrator will ensure reeducation to all internal staff regarding review of all medications with Comprehensive Assessment In-service, completed by 11/4/19. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. see attachments	
G 0590 Bldg. 00	Based on record review and interview, the agency failed to ensure the physician was notfied when it was decided the patient declined to have skilled nursing services as ordered per the plan of care (Patient #6), changes in feeding supplements (Patient #2), and unrelieved pain (Patient #7) for 3	G 0590	The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics of changes needing an order and must be authenticated by physicians, patient preference	11/29/2019

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	of 8 records reviewed. Findings include: 1. A home observation was completed on 09/11/19 at 6:50 am, for patient #2. During the home visit the patient was given a carton of Boost to drink. Plan of care review for certification period of 05/20/19 - 07/18/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." And Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Record review of plan of care for certification period of 07/19/19 - 09/16/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." And Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Record review was completed on 09/11/19, which did not include any updated physician order for Boost or any documented communication with the physician to change the order from Pediasure to Boost. Interview with employee K, RN, on 09/11/19, stated "we use Boost and only use Pediasure when we run out of Boost." 2. A review of record #6 with a start of care 7/02/2019, evidenced a "Home Health Certification and Plan of Care" for the certification period of 7/02/2019 to 8/30/2019, with orders for skilled nursing services 8 hours per day 5 days a week throughput the certification period. The clinical record failed to evidence skilled nursing services		requirements has been completed by 11/4/19. The Administrator will provide Not meeting patient's needs in-service to all internal staff in regards to documenting on all missed shifts and inability to meet client needs. completed by 11/4/19. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Patient #2 failed to notify MD of client using Boost instead of Pediasure. Supplemental order has been sent to MD for Boost or Pediasure and plan of care has been updated to show client can have Pediasure or Boost. Charts will be reviewed after each home supervisory visit to ensure compliance with notifying MD of any changes to the plan of care. All clinical managers have received the Comprehensive Assessment In-service to re-educate them on MD must be notified of any changes/updates to	

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	were provided as ordered and communication notes to explain why services were not provided. During an interview on 9/10/2019 at 3:20 PM, the office manager, indicated patient #6 did not receive any nurse services due to the primary care giver decided, after meeting multiple nurses, they did not want other individuals in the home. 3. The clinical record of Patient #7, start of care 12/19/18, was reviewed and indicated a primary diagnosis is rheumatoid arthritis with rheumatoid faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Plan of care for certification period of 02/17/19 - 04/17/19, page 2 of 4 stated "She explained that she will be prescribed stronger pain medication when she receives a keypad lock box for per narcotic pain medications due to past experiences of her medications getting stolen from her. Documented pain score was +8/10. Additionally, the plan of care stated "She has recently received a lockbox for her pain medication and will request more from her doctor next visits." The clinical record of Patient #7, start of care 12/19/18, was reviewed and indicated a primary diagnosis is rheumatoid arthritis with rheumatoid faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Review of an Aide Daily Visit Sheet for patient #7, date of 03/28/19 was reviewed. The document stated "gave her a quick sink bath because of pain."		the plan of care. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Patient #6 Failed to evidence documentation for why services were not documented. Chart has been updated to show documentation with mom requesting to hold off on skilled nurse starting due to no hoyer lift in the home. Documentation of when mom decided services were no longer needed due to she was going to stay home with him. All charts being reviewed to ensure all communication with client/primary caregiver is documented. All employees received in-service not meeting client needs to re-educate on steps and documentation needed when unable to meet needs of client. Administrator reviewing schedules and documentation weekly to ensure plan of care is being	

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	Communication note, dated 03/28/19 was completed by the supervisory case manager that stated "Client requested her bathing type be changed to sink bath as her shower is upstairs and she does not feel safe climbing stairs." Review of an Aide Daily Visit Sheet for patient #7, date of 03/29/19 was reviewed. The document stated (1) Assist with Ambulation, "Helped with her walker to take her to the bathroom and back to her bed. She was unable to hold on because of her hands and arms were in a lot of pain. (2) Mobility Assist, "Too much pain for me to move her." (3) Skin Care "She was in some pain and did not want anything on her." Pain assessment, dated 04/12/19, documented "worst pain level over last 48 hours - 9." The clinical record failed to evidence that the physician was notified of the patient's ongoing high level of pain. 410 IAC 17-13-1(a)(2)		followed as ordered. Patient #7 has been discharged unable to fix deficiency in this chart. All charts being reviewed to ensure proper follow up and notification to MD of change in ADLs/health assessment such as change in ADLs due to increased/unrelieved pain. All clinical managers received in-service to re-educate comprehensive assessment to include weekly review of daily visit sheets to ensure anything unusual is followed up on and MD notified. All HHAs to receive in-service Abnormal Observation/Unusual Findings to re-educate they need to notify office of any unusual findings during their care so that it may be addressed right away. Clinical Manager to follow up on these issues and ensure MD is notified and plan of care updated. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0592 Bldg. 00	Based on record review, the agency failed to ensure the revised plan of care included patient preference for bathing and failed to be developed based on the comprehensive assessment in 1 of 4 closed records reviewed. (Patient #7) Findings include: Record review for patient #7, a form titled "Nutritional Risk Assessment" dated 12/19/18, was reviewed indicating a risk score of 30, medium risk (score range 30-55). This score was comprised of "has tooth/ mouth problem which makes it hard to eat (dentures, does not wear), does not always have enough money to buy foods needed, takes 3 or more prescribed or OTC (over the counter) medications per day, is not always physically able to cook and/or feed self and has no caregiver to assist." The Plan of care review for certification period 12/18/18-02/16/19, the nutritional requirements stated "Medium nutritional risk." Medium risk score stated "provide education, appropriate dietary instructions, consult with dietitian as needed, consult with physician and discuss need for dietary supplement (tablet or liquid). Continue monitoring and instructions as indicated." Review of a form titled "Nutritional Risk Assessment" dated 02/15/19, indicated a risk	G 0592	see attachments Patient#7 Client has been discharged, we are unable to update plan of care. All charts being reviewed to ensure that every section of the plan of care accurate and up to date with any changes in assessment to include all assessments and patient preference. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics of changes needing an order and must be authenticated by physicians for patient preference requirements has been completed by 11/4/19. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.	11/29/2019

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	15K167	A. BUILDING 00 B. WING	09/13/2019

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	score of 10, low risk (score range 0-25). This score was comprised of "takes 3 or more prescribed or OTC (over the counter) medications per day, frequently has problems with diarrhea or constipation." The Plan of care review for certification period 02/17/19-04/17/19, the nutritional requirements stated "Medium nutritional risk." 60-day summary (page 2 of 4) stated "She isn't physically able to provide her own personal care, cook her own meals . . ." and "Patient #7 has no willing or able caregivers outside of agency name . . ." A communication note from the RN, case manager, dated 03/28/19 stated "Client requesting sink bath . . ." Record review evidenced sink baths was started on 3/26. The clinical record failed to evidence MD notification of the change. The Plan of Care for certification period of 04/18/19-06/16/19, professional services order section (page 2 of 4) stated "HHA (home health aide) to assist with all ADLs (activities of daily living) such as bathing (shower). 410 IAC 17-14-1(a)(1)(C)		Administrator will review all charts for completion by 11/29/2019 see attachments	
G 0640 Bldg. 00	Based on record review and interview, the agency failed to: ensure there was a quality assurance program that was capable of showing measurable improvement and must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that enable the agency to assess processes of care, HHA (home health aide) services, and operations, utilize quality indicator data to monitor the	G 0640	Administrator created new logs including falls and hospitalization. new process to include quarterly QAPI meetings and minutes. Administrator provided training of logs and new process on 10/29/19. Administrator will conduct a staff survey to include willingness to report adverse events and	11/05/2019

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	effectiveness and safety of services and quality of care as well as to identify opportunities for improvement, implement performance improvement activities based on high risk, high volume, or problem-prone, implement performance improvement activities with consideration to incidence, prevalence, and severity of problem areas, to take immediate action of identified problems that could potentially threaten the health and safety of patients, to track adverse patient events in order to implement preventive actions, implement performance improvement activities in an effort to measure success of activities to ensure that improvements are sustained, conduct quality improvement projects, and ensure the implementation of an agency-wide, ongoing quality assessment and performance improvement program that includes priorities for improved quality, and patient safety. These practices has the potential to impact all forty-our (44) active patients for 1 of 1 agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment. Findings include: 1. The agency policy entitled "Quality Assurance/Performance Improvement," dated April 25, 2019 stated (1) "Data will be collected to allow the agency to monitor its performance"; (2) "Data that may be used for data collection include the following: (a) Staff perception of risks to individuals and suggestions for improving safety for clients, (b) Staff willingness to report unanticipated adverse events, (c) Utilization of services, (d) Staff opinion and needs, (e) Adverse events/outcomes of processes and services, (f) Infection control surveillance and reporting of		willingness to suggest improvements by 11/29/19. Administrator will track patient demographics quarterly with report from Matrix in QAPI binder. Administrator will reeducate all internal staff in regards to grievance/incidents with Investigation of Mistreatment, Neglect and Abuse in-service to be completed on 11/4/19. **Administrator will ensure reeducation to all clinical managers regarding incident reports with Comprehensive Assessment In-service, completed by 11/4/19.** **Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.** **See attachment** ="" span="">	

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	individuals and organizations served, (g) The needs, expectations and satisfaction of individuals and organizations served, (h) Perceptions of care, treatment and services, (i) Client diagnosis and demographics, (j) Environmental conditions of the organization or clients, (k) Focus on indicators related to improved outcomes - use of emergent care services and hospital admissions/readmissions; (3) Data will be systematically collected to measure process and outcomes of each individual client." 2. Agency policy entitled "Incident Reporting", dated July 26, 2018, stated (1) "The reporting of incidents and the investigation are part of the agency's performance improvement program. (2) Incident reports are reviewed by appropriate supervisors and a determination of whether further action is needed is made. After the report is reviewed by the administrator, the leadership team determines opportunities for performance improvement or whether to continue monitoring. (3) Aggregated results are part of the annual performance improvement plan evaluation." 3. The agency policy entitled "Sentinel Events," dated April 25, 2019, purpose stated "To respond appropriately at ALL sentinel events by reporting the event, completing a timely, thorough, root cause analysis focusing on systems and processes, developing an action plan, implementing changes and monitoring effectiveness of changes," and special instructions stated "Both reportable and non-reportable sentinel events, sometimes referred to as "near misses", are intensely investigated using principles of root cause analysis and developing an action plan."			

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	4. Record review of quality assurance/ performance improvement documentation was completed on 09/10/19. The section entitled "2018" was blank. The section entitled "2019", "Quarter 1 was blank. Quarter 2, included two performance improvement plans. (1) Dated 04/15/19, documented "Deficiency Identified: Under 50% of PA client satisfaction reports return. Corrective Action Needed: Reach a return rate of over 50%. How will this be monitored and by whom? Case manager will take client satisfaction surveys with her to each client visit. The office manager and clinical manager will monitor how many we have received by checking the binder on a bi-weekly basis. Date Corrective Action Completed: Reach at least 50% return rate by the end of quarter 2." There were no details of the actions and documentation that it was ongoing. One included document entitled "Indy North Quarter 2 2019, Missed Nursing Visits Q2 (quarter 2) Indy North" stated "1, schedule conflict". Quarter 3 dated 06/19/19, documented "Deficiency Identified: Multiple extra supervisory visits missed. Corrective Action Needed: Agency clinical manager to continue to review visit schedules upon admission and recertification completion as well as pull weekly office visit schedules to ensure all visits are scheduled to be completed. How will this be monitored and by whom? Agency clinical manager to monitor. Date Corrective Action Completed: Ongoing." One included document entitled "Missed Visit Log" was blank. 5. The following incident report documents were			

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	included in the QAPI information that was provided by the agency. The agency failed to evidence that these incident reports were investigated, tracked, followed up, incorporated into the agency's QAPI program and put preventable measures in place: Incident report dated 01/06/19, patient #5, hospitalization Incident report dated 01/14/19, patient #15, hospitalization Incident report dated 01/25/19, patient #11, fall Incident report dated 01/26/19, patient #11, fall Incident report dated 01/29/19, patient #16, hospitalization Incident report dated 02/27/19, patient #17, hospitalization Incident report dated 03/12/19, Patient #10, new wound. Incident report dated 03/24/19, Patient #7, new wound Incident report dated 04/01/19, patient #3, emergency room visit Incident report dated 04/02/19, patient #3, emergency room visit Incident report dated 04/04/19, patient #3, emergency room visit Incident report dated 04/17/19, patient #3, hospitalization			

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	Incident report dated 04/30/19, patient #3, emergency room visit Incident report dated 05/01/19, patient #23, emergency room visit Incident report dated 05/09/19, patient #24, emergency room visit Incident report dated 06/04/19, patient # 18, hospitalization Incident report dated 06/18/19, patient #12, fall Incident report dated 06/20/19, patient #13, fall Incident report dated 06/24/19, patient # 19, hospitalization Incident report dated 06/24/19, patient #3, hospitalization Incident report dated 06/25/19, patient #14, fall with hospitalization for broken vertebrae. Incident report dated 07/16/19, patient #21, hospitalization Incident report dated 08/04/19, patient # 11, fall Incident report dated 08/15/19, patient #22, hospitalization Incident report dated 08/19/19, patient #20, hospitalization Incident report dated 09/04/19, patient #12, hospitalization			

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	6. The following Activity Tracking Log, Complaint/ Grievance documents that failed to be incorporated into the QAPI programs for each quarter: Activity Tracking Log, Complaint/ Grievance date 12/19/18, patient #10, aide left early and patient fell, no incident report form completed. Activity Tracking Log, Complaint/ Grievance date 01/02/18, patient #25, missing property; no incident report form completed. Complaint/ Grievance dated 03/14/19, related to patient #3, documented "I received a call from [patient] and she is balling her eyes out. Basically, her aide in the evening and her do not get along. The aides name is [name of aide]. She works at [name] hospital as a MA (medical assistant) and has been doing patient care for a long time so I trust she knows what she is doing. Patient doesn't like her because she bought the wrong kind of Mt. (Mountain) Dew and because [aide name] wouldn't take a box of incontinent supplies down the street to a different house (agency told her not to do this). I asked patient if she is being fed, showered, and kept clean and she said yes, so those are my biggest concerns. I will replace this caregiver per patient request, but it will take us time to interview, hire, and train someone." Activity Tracking Log, Complaint/ Grievance date 03/27/19, employee J, back injury while lifting patient, no incident report form completed. Activity Tracking Log, Complaint/ Grievance date 04/02/19, patient #26, swollen wrist/ unknown origin, no incident report form completed. Activity Tracking Log, Complaint/ Grievance date			

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	06/21/19, patient #19, altercation with aide (reported to the state), no incident report form completed. Complaint/ Grievance dated 08/13/19, patient #27, documented "Caregiver [sent] text - I can no longer work for patient #27. I refuse to put myself in that environment. Him and Ms. [patient] want to much out of me. I have to hear them argue and see [patient] have screaming episodes plus more. He needs more help than I can give him. If that means I have to resign then I am sorry. $12 isn't worth it. CK." The agency failed to evidence a resolution. Complaint/ Grievance dated 09/05/19, patient #28, documented "Patient #28 is threatening to leave us again because aide isn't able to do 7:15 am - 5:15 PM. She is scheduled for 7:30-5:30 PM. She also said that everything else is great, but she wants us to replace her ASAP if she can't do the schedule she needs. Neither the aide nor the patient are coming to an agreement with the times. We are pretty much staffing all of her hours at this time and I am not sure what else to do to keep the patient happy." 7. An interview was conducted on 9/10/19 at 11:45 a.m. with the office manager and administrator. The office manager indicated that the agency did not have a separate infection control policy. The office manager stated "It is all inclusive in the incident reporting policy," dated 07/26/18. During said interview, the surveyor confirmed that all Quality Assessment/ Performance Improvement Quality Assessment/ Performance Improvement (QAPI) plans/ documents were provided. Quality Assessment/ Process minutes were also requested. The office manager and administrator both confirmed that			

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	everything they had, was provided. The office manager further indicated that sometimes the team will mention or discuss an issue for Quality Assessment/ Performance Improvement (QAPI) in the Monday morning staff meetings, but there was not a Quality Assessment/ Performance Improvement (QAPI) meeting. 8. An interview was conducted on 9/11/19 at 2:00 p.m. with the administrator, office manager and program manager regarding the incident reports. The program manager stated "I guess the nurse forgot to complete the incident reports." 410 IAC 17-12-2			
G 0680 Bldg. 00	Based on observation, interview and record review, the agency failed to ensure infection control practices were followed in the use of gloves and handwashing during personal care and failed implement an agency-wide infection control program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases. These practices has the potential to impact all forty-our (44) active patients for 1 of 1 agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure infection practices within the provision of quality health care in a safe environment.	G 0680	Administrator updated HHA Skills In-service and will reeducate all home health aids and Clinical Managers by 11/29/19. Administrator updated Handwashing Policy on 10/31/19. See attachment for Handwashing and Infection Control Policies. Administrator will ensure all current and new hire HH aides will receive the HHA Skills In-service.	11/29/2019
G 0682 Bldg. 00				

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	Based on observation, interview and record review, the agency failed to ensure infection control practices were followed in the use of gloves and handwashing during personal care of a client during 1 of 3 home visits. (Client 4) Findings include: The "OSHA Infection Control/Exposure Control Plan" policy, dated March 21,2012, and the "Handwashing policy," dated 7/2/2018, was provided by Employee B on 9/12/19 at 3:07 p.m. The current policy "OSHA Infection Control/Exposure Control Plan" was "POLICY (facility's name) shall maintain policies and procedures for the care of clients...and for infection control practices by employees; these policies shall conform with OSHA regulations, Accreditation standards, local and state laws, and currently accepted standards of practice...SPECIAL INSTRUCTIONS 1. Client infection control procedures shall include, but not be limited to: a. Wearing and changing gloves as necessary during the delivery of client care...f. Frequent hand washing by home health care employees: * Before and after the provision of direct client care. *After handling soiled or contaminated materials...*After removing gloves...." The "Handwashing policy" was "Purpose To prevent the spread of infection by contaminated hands. To remove soil and transient organisms from the hands and to reduce total microbial counts over time...The Center for Disease Control (CDC) recommends routinely washing hands in the following situations:...*After caring for a client...Procedure...13. Rinse hands and wrists thoroughly, keeping hands down and elbows up. 14. Dry hands thoroughly from fingers to wrists	G 0682	Administrator updated HHA Skills In-service and will reeducate all home health aids and Clinical Managers by 11/29/19. Administrator updated Handwashing Policy on 10/31/19. See attachment for Handwashing and Infection Control Policies. Administrator will ensure all current and new hire HH aides will receive the HHA Skills In-service. This Home Health Aide will in reference to this visit will be in-serviced on proper hand washing/alcohol gel use and infection control. This caregiver will also be re-comped by contract nurse to determine if appropriate for Home Health Aide shifts. Agency will ensure that all home health aides will have home observation within first 30 days of employment as home health aide and annually to ensure proper technique is followed with all home health aide skills. Administrator will monitor that all current and new home health aides receive the HHA Skills in-service and that they are observed in the home with in first 30 days and then annually after. See attachments	11/29/2019

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	and forearms. 15. Discard paper towel in waste receptacle. 16. Turn off water faucet using a clean, dry paper towel...Instant Hand Antiseptic Gel...c. Continue rubbing hands together until the skin is dry, approximately 10-15 seconds" On 9/10/19 from 10:46 a.m. to 1:35 p.m., Client 4's home visit was conducted. Upon entering the home, Employee L and Employee M were present awaiting Client 4 to finish her breakfast, which was a bowl of cereal. She was lying in her bed and wore a hospital gown with wet and soiled sheets visible underneath her shoulders to her upper legs. As the client finished eating the bowl of cereal, she requested to complete her oral care. With gloved hands Employee M prepared and handed the client the equipment for oral care to include her toothbrush with toothpaste, an emesis basin, and rinse cup. After the client was observed to complete this task, Employee M removed the equipment and returned it to the kitchen emptying the contents. No change of gloves, handwashing or handgel use was observed. With the same gloves Employee M was observed to change the bath water basins several times between washing the client's hair and bathing the client. During this bath when the client requested to be covered up, Employee L removed a cover from the electric wheelchair (w/c) and assisted the resident with the cover. No handwashing/handgel was observed used by Employee L after positioning the cover on the client and later removing this cover during the bath. When the client was turned onto her right side exposing the wet, soiled mattress and sheets, Employee M had donned a new pair of gloves. Then, Employee M was observed to cleanse the wet, soiled mattress on the left side of the bed with "Huggies" wipes. With the same gloved hands Employee M was observed to wash the			

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	client's back, the lateral left side of the chest, and the upper buttocks with the same gloved hands. Next, Employee M was observed to return to the kitchen, removed her gloves, and change the wash and rinse basins of water 2 more times. No handwashing/handgel use was observed. After cleansing the lower abdomen, legs and feet, the towel from the floor was retrieved and used to dry the abdominal, legs and feet areas. This time Employee M was observed to remove her gloves, used a squirt of handgel and donned another pair of gloves with difficulty as Employee M's hands were still wet from the handgel. As the bed bath was completed, Employee M continued to use the same gloves, which included dressing and returning the equipment to the bedside. Finally, Employee M was observed to handwash at the kitchen sink, turned the water off with her wet hand, shook her hands to dry as no towel or paper towels were available. She indicated her visit was completed. During an interview, Employee M indicated one could switch out gloves during care. She indicated handwashing would be completed after care is completed. 410 IAC 17-12-1(m)			
G 0684 Bldg. 00		G 0684	**Infection Control** Due to nursing turnover, incident/infection logs were kept up to date accurately in 2018. Infection Control policy has been attached. All clinical managers have been re-educated with in-services to be more thorough with incident and infection reporting and follow up. Logs for	11/04/2019
	Based on record review and interview, the agency failed implement an agency-wide infection control program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases for 1 of 1 agency. Findings include: The agency policy entitled "Quality Assurance/			

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

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	Performance Improvement," dated April 25, 2019, stated (1) "Data will be collected to allow the agency to monitor its performance"; (2) "Data that may be used for data collection include the following: (f) Infection control surveillance and reporting of individuals and organizations served; (3) Data will be systematically collected to measure process and outcomes of each individual client." Review of the policy entitled "Incident Reporting", dated 07/26/18, did not include any verbiage surrounding infection control. A record review of the infection control program envelope for 2018, and infection control binder for 2019 was completed on 9/10/19. The infection control binder for 2018 included a document entitled "Infection Control Log Report, Indy North, Quarter 1, 2018." The report indicated one eye infection, with no further information. There was nothing for quarter 2, 3, 4 for 2018. The infection control binder for 2019 contained a blank form entitled "Infection Control Log" in the section marked Q3 2019. There was nothing for quarter 1 or quarter 2 for 2019. A review of the incident log, dated (Quarter 2) April 1st, 2019 to June 30th, 2019, indicated on 06/24/19, (1) Patient #3 went to the emergency room, was hospitalized for a urinary tract infection; (2) Patient #19 went to the emergency room, was hospitalized for a urinary tract infection. Neither of the urinary tract infections appear on an infection control log. An interview was conducted on 9/10/19 at 11:45 a.m. with the office manager and administrator. The office manager indicated that the agency did not have a separate infection control policy. The		incident have been updated to prompt more information and follow up. All infections to be added to the infection log. All incidents to be sent to Administrator for review to ensure proper documentation and follow up is reported. All infections will be reported quarterly with QAPI meeting and minutes to report trends and processes implemented to decrease trends. **Administrator will ensure reeducation to all Clinical Manager regarding infection control with Comprehensive Assessment In-service, completed by 11/4/19** **Administrator will review infection logs with Clinical Managers weekly to ensure that proper documentation is being maintained. Infections will be reported quarterly to assess for trends and new processes to decrease those trends will be implemented quarterly.**	

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	office manager stated "It is all inclusive in the incident reporting policy," dated 07/26/18. During said interview, the surveyor confirmed that all infection control plans/documents and all QAPI (quality assessment/performance improvement) plans/documents were provided. The office manager and administrator both confirmed that everything had, was provided. An interview was conducted on 9/11/19 at 2:00 p.m. with the administrator, office manager and program manager regarding the incident reports, dated 06/24/19. In regards to Patient #3, the administrator indicated they were not aware of the urinary tract infection. In regards to Patient #19, the administrator found the Transfer Summary Form, dated 06/24/19, completed by employee E that stated "Client reports falling while trying to transfer to bedside commode. Went to ER (emergency room) to be assess and was found to have UTI (urinary tract infection)." The team could not explain why the infection control log was not completed.			
G 0710 Bldg. 00	Based on record review and interview, the agency failed to ensure care and services were not provided prior to the physician approving the plan of care (Patient #2), failed to ensure nutritional supplement was provided per the plan of care (Patient #2), failed to ensure an OSHA kit was in place per agency policy/ and plan of care, failed to ensure skilled nursing visits were provided as ordered per the plan of care (Patient #1), and failed to ensure medications and gastronomy tube feeding were administered per the plan of care (Patient #1), and for 2 of 2 active	G 0710	Patient #2 Chart reviewed and processes put in place to prevent any future services being provided without physician order. Clinical Managers will notify scheduling staff when VSOC is received so that services can be scheduled. All employees re-educated with in-service to ensure that MD order obtained prior to any service being provided. Supplemental order has been sent to MD for Boost or	11/08/2019

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	skilled records reviewed. Findings include: 1. A review of policy entitled "Admission Criteria", dated 03/20/18, section 5 stated "No patient is admitted for services without an order from a physician." 2. A review of policy entitled "Clinical Documentation/ Missed Shifts", dated February 14, 2014, section #2 stated "A separate note shall be completed for each visit/shift and signed and dated by the appropriate professional." 3. A home observation was completed on 09/11/19 at 6:50 am, for patient #2. During the home visit, the skilled nurse offered the patient a carton of Boost to drink. During this time, Employee K was interviewed in regards to the Boost being provided versus the Pediasure that was ordered. Employee K stated "we use Boost and only use Pediasure when we run out of Boost." During this visit, surveyor asked employee K, RN to see the OSHA kit. Employee K stated "I have no idea what that is." A plan of care review for certification period of 05/20/19 - 07/18/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day" and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." The section DME [durable medical supplies]/ Supplies (page 3 of 4) stated "OSHA kit" as one of the supplies in the patient home. The plan of care failed to evidence instruction to use Boost supplement and to use the Pediasure supplement when the patient is out of Boost. The plan of care indicated the registered nurse obtained verbal start of care		Pediasure. All employees have been educated on maintaining accurate supplies and documentation, ensuring that each home has these supplies listed. All nurses to have extra gloves, sanitizer and OSHA kits, and CPR masks to replace those missing supplies provided by Adaptive immediately. RN will send supplemental order for all updated changes to the plan of care to ensure that the plan of care matches what is in the home and being provided to the client. All charts are being reviewed to ensure that services did not begin prior to MD order. All charts are being reviewed by the Administrator after each visit to ensure order received from MD prior to services being provided. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics patient preferences, supplemental orders, physician authorization requirements has been completed by 11/4/19. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing	

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	orders on 10/22/19. Review of the clinical record evidenced two Skilled Nurse Visit notes dated of 05/20/19 and 05/21/19. Review of the physician order on 05/22/19 stated "Admission completed on 05/20/19. Spoke with [NAME] RN at physician's office on 05/22/19 at 9:57 am for VSOC (verbal start of care) for SN (skilled nurse) services." The 5/20/19 to 7/18/19 plan of care evidenced that a verbal start of care date was documented as completed on 05/22/19. The agency provided skilled nursing services prior to obtaining orders from the physician. Further record review evidenced a plan of care for certification period of 07/19/19 - 09/16/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day" and section DME [durable medical supplies]/ Supplies (page 3 of 4) stated "OSHA kit" as one of the supplies in the patient home. The plan of care failed to evidence an order for Boost, the physician order was for Pediasure. Supervisory visit note dated 07/17/19, section #15 documented "no OSHA kit in the home". An interview was conducted on 09/11/19 at 10:50 am with employee F, who indicated that the program manager would go out and complete a home assessment prior to accepting each patient to ensure the home environment was appropriate and services were needed. That assessment would then be given to the case manager to obtain an order from the physician to complete the initial comprehensive assessment, which would include putting hands on the patient prior to the		each chart with home visits completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/29/19 Patient #1 Chart reviewed and documentation has been updated to show communication with primary caregiver that she was okay to wait after skilled nurse did not show up for orientation. Mom reported that she was oaky to wait for new skilled nurse as she had someone providing the services and wanted to give them an appropriate notice that they were no longer needed. All charts have been reviewed to ensure services are being provided as orderd. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's needs exceed the capabilities of the HHA with HHA Not Meeting Patient Needs In-service to be completed on 11/4/19. Administrator will review all client admission charts to ensure 100% compliance. All skilled charts reviewed to ensure the proper documentation and matches the plan of care. Administrator will review all charts the week after the clinical manager completes the home supervisory visits to ensure any changes are sent to MD for signature and that the plan of care	

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	start of care order. Once the initial comprehensive assessment was completed, the physician would be called to get an order to admit. Employee F, case manager, indicated that the OSHA kit was a spill kit for infectious fluids and had a CPR mouthpiece as well. Employee F showed the surveyor an example of one, which also contained a red hazard bag. Employee F stated "one is brought to each home on admission." Employee F further stated "This patient does not have one; don't know where it is. I've only seen her once." On 09/11/19 at 12:00 PM, the administrator confirmed that there was only one order from the physician for patient #2 and that it was dated for 05/22/19. During an interview on 09/12/19 at 2:25 PM, the administrator indicated that she saw the supervisory note dated 07/17/19 that stated "No OSHA kit in the home." She agreed that there should be one in the home. 4. The clinical record for patient # 1, with start of care [SOC] 7/15/2019, included a plan of care for the certification period of 7/15/19 to 9/12/19, with orders for skilled nurse services, 8 hours a day, 5 days a week, effective 7/15/19. The plan of care included orders for the skilled nurse to administer medications "ordered by the physician and document on the MAR [medication administration record]." Review of the electronic medical record for patient #1 failed to evidence skilled nurse visits were provided as ordered. The first skilled nurse visit note, dated 8/13/2019, by employee I, a registered nurse, was the first documentation of skilled nurse services. The clinical record failed to evidence documentation to explain why skilled nurse services were not completed as ordered on the		is being followed. Chart has been reviewed and order clarification has been sent to MD to ensure plan of care matches the services being provided. All employees have been re-educated and received in-service on all documentation must be reviewed by nurse and uploaded into the office chart to match home chart. Clinical Manager will review all documentation of the home nurse to ensure all orders are being followed and documented accurately. All skilled charts reviewed to ensure the proper documentation and matches the plan of care. Administrator will review all charts the week after the clinical manager completes the home supervisory visits to ensure any changes are sent to MD for signature and that the plan of care is being followed. Administrator will reeducate all internal staff and skilled nurses regarding documentation, medication, beginning services, supplemental orders, patient preference, missed shifts, and ensuring OSHA kits are in the home with Comprehensive Assessment, Home Safety Evaluation, and Not Meeting	

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	plan of care. Review of the electronic medical record evidenced skilled nurse visits were made 3 days a week, on Tuesdays, Wednesdays, and Thursdays, beginning 8/13/2019. The record evidenced skilled nurse visit notes dated August 13, 14, 15, 20, 21, 22, 27, and 28, and September 3, 4, and 5, 2019. The skilled nurse visit notes failed to evidence documentation of the medications and gastronomy tube feeding were administered by the nurse, during the visit. On 9/10/2019 at 2:10 PM, the clinical record was reviewed with the administrator. The administrator confirmed that skilled nurse services were provided 3 times a week and not 5 days a week as on the plan of care. The administrator indicated the record failed to evidence documentation that the physician was updated and the plan of care revised. During interviews on 9/12/19 at 4:30 PM, the office manager indicated the patient was accepted and the plan of care was established and the nurse for the case was to begin the following day, 7/16/2019, and failed to arrive for her first day of orientation, therefore, the agency did not have a nurse for the case. Employee A indicated the communication between the agency and the primary care giver was in her agency emails. At 5:45 PM, the administrator relayed that the clinical record failed to evidence documentation of the liquid nutrition and the medications that were administered by the nurse during the skilled nurse visit. Employee A indicated the documents were not turned into the agency by the nurse that completed the visits. No information was provided by survey exit on 9/13/19.		Client's Needs In-services to be completed by 11/8/19. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. See attachments	

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G 0716 Bldg. 00	Based on record review and interview, the skilled professional failed to ensure skilled nursing clinical notes were completed for 1 of 1 skilled pediatric clinical record reviewed. Findings include: Policy entitled "Flowsheets", dated August 1, 2012, stated "Agency personnel shall use appropriate flow sheets to document ongoing client assessment, care, and needs when visits are made . . . " and "All originals (white copies) will be turned into the office weekly and the yellow copy will be maintained in the home chart." Record review of patient #2, completed on 09/12/19, included skilled nursing notes through 08/31/19. Plan of care certification period of 07/19/19-09/16/19 indicated skilled nursing services to provide care 5 days a week. An interview with the office manager was conducted on 09/12/19 at 3:20 pm, where she stated "Skilled nurse should have turned in notes for time period 09/01/19 - 09/07/19 by Monday, 09/09/19, but she has not turned them in and that is a problem." 410 IAC 17-14-1(E)	G 0716	**Patient #2** Copies of skilled nurse flowsheets have been uploaded to client's office chart. All skilled client charts have been reviewed to ensure all care has been provided as ordered. Copies of skilled flowsheets and MARs have been uploaded after being reviewed by clinical manager. Clinical manager will review for completeness and initial after review and upload to client electronic office record. **Administrator will ensure reeducation to all Clinical Managers and skilled nurses regarding documentation not being submitted and uploaded in a timely manner with Comprehensive Assessment In-service, completed by 11/5/19.** Administrator will review skilled client charts to ensure that skilled nurse documentation has been uploaded to client office chart weekly for 100% accuracy and completion.	11/05/2019
G 0718 Bldg. 00	Based on record review and interview, the skilled professional failed to ensure the physician was	G 0718	Patient #2 Failed to ensure the physician was notified of changes in feeding	11/05/2019

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	notfied when it was decided the patient declined to have skilled nursing services as ordered per the plan of care (Patient #6), changes in feeding supplements (Patient #2), and unrelieved pain (Patient #7) for 3 of 8 records reviewed. Findings include: 1. A home observation was completed on 09/11/19 at 6:50 am, for patient #2. During the home visit the patient was given a carton of Boost to drink. Plan of care review for certification period of 05/20/19 - 07/18/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." And Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Record review of plan of care for certification period of 07/19/19 - 09/16/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." And Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Record review was completed on 09/11/19, which did not include any updated physician order for Boost or any documented communication with the physician to change the order from Pediasure to Boost. Interview with employee K, RN, on 09/11/19, stated "we use Boost and only use Pediasure when we run out of Boost." 2. A review of record #6 with a start of care 7/02/2019, evidenced a "Home Health Certification and Plan of Care" for the certification period of		supplements. Chart reviewed and processes put in place to prevent any future services being provided without physician order. All employees re-educated with in-service to ensure that MD order obtained prior to any service being provided. Supplemental order has been sent to MD for Boost or Pediasure. All employees have been educated on updating plan of care with all changes and notifying the MD of changes. RN will send supplemental order for all updated changes to the plan of care to ensure that the plan of care matches what is in the home and being provided to the client. All charts are being reviewed by the Administrator after each visit to ensure order received from MD prior to services being provided. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics patient preferences, supplemental orders, physician authorization requirements has been completed by 11/5/19. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor	

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	7/02/2019 to 8/30/2019, with orders for skilled nursing services 8 hours per day 5 days a week throughput the certification period. The clinical record failed to evidence skilled nursing services were provided as ordered and communication notes to explain why services were not provided. During an interview on 9/10/2019 at 3:20 PM, the office manager, indicated patient #6 did not receive any nurse services due to the primary care giver decided, after meeting multiple nurses, they did not want other individuals in the home. 3. The clinical record of Patient #7, start of care 12/19/18, was reviewed and indicated a primary diagnosis is rheumatoid arthritis with rheumatoid faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Plan of care for certification period of 02/17/19 - 04/17/19, page 2 of 4 stated "She explained that she will be prescribed stronger pain medication when she receives a keypad lock box for per narcotic pain medications due to past experiences of her medications getting stolen from her. Documented pain score was +8/10. Additionally, the plan of care stated "She has recently received a lockbox for her pain medication and will request more from her doctor next visits." Pain assessment, dated 04/12/19, documented "worst pain level over last 48 hours - 9." The clinical record failed to evidence that the physician was notified of the patient's pain.		for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/5/19 Patient #6 Failed to ensure the physician was notified when it was decided the patient declined to have skilled nursing services as ordered per the plan of care. Chart has been updated to show documentation with mom requesting to hold off on skilled nurse starting due to no hoyer lift in the home. Documentation of when mom decided services were no longer needed due to she was going to stay home with him. All charts being reviewed to ensure all communication with client/primary caregiver is documented. All employees received in-service not meeting client needs to re-educate on steps and documentation needed when unable to meet needs of client. Administrator reviewing schedules and documentation weekly to ensure plan of care is being followed as ordered. Patient #7 Failed to ensure MD was notified	

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			of patient's pain. Patient has been discharged and are unable to fix this deficiency for this chart. All charts being reviewed to ensure appropriate documentation of pain assessment. All clinical managers re-educated with Comprehensive Assessment in-service to be sure to document completely all pain assessments and notify MD of any increased or uncontrolled pain. Clinical Managers have been educated on falls, aspiration and pain interventions to be added to the plan of care as appropriate with measurable goals/outcomes to monitor. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Administrator will review all charts for compliance by 11/5/19 See attachments	
G 0750 Bldg. 00	Based on record review and interview, the agency failed to ensure a Home Health Aide was	G 0750	Administrator will ensure all competencies will be completed by a contract nurse in the home	11/04/2019

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	competent in performing a bed bath, failed to ensure that all prospective home health aide (HHA) staff performed all tasks, in their entirety with a patient and not simulated, as required, to demonstrate competence for placement on the home health aide registry and failed to ensure that the aide applications submitted to the Indiana State Department of Health, after a change in administrator on June 07, 2019, was signed by the current administrator, failed to ensure the continuing education for the Home Health Aides (HHA) annual in-services met the requirements, failed to ensure the home health aide care plan was updated and accurately reflected patient preference for bathing, failed to ensure that the home health aide only provided services that were ordered by the physician and included in the plan of care for shower, and failed to ensure that the home health supervision of the aide for completion of bathing was provided according to the plan of care. These practices impacted 2 (Patient #5, 7) out of 7 sampled patient records reviewed and 23 (Employee M, P, Q, R, GG, JJ, OO, PP, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC, DDD, EEE, FFF, GGG) out of 23 home health aide personnel files reviewed. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate Aide care and services which could result in the agency not providing quality health care.		prior to HHA application submission. Administrator has updated all license applications with current Administrator signatures. Administrator will review this monthly and quarterly with checklist. Administrator will ensure all internal staff are reeducated with Comprehensive Assessment In-service in regards to proper competency requirements by 11/4/19	
G 0754 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure a Home Health Aide was competent in performing a bed bath for 1 of 3 home visits conducted. (Employee	G 0754	Clinical Manager will be individually counseled and retrained on 11/4/19 by Administrator regarding competency assessment of Home	11/29/2019

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	M) Findings include: The "Competency Assessment" policy was provided by Employee C on 9/11/19 at 1:02 p.m. This current policy indicated the following: "POLICY competency of all staff will be assessed during the interview process orientation program and ongoing through out employment...SPECIAL INSTRUCTIONS 1. All employees will complete a self-assessment of the skills area for their job description. This assessment will be used to determine the orientation and specific training required by each person. 2. The skills assessment checklist and the orientation checklist will be used by the supervisor/preceptor to document the completion of satisfactory demonstration of skills...COMPETENCY EVALUATION OF HOME CARE STAFF...2. Skill tests including written tests and direct observation of skill will be completed as determined by the agency policies and individual assessments...Home Health Aide Competency: 2. Skills competency is evaluated by observing the aide with client,...NOTE: The following subject areas marked with an * must be evaluated after observation of the Home Health Aide's performance of the tasks with a client...* --Bed bath.... The "Personal Care Attendant (PCA)/ Home health Aide Exam" was provided by Employee B on 9/11/19 at 1:25 p.m. This written test was taken by a new hire to determine their knowledge. The new employee may do a self assessment of their own skills also. Employee M's hire date was on 9/5/19. Her last work area was as a laundry assistant in a long term care facility. She passed the written Home Health Aide exam on 9/5/19. Personnel file of		Health Aides. Administrator reeducated all Clinical Managers of assessing clients and home safety in meeting 10/29/19. Administrator updated PCA Skills checklist to ensure for accurate assessment of whether an employee is appropriate to be comped and added to Home Health Aide registry on 10/31/19 Administrator reeducated all internal staff on determining eligibility for competency with in-serivce attached on 11/4/19 Nurses must sign off on the PCA skills checklist whether employee is appropriate for competency assessment to be added to registry or not Administrator and Office Manager will review all PCA skills checklist of any new hires that this process is followed. All new competencies will be completed in the home with a patient by contracted nurse. Administrator will review all HHA registry applications and skills competency check offs to ensure process is being followed weekly to ensure that any inexperienced caregivers are not providing services or being submitted to the HHA registry.	

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	Employee M included a document titled, "PCA Skills Check List - CNA, HHA" and was provided to surveyor on 9/12/19 at 4:55 p.m. Employee M indicated on this document that she was knowledgeable and experienced to perform the specified skills of a sponge bath / bed bath, incontinent care, and handwashing. On 9/10/19 from 10:46 a.m. to 1:35 p.m., a home visit observation was conducted at the residence of Patient 4 and Employee M was observed to perform a bed bath with Patient. During this bed bath, Employee M was observed to don and remove gloves throughout the care with no handwashing or handgel use observed. After care was completed, Employee M was observed to handwash, turn the water off with her wet hand and shake her hands in attempt to dry them with no paper towel or other means present to dry her hands. The Patient was incontinent of urine and bowel movement during the bed bath observation. At the time for the rectal care and perineal care, Employee L (RN) indicated she had to leave for a short period. Employee L (RN) left at 12:35 p.m. and returned at 12:46 p.m. During this time that the RN was not present, Employee M was observed to cleanse the Patient's back, lateral left chest area and upper buttocks only. This cleansing did not include the rectal area. As the clean sheets were positioned on the bed, the client's female roommate acknowledge the remaining incontinent bowel movement and used wipes to cleanse the area. No perineal care was observed completed by Employee M on this client during this visit. Prior to exiting the home visit, Employee L informed the client she had been present to watch Employee M give her a bath. On 9/11/9 from 11:40 a.m. to 12:09 p.m., during an interview Employee L admitted she had left the			

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	house during the client's personal care, and these tasks (rectal and perineal care) were not seen by her. Employee's "COMPETENCY ASSESSMENT - -HHA," dated and signed electronically by Employee L on 9/10/2019, was provided by Employee B on 9/11/19 at 12:28 p.m. This competency checklist indicated Employee M "Successfully Completed" the skills of "Infection control / Hazardous Waste, Bathing Bed / Sponge, Safe Transfer techniques and ambulation." On 9/12/19 at 4:00 p.m., during an interview Employee B indicated the new hire for a HHA position would take the written test. She indicated the new hire would indicated if they were comfortable with the skill check list, and it would be the nurse's discretion to determine the knowledge a new hire may have with HHA skills. On 9/12/19 at 5:05 p.m., during an interview Employee C indicated during a Home Health Aide's testing for the HHA skills no prompting was allowed in order to understand their basic knowledge. The corrections, if needed, would be completed after the testing. 410 IAC 17-14-1(l)(1)(a)			
G 0768 Bldg. 00	Based on record review and interview, the agency failed to ensure that all prospective home health aide (HHA) staff performed all tasks, in their entirety with a patient and not simulated, as required, to demonstrate competence for	G 0768	Agency failed to ensure that all prospective home health aide staff performed all tasks in their entirety with a patient and not simulated to demonstrate competence for placement on the home health	11/08/2019

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	placement on the home health aide registry and failed to ensure that the aide applications submitted to the Indiana State Department of Health, after a change in administrator on June 07, 2019, was signed by the current administrator for 19 of 19 aide competencies reviewed. (Employees GG, JJ, OO, PP, SS, TT, UU, VV WW, XX, YY, ZZ, AAA, BBB, CCC, DDD, EEE, FFF, GGG) The findings include: The Indiana State Department of Health [ISDH], conducted an initial survey, exit date 6/01/2017. The results of the survey precluded the agency from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 6/01/2017, due to being out of compliance with the Conditions of Participation at 42 CFR 484.14, Organization, Services, and Administration; 42 CFR 484.16 Group of Professional Personnel; 42 CFR 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision; 42 CFR 484.30, Skilled Nursing Services, 42 CFR 484.48 Clinical Records, and 42 CFR 484. 55, Comprehensive Assessment of Patients. The ISDH received notice that on June 07, 2019, the agency had a change in the administrator; the administrator was employee E, effective 6/07/2019, employee C became the administrator. During an interview with employee C on 9/13/2019 at 3:15 PM, she relayed, when asked, that the last date of work for employee E was July 26, 2019, with the last date she saw a patient was July 11, 2019. During an interview on 9/09/2019, the office manager provided a contract for Contract Nurse		registry and failed to ensure that the aide applications had the new administrator signature on the registry applications after June 7, 2019. All employees have been in-serviced to be sure current Administrator is on the registry applications. All prospective home health aides to comped in the home with all tasks to be completed with patient without needing prompting or re-direction with skills before being submitted to registry. All comps will be completed with contract nurse. All contract nurses will have expirations tracked annually to ensure that contracts are current and up to date. Administrator updated contract for all Comp Nurses and they will be signed by 11/8/19. Administrator updated HHA license application with current Administrator's name. Administrator will review this form monthly for accuracy with checklist. Administrator will ensure that all competency will be completed in the home with a contact nurse prior to HHA application submission.	

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	01 [CN01], with initiation date of 11/16/2017 and predetermined expiration date of one year. The contract failed to evidence expectations for the completion of the aide competencies. A contract was provided for Contract Nurse 02 [CN02], with active date 6/27/2019; the contract was with Adaptive Indianapolis and Muncie locations. The contract failed to evidence expectations for the completion of the aide competencies. During interviews on 9/12/2019 at 5:45 PM, the office manager indicated that neither contracted nurse and aide would go to the Patient's homes, and that the agency did not want them to go. The office manager indicated the training and competency testing was all done in the agency office and that the agency case mangers, or case managers from other Adaptive locations, completed the competency evaluation in the patient homes with the aides. The administrator relayed that she did not want a contracted nurse to determine that an aide was competent, that she had not observed because the contracted nurse may determine an individual was competent and the agency nurses may not have determined the same individual to be competent. The following aide competency files and their corresponding application to the state agency evidenced the following: Employee file GG evidenced an in lab only competency with CNO1, dated 5/23/19 and application was submitted to the state agency on 5/23/2019. Employee file JJ evidenced an in lab only competency with CNO1, dated 5/23/19 and			

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	application was submitted to the state agency on 5/23/2019. Employee file OO evidenced an in lab only competency with CNO2, dated 7/18/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 7/18/2019. Employee file PP evidenced an in lab only competency with CNO2, dated 8/29/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/29/2019. Employee file SS evidenced an in lab only competency with CNO2, dated 8/29/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/29/2019. Employee file TT evidenced an in lab only competency with CNO2, dated 7/11/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 7/11/2019. Employee file UU evidenced an in lab only competency with CNO2, dated 8/08/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/08/2019. Employee file VV evidenced an in lab only competency with CNO2, dated 8/29/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/29/2019. Employee file WW evidenced an in lab only			

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	competency with CNO2, dated 8/01/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/01/19. Employee file XX evidenced an in lab only competency with CNO2, dated 8/15/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/15/2019. Employee file YY evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and was dated 8/08/19. Employee file ZZ evidenced an in lab only competency with CNO2, dated 8/22/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/22/2019. Employee file AAA evidenced an in lab only competency with CNO2, dated 8/29/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/29/2019. Employee file BBB evidenced an in lab only competency with CNO2, dated 8/29/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/29/2019. Employee file CCC evidenced an in lab only competency with CNO2, dated 7/11/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 7/11/2019.			

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	Employee file DDD evidenced an in lab only competency with CNO2, dated 7/11/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 7/11/2019. Employee file EEE evidenced an in lab only competency with CNO2, dated 6/27/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 6/27/2019. Employee file FFF evidenced an in lab only competency with CNO2, dated 7/11/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 7/11/2019. Employee file GGG evidenced an in lab only competency with CNO2, dated 8/15/19 and evidenced the application was submitted to the state agency with the signature of the previous administrator, employee E, and dated 8/15/19. 410 IAC 17-14-1(l)(A)			
G 0774 Bldg. 00	Based on interview and record review, the agency failed to ensure the continuing education for the Home Health Aides (HHA) annual inservices met the requirements for 8 of the 12 required inservices for 3 of 3 HHAs reviewed for these inservices. (Employee P, Employee Q, and Employee R) Findings include:	G 0774	Failed to ensure that continuing education for the Home Health Aides annual inservices met requirements. All Home Health Aides will receive in-services to cover all requirements. All home health aide files will be reviewed to ensure the requirements have been met. Any Home health aides that have not received all	11/29/2019

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	On 9/10/19 at 9:22 a.m., the HHA inservices were provided by Employee B. These 1 hour inservices included the following topics: OSHA, Culture Diversity, Handling Complaints, Abuse, Patient's Bill of Rights, Infection Control, Disaster Planning, Abnormal Observations, Working with a Non-compliant Client, Ethical Dilemma in Healthcare, Neglect, Specific Communication Needs, and Quality Improvement totaling 13 hours. These inservices were completed by Employee P (hire date of 4/18/17), Employee Q (hire date of 3/4/18), and Employee R (hire date of 8/28/18). On 9/11/19 at 1:30 p.m., Employee C provided the identified inservice information for each inservice obtained from Employee O (Director of Home Care Operations). This provided information was as follows: OSHA (all abut OSHA), Culture Diversity (understanding of culture diversity), Grievances/Complaints (handling complaints), Patient's Rights (Patient's Bill of Rights), Infection Control (infection control in home care), Emergency/Disaster Planning (disaster planning), Compliance Program (working with a non-compliant Client), Ethics (Ethical Dilemma in Healthcare), and Communication Barriers (understanding special communication needs). These inservices failed to evidence the content of the required inservice information to include vital signs, changes in a client's condition requiring notification to the supervisor, understanding of the basic elements of body functioning, maintaining a clean, safe, and healthy environment, appropriate and safe techniques in personal hygiene, grooming, transfer/ambulation, normal range of motion and positioning , adequate nutrition and fluid intake, medication assistance, and/or any other task the home health agency		requirement topics will receive the following in-services to get those covered. All of this information is also covered with a skills day competency annually. Administrator has attached current required in-service that covered areas of vital signs, basic elements of body function, fluid intake, and changes in client condition that require notification of a supervisor. This In-service titled Recognizing and Reporting Normal Observations has been a required and completed in-service for 2019. Administrator implementing all current HHA's receive the following in-services by 11/29/19 to ensure total compliance: Helping with Activities of Daily Living, Understanding Falls Risks, Nutrition for the Elderly, and Caregiver Basics Traiing. See attachments Administrator will ensure that all new hire HHAs receive all required in-services. Administrator will monitor that all required in-services are completed annually for all Home Health Aides.	

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	may choose to have the home health aide perform. On 9/12/19 at 5:44 p.m., during an interview Employee C acknowledged this Home Health Agency's identified inservices did not meet the requirements for the required continuing education of HHAs. 410 IAC 17-14-h(1)			
G 0798 Bldg. 00	Based on record review, the agency failed to ensure the home health aide care plan was updated and accurately reflected patient preference for bathing in 1 of 4 closed records reviewed. (Patient #7) Findings include: A communication note from the RN, case manager, dated 03/28/19 states "Client requesting sink bath . . ." The HHA Service Plan failed to be updated prior to 04/17/19 for a sink bath.	G 0798	Patient #7 Failed to ensure the home health aide care plan was updated and accurately reflected patient preference for bathing. Chart was reviewed and noted that the HHA service plan dated and time stamped 3/28/19 matches the communication note that the client preferred a sink bath. Clinical manager was notified of the patient's preference to receive sink bath, documented it in communications and updated the HHA service plan at that time. All HHA timesheets are being reviewed weekly to note any such changes/updates and Home Health Aides will be re-educated to notify office of any changes including patient preference so that plan of care and service plan can be updated at that time by 11/29/19. Please see attached date and	09/13/2019

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			time stamped (3/28/19) to match communication dated 3/28/19 updated HHA Service plan with updated client preference for bathing. Clinical Managers will continue to review time sheets weekly to ensure compliance with updating plan of care/HHA service plan.	
G 0800 Bldg. 00	Based on record review and interview, the agency failed to ensure visits were provided as ordered on the plan of care for 2 of 5 home health aide only records reviewed. (Patient 5 and 7) Findings include: 1. On 9/12/19 at 4:58 p.m., Employee B indicated there was no policy for missed visits only the provided procedure. 2. The "Missed Visit Notification to MD (Medical Doctor)" current policy was provided by the Office Manager on 9/10/19 at 4:10 p.m. This current policy indicated "...For any Patients that have a remaining # (number) of hours [greater than 1 hour], a missed visit notification will be faxed to the MD." 3. Patient 5's clinical record was reviewed on 9/11/19 at 1:50 p.m. This Patient's diagnoses included, but were not limited to, Type 2 Diabetic Mellitus, lumbar spinal stenosis, chronic diastolic heart failure, hypertension, neurogenic bladder, and chronic kidney disease, Stage 4. The Start of	G 0800	Administrator will ensure reeducation to all internal staff on documentation of missed shifts with Not Meeting Patient's Needs In-service completed by 11/4/19. HHA (Home Health Agency) will provide documentation daily as to why services are not provided as ordered and document communication between agency and patient/primary caregiver under the shift that was scheduled as well as in activities/communications. HHA (Home Health Agency) will provide documentation of communication between agency and patient's physician who is responsible for the home health plan of care in activities/communications. Follow-up documentation will be provided daily that includes how and when the patient and/or primary caregiver were notified of staffing status. Review of daily visit sheets to be completed	11/04/2019

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	Care was 9/10/18. The Plan of Care for the certified period of 7/7/19 through 9/4/19 was to provide 3-5 hours a day for 5 to 7 days per week. The HHA was to assist with all Activities of Daily Living to include, but not limited to, bathing, hair care, incontinence care and light housekeeping. The week of 8/25/19 to 8/31/19 included a HHA visit on 8/26 (Monday), 8/28 (Wednesday), and 8/29 (Thursday) only. On 9/12/19 at 3:30 p.m., during an interview Employee B indicated the HHA had moved a scheduled visit day during the week of 8/25/19 to 8/31/19 to 8/31/19 (Saturday). She also indicated the HHA then called in on 8/31 (Saturday), and no replacement was found. The agency failed to evidence any further information related to the missing 2 days of the HHA's home visits. On 9/12/19 at 3:50 p.m., during an interview Employee C indicated if 50% of approved visits and over 1 hour or more in a week were missed, a supplemental order was to be sent to the physician. 4. Patient #7 clinical record was reviewed and evidenced a plan of care for certification period of 02/17/19-04/17/19, indicated within the professional services orders section that the aide will assist with bathing (shower). Review of the Home health aide Plan of Care Service Plan, dated 01/16/19, indicated tub/shower for bath. Communication note, dated 03/28/19 was completed by the supervisory case manager that stated "Patient requested her bathing type be changed to sink bath as her shower is upstairs and she does not feel safe climbing stairs." The clinical record failed to evidence a physician order		weekly by Clinical Manager by either reviewing individual daily visit sheets or running Service Plan Task Frequency Variance Report. Clinical Manager will document in Communications/QA that every shift has been reviewed weekly. All documentation must be signed by the individual making the entry with individuals first initial of first name, last name and title. If after 15 days, the HHA (Home Health Agency) is unable to meet the needs of the patient, the agency will offer to assist transfer to another HHA (Home Health Agency) that is able to meet the needs of the patient by providing them with a list of providers in the area. The Administrator/Operations Manager will check weekly for this documentation and verify in activities/QA under the office that missed shifts and grievances were reviewed for concerns. This note will be printed and placed in the QAPI binder weekly. Please see attached correct service plan made on 3/28/19 for patient 7 for compliance. Please see attached Missed Shift policy.	

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	and the plan of care failed to be updated to indicate the change in patient preference. Review of the home health aide daily visit sheets for care dates from 03/26/19 through 04/17/19, indicated the patient was given a sink bath. The home health aide failed to follow the plan of care.			
G 0818 Bldg. 00	Based on record review, the home health aide failed to notify the case manager of patients pain for 1 of 4 closed clinical records reviewed. (Patient #7) Findings include: The clinical record of Patient #7, start of care 12/19/18, was reviewed and indicated a primary diagnosis is rheumatoid arthritis with rheumatoid faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Review of an Aide Daily Visit Sheet for patient #7, date of 03/28/19 was reviewed. The document stated "gave her a quick sink bath because of pain." The note and record failed to evidence that the home health aide notified the case manager of the patient's pain. Communication note, dated 03/28/19 was completed by the supervisory case manager that stated "Client requested her bathing type be changed to sink bath as her shower is upstairs and she does not feel safe climbing stairs." No documentation in the clinical record addressing	G 0818	The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics for pain and review of daily visit records weekly requirements has been completed by 11/4/19.Administrator will provide Abnormal Observation/Unusual Findings In-service for all HHAs to specify that they call a Clinical Manager with every abnormal observation or unusual finding completed by 11/29/19. Abnormal Observation/Unusual Findings In-service upon hire.	11/29/2019

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	the patient's pain. Review of an Aide Daily Visit Sheet for patient #7, date of 03/29/19 was reviewed. The document stated (1) Assist with Ambulation, "Helped with her walker to take her to the bathroom and back to her bed. She was unable to hold on because of her hands and arms were in a lot of pain. (2) Mobility Assist, "Too much pain for me to move her." (3) Skin Care "She was in some pain and did not want anything on her." The note and record failed to evidence that the home health aide notified the case manager of the patient's pain. An interview conducted on 09/12/19 at 5:45 pm with the administrator and office manager indicated that they were in agreement that there was a failure to communicate.			
G 0940 Bldg. 00	Based on record review and interview, the agency failed to ensure the organizational chart for this agency was accurate, complete, and in writing, the clinical manager failed to ensure communication among staff and with physicians were conducted, failed to ensure a system was in place for tracking referrals, to ensure patients were assessed, and a timely start of care, failed to ensure care and services were not provided prior to the physician approving the plan of care, failed to ensure nutritional supplement was provided per the plan of care, failed to ensure OSHA kit was in place per agency policy and plan of care failed to ensure home health aide visits and skilled nursing visits were provided as ordered per the plan of care, and failed to ensure medications and gastronomy tube feeding were administered per	G 0940	Administrator updated Organization Chart for Indianapolis Agency for clarification on 11/8/19. Please see attached. Administrator updated Organization Chart for the Agency on 11/1/19. This will be updated monthly with checklist in place. Administrator added tracking information to our date base, Matrix for monthly tracking of contract expiration for nurses. Administrator updated all nurse contracts to be signed by 11/8/19. Administrator will ensure all Clinical Manager are reeducated	11/08/2019

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	the plan of care, failed to ensure a current written contract was in place for the contracted Registered Nurse (RN), Contract RN 01, who was completing the Home Health Aide's competency of skills, prior to placement on the Indiana State Registry, and failed to offer skilled services to new patients, following their certification survey dated 6/15/2018. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure apatient rights were adhered to which could result in the agency not providing quality health care for all 44 current patients in 1 of 1 agency. Findings include: On 9/9/19 from 10:30 a.m. to 11:05 a.m., the entrance conference was completed with Employee C., who indicated the co-owners were the Governing Body. On 9/12/19 at 9:50 a.m., Employee C provided the undated "Adaptive Organizational Chart." This current chart included no identifying personnel. The positions on this chart started with the "Governing Body" with the attached breakdown was to the "Director of Clinical Operations" and "Director of Corporate Operations and Training,"" leading to "Area Clinical Managers (ACM's)" and then, to "Clinical Managers (CM's)" indicating 2 to 4 per office, and lastly, to the "Clients." The positions on the next breakdown branching off from the "Governing Body" was the position of "Director of Homecare Operations/ Territory Development Managers" leading to the "Operations Managers (OM's) indicating 1 per office (southern Indiana), and then, to the "Program Managers (PM's) indicating 2 to 4 per office, and lastly, "Caregivers." The last position breakdown was to the "Director of Human		on referral tracking with Comprehensive Assessment In-service and the operations staff with the Plan of Care - Operations In-service to be completed by 11/4/19.	

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	Resources" to the "Human Resources (sic) Supervisor" to "Human Resources Assistant" and lastly, to "Personnel Specialist (PS's) indicating 1 per office. The Organizational chart failed to be specific to the Indianapolis office, failed to show who reports to the Administrator and/ or Clinical Supervisors within the Indianapolis office, and failed to show that the Administrator for the Indianapolis office reported to the Governing Body. On 9/12/19 at 9:50 a.m. when queried Employee B provided a second undated "Adaptive Organizational Chart". This chart included the personnel for the Governing Body, the 4 directors, one area clinical manager, the Human Resources (HR) supervisor and HR assistant. No names were included for the operations managers, program managers, clinical managers, clients, HR's personnel specialist, or caregivers. 410 IAC 17-12-1(a)(1) 410 IAC 17-12-1(a)(2)			
G 0962 Bldg. 00	Based on observation, record review, and interview, the clinical manager failed to ensure communication among staff and with physicians were conducted for 3 of 8 clinical records reviewed (#2, 6, 7). Findings include: 1. A home observation was completed on 09/11/19 at 6:50 am, for patient #2. During the home visit the patient was given a carton of Boost to drink.	G 0962	Patient #2 Supplemental order has been sent to MD for Boost or Pediasure. All Clinical Managers have been in-serviced and re-educated to update MD with any changes to POC including patient preference and update POC to reflect these changes. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics patient	11/04/2019

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	Plan of care review for certification period of 05/20/19 - 07/18/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." And Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Record review of plan of care for certification period of 07/19/19 - 09/16/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." And Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." Record review was completed on 09/11/19, which did not include any updated physician order for Boost or any documented communication with the physician to change the order from Pediasure to Boost. Interview with employee K, RN, on 09/11/19, stated "we use Boost and only use Pediasure when we run out of Boost." 2. A review of record #6 with a start of care 7/02/2019, evidenced a "Home Health Certification and Plan of Care" for the certification period of 7/02/2019 to 8/30/2019, with orders for skilled nursing services 8 hours per day 5 days a week throughput the certification period. The clinical record failed to evidence skilled nursing services were provided as ordered and communication notes to explain why services were not provided. During an interview on 9/10/2019 at 3:20 PM, the office manager, indicated patient #6 did not receive any nurse services due to the primary care giver decided, after meeting multiple nurses, they did not want other individuals in the home.		preferences, supplemental orders, physician authorization requirements has been completed by 11/4/19. All charts are being reviewed by the Administrator after each visit to ensure order and notification sent to MD for any changes to POC for any changes. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics patient preferences, supplemental orders, physician authorization requirements has been completed by 11/4/19. Patient #6 Documentation from interoffice emails showing communication with primary caregiver and her wishes to wait on services until she received a hoyer lift in the home is in chart. All charts have been reviewed to ensure services are being provided as orderd. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's needs exceed the capabilities of the HHA with HHA Not Meeting Patient Needs In-service to be completed on 11/4/19. See attachments Administrator will review all client admission charts to ensure 100% compliance. Patient #7	

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	3. The clinical record of Patient #7, start of care 12/19/18, was reviewed and indicated a primary diagnosis is rheumatoid arthritis with rheumatoid faction. Other pertinent diagnoses include essential primary hypertension, anxiety disorder, anemia, chronic pain syndrome, type II diabetes mellitus, and mixed incontinence. Plan of care for certification period of 02/17/19 - 04/17/19, page 2 of 4 stated "She explained that she will be prescribed stronger pain medication when she receives a keypad lock box for per narcotic pain medications due to past experiences of her medications getting stolen from her. Documented pain score was +8/10. Additionally, the plan of care stated "She has recently received a lockbox for her pain medication and will request more from her doctor next visits." Pain assessment, dated 04/12/19, documented "worst pain level over last 48 hours - 9." The clinical record failed to evidence that the physician was notified of the patient's pain. Review of an Aide Daily Visit Sheet for patient #7, date of 03/28/19 was reviewed. The document stated "gave her a quick sink bath because of pain." The note and record failed to evidence that the home health aide notified the case manager of the patient's pain. Communication note, dated 03/28/19 was completed by the supervisory case manager that stated "Client requested her bathing type be changed to sink bath as her shower is upstairs and she does not feel safe climbing stairs." No documentation in the clinical record addressing the patient's pain.		Patietn #7 has been discharged and are unable to fix this deficiency for this chart. All charts being reviewed to ensure appropriate documentation of pain assessment. All clinical managers re-educated with Comprehensive Assessment in-service to be sure to document completely all pain assessments and notify MD of any increased or uncontrolled pain. Clinical Managers have been educated on falls, aspiration and pain interventions to be added to the plan of care as appropriate with measurable goals/outcomes to monitor. All current and new home health aides will be educated on letting nurse and office staff know of any change in client preferences or health immediately so that it can be followed up with MD and plan of care updated. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.	

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	Review of an Aide Daily Visit Sheet for patient #7, date of 03/29/19 was reviewed. The document stated (1) Assist with Ambulation, "Helped with her walker to take her to the bathroom and back to her bed. She was unable to hold on because of her hands and arms were in a lot of pain. (2) Mobility Assist, "Too much pain for me to move her." (3) Skin Care "She was in some pain and did not want anything on her." The note and record failed to evidence that the home health aide notified the case manager of the patient's pain. An interview conducted on 09/12/19 at 5:45 pm with the administrator and office manager indicated that they were in agreement that there was a failure to communicate. 410 IAC 17-12-2(g)			
G 0964 Bldg. 00	Based on interview and document review, the clinical manager failed to ensure a system was in place for tracking referrals, to ensure patients were assessed, and a timely start of care for 1 of 1 agency. The findings include: During the entrance conference on 9/09/2019 at 10:30 AM, the office manager indicated referrals for home health services, go to a program manager, who makes the initial contact with patient, by phone. The physician is contacted for a verbal order to make the initial assessment and then the agency tries to start staffing within 5 days. Per Office Manager, if the agency does not complete the initial assessment within 48 hours,	G 0964	Administrator updated referral process and will provide reeducation with Plan of Care - Operation In-Service by 11/4/19. Administrator will monitor referral process by reviewing non binder and admissions weekly.	11/04/2019

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	the physician is to be called for another verbal order for a new start of care order. On 9/10/2019 at 4 PM, the office manager indicated the referrals for home health services and not admitted, were not retained. On 9/11/2019 at 10 AM, a 3 ring binder was provided and indicated that there was no other information available for past referrals, not admitted. The binder contained 4 referrals for personal services and / or home health aide services. During interviews on 9/12/1919 at 1:40 PM: Employee B, the office manager, indicated the agencies do not keep a log of all the referrals the agency receives, relayed that the agency receives multiple inquires a day, and would need to search emails and call referring organization for information. Employee A, a program director, indicated initial referrals go to a non clinical staff member that checks eligibility and makes the initial contact with the patient, whom either contacts, patient referred, by phone or goes to their home. Then the referral information is given to the registered nurse [RN] case manager. Employee A indicated she does not keep a record of the referrals, that once the agency decides to admit, the information is given to the RN case manager, and that she [employee A] does not retain any of the referral information. Record review of patient #2 clinical record indicated the start of care date on the plan of care order to be 05/20/19 and the verbal start of care date on the plan of care order was documented to be 05/22/19.			

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	Review of the physician order on 05/22/19 stated "Admission completed on 05/20/19. Spoke with [Namee] RN at physician's office on 05/22/19 at 9:57 am for VSOC (verbal start of care) for SN (skilled nurse) services . . ." Review of Intake/Referral Form indicated the date of referral to be 05/20/19 with no time documented. Review of Medical History/Functional Assessment indicated the date of assessment to be 05/20/19. Review of Skilled Nurse Visit notes included care dates of 05/20/19 and 05/21/19. An interview was conducted on 09/11/19 at 10:50 am with employee F, who indicated that the program manager goes out and completes a home assessment prior to accepting each patient to ensure the home environment is appropriate and services are needed. That assessment is then given to the case manager to get an order from the physician to complete an initial comprehensive assessment, which includes putting hands on the patient prior to the start of care order. Once the Initial comprehensive assessment is completed, the physician is called to get an order to admit. On 09/11/19 at 12:00 pm, the administrator confirmed that there was only one order from the physician for patient #2 and that it was dated for 05/22/19.			
G 0968 Bldg. 00	Based on observation, record review and interview, the clinical manager failed to ensure	G 0968	Patient #2 Chart reviewed and processes put in place to prevent any future	11/04/2019

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	care and services were not provided prior to the physician approving the plan of care (Patient #2), failed to ensure nutritional supplement was provided per the plan of care (Patient #2) and OSHA kit was in place per agency policy and plan of care for 1 of 1 skilled pediatric reviewed, failed to ensure home health aide visits and skilled nursing visits were provided as ordered per the plan of care for 1 (Patient #1) out of 1 active skilled nursing for an adult and 1 (Patient #7) out of 2 closed records reviewed of patients receiving home health aide only, and failed to ensure medications and gastronomy tube feeding were administered per the plan of care (Patient #1), and for 1 of 1 active skilled nursing records reviewed. Findings include: 1. A review of policy entitled "Admission Criteria", dated 03/20/18, section 5 stated "No patient is admitted for services without an order from a physician." 2. A review of policy entitled "Clinical Documentation/ Missed Shifts", dated February 14, 2014, section #2 stated "A separate note shall be completed for each visit/shift and signed and dated by the appropriate professional." 3. A home observation was completed on 09/11/19 at 6:50 am, for patient #2. During the home visit, the skilled nurse offered the patient a carton of Boost to drink. During this time, Employee K was interviewed in regards to the Boost being provided versus the Pediasure that was ordered. Employee K stated "we use Boost and only use Pediasure when we run out of Boost." During this visit, surveyor asked employee K, RN to see the OSHA kit. Employee K stated "I have no idea what that is."		services being provided without physician order. Clinical Managers will notify scheduling staff when VSOC is received so that services can be scheduled. All employees re-educated with in-service to ensure that MD order obtained prior to any service being provided. Supplemental order has been sent to MD for Boost or Pediasure. All employees have been educated on maintaining accurate supplies and documentation, ensuring that each home has these supplies listed. All nurses to have extra gloves, sanitizer and OSHA kits, and CPR masks to replace those missing supplies provided by Adaptive immediately. RN will send supplemental order for all updated changes to the plan of care to ensure that the plan of care matches what is in the home and being provided to the client. All charts are being reviewed to ensure that services did not begin prior to MD order. All charts are being reviewed by the Administrator after each visit to ensure order received from MD prior to services being provided. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics patient preferences, supplemental orders, physician authorization	

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	A plan of care review for certification period of 05/20/19 - 07/18/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day" and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day." The section DME [durable medical supplies]/ Supplies (page 3 of 4) stated "OSHA kit" as one of the supplies in the patient home. The plan of care failed to evidence instruction to use Boost supplement and to use the Pediasure supplement when the patient is out of Boost. The plan of care indicated the registered nurse obtained verbal start of care orders on 10/22/19. Review of the clinical record evidenced two Skilled Nurse Visit notes dated of 05/20/19 and 05/21/19. Review of the physician order on 05/22/19 stated "Admission completed on 05/20/19. Spoke with [NAME] RN at physician's office on 05/22/19 at 9:57 am for VSOC (verbal start of care) for SN (skilled nurse) services." The 5/20/19 to 7/18/19 plan of care evidenced that a verbal start of care date was documented as completed on 05/22/19. The agency provided skilled nursing services prior to obtaining orders from the physician. Further record review evidenced a plan of care for certification period of 07/19/19 - 09/16/19 was completed. Gastrointestinal section (page 2 of 4) stated "Pediasure 237 ml four times a day." and Nutritional Requirements section (page 3 of 4) stated "Pediasure four times a day" and section DME [durable medical supplies]/ Supplies (page 3 of 4) stated "OSHA kit" as one of the supplies in the patient home. The plan of care failed to evidence an order for Boost, the physician order was for Pediasure.		requirements has been completed by 11/4/19. Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur with weekly reporting checks. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/29/19 Patient #7 Chart reviewed and last date HHA services were provided was 4/19/19. Shift on 4/20/19 was cancelled due to caregiver being sick, client stated she would have granddaughter help her for the day. Shift for 4/21 was unable to staff and client stated she would be good without anyone since it was Easter. Documentation for 4/22, 4/23, & 4/25 states they were unable to find replacement for the usual caregiver. 4/25/19 Client called and stated she no longer needed services and was looking for a new provider. Discharge order was sent to MD on 5/7/19 but had not been signed by MD. All charts have been reviewed for unauthenticated supplemental orders and re-sent to MDs for validation signatures.	

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	Supervisory visit note dated 07/17/19, section #15 documented "no OSHA kit in the home". An interview was conducted on 09/11/19 at 10:50 am with employee F, who indicated that the program manager would go out and complete a home assessment prior to accepting each patient to ensure the home environment was appropriate and services were needed. That assessment would then be given to the case manager to obtain an order from the physician to complete the initial comprehensive assessment, which would include putting hands on the patient prior to the start of care order. Once the initial comprehensive assessment was completed, the physician would be called to get an order to admit. Employee F, case manager, indicated that the OSHA kit was a spill kit for infectious fluids and had a CPR mouthpiece as well. Employee F showed the surveyor an example of one, which also contained a red hazard bag. Employee F stated "one is brought to each home on admission." Employee F further stated "This patient does not have one; don't know where it is. I've only seen her once." On 09/11/19 at 12:00 PM, the administrator confirmed that there was only one order from the physician for patient #2 and that it was dated for 05/22/19. During an interview on 09/12/19 at 2:25 PM, the administrator indicated that she saw the supervisory note dated 07/17/19 that stated "No OSHA kit in the home." She agreed that there should be one in the home 4. Clinical record review for patient #7 was completed on 09/12/19. The plan of care for recertification period 4/18/19 to 6/16/19 included		Administrator will review each chart when home visits are done to ensure all changes have supplemental order sent to MD for signature. Administrator will check weekly to ensure all sent orders have been authenticated by MD or re-sent to MD for signature. Administrator will review client schedules weekly to ensure that schedule/services provided match the order in the plan of care. If it does not match that there is documentation to support the changes. Patient #1 Chart has been reviewed and order clarification has been sent to MD to ensure plan of care matches the services being provided. All employees have been re-educated and received in-service on all documentation must be reviewed by nurse and uploaded into the office chart to match home chart. Clinical Manager will review all documentation of the home nurse to ensure all orders are being followed and documented accurately. All skilled charts reviewed to ensure the proper documentation and matches the plan of care. Administrator will review all charts the week after the clinical manager completes the home supervisory visits to ensure any	

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	orders for aide services to be provided 5-7 days per week. Review of aide visit notes evidenced the last date of care provided by the aide was 04/17/19. The record failed to evidence any further aide visits were provided. A communication note, dated 4/26/19 was reviewed on 9/12/19, which stated "Wanted to update you all on patient #7. She called me yesterday and said she doesn't need our services anymore because she is looking for another company. I told her we can continue to staff until she finds a replacement, but she said no." A communication note, dated 04/29/19 was reviewed on 09/12/19, which stated "We called patient #7 to verify her waiver services and she said that we should not call her anymore and that we need to discharge her as a client because she no longer wants to deal with us." Review of physician order dated 05/07/19 stated "discharge client from agency effective 05/07/19 due to client switching to another home health company;" no physician authentication. An interview was conducted on 09/12/19 at 4:15 PM with the office manager who indicated that the last day of direct, hands on care was 04/19/19. An interview was conducted on 09/12/19 at 5:45 PM with the office manager and administrator. At that time the office manager stated "Caregiver (aide) called off full week of 04/21/19-04/27/19. Patient called and stated not to send anyone as she was mad and wanted to find a new company. We could not discharge without a new company in place." The office manager agreed that there were missed visits. 5. The clinical record for patient # 1, with start of		changes are sent to MD for signature and that the plan of care is being followed. Clinical Managers will communicate with office staff when VSOC is received from the MD to start/continue services. Services will not be scheduled until VSOC is obtained. Supplemental order for VSOC will be sent to MD for signature validating approval of services. Administrator will monitor this weekly with review of all charts that had home visit for that week. p="" by="" completion="" for="" weekly. administrator="" completed="" this="" prior. ="" week="" visits="" home="" with="" chart="" each="" reviewing="" compliance="" 100%="" monitor="">see attachments	

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	care [SOC] 7/15/2019, included a plan of care for the certification period of 7/15/19 to 9/12/19, with orders for skilled nurse services, 8 hours a day, 5 days a week, effective 7/15/19. The plan of care included orders for the skilled nurse to administer medications "ordered by the physician and document on the MAR [medication administration record]." Review of the electronic medical record for patient #1 failed to evidence skilled nurse visits were provided as ordered. The first skilled nurse visit note, dated 8/13/2019, by employee I, a registered nurse, was the first documentation of skilled nurse services. The clinical record failed to evidence documentation to explain why skilled nurse services were not completed as ordered on the plan of care. Review of the electronic medical record evidenced skilled nurse visits were made 3 days a week, on Tuesdays, Wednesdays, and Thursdays, beginning 8/13/2019. The record evidenced skilled nurse visit notes dated August 13, 14, 15, 20, 21, 22, 27, and 28, and September 3, 4, and 5, 2019. The skilled nurse visit notes failed to evidence documentation of the medications and gastronomy tube feeding were administered by the nurse, during the visit. On 9/10/2019 at 2:10 PM, the clinical record was reviewed with the administrator. The administrator confirmed that skilled nurse services were provided 3 times a week and not 5 days a week as on the plan of care. The administrator indicated the record failed to evidence documentation that the physician was updated and the plan of care revised. During interviews on 9/12/19 at 4:30 PM, the office			

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	manager indicated the patient was accepted and the plan of care was established and the nurse for the case was to begin the following day, 7/16/2019, and failed to arrive for her first day of orientation, therefore, the agency did not have a nurse for the case. Employee A indicated the communication between the agency and the primary care giver was in her agency emails. At 5:45 PM, the administrator relayed that the clinical record failed to evidence documentation of the liquid nutrition and the medications that were administered by the nurse during the skilled nurse visit. Employee A indicated the documents were not turned into the agency by the nurse that completed the visits. No information was provided by survey exit on 9/13/19.			
G 0978 Bldg. 00	Based on interview and record review, the agency failed to ensure a current written contract was in place for the contracted Registered Nurse (RN), Contract RN 01, who was completing the Home Health Aide's competency of skills, prior to placement on the Indiana State Registry, for 1 of 1 agency. Finding include: 1. Following a previous survey conducted by the Indiana State Department of Health, exit date 6/01/2017, Adaptive Home Health, was precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 6/01/2017, due to being out of compliance with the Conditions of Participation at 42 CFR 484.14, Organization, Services, and Administration; 42 CFR 484.16 Group of	G 0978	Administrator added tracking information to our date base, Matrix for monthly tracking of contract expiration for nurses. Administrator updated all nurse contracts to be signed by 11/8/19.	11/08/2019

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	Professional Personnel; 42 CFR 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision; 42 CFR 484.30, Skilled Nursing Services, 42 CFR 484.48 Clinical Records, and 42 CFR 484. 55, Comprehensive Assessment of Patients. 2. On 9/9/19 from 10:30 a.m. to 11:05 a.m., the entrance conference was completed with Employee C. She indicated the agency contracted a registered nurse for the aide competencies. She indicated newly hired individual, complete a written test and a self assessment skills check list. If they pass the written test, the new hire would complete a competency skill test in the laboratory in the agency's office with the contracted nurse. 3. A review of the contract between Contract RN 01 and the agency titled, "Independent Contractor Agreement" was signed by RN Contract 01 and Employee O (Administrator at the time). The contract stated, "11. Term. This Agreement shall be effective for a term of 1 year beginning on 11/16/17, unless terminated earlier in accordance with this Agreement." 4. On 9/11/19 at 11:20 a.m., during an interview, Employee B indicated the agency did not renew the contract with Contract RN 01. Employee B indicated the RN did continue to complete the aide competencies for new hires, without a contract, since the expiration of the contract 11/15/2018. 5. The list of the 20 individuals whose competency was completed by Contracted RN 01 were provided by Employee C on 9/11/19 at 10:30 a.m. This list included the following new HHAs employees and their "Competency Assessment" completion date: #S, #aa, and #kk completed on			

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	5/9/19; #T, #X, #Y, #cc, #ff, and #ll completed on 4/4/19; #U completed on 10/18/18; #V completed on 8/1/18; #W completed on 3/8/19; #Z completed on 4/11/19; #bb, #gg, #hh, and #jj completed on 5/23/19; #dd completed on 8/16/18; #ee completed on10/22/18; and #mm completed on 9/27/18. 410 IAC 17-12-2(d)			
G 0982 Bldg. 00	Based on interview and record review, the agency failed to offer skilled services to new patients, following their certification survey dated 6/15/2018, for 1 of 1 home health agency. The findings included: 1. On 9/09/2019, following the entrance conference, the office manager provided the total count of two [2] skilled patients since the agency received their certification, surveyed by an accreditation organization on 6/15/2018. The two skilled patents were Patient 1 with start of care [SOC] 7/15/2019 and Patient 2 with SOC of 5/20/2019. The office manager indicated the agency focused on home health aide services, staffed for home health aide, that they enjoyed the niche market, and had not sought out to provide skilled nursing services. 2. A review of record #6 with a start of care 7/02/2019, included a Home Health Certification and Plan of Care for the certification period of 7/02/2019 to 8/30/2019, and included orders for skilled nursing services 8 hours per day 5 days a week throughput the certification period. The	G 0982	Agency failed to offer skilled services for new patients. Agency has 2 current skilled clients. A 3rd pediatric skilled client was admitted 9/12/19. This client was discharged on 11/7/19 due to hospitalization during recertification window. This client will be re-admitted once returned home if primary caregiver agreeable. Patient #6 Documentation from interoffice emails showing communication with primary caregiver and her wishes to wait on services until she received a hoyer lift in the home is in chart. Office manager did not have the correct information when stated that it was after multiple nurses that they did not want other indivisuals in the home. All charts have been reviewed to ensure services are being provided as ordered.	11/04/2019

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	clinical record failed to evidence that any skilled nursing services were provided, nor documentation to explain why the skilled nurse services were not provided. A discharge summary dated 8/21/2019, completed by registered nurse F, stated, "Client will be discharged to family and MD [medical director] when services are no longer needed or desired. Patient's mother called the office [date not specified] and decided to stay home with Patient. Client will no longer need HHA [home health agency] services." During an interview on 9/10/2019 at 3:20 PM, the office manager, indicated patient #6 did not receive any nurse services, that after meeting multiple nurses, they did not want other individuals in the home to care for Patient 6. Documentation of these meetings with the patient and primary care giver were requested at time of interview. No further information was received by survey exit 3. During an interview on 9/12/2019 at 5:45 PM, the office manager indicated in the Spring of 2018, the agency admitted 10 skilled patients, prior to their certification survey by an accrediting organization, for purposes of obtaining medicaid certification. Per the office manager, the last of the 10 skilled patients to be discharged, following the certification survey was Patient 9; the office manager relayed that they [agency] could not find another agency to accept the patient. When asked why did they discharge the patient, the office manager indicated the agency did not want skilled patients at the time. 4. Review of the clinical record for Patient 9, included the start of care date of 3/29/2018, the		Administrator has in-serviced all internal staff on documentation of all communication with clients and primary caregivers. They have also received in-service regarding safe transfer to another agency if we are unable to meet their needs. Patient #9 was discharged to another agency when Adaptive was unable to provide her services. Communciation note dated 9/14/18 states that they spoke with Miranda at Golden Hearts Home Care and they were going to do a PA provider switch today. Administrator and Office Manager reviewing all referrals skilled and unskilled weekly to ensure that all client referrals can be met before admitting for services.	

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	last certification period was 7/27/2018 to 9/24/2018 with orders for skilled nurse weekly for medication pre-set. The patient's last date of service was 9/11/2018 with discharge date of 9/14/2018.			
G 1008 Bldg. 00	Based on record review and interview, the agency failed to ensure the clinical record included documentation with primary caregivers and the agency regarding staff scheduling, communication and documentation with the attending physician, documentation of medications and feedings by gastronomy tube, and the most recent clinical notes, failed to ensure contact information for the patient / caregiver was current and accurate, failed to complete a discharge summary within 5 business days of the patient's discharge from the agency, and failed to ensure all documentation was appropriately authenticated with signature, title, date, and times. These practices impacted 5 patients (#1, 2, 6, 7, 8) out of 8 sampled records reviewed. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.	G 1008	Administrator will provide reeducation on requirements of order authentication and discharge summary with Comprehensive Assessment for clinical managers and Not Meeting Patient's Needs In-services for all internal staff. p> Administrator will review all charts for completion by 11/5/19. Follow-up documentation will be provided daily that includes how and when the patient and/or primary caregiver were notified of staffing status. Review of daily visit sheets to be completed weekly by Clinical Manager by either reviewing individual daily visit sheets or running Service Plan Task Frequency Variance Report. Clinical Manager will document in Communications/QA that every shift has been reviewed weekly. All documentation must be signed by the individual making the entry with individuals first initial of first name, last name and title. If after 15 days, the HHA (Home Health Agency) is unable to meet the needs of the patient, the agency will offer to assist	11/04/2019

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			transfer to another HHA (Home Health Agency) that is able to meet the needs of the patient by providing them with a list of providers in the area. The Administrator/Operations Manager will check weekly for this documentation and verify in activities/QA under the office that missed shifts and grievances were reviewed for concerns. This note will be printed and placed in the QAPI binder weekly. see attachments	
G 1012 Bldg. 00	Based on record review and interview, the agency failed to ensure the clinical record included documentation with primary caregivers and the agency regarding staff scheduling, communication and documentation with the attending physician, documentation of medications and feedings by gastronomy tube, and the most recent clinical notes for 3 of 3 skilled clinical records reviewed. [1, 2, and 6] Findings include: 1. Policy entitled "Flowsheets", dated August 1, 2012, stated "Agency personnel shall use appropriate flow sheets to document ongoing client assessment, care, and needs when visits are made . . . " and "All originals (white copies) will be turned into the office weekly and the yellow copy will be maintained in the home chart." 2. Record review of patient #2, completed on	G 1012	Patient #2 In home nurse failed to turn in weekly documentation sheets. Chart has been reviewed and all documentation has been turned into office and uploaded in office chart to match home chart. In-home staff has been re-educated on the need to turn in all documentation weekly for review and to be added to office chart. Clinical Managers will monitor and review all documentation for completeness, initial and upload to attachments. Administrator will review weekly all skilled client charts to ensure all documentation has been received and uploaded to chart. Patient #1	11/05/2019

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	09/12/19 included skilled nursing notes through 08/31/19. Plan of care certification period of 07/19/19-09/16/19 indicated skilled nursing services to provide care 5 days a week. Interview with the office manager was conducted on 09/12/19 at 3:20 PM. At that time, the office manager stated "Skilled nurse should have turned in notes for time period 09/01/19 - 09/07/19 by Monday, 09/09/19, but she has not turned them in and that is a problem." 3. Review of clinical record # 1, with start of care [SOC] 7/15/2019, included a plan of care for the certification period of 7/15/19 to 9/12/19, with orders for skilled nurse services, 8 - 10 hours a day, 5 days a week, effective 7/15/19. The plan of care included orders for the skilled nurse to administer medications "ordered by the physician and document on the MAR [medication administration record]." The record failed to evidence skilled nurse visits were provided until 8/13/19 and failed to evidence documentation to explain why skilled nurse services were not completed as ordered on the plan of care. The record evidenced the first skilled nurse visit was made on 8/13/2019 and that skilled nurse visits were made 3 days a week, on Tuesdays, Wednesdays, and Thursdays, beginning 8/13/2019. The record evidenced a skilled nurse visit notes dated August 13, 14, 15, 20, 21, 22, 27, and 28, and September 3, 4, and 5, 2019. The skilled nurse visit notes failed to evidence documentation of the medications and tube feeding that were administered by the nurse, during the visit. During interviews on 9/12/19 at 4:30 PM, the office manager indicated the patient was accepted and the plan of care was established and the nurse for		Chart has been reviewed and order clarification has been sent to MD to ensure plan of care matches the services being provided. All employees have been re-educated and received in-service on all documentation must be reviewed by nurse and uploaded into the office chart to match home chart. Clinical Manager will review all documentation of the home nurse to ensure all orders are being followed and documented accurately. Documentation from interoffice emails has been added to communications to show communication with primary caregiver and reason for waiting to start services was due to a nurse being a no call no show and primary caregiver wanting to wait until she could give 2 week notice to the nurse that was currently helping her before our services started with another nurse. All skilled charts reviewed to ensure the proper documentation and matches the plan of care. All employees have been in-serviced to document all communication with client and primary caregivers. If unable to staff/meet their needs as ordered after 15 days, Adaptive will assist with safe transfer to another agency able to meet the client's needs.	

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	the case was to begin the following day, 7/16/2019, and failed to arrive for her first day of orientation, therefore, the agency did not have a nurse for the case. Employee A indicated the communication between the agency and the primary care giver was in her agency emails. At 5:45 PM, the administrator relayed that the clinical record failed to evidence documentation of the liquid nutrition and the medications that were administered by the nurse during the skilled nurse visit. Employee A indicated the documents were not turned into the agency by the nurse that completed the visits. No information was provided by survey exit on 9/13/19. 4. A review of record #6 with SOC 7/02/2019, failed to evidence physician orders to provide care were received, prior to the SOC, and failed to evidence the physician was notified that skilled nurse services were not provided as ordered, evidenced by the following: The Home Health Certification and Plan of Care [POC] for the certification period of 7/02/2019 to 8/30/2019, included a SOC date of 7/02/2019 and a verbal start of care date of 7/05/2019 and included orders for skilled nursing services 8 hours per day 5 days a week throughout the certification period. The clinical record failed to evidence that skilled nursing services were provided as ordered, failed to evidence communication to explain why services were not provided, and failed to evidence the physician was notified when skilled nurse services were not provided. During an interview on 9/10/2019 at 3:20 PM, the office manager, indicated patient #6 did not receive any nurse services due to the primary care giver decided, after meeting multiple nurses, that they did not want other individuals in the home.		Administrator will review all charts the week after the clinical manager completes the home supervisory visits to ensure any changes are sent to MD for signature and that the plan of care is being followed. Patient #6 Documentation from interoffice emails showing communication with primary caregiver and her wishes to wait on services until she received a hoyer lift in the home is in chart. All charts have been reviewed to ensure services are being provided as orderd. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's needs exceed the capabilities of the HHA with HHA Not Meeting Patient Needs In-service to be completed on 11/4/19. See attachments Administrator will review all client admission charts to ensure 100% compliance. Administrator will provide reeducation on Comprehensive Assessment for clinical managers and Not Meeting Patient's Needs In-services for all internal staff. All employees will be re-educated that MD must be made aware of inability to staff as ordered on plan of care and update plan of care.	

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	15K167	A. BUILDING 00 B. WING	09/13/2019

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	During an interview on 9/10/2019 at 3:20 PM, the administrator indicated there were no other assessments for the patient found in the clinical record and when queried as to why Patient 6 did not receive skilled services, the administrator asked employee A, who indicated she would need to go through her emails to find the communication. No further information was provided by survey exit on 9/13/2019. 410 IAC 17-15-1(a)(1)-(7)		Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Follow-up documentation will be provided daily that includes how and when the patient and/or primary caregiver were notified of staffing status, including notification to MD and supplemental order sent to MD. If after 15 days, the HHA (Home Health Agency) is unable to meet the needs of the patient, the agency will offer to assist transfer to another HHA (Home Health Agency) that is able to meet the needs of the patient by providing them with a list of providers in the area. The Administrator/Operations Manager will check weekly for this documentation and verify in activities/QA under the office that missed shifts and grievances were reviewed for concerns. This note will be printed and placed in the QAPI binder weekly. Administrator will review all charts for completion by 11/5/19. see attachments	

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G 1018 Bldg. 00	Based on record review and interview, the agency failed to ensure contact information for the patient / caregiver was current and accurate for 1 of 3 home visit observations with clinical record reviews. (#1) Findings include: A home visit was conducted on 9/11/2019 at 4 PM, the address of the home visit was provided by the office manager on 9/10/2019. The Patient's residential addresses was not the address on the plan of care, dated 7/15/2019 to 9/12/2019. During the home visit on 9/11/2019 at 4 PM, interview with registered nurse, employee I, indicated she provided skilled nurse services, beginning 8/13/2019, every Tuesday, Wednesday, and Thursday, and had always come to the same address, in which the home visit occurred. Employee I indicated she was not aware of a different address, the address on the Plan of Care. The clinical record of patient # 1 was reviewed on 9/12/2019 and indicated a start of care date of 7/15/19. The plan of care for the certification period of 7/15/19 to 9/12/19 failed to include the accurate home address of the patient. On 9/12/19 at 3 PM, the administrator was informed that the address provided for the home visit was not the address as listed on the plan of care. The administrator was observed at a computer and reviewed the information. The administrator confirmed that the patient's address did change, on an unknown date, the address was	G 1018	Patient #1 Chart has been reviewed and order sent to MD to clarify new address of where services are to be provided. All charts to be reviewed for accuracy of contact information. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics updating POC with demographic requirements has been completed by 11/4/19. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/5/19. see attachments	11/19/2019

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	updated in system and the plan of care was not updated. 410 IAC 17-15-1(a)(1)			
G 1022 Bldg. 00	Based on record review and interview, the agency failed to evidence a discharge summary, that included accurate information and was provided the the primary care physician within 5 business days, in 3 of 4 closed records reviewed. [Patient #6, 7, 8] The findings include: 1. A review of record #6 with a start of care 7/02/2019, failed to evidenced that the patient's needs were met. The Home Health Certification and Plan of Care for the certification period of 7/02/2019 to 8/30/2019, evidenced orders for skilled nursing services 8 hours per day 5 days a week throughput the certification period. The clinical record failed to evidence that any skilled nursing services were provided, nor documentation to explain why the skilled nurse services were not provided. A discharge summary dated 8/21/2019, completed by registered nurse F, stated, "Client will be discharged to family and MD [medical director] when services are no longer needed or desired. Patient's mother called the office [date not specified] and decided to stay home with Patient. Client will no longer need HHA [home health agency] services." During an interview on 9/10/2019 at 3:20 PM, the	G 1022	Patient #6 Failed to document why nursing services were not provided. Client has been discharged and not able to add documentation at this time. No documentation to support that client met with multiple nurses. All charts have been reviewed for appropriate documentation when unable to meet the clients needs. All communication with client and primary caregiver will be added to client chart at time of communication. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinical Managers on the specifics discharge requirements has been completed by 11/4/19. Administrator to provide in-service to all employees unable to meet client needs. Administrator will monitor for 100% compliance by reviewing each chart with discharges completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/5/19.	11/05/2019

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	office manager, indicated patient #6 did not receive any nurse services, that after meeting multiple nurses, they did not want other individuals in the home to care for Patient 6. Documentation of these meetings with the patient and primary care giver were requested at time of interview. No further information was received by survey exit. 2. Clinical record 8 was reviewed on 9/10/19 at 12 PM. The record include a plan of care for the certification period 7/24/19 to 9/24/19 with orders for aide services 7-8 hours, 5 - 6 days per week, start of care was 01/30/2019. The record evidenced the last aide visit was completed on 8/15/19. A document titled "Discharge Summary," dated 8/16/19, indicated the family member assumed care of the patient and the patient was discharged. The discharge summary was not provided to the physician until 9/05/2019. The administrator provided on 9/10/2019 at 4 PM, an email / fax transmission and indicated it was the only evidence that the summary was sent to the physician. The administrator indicated the case manager that creates the discharge summary, saves the document as a PDF and then sends to the physician; the administrator indicated that the electronic records system used does not save the evidence. 3. Review of clinical record for patient #7, physician order dated 05/07/19 stated "discharge client from agency effective 05/07/19 due to patient changed to another home health company." No physician authentication. Review of clinical record completed on 09/12/19 did not include a discharge summary. An interview was conducted on 09/12/19 at 5:45 PM with the administrator and office manager.		Patient #8 Discharge order and summary were sent to MD for authentication signature on 8/16/19. Last shift service was provided was 8/16/19. Discharge order and summary were signed by MD and received by HHA on 8/23/19. All discharged client charts have been reviewed to ensure discharge order and summary have been sent to MD for signature authentication. All clinical managers have been re-educated with in-service on Comprehensive Assessment that all discharge orders and summaries are to be sent to MD for authentication within 2 days of discharge. Administrator will monitor for 100% compliance by reviewing each chart with discharges completed week prior. This review will be completed weekly. Administrator will review all charts for completion by 11/5/19. Patient #7 Discharge order dated 5/7/19 has no physician authentication. Discharge order has been re-sent to MD for authentication. This will be uploaded to chart once it is received. All discharged charts have been reviewed for any unauthenticated	

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	They reviewed the clinical record and agreed that there was no discharge summary completed. 410 IAC 17-15-1(a)(6)		orders that have been sent to MD for authentication. Once received they will be uploaded to office chart. All clinical managers have been re-educated with in-service on Comprehensive Assessment that all supplemental orders including discharge orders must be authenticated by MD with signature. Administrator will monitor for 100% compliance by reviewing each chart with discharges completed week prior. This review will be completed weekly. see attachments	
G 1024 Bldg. 00	Based on record review and interview, the agency failed to ensure all documentation was appropriately authenticated with signature, title, date, and times for 2 of 8 clinical records reviewed. [2 and 7] Findings include: A policy entitled "Supplemental Physician Orders", dated 07/25/18, stated "The order must include: (a)(iii) Signature and title of licensed	G 1024	Administrator will provide reeducation regarding authentication of physicians orders with Comprehensive Assessment In-service completed by 11/4/19. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This review will be completed weekly.	11/05/2019

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	personnel, accepting order and date and time order is taken" and "(2) . . . Verbal orders must be authenticated and dated by the physician in accordance with applicable state law and regulations, as well as the agency's name policies and must document the orders in the patient's clinical record, and sign, date and time the orders." 1. Clinical record review for patient #2 was completed on 09/11/19. Plan of Care for certification period 05/20/19 - 07/18/19 did not include a time authentication for the staff signature nor the physician signature. Plan of Care for certification period 07/19/19 - 09/16/19 did not include a time authentication for the staff signature nor the physician signature. Skilled Nurse Visit note, dated 07/17/19, did not include a time authentication for staff signature. 2. Patient #7, review of physician order dated 05/07/19, stated "discharge client from agency effective 05/07/19 due to client switching to another home health company." No physician authentication. Review of communication note for patient #7, dated 03/28/19, did not include a signature or date of authentication from the clinical staff. During an interview with the office manager on 09/11/19 at 3:15 pm, when authoring surveyor requested agency policy / procedure for authentication, the office manager relayed that the agency did not have a separate authentication policy.			

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	410 IAC 17-15-1(7)			
N 0000 Bldg. 00		N 0000		
	This visit was for a State Licensure survey of a Medicaid agency. Survey Dates: September 09, 10, 11, 12, and 13, 2019 Facility #: IN014118 Provider #: 15K167 Census: 90 Skilled: 2 Aide only: 65 Personal Service: 23 Active Census: 44 Skilled: 2 Aide only: 42			
N 9999 Bldg. 00		N 9999	Administrator updated process to reflect regulation of 50% employee drug screening of all employees annually. Administrator will have reached 100% compliance with this by 11/29/19. Randomizer is in place to choose staff randomly at a rate of 50% annually going forward. Administrator will monitor drug screen completion spreadsheet monthly with checklist.	11/29/2019
	Based on interview, the agency failed to evidence they developed a policy and procedure and failed to ensure compliance with the Indiana State requirement, pursuant to Indiana Code 16-27-2.5, effective 7/01/2017 for 1 of 1 agency. The findings included: The agency policy titled, "Substance Abuse and Drug Screening Policy," effective date 3/18/2018, stated, the testing program is managed by the human resource manager. ... Each month			

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	Adaptive will test 5 % of the previous months end employee count ... The selection will result in an equal probability that any employee from a group of employees will be tested." On 9/10/2019 at 12:20 PM, the office manager indicated that the agency at corporation level, chooses 5 % of their employees to collect a random drug screen and sends each individual home health agency the employees working at their site, to collect. The office manager indicated they give the employees 24 hours to show up and complete; she relayed that the random screen is completed in house. The agency failed to evidence they completed a random drug screen on 50 % of their employees, pursuant to the IC 16-27-2.5 by the following: At 1 PM, on 9/10/2019, the office manager provided 8 drug screens for 2018. She indicated, as previously stated, that the corporate office chooses the 5% per month and if the staff are from the office [home health agency], then that agency performs the drug screen. At 1:15 PM, the office manager relayed that after review, they have determined that the agency did not set up a process to complete 50% of their employees with direct contact with patients and not licensed under Indiana Code 25 [Indiana Code 16-27-2.5-0.5 and 16-27-2.5-2(b)(1)(A) and (B)].			