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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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 was a post visit for a Federal Recertification and State Licensure survey of a Medicaid agency, conducted on September 09, 10, 11, 12, and 13, 2019 which was fully extended.

Survey Dates: December 17 and 18, 2019

Facility #: IN014118
Provider #: 15K167

Active Census: 48
Skilled: 3
Aide only: 45

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

During this survey nine (9) Conditions and thirty (30) standards were found to be corrected. Eight (8) standards deficiencies were recited, one (1) new federal standard and two (2) new state standard deficienceis were cited.

Adaptive Nursing and Healthcare Services, INC continues to be 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

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	administration of services; and §484.110 Clinical Record, and continuation of noncompliance of §484.65 Quality Assessment and Performance Improvement and §484.70 Infection Prevention and Control. . Quality Review Completed 2/18/20 by area 3			
G 0534 Bldg. 00	484.55(c)(4) Patient's needs The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the agency failed to ensure the comprehensive assessment included discharge planning for 1 of 1 skilled active record reviewed that required a recertification assessment. [Patient #1] The findings include: 1. The "Comprehensive Client Assessment" policy, with revision date of 10/31/19, was provided by administrator on 12/17/19 at 1:15 P.M. indicated this policy was a current agency policy. The policy stated, "3. ... the agency comprehensive assessment will include: ... 8. Discharge planning ... goals are identified, and / or continuing care needs are recognized." 2. Record #1, with SOC 7/15/2019, was reviewed on 12/17/2019. The record included a Plan of Care [POC] for the certification period 11/12/19 to 01/10/2010 with orders for skilled nurse 6 to 10 hours per day, 3 - 5 days a week with orders for each visit, the Skilled nurse was to perform a head to toe assessment, assess vital signs, administer medications as directed, transfers, feedings per gastrostomy tube [an opening into the stomach	G 0534	All clinical managers will be in-serviced on the need to include discharge planning with completion of comprehensive assessments, as well as the need to complete all sections of the OASIS comprehensive assessment forms with the OASIS Discharge planning inservice. Administrator will monitor and review all OASIS/comprehensive assessments weekly as they are completed to ensure 100% compliance. Once 100% compliance is achieved will continue to monitor quarterly.	02/28/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	from the abdominal wall, made surgically for the introduction of liquids, food medications], and hygiene care. 3. The recertification comprehensive assessment, dated 11/11/19 failed to evidence discharge planning; the area of the assessment was left blank. 4. During an interview on 12/18/19 at 2 PM, the administrator indicated that the comprehensive assessment should have included the patient's discharge planning. 410 IAC 17-14-1(a)(1)(B)			
G 0550 Bldg. 00	484.55(d)(3) At discharge At discharge. Based on record review and interview, the agency failed to complete an updated comprehensive assessment at discharge for 1 of 1 closed clinical records reviewed (patient #29) Findings include: Review of clinical record for patient #29 completed on 12/17/19, did not include a discharge comprehensive assessment for discharge date of 12/10/19. An interview was conducted on 12/18/19 at 2:10 PM, with the administrator, who confirmed that an updated comprehensive at discharge was not completed. 410 IAC 17-13-2(2)(b)(9)	G 0550	All clinical managers will be inserviced on completing the discharge summary in full upon discharge, including the evaluation of goals, condition of client at discharge and disposition witht the discharge summary inservice. Administrator will monitor and review all discharges weekly to ensure 100% complaince.	02/28/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Based on record review and interview, the agency failed to update the Plan of Care (POC) with patient-specific interventions and measurable outcomes for patient with wounds (patient #29) for 1 of 1 closed records reviewed. Findings include:	G 0574	All clinical managers will be inserviced on updating the plan of care and service plan with all changes in client status. Including updating with any decline in status, wounds, infections, patient specific interventions and measurable outcomes. The plan	02/28/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	Record review completed on 12/17/19 included two wound assessments, dated 11/07/19. The first wound to the scrotum measured 5 x 3 at stage I; the second wound to the right lower leg measured 8 x 5 at stage I. The POC, dated 10/10/19 was not updated with the change of condition to include wounds. An interview was conducted on 12/17/19 at 4:15 PM, with the administrator, who stated "The POC gets updated at recertification" and "The HHA (Home Health Aide) will report unusual findings as per the HHA service plan until the recertification." The administrator relayed that one of the wounds was from shearing. During an interview on 12/18/19 at 11 AM, employee F, a registered nurse, relayed that she arrived to the Patient's home on 11/07/2019, to conduct a supervisory visit and discovered the patient had 2 stage 1 wounds. [intact reddened skin]. When asked if the plan of care or aide assignment was updated, Employee F relayed that the POC and aide assignment was not updated when areas were identified. She relayed that the POC and aide assignment would be updated with the next recertification. 410 IAC 17-13-1(a)(1)(D)(x)		of care will be updated at the time the change was noted, not waiting until recertification. Administrator will review all client assessment forms and compare to plan of care to ensure proper updates haven been completed to ensure 100% compliance.	
G 0682 Bldg. 00	484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.	G 0682	All external caregivers will have	03/19/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	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 two clients during 2 of 2 home visits (patient #30 and #31). Findings include: 1. Review of Handwashing Policy, dated 10/31/19 noted the following: a. Procedure: (1) Use an easy-to-reach sink with warm, running water, soap or disinfectant, and paper towels; (2) Push wristwatch and sleeves above your wrists. If wearing rings, remove during washing; (3) Keep fingernails short and filed; (4) Inspect surface of hands and fingers for breaks or cuts in skin and cuticle; (5) Stand in front of sink, keeping hands and clothing away from sink surface; (6) Turn on water faucet by covering it with paper towel; (7) Avoid splashing water against clothing; (8) Regulate flow of water so that temperature is warm; (9) Wet hands and lower arms thoroughly under running water. Keep hands and forearms lower than elbows during washing; (10) Apply soap to hand, lathering thoroughly; (11) Wash hands, using plenty of lather and friction for at least 45 seconds. Interlace fingers and rub palms and back of hands with circular motion at least five times each. (12) If areas underlying fingernails are soiled, clean them with fingernails of other hand and additional soap or clean orangewood stick. Avoid tearing or cutting skin under or around nail; (13) Rinse hands and wrists thoroughly, keeping hands down and elbows up; (14) Dry hands thoroughly from fingers to wrists and forearms; (15) Discard paper towel in waste receptacle; (16) Turn off water faucet using a clean, dry paper towel. b. If hands not visibly soiled, use an alcohol-based rub for routinely		direct observation of handwashing and hand gel use and re-educated if needed on proper handwashing technique and following the handwashing policy. Clinical Managers will directly observe all caregivers within the next 30 days to re-educate them on proper handwashing, hand gel, and glove use technique. Administrator will continue to review all supervisory visit documentation to ensure direct observation of handwashing, hand gel, glove use technique and infection control measures are being observed with supervisory visits. All clinical managers will be re-educated by inservice on importance of documenting all assessment forms including supervisory visit form and documenting everything observed. Documentation must include whether or not the task was observed and caregiver compliant with infection prevention/control by 03/19/2020 Administrator will reveiw all assessment forms weekly to ensure 100% compliance.	

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	decontaminating hands and in the following situations: i. Before and after having direct contact with patients; ii. Between tasks and procedures on the same patient; iii. After touching inanimate sources that are potentially contaminated; iv. After removing gloves 2. A home observation for patient #30 was completed on 12/18/19 at 9:50 AM. The agency administrator arrived at the home at 10:05 AM to observe as well. Upon surveyor arrival, the aide was sweeping the floor for the patient with bare hands. After completing the sweeping and pickup up of dirt with a dustpan (bare-handed). The aide asked the patient if she wanted breakfast, to which the patient acknowledged yes. The aide went into the kitchen, ran her bare hands under the water at the sink for 5 seconds, with no soap, wiped hands on a paper towel then proceeded to retrieve a breakfast meal from the freezer, opened a package, and put it in the microwave. Halfway through cooking, the aide removed the food, stirred with a fork (bare-handed) and finished the cooking process in the microwave. Once cooking was completed, the aide took the fork and stirred the food again and served the food to the patient in the microwave container with the same fork. It should be further noted that there was hand gel on the kitchen counter, but it was not observed to be used by the aide. Employee record review was completed on 12/18/19 at 1:00PM for employee # HHH. The documentation entitled "HHA Skills In-Service" was signed by the employee on 11/7/19 which included hand washing. Supervisory visit notes dated 10/10/19 and 12/06/19 were reviewed. The Supervisory Visits of Home Health Care Staff note, item #16 - Other,			

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	comments section states "HHA complaint with infection prevention" as one of the items for observation, but it is not checked off on either date. Both dates note that the staff person was in the home during the supervisory visit. An interview was conducted on 12/18/19 at 12:45 PM with the administrator regarding the home visit. The administrator explained that everyone was in-serviced on hire and annually for infection control. She did not know why the aide did not wash properly. 3. Home observation for patient #31 was completed on 12/18/19 at 11:30 AM. The agency administrator arrived at the home at 11:30 AM to observe as well. Upon entering the home, the aide was running late and arrived at 11:38 AM. The aide put on gloves to assist the patient into the tub for his shower. The patient is somewhat independent; while showering, the aide went into the kitchen, began washing the dishes in the sink, still wearing the same gloves. After washing the dishes, the aide took the gloves off, but did not wash her hands or use gel that was observed in her pocket. The patient asked for assistance in the shower. The aide put on new gloves, without washing or using gel, and began washing the patient. Upon completion of the shower, the aide assisted the patient out of the shower, took the gloves off and went to get the patients' clothes, but still did not wash her hands. Employee record review was completed on 12/18/19 at 1:00 PM for employee #PP. The documentation entitled "HHA Skill. In-Service" was signed by the employee on 11/13, which included hand washing. Supervisory visit note dated 12/05/19 was			

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	reviewed. The Supervisory Visits of Home Health Care Staff note, item #16 - Other, comments section states "HHA complaint with infection prevention" as one of the items for observation, but it was not checked off. The note indicates that the staff person was in the home during the supervisory visit. An interview was conducted on 12/18/19 at 12:45 PM with the administrator regarding the home visit. The administrator stated "The aide used hand gel upon entering the home." When asked if she witnessed any further hand hygiene during the home observation, the administrator indicated no, she did not and she saw that the aide did not wash between glove changes. 410 IAC 17-12-1(m)			
G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review, the agency failed to ensure visits were provided as ordered on the plan of care (POC) for 1 of 1 closed clinical records reviewed. (Patient #29) Findings include: Review of policy entitled "Clinical Documentation / Missed Shifts, dated 10/14/19 was reviewed on	G 0800	All internal staff will be inserviced on scheduling shifts as ordered in plan of care. All shifts to be scheduled as ordered on plan of care. Any missed shifts/treatment MD will be notified to determine if okay to skip or additional intervention needed. PM will check daily patient	03/06/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	12/17/19, section entitled "Special Instructions, #6" states "Significant hours not provided will be documented and reported to the physician, documented on interagency communication form and maintained in the client chart at least every 60 day recertification period." Review of clinical record was completed on 12/17/19. Review of the HHA Service Plan, dated 10/10/19 and 11/07/19 indicated the HHA was to visit 4 times a week. Review of the POC that was signed by the physician, dated 10/16/19 stated "HHA to provide 3 hours a day, 4 days per week throughout the 60-day certification period." Review of Daily Visit Sheets 11/4 to 11/10/19, 11/18 to11/24/19, and 11/25 to 12/1/19, only 3 of the 4 required visits had been provided for each week. An interview was conducted on 12/17/19 at 4:15 PM with the administrator who reviewed the electronic calendar and confirmed that there was a missed visit each of the above three weeks. 410 IAC 17-14-1(g)		schedules for any missed shifts. The clinical manager will then notify the MD regarding if okay to miss the treatment/shifts or if further intervention needed. Administrator will review all charts weekly to ensure that shifts are scheduled as written and any missed shifts have been reported to MD for guidance. Once 100% compliance achieved Administrator will review quarterly for 100% compliance.	
G 0818 Bldg. 00	484.80(h)(4)(i-vi) HH aide supervision elements Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if			

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and interview, the case manager failed to ensure documented observation compliance with infection control practices for 2 of 2 home observations. (Patient #30 and #31). Findings include: 1. Review of supervisory visit notes dated 10/10/19 and 12/06/19 were reviewed for patient #30. The Supervisory Visits of Home Health Care Staff note, item #16 - Other, comments section states "HHA complaint with infection prevention" as one of the items for observation, but it is not checked off on either date. Both dates note that the staff person was in the home during the supervisory visit. 2. Review of supervisory visit note dated 12/05/19 was reviewed for patient #31. The Supervisory Visits of Home Health Care Staff note, item #16 - Other, comments section states "HHA complaint with infection prevention" as one of the items for observation, but it is not checked off. The note indicates that the staff person was in the home during the supervisory visit. An interview conducted with the RN Case Manager (employee # F) was completed on 12/18/19 at 11:00 AM. The RN Case Manager explained that during the supervisory visit item #16 always says HHA compliant with infection	G 0818	All clinical managers will be in-serviced on the importance of completing all sections of assessment forms, including the supervisory form, noting the OSHA kit and expiration as well as HHA compliance with infection prevention and control. Administrator will monitor and review all nursing assessment forms weekly to ensure 100% compliance.	02/28/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	prevention, but if it was observed then the item would be checked off. During the exit conference completed on 12/18/19 at 4:00 PM, it was asked of the administrator if they have begun any surveillance of the provision of care to which she indicated that there was not at this time. 410 IAC 17-14-1(n)			
G 1012 Bldg. 00	484.110(a)(1) Required items in clinical record The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician orders; Based on record review and interview, the agency failed to ensure the clinical record included documentation of the care provided by the skilled nurse and documentation of the medications and feedings by gastronomy tube for 1 of 2 current skilled clinical records reviewed. [#1] The findings include: On 12/17/2019 at 11:15 AM, the administrator provided the polity titled, "Clinical Records," with revision date 3/29/2018, as a current agency policy. The policy stated, "Clinical notes are written the day service is rendered and incorporated into the clinical record within 14 days." Review of clinical record # 1, with start of care [SOC] 7/15/2019, included a plan of care for the certification period of 11/12/2019 to 01/10/2020,	G 1012	All clinical managers will be re-educated regarding reviewing all external nurses documentation to ensure documentation is complete. All external nurses will be re-educated by inserviceregarding all nursing assessment documentation being turned in weekly and all documentation completed accurately in full. This includes all skilled nursing assessments, Medication Adminsitration Records, and any other assosciated forms for each clietnt. Administrator will review all skilled client charts weekly to ensure that Clinical Managers are reviewing	03/06/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	with orders for skilled nurse services, 6 - 10 hours a day, 3-5 days a week. The plan of care included orders for the skilled nurse that stated, "SN [skilled nurse] to administer medications as ordered by the physician and document on the MAR [medication administration record]." A request for all visit notes and MAR's were requested of the administrator on 12/17/19 at 4 PM. On 12/18/2019 at 12:10 PM, employee A indicated the visit notes for week one were not turned into the agency by the nurse that completed the visits. No information was provided by survey exit on 12/18/19. The record failed to evidence that skilled nurse visits were provided as ordered during week one of the certification period. The record evidenced skilled nurse visit notes for week two of the certification period, dated November 19, 20, and 21, 2019. These skilled nurse visit notes failed to evidence documentation of the medications and tube feeding that were administered, by the registered nurse, during these visits. On 12/18/2019 at 4 PM, the administrator confirmed 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 visits. 410 IAC 17-15-1(a)(3) 410 IAC 17-15-1(a)(4)		external nurse documentation and providing re-education as needed to ensure complete and accurate documentation for client's chart. Once 100% compliance achieved, Adminsitrator will review charts monthly.	
G 1022	484.110(a)(6)(i-iii) Discharge and transfer summaries			

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
Bldg. 00	(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to evidence a discharge summary that included current, accurate information for 1 of 1 closed records reviewed. (Patient #29) Findings include: Record review for patient #29 was completed on 12/17/19. Discharge Summary completed on 12/10/19 included the primary diagnosis (obesity) and discharge reason "patient stated he will start with a new company on 12/12/19 and services are no longer needed. Patient certification ended 12/10/19." The sections (1) Evaluation of Goals, Condition of Client at Discharge, and Disposition of Client, were blank. An interview was conducted on 12/18/19 at 2:10 PM with the administrator who questioned what was needed to be included in the discharge summary. After the administrator reviewed the	G 1022	All clinical managers will be re-educted by inservice on need to complete all discharges accurately and completely per discharge policy. Administrator will review all discharges to monitor that they are completed per policy and are complete.	02/28/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	regulation, he/ she agreed that the discharge summary was incomplete. 410 IAC 17-15-1(a)(6)			
N 0000 Bldg. 00	This was a follow-up revisit for a state relicensure survey of a Medicaid agency, that was conducted on September 13, 2019. Current Survey Dates: December 17 and 18, 2019 Facility #: IN014118 Provider #: 15K167 Active Census: 48 Skilled: 3 Aide only: 45 Home visits conducted: 2 During this survey, 1 new state deficiency was cited.	N 0000		
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on record review and interview, the agency failed to complete a supervisory visit for 1 of 1	N 0606	All clinical managers will be re-educated on supervisory visit regulations and need to see client	02/28/2020

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	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	6602 E 75TH STREET STE 230 INDIANAPOLIS, IN 46250

(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
	closed records reviewed. (Patient #29). Findings include: Record review of patient #29 clinical chart was completed on 12/17/19 that included only one supervisory visit note dated 11/07/19, which included a note under the Summary Checklist section, "Approximate next visit date: 12-06-2019." The SOC was 10/10/19 and discharge was 12/10/19. The patient expressed a desire to change providers on 12/09/19. Interview was conducted on 12/17/19 at 4:15 PM, with the administrator, who looked through the electronic medical record and could not find the next 30-day supervisory note, and agreed that it was missed.		every 30 days. Administrator will monitor all client visits activity weekly to ensure proper scheduling of clients for HHA oversight. Once 100% compliance is achieved will monitor monthly.	
N 9999 Bldg. 00		N 9999	N9999 is blank	02/28/2020