STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
N 0000 Bldg. 00	This visit was for a state licensure home health initial survey. Survey dates 6/4/18 to 6/7/18 Facility # 014342 Skilled unduplicated census: 3 Active census: 3 Discharged : 0 Home Visits: 2 Charts reviewed with Home visits: 2 Total Charts reviewed: 3	N 0000		
N 0441 Bldg. 00	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Administrative and supervisory responsibilities shall not be delegated to another agency or organization, and all services not furnished directly, including services provided through a branch office, shall be monitored and controlled by the parent agency. Based on record review and interview, the agency administrator failed to ensure Adaptive Nursing Services and Healthcare-Muncie was responsible for the development, implementation, and evaluation of their QAPI (quality assessment and performance improvement) program and QAPI	N 0441	The outlined findings speak towards the chart audit practice completed between Agency and Adaptive Corporate Location. Communication between Agency and the Governing Body, and/or Designee, as outlined in the	07/06/2018

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
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	responsibilities were not delegated to another entity for 1 of 1 agency. Findings include: 1. An agency policy dated 12/10/15 and titled, "Quality Assurance/Performance Improvement" was reviewed and stated, "Agency shall establish a quality assurance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes ... the development of a quality assurance and performance improvement plan will be guided by the mission, vision and strategic goals of the organization ... Additional activities for quality assurance and performance improvement will be prioritized by the agency's management team ... Data will be collected to allow the agency to monitor it's performance ... data will be systematically collected to measure process and outcomes of each individual client ... identify currently level of performance ... identify areas to be improved .... " 2. Employee E, alternate administrator, was asked to providee documentation of data collected or audit tools for the 3 admission chart audits on 6/4/18 at 10:36 AM, in which Employee E provided emails from the alternate clinical manager. The admission audit emails were reviewed which included instructions to correct the plan of care for various omissions and for 3 of 3 clinical record audits to correct the visit frequency as follows: An email from Employee D to Employee E, dated 5/9/18 at 10:45 AM, was in regards to clinical record # 3. The email stated, "Cannot use PRN for Frequency. must be PRN/as needed ... not to exceed hours on orders."		Governing Body Meeting Minutes which were provided and/or available dated 01/09/2018, included designee Tara Smith, RN, Director of Nursing and Compliance (and Alternate Nursing Supervisor – Muncie). Purpose of these communications is to assist in the initial preparation of patient care plan and clinical record. In addressment of the survey findings; immediately and ongoing the Administrator and/or designee will utilize the initial POC/chart preparation as a data collecting activity to be introduced in the QAPI process. Utilization of the attached form 'Form-Medical Record Review (MRR),' will be utilized in this process by Nursing Supervisor and/or Designee. Administrator and/or designee will review the MRR form for identifiable trends and will create QAPI POC as appropriate. Immediately and ongoing, the Administrator and/or designee will continuously measure, assess and improve the performance of clinical and other processes. This will be evidenced by quarterly meetings, at minimum, of agency QAPI team. Team will include Administrator, Nursing Supervisor and additional office personnel. Points of emphasis can include, but will not be limited to, ongoing assessment of client care services, communication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	An email from Employee D to Employee E and Employee B, dated 5/23/18 at 10:56 AM, was in regards to clinical record # 1. The email stated, " ... once per week for 4 weeks then every 2 weeks for 4 weeks ...sup visits say every 30 days, needs to be every 14 days with dual discipline .... " An email from Employee D to Employee E and Employee B, dated 5/25/18 at 9:48 AM, was in regards to clinical record # 2. Them email stated, " ... address goals and when RN will return .... " 3. During an interview on 6/4/18 at 10:36 AM, Employee E was asked if audit tools were used for record review. Employee E reported there were no audit tools used for the 3 charts reviewed. Employee E reported, "The QAPI focus area are admissions." Employee E reported the patient admission chart would be sent to Employee D, a Corporate Director of Nursing and Compliance/ Alternate Clinical Manager, Non-Employee G, Corporate Administrator and Non-Employee H, Corporate Quality, and they would do quality checks. Employee E reported an email would be sent back to him/ her and corrections would be made in the clinical record. Employee E reported there was no data collected or documented from the audits and no performance improvement plan as a result of the 3 admissions audited. 4. During an interview on 6/6/18 at 9:40 AM, Employee E reported Employee B, the agency administrator, would review the QAPI information provided from the corporation and would seek guidance from corporate Non-Employee G. Employee E reported his/ her responsibility with the QAPI program was to "Upload the information into the computer, put charts together, implement any new forms or process that comes down the line from corporate, review changes recommended		systems, professional standards, client care satisfaction, state and/or federal regulations, caregiver retention, community engagement, etc. Meeting minutes will be documented and kept in ongoing QAPI binder. Binder to include outlining policy, meeting findings, MRR findings, active internal plan of correction(s), closed internal plan of correction(s), etc. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor or designee on 15 active clients, or 20% of active clients - whichever is larger, utilizing the Medical Record Review form, to verify this deficiency is corrected. Findings/trends will be reported to the Administrator to be entered into the QAPI data cycle to determine the necessity of an internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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 out QA department (our corporation). Employee E reported, "When I get emails from corporate and consultant I make corrections." Employee E reported he/ she had not developed a performance improvement plan but if he/ she noticed a trend, he/ she would initiate one.			
N 0442 Bldg. 00	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on record review and interview, the governing body failed to oversee the management of the agency by failing to appoint an alternate administrator before the agency assigned the employee for the role for 1 of 1 agency. Findings include: 1. The Governing Body failed to approve the changes in the leadership roles until after the changes had been made and documentation sent to the State Agency Program Director for approval as follows: An agency document dated 5/10/18, addressed to the Program Director of Acute Care, Indiana State Department of Health and signed by the agency administrator was reviewed and stated, "Staff Change Notification: [Agency Name] is writing to	N 0442	Immediate and ongoing the Governing Body, in collaboration with the Administrator, will maintain real-time documentation (minutes) of the decision-making discussions – specifically including those addressing the changing of agency personnel. To be evidenced by the inclusion of ongoing Governing Body meeting minutes, copy of documentation submitted to ISDH for review and copy of accepted documentation by ISDH within internal office Governing Body binder.	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	notify of a staff change that has taken place ... 2. The new staff and title. ..a. [Employee E] (Alternate Administrator) to replace [Non-Employee F] i. [Employee E] will remain the Clinical Supervisor as well, as currently set .... " An agency documented dated 5/21/18, titled "Governing Board Minutes", signed by the Governing Body Members was reviewed and stated, "On this date, the GB(Governing Body) discussed the change in leadership for this new location pending licensure. [Employee B] Administrator, [Employee E] Alternate Administrator [Employee E] Nursing Supervisor [Employee D] Alternate Nursing Supervisor. Governing Body assumes full legal authority and responsibility for the operation of this location. 3. An interview was conducted with Employee E on 6/4/18 at 9:45 AM. Employee E was asked if the governing body had appointed him/ her as the alternate administrator. He/ She stated, "I don't know [Employee B] usually takes care of that." 4. The governing body minutes from 5/21/18 were reviewed with Employee E on 6/4/18 at 10:36 AM. Employee E was informed that the Board of Directors appointmented him/ her (Employee E) as the alternate administrator on 5/21/18 and this was documented after the agency appointed him/ her (Employee E) on 5/10/18. Employee E was unable to provide any further information.			
N 0449 Bldg. 00	410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	(6) Ensure that the home health agency meets all rules and regulations for licensure. Based on record review and interviews, the agency administrator failed to ensure the home health agency met all rules and regulations for personnel record for TB testing for 1 of 5 personnel records reviewed (Employee A), appointed a new alternate administrator before the board of directors appointment for 1 of 1 employee (Employee E) 1 of 1 agency and assured current criminal checks were obtained for all employees hired at the agency. (Employee D) Findings include: 1. An agency policy titled, "Tuberculosis Testing" was reviewed and stated the following. "Any employee or agent of [agency name] who will have direct client contact must complete a Tuberculosis test in the same manner as required by the state department for licensed home health agency employees and agents ... 1. Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve months and the result was negative .... " The personnel health record of Employee A, with a hire date of 2/6/18 and first patient contact date of 5/3/18, was reviewed. The most recent tuberculin skin test (TST) in the employee file was administered on 10/19/17 and read on 10/22/17, with a result of 0 mm induration. The file failed to have documentation of a second step TST or a prior negative TST with in the past year before the date of first patient contact.	N 0449	The Administrator/Nursing Supervisor/designee will ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis per policy prior to hire. Ongoing the Administrator/Nursing Supervisor/designee will complete 100% personnel record reviews upon hire and 20% quarterly to ensure adherence to documentation requirements, verifying this deficiency is corrected. Immediate and ongoing the Governing Body, in collaboration with the Administrator, will provide real-time documentation (minutes) of the decision-making discussions – specifically including those addressing the changing of agency personnel. To be evidenced by the inclusion of ongoing Governing Body meeting minutes, copy of documentation submitted to ISDH for review and copy of accepted documentation by ISDH within Governing Body binder. In addressment to the findings, it is to be noted that the required criminal background report was run for the employee in question, as can be evidenced by the attached material submitted to ISDH for approval. Attachment	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	The findings was reviewed with the clinical manager on 6/4/18 at 4:40 PM. The clinical manager was unable to provide any further documentation. 2. The administrator made a change in leadership roles for a new alternate administrator, prior to the governing body's appointment as evidenced by: An agency document dated 5/10/18, addressed to the Program Director of Acute Care, Indiana State Department of Health and signed by the agency administrator was reviewed and stated, "Staff Change Notification: [Agency Name] is writing to notify of a staff change that has taken place ... 2. The new staff and title. ..a. [Employee E] (Alternate Administrator) to replace [Non-Employee F] i. [Employee E] will remain the Clinical Supervisor as well, as currently set .... " An agency documented dated 5/21/18, titled "Governing Board Minutes", signed by the Governing Body Members was reviewed and stated, "On this date, the GB(Governing Body) discussed the change in leadership for this new location pending licensure. [Employee B] Administrator, [Employee E] Alternate Administrator [Employee E] Nursing Supervisor [Employee D] Alternate Nursing Supervisor. Governing Body assumes full legal authority and responsibility for the operation of this location. An interview was conducted with Employee E on 6/4/18 at 9:45 AM. Employee E was asked if the governing body had appointed him/her as the alternate administrator. He/She stated, "I don't know [Employee B] usually takes care of that." The governing body minutes from 5/21/18 were reviewed and another interview was conducted		"Staff Change Notification – TS as Alt NS." It is to be noted however, the updated/current criminal background check which was submitted to ISDH was not placed into the personnel file in error and was unable to be produced during survey, as noted within the findings. Immediately the Administrator/designee will ensure all updated/current criminal background checks will be run and placed into the appropriate personnel file. Ongoing the Administrator/designee will complete 100% personnel record reviews upon hire and 20% quarterly to ensure adherence to documentation requirements, verifying this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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 Employee E on 6/4/18 at 10:36 AM. Employee E was informed the Board of Director appointment of him/her as alternate administrator on 5/21/18 was documented after the agency appointment on 5/10/18. Employee E was unable to provide any further documentation. 3. The administrator failed to ensure current criminal checks were completed for all employees as evidenced by : The Indiana Code 16-72-2 was reviewed and stated, "The agency shall submit current copies of criminal history for the administrator, alternate administrator, nursing supervisor, alternate nursing supervisor and officers/owners ... Employees Criminal History Check -IC-16-27-2-4 Employees:criminal history ... sec 4 (d) A home health agency or personal services agency may not employee a person to provide services in a patient's or client's temporary or permanent residence for more than three (3) business days without applying for a national criminal history background check or an expanded criminal history check ... Amended 2016 session .... " A documented titled "Governing Body Minutes" dated 5/21/18 was reviewed and stated, "On this date, the GB [governing body] discussed the change in leadership for this new location pending licensure. [Employee B] administrator, [Employee E] alternate administrator and nursing supervisor, [Employee D] alternate nursing supervisor .... " A. The confidential personnel file of Employee D was reviewed with the following findings: B. A criminal check (Indiana State Police)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	dated 6/28/12, Subject of record [Employee D]. Information release to [Non-Employee I] 702 North Shore Drive Jeffersonville, IN 47130 C. A criminal check (National Lifetime Search IN) ,"Safe Hiring Solutions" Report ordered by [Agency name] 702 North Shore Dr Ste 103 Jeffersonville, Ind. Applicant Screened [Employee D] and completion date of 12/20/16 was reviewed. D. A document (National Sex Offender Search Results) for [Employee D] and OIG (Office of Inspector General) report for [Employee D], both conducted on 2/16/17. The findings were reviewed with Non-Employee F and Employee E on 6/7/18 at 3:09 PM and they were unable to provide any further documentation of a current criminal check from the Muncie office conducted for Employee D upon request.			
N 0454 Bldg. 00	410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to: (1) respond to an emergency; (2) provide guidance to staff; (3) answer questions; and (4) resolve issues; within a reasonable amount of time, given the emergency or issue that has been raised. Based on interviews, the (RN) Registered Nurse clinical manager and alternate clinical manager failed to ensure their availability to respond to an emergency within a reasonable amount of time for	N 0454	In addressment of the findings it is to be noted that effective 07/02/2018 the Governing Body, in collaboration with the Administrator, has appointed a	07/09/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	1 of 1 agency (Employee E and Employee D) Findings Include: 1. An interview was conducted on 6/4/18 at 2:59 PM with Employee C, the operations manager for the Muncie office at the time of the entrance conference. Employee C reported the administrator was on vacation and the alternate administrator was Employee E. Requested to have Employee E to be present for the entrance conference. Employee C reported Employee E is the clinical manager for Muncie office and 2 other offices. Employee E was in Lafayette seeing patients and was 2 1/2 hours away. Employee C reported the alternate clinical manager for Employee E was Employee D, and he/ her was in Jeffersonville, which was 3 hours from the Muncie office. Employee C reported [Employee E] was the only RN for the Muncie office. 2. An interview was conducted with Employee E on 6/5/18 at 3:50 PM regarding supervision of HHA and review of HHA documentation of care. Employee E reported he/ she would review the HHA documentation when he/ she was at the office and would try to get at the Muncie office at least once a week. Employee E reported the remainder of the time was between the other two offices. Employee E reported if a call came in from the Muncie office and she was seeing a patient at another location, he/ she would respond back to the call as soon as possible. Employee E reported that on 6/4/18 at 2:49 PM, he/ she was in Lafayette conducting home visits. 3. An interview was conducted with the Non-Employee F, an owner of the agency on 6/7/18 at 3:09 PM regarding a registered nurse availability at the Muncie office. Non-Employee F		Staff Change to specifically address the continued availability of a Registered Nurse in Muncie location. The newly joined/proposed RN has residence in Portland, IN putting an internal RN within 20 minutes of the office location. RN is requested to be added as Alternate Nursing Supervisor. This is evidenced by the attached Staff Change Notification documentation submitted to ISDH review on 07/02/2018. Attachment “Staff Change Notification – ML as Alt NS.” While not associated directly with Adaptive – Muncie, it is to be noted that another RN hiring has taken place within the noted Lafayette office on 07/09/2018, which will allow for a narrowed focus for the Nursing Supervisor. Nursing Supervisor remains available via phone both during regular office hours and during on-call hours in case of emergency, care coordination, change of condition, etc. Ongoing, the Administrator will continue to work through the recruitment, interview and onboarding process to ensure proper personnel availability within the Muncie location. Any and all necessary staff change notifications will be submitted into ISDH for review/approval when needed and as applicable.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	reported, "This is not our model. The administrator is on vacation. [Name of Administrator] does cover 3 offices, but we are in transition. Right now that is not our plan for the future, the structure is Administrator/ Alternate Administrator and Clinical Manager at the office at all times." Non - Employee F reported the prior clinical manager at the Muncie office was terminated and was actively looking for a nurse for the full time position of Clinical Manager at the Muncie office. Non-Employee F was asked if he thought the Muncie office, with current staffing, was ready to operate the agency appropriately in which Non-Employee F reported " I think we will be."			
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency administrator failed to ensure a current criminal check was conducted for all employees of the	N 0458	In addressment to the findings, it is to be noted that the required criminal background report was run for the employee in question,	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	branch for 1 of 5 employees records reviewed. (Employee D) Findings include: 1. The Indiana Code 16-72-2 was reviewed and stated, "The agency shall submit current copies of criminal history for the administrator, alternate administrator, nursing supervisor, alternate nursing supervisor and officers/owners ... Employees Criminal History Check -IC-16-27-2-4 Employees:criminal history ... sec 4 (d) A home health agency or personal services agency may not employee a person to provide services in a patient's or client's temporary or permanent residence for more than three (3) business days without applying for a national criminal history background check or an expanded criminal history check ... Amended 2016 session .... " 2. A documented titled " Governing Body Minutes" dated 5/21/18 was reviewed and stated, "On this date, the GB discussed the change in leadership for this new location pending licensure. [Employee B] administrator, [Employee E] alternate administrator and nursing supervisor, [Employee D] alternate nursing supervisor .... " 3. The confidential personnel file of Employee D was reviewed with the following findings: A criminal check (Indiana State Police Limited Criminal Check) dated 6/28/12, Subject of record [Employee D]. Information release to [wieners name] 702 North Shore Drive Jeffersonville, IN 47130 A criminal check (National Lifetime Search IN) document titled "Safe Hiring Solutions" Report ordered by [Agency name] 702 North Shore Dr		as can be evidenced by the attached material submitted to ISDH for approval. Attachment "Staff Change Notification – TS as Alt NS." It is to be noted however, the updated/current criminal background check which was submitted to ISDH was not placed into the personnel file in error and was unable to be produced during survey, as noted within the findings. Immediately the Administrator/designee will ensure all updated/current criminal background checks will be run and placed into the appropriate personnel file. Ongoing the Administrator/designee will complete 100% personnel record reviews upon hire and 20% quarterly to ensure adherence to documentation requirements, verifying this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Ste 103 Jeffersonville, Ind. Applicant Screened [Employee D] and completion date 12/20/16 was reviewed. A document (National Sex Offender Search Results) for [Employee D] and OIG (Office of Inspector General) report for [Employee D], both conducted on 2/16/17. 4. The findings was reviewed with Non-Employee F and Employee E on 6/7/18 at 3:09 PM and they were unable to provide documentation of a current criminal check from the Muncie office conducted for Employee D upon request.			
N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	(i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review, and interview, the agency failed to ensure the personnel files of direct care providers contained a valid negative TST (Tuberculin skin test) within the prior 12 months for 1 of 3 direct care employees whose personnel files were reviewed (Employee A). Findings include: 1. An agency policy titled, " Tuberculosis	N 0464	The Administrator/Nursing Supervisor/designee will ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis per policy prior to hire. Ongoing the Administrator/Nursing Supervisor/designee will complete 100% personnel record reviews	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Testing" was reviewed and stated the following. "Any employee or agent of [agency name] who will have direct client contact must complete a Tuberculosis test in the same manner as required by the state department for licensed home health agency employees and agents ... 1. Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve months and the result was negative .... " 2. The personnel health record of Employee A, with a hire date of 2/6/18 and first patient contact date of 5/3/18, was reviewed. The most recent TST in the employee file was administered on 10/19/17 and read on 10/22/17 with a result of 0 mm induration. The file failed to have documentation of a second step TST or a prior negative TST with in the past year before the date of first patient contact. 2. The findings was reviewed with the clinical manager on 6/4/18 at 4:40 PM. The clinical manager was unable to provide any further documentation upon request.		upon hire and 20% quarterly to ensure adherence to documentation requirements, verifying this deficiency is corrected.	
N 0470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the home health agency failed to ensure	N 0470	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	the agency staff followed their own policy and procedures for infection control during for 2 of 2 employees observed. (Employees A and E) Findings Include: 1. An agency policy titled, " Hand Washing Policy" dated 5/16/14 was reviewed and stated, " Purpose: To prevent the spread of infection by contaminated hands. The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: ... After caring for a client ... Before and after handling dressings or touching open wounds ... After handling contaminated equipment ... 2. An agency policy titled, "Bag Barrier Technique" dated 3/20/18 was reviewed and stated, "When entering the patient's home the nursing bag should be placed on a clean, dry surface ... Clean equipment needs to be kept separate from dirty equipment. .. Remove needed equipment from the bag and place it on a clean, dry surface, close the nursing bag, proceed with examination and care of the patient ...." 3. A home visit observation for the HHA (Home Health Aide) with Patient # 1 was conducted on 6/6/18 at 2:08 PM. Employee A brought a notebook and stethoscope in the home and placed them on the patient's sofa (a soft surface that was not disinfected) and without a barrier. 4. A home visit observation for the RN (Registered Nurse) with Patient # 2 was conducted on 6/6/18 at 2:55 PM with the following findings: Employee E performed hand hygiene, placed equipment on barrier, applied gloves. Then		Clinical Managers. The in-service will include review of findings and re-education/review of the noted Hand Washing and Bag Barrier Technique policies. Evidenced by the executed in-service attendance log. The Administrator will provide a Client Care Module for Caregivers, 'In the Know,' entitled An Infection Control Module: Hand Washing to Clinical Manager. Evidenced by the executed in-service post test. Ongoing, during orientation, all new internal/external staff with patient contact will include discussion and demonstration of proper hand washing and bag technique. Clinical Manager/Designee will be responsible to monitor. Clinical Manager will observe staff hand washing and bag technique during supervisory visits, and any staff not utilizing proper technique will be immediately re-educated on proper hand washing and bag technique. Internal/External staff with patient contact will be in-serviced yearly and as needed, by Clinical Manger/Designee, on proper hand washing and bag technique.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	assessed the patient and palpated a lump on the patients head, and without removing the gloves, entered the nurse bag, obtained disinfectant wipes, cleaned equipment and placed it in the bag. Employee E took off the gloves, but did not perform hand hygiene. Employee E picked up a stethoscope and listened to the patients chest and abdomen. Employee E without hand hygiene applied 1 glove to the right hand , opened the nurse bag, obtained disinfectant wipes and cleaned the stethoscope. Employee E took off the right glove and without hand hygiene, applied new gloves. Employee E then touched the patient's left leg and hip incisions. After the home visit, an interview was conducted with Employee E on 6/6/18 at 3:46 PM. Employee E reported he/ she did not realize the failure to do proper hand hygiene throughout the visit.			
N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the agency failed to collect data, develop and implement a Quality Assessment and Performance	N 0472	In addressment of the survey findings; immediately and ongoing the Administrator and designees will utilize the initial POC/chart	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Improvement program for 1 of 1 agency. Findings Include: 1. An agency policy dated 12/10/15 and titled, "Quality Assurance/Performance Improvement" was reviewed and stated, "Agency shall establish a quality assurance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes ... the development of a quality assurance and performance improvement plan will be guided by the mission, vision and strategic goals of the organization ... Additional activities for quality assurance and performance improvement will be prioritized by the agency's management team ... Data will be collected to allow the agency to monitor it's performance ... data will be systematically collected to measure process and outcomes of each individual client ... identify currently level of performance ... identify areas to be improved .... " 2. Employee E, alternate administrator, was asked to providee documentation of data collected or audit tools for the 3 admission chart audits on 6/4/18 at 10:36 AM, in which Employee E provided emails from the alternate clinical manager. The admission audit emails were reviewed which included instructions to correct the plan of care for various omissions and for 3 of 3 clinical record audits to correct the visit frequency as follows: An email from Employee D to Employee E, dated 5/9/18 at 10:45 AM, was in regards to clinical record # 3. The email stated, "Cannot use PRN for Frequency. must be PRN/as needed ... not to exceed hours on orders." An email from Employee D to Employee E and		preparation as a data collecting activity to be introduced in the QAPI process. Utilization of the attached form 'Form-Medical Record Review (MRR),' will be utilized in this process by Nursing Supervisor and/or Designee. Administrator and/or designee will review the MRR form for identifiable trends and will create QAPI POC as appropriate. Immediately and ongoing, the Administrator and/or designee will continuously measure, assess and improve the performance of clinical and other processes. This will be evidenced by quarterly meetings, at minimum, of agency QAPI team. Team will include Administrator, Nursing Supervisor and additional office personnel. Points of emphasis can include, but will not be limited to, ongoing assessment of client care services, communication systems, professional standards, client care satisfaction, state and/or federal regulations, caregiver retention, community engagement, etc. Meeting minutes will be documented and kept in ongoing QAPI binder. Binder to include outlining policy, meeting findings, MRR findings, active internal plan of correction(s), closed internal plan of correction(s), etc. Immediately and ongoing, quarterly chart audits will be conducted by Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Employee B, dated 5/23/18 at 10:56 AM, was in regards to clinical record # 1. The email stated, " ... once per week for 4 weeks then every 2 weeks for 4 weeks ...sup visits say every 30 days, needs to be every 14 days with dual discipline .... " An email from Employee D to Employee E and Employee B, dated 5/25/18 at 9:48 AM, was in regards to clinical record # 2. Them email stated, " ... address goals and when RN will return .... " 3. During an interview on 6/4/18 at 10:36 AM, Employee E was asked if audit tools were used for record review. Employee E reported there were no audit tools used for the 3 charts reviewed. Employee E reported, "The QAPI focus area are admissions." Employee E reported the patient admission chart would be sent to Employee D, a Corporate Director of Nursing and Compliance/ Alternate Clinical Manager, Non-Employee G, Corporate Administrator and Non-Employee H, Corporate Quality, and they would do quality checks. Employee E reported an email would be sent back to him/ her and corrections would be made in the clinical record. Employee E reported there was no data collected or documented from the audits and no performance improvement plan as a result of the 3 admissions audited. 4. During an interview on 6/6/18 at 9:40 AM, Employee E reported Employee B, the agency administrator, would review the QAPI information provided from the corporation and would seek guidance from corporate Non-Employee G. Employee E reported his/ her responsibility with the QAPI program was to "Upload the information into the computer, put charts together, implement any new forms or process that comes down the line from corporate, review changes recommended from out QA department (our corporation).		Supervisor/designee on 15 active client charts, or 20% - whichever is larger, utilizing the Medical Record Review form, verifying this deficiency is corrected. Any findings/trends will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Employee E reported, "When I get emails from corporate and consultant I make corrections." Employee E reported he/ she had not developed a performance improvement plan but if he/ she noticed a trend, he/ she would initiate one.			
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview, the agency failed to ensure effective communication occurred between the HHA (home health aide) and RN (registered nurse) for 3 of 3 clinical records reviewed. (Patient's # 1, 2, and 3) (Employees A and E) Findings Include: 1. An agency policy titled, "Coordination of Care" dated 3/29/18 was reviewed and stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete current care plans and written and verbal interactions ... Purpose ... to ensure services are coordinated between members of the interdisciplinary team ... to establish effective interchange, reporting and coordination of client care does occur ... to modify the plan to reflect needs or changes identified by members of the	N 0484	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of findings, review of situational processing and re-education of the noted Care Coordination and Home Health Aide Supervision polices. Evidenced by the executed in-service attendance log. The Administrator will provide an in-service to all current external employees by 07/06/2018, which refers to active Home Health Aide(s) – including the HHA noted within the findings. The in-service will include specific review of findings, review of situational processing, communication and re-education on care coordination policy. Evidenced by the executed in-service attendance	07/14/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	team ... to identify needs to modify the plan of care ... to provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided ... Special Instructions ... The primary nurse will assume responsibility for update/changing the care plan and communicating charges to caregivers ...the physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in client conditions ... client care will be coordinated with other agencies in the home ... this will be documented in the client records .... " 3. A policy titled, "Home Health Aide Supervision" was reviewed and stated, " Policy ... Agency shall provide HHA (Home Health Aide) services under the direction and supervision of a (RN) Registered Professional Nurse/ Therapist ... Purpose ... To provide the aide with the opportunity for direct interaction with nurse and client as it relates to the current plan of care ... Special Instructions ... The aide visit record is reviewed by the supervising nurse/ therapist to assure services are being provided according to the care plan." 4. The clinical record of patient # 1 was reviewed with the following findings: The HHA (home health aide) plan of care developed by the Employee E on 5/18/18 was reviewed. The HHA care plan was not updated after the patient's hospitalization and resumption of care nursing assessment on 5/31/18. A HHA note dated 6/1/18 failed to include bathing, dressing, skin care, oral care or skin assessment as assigned by the nurse. The note failed to have documentation of the patient's refusal of care, reason for omission, or documentation the nurse was informed.		log. The Nursing Supervisor completed a care coordination note on 06/11/2018 regarding the noted PT provider (Great Lakes Caring). The care coordination note and Adaptive Plan of Care was faxed to Great Lakes Caring on 06/11/2018 for their review. A plan of care from Great Lakes Caring (PT) was also requested, however, still awaiting receipt. The Nursing Supervisor / Clinical Manager (CM) provided re-education to the HHA on 06/12/18 regarding documentation on the daily visit note to include communication with the CM, as well as documentation of patient refusing care. Nursing Supervisor also reviewed expectations of HHA to include documentation on daily visit note and what to report to CM. Reminded HHA to contact the office/CM with any changes that are unusual for the patient even if the patient is going to report it to the doctor. The Administrator provided re-education to the Home Health Aide on 07/06/2018 regarding proper documentation technique, as it relates to the HHA care plan. Specifically the necessity of providing documentation on all tasks associated within the HHA care plan, including both completed tasks and non-completed/refused tasks. Nursing Supervisor completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	An interview was conducted with the Employee E on 6/7/18 at 11:00 AM. Employee E reported the HHA had not informed him/ her of the change in the services provided to patient # 1 on 6/1/18. 5. The clinical record of patient # 2 was reviewed with the following findings: A skilled nurse note dated 5/23/18 was reviewed and stated, "Patient has PT (physical therapy) eval through [another agency name] scheduled for tomorrow." The clinical record failed to provide documentation of care coordination between other agency's physical therapist and Employee E. An interview was conducted with Employee E on 6/5/18 at 1:45 PM. Employee E validated there was no documentation of care coordination with the PT from other agency for Patient # 2. A home health aide note by Employee A, dated 5/4/18 was reviewed and stated, "right side on top of his/ her scalp there is a raised lump that is the size of a dime. He/ she will be having his/ her Dr. look at it on his/ her next visit which is June 20th, 2018 at PM." There was no documentation the nurse was informed. An interview was conducted with Employee E on 6/5/18 at 1:45 PM. Employee E reported the HHA did not inform him/ her of lump on scalp and his/ her expectation was that the HHA will report new observation and changes. 6. The clinical record of patient # 3 was reviewed with the following findings: A HHA care plan developed by Employee E, and dated 5/3/18 was reviewed. The RN assigned the HHA to do the following at each visit: shower, assist with dressing, hair care/ shampoo, skin		100% review of active clients, specifically addressing the HHA care plan, to ensure that 100% accuracy of current care requirements exists. Upon review, it was noted that 2 of 2 active clients charts required updates to the HHA care plan. Regarding client AlWe - corrective supplemental order was written on 07/12/2018 and sent to the MD on 07/13/2018 for signature. The HHA was provided education on the updated HHA care plan on 07/12/2018 by the Nursing Supervisor. Regarding client LaWi – corrective supplemental order was written on 07/14/2018 and sent to the MD on 07/16/2018 for signature. The HHA was provided education on the updated HHA care plan on 07/14/2018 by the Nursing Supervisor. Nursing Supervisor conducted 100% review of active clients HHA care plans, corrective action was taken as outlined above. Immediately, Nursing Supervisor will complete 100% review of weekly notes for the next 30 days to ensure HHA compliance with proper documentation technique; providing real time/weekly reeducation to the Home Health Aide, as required. Ongoing, the Nursing Supervisor will complete quarterly chart reviews, including HHA care plans and HHA documentation, on 15 active clients, or 20% - whichever is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	care, foot care, nail care. The HHA notes completed and signed by Employee A and dated 5/3/18, 5/7/18, 5/9/18, 5/10/18, 5/14/18, 5/16/18, 5/17/18, 5/21/18, 5/23/18, 5/30/18, 5/31/18, were reviewed. The notes failed to evidence documentation if the personal care that was assigned had been provided, the patient's refusal of care, the reason for omission or that the nurse was informed. A HHA note dated 5/14/18 was reviewed and stated, "[Patient name] informed me of a rash on lower back area, lower abdomen, right hip and small areas on both of his/her legs. He/ She states that he/ she is using cream that his/ her doctor ordered but is not working." The note failed to include documentation the nurse was notified of rash and patient's complaints. An interview was conducted with Employee A on 6/5/18 at 3:00 PM. Employee A reported he/ she informed the nurse on 5/14/18 of the rash, but didn't document the call. He/ she reported patient # 3 refused personal care. An interview was conducted with Employee E on 6/5/18 at 3:50 PM regarding personal care not being provided as assigned by the HHA. Employee E reported he/ she would review aide assignment notes when he/ she was at the agency and "tries to get here (at the agency) at least weekly". Employee E reported she was not aware of the patient not getting a bath or personal hygiene care by the aide and he/ she expected the aide would have reported this to him/ her. Employee E reported the aide had called and only reported the rash.		larger, to ensure deficiency remains corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of additional internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the agency failed to ensure services were coordinated with other health providers serving the patient for 2 of 3 clinical records reviewed. (Patients 1 and 2) (Employee E) Findings include: 1. An agency policy titled, "Coordination of Care" dated 3/29/18 was reviewed and stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete current care plans and written and verbal interactions ... Purpose ... to establish effective interchange, reporting and coordination of client care does occur ... to modify the plan to reflect needs or changes... to identify needs to modify the plan of care ... to provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided ... Special Instructions ... The primary nurse will assume responsibility for update/changing the care plan and communicating charges to caregivers ...the physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in client conditions ... client care will be coordinated with other agencies in the home ... this will be documented in the client records .... " 2. A policy titled, "Client Transfer" was reviewed	N 0486	During discussion of outlined findings between Administrator and Clinical Manager (CM), it was noted that CM attempted to contact Community Anderson ER several times on 05/23/2018 without success. CM spoke to hospital nurse staff on 05/24/2018 to obtain notification that patient was admitted. CM also spoke with hospital nursing staff over duration of hospitalization to obtain update on patient condition. However, it was substantiated by Administrator that no written communication/transfer order was sent per policy. In correction of outlined findings, it is to be noted that a care coordination note was completed on 06/11/2018 by the Clinical Manager (CM) to coordinate PT services. The care coordination note and a copy of our plan of care was faxed to the PT provider (Great Lakes Caring) on 06/11/2018. A request was made for their POC to be sent to Adaptive, to date, still awaiting receipt. The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	and stated, "... A transfer summary/ Form shall be completed by the clinical manager and communicated/faxed to the receiving agency / facility ... This summary will be based on data collected on the last visit, and shall include documentation of services received, reason for transfer... the client's physical and psychosocial status, current medications, continuing symptom management needs ... A copy of the most recent POC (plan of care), updated medication profile, and any advance directives/ code status forms will also be sent with the transfer summary .... " 3. The clinical record of patient # 1 was reviewed with the following findings: A resumption of care Comprehensive Nursing Assessment dated 5/31/18 was reviewed and stated, "Patient hospitalized x 7 days for GI bleed. Discharged 5/30/18 to home. No order changes at this time." The clinical record failed to have documentation of a transfer summary sent to the hospital. An interview was conducted with the Employee E on 6/7/18 at 11:00 AM. Employee E validated no transfer papers were sent to the hospital from the agency for Patient #1. 4. The clinical record of patient # 2 was reviewed with the following findings: A skilled nurse note dated 5/23/18 was reviewed and stated, "Patient has PT (physical therapy) eval through [another agency name] scheduled for tomorrow." The clinical record failed to provide documentation of care coordination between the other home health care agency or the physical therapist and Employee E.		in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Coordination of Care and Client Transfer policies. Evidenced by the executed in-service attendance log. Immediately, for the next 60 days, 100% of all client hospitalizations/hospital admissions will be reported to the Administrator to allow for observation of the internal client transfer process to ensure the deficiency has been corrected. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor or designee on 15 active clients charts, or 20% - whichever is larger, to ensure services are being properly coordinated with all other health providers serving the patient, verify this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	An interview was conducted with Employee E on 6/5/18 at 1:45 PM. Employee E validated there was no documentation of care coordination with the other home health care agency or the physical therapist for Patient # 2.			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on observation, record review and interviews, the agency failed to ensure the medical doctor established the plan of care prior to providing services and to hold services for a patient's hospitilization and for resumption of care for 1 of 3 clinical records reviewed. (Patient # 1) Findings Include: 1. An agency policy titled, "Plan of Treatment" was reviewed and stated, "The plan of treatment shall be developed in consultation with the agency staff and shall cover pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral and other appropriate items ... The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care ... Nursing Plan of Care ... A nursing plan of care must be developed by a registered nurse for	N 0522	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Plan of Treatment policy. Evidenced by the executed in-service attendance log. In review of findings, and in corrective actions, it was noted the verbal order was obtained that same day. Clinical Manager (CM) forgot to take out the “voicemail” after speaking with live person and before creating the order. The CM has sent a clarification order to the MD. The CM is no longer typing the order into the system until speaking to the MD to avoid placeholders being sent in error. Additionally, orders for hospitalization hold and resumption of care have been obtained.	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The nursing plan of care must contain the following: 1. A plan of care and appropriate patient identifying information, 2. The name of the patient's physician 3. Services to be provided 4. the frequency and duration of visits, 5. Medications, diet and activities 6. Signed and dated clinical notes from all personnel providing services ...." 2. The clinical record review of Patient # 1 with a start of care date of 5/18/18 was reviewed. The patient's diagnosis included cerebral infarction due to embolism of unspecified cerebral artery, type 2 diabetes mellitus with diabetic neuropathic arthropathy, chronic obstructive pulmonary disease, dependence on supplemental oxygen. The following findings were noted: The plan of care developed on 5/18/18 had the following services orders: "HHA (Home Health Aide) to provide 3 hours a day/ 2 days week, not to exceed 6 hours per week throughout the certification period. Home Health Aide to assist with all ADL's (activities of daily living) such as bathing (bed/tub/shower), hair care, dressing, nail care, incontinence care, meal prep, light housekeeping, transfer and medication reminders only ... to report findings immediately to office RN ... " A faxed start of care order, signed by the attending MD and dated 5/25/18, stated the following for this (initial start of care): "New Order: 5/18/2018 at 4:30 PM...completed on 5/18/18. Spoke to voice mail on 5/18/18 for VSOC (verbal start of care) for HHA services for 3 hours per day, 2 days a week over the next 60 days. To		Immediately, 100% review of active medical records was complete to ensure accuracy. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client charts, or 20% - whichever is larger, to ensure the medical doctor established the plan of care prior to providing services and to hold services for a patient's hospitalization and for resumption of care, verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	include assistance with personal care, med reminders, meal prep, light housekeeping, etc. Orders clarified with left voice mail at physician's office." A hand written note stated, "received 5/25/18 0947" and was signed by Employee E. An interview was conducted with Employee E on 6/7/18 at 11:26 AM regarding delay of obtaining start of care order from physician until 5/25/18. Employee E reported there was no other documentation to be provided for start of care orders before 5/25/18. A resumption of care nurse assessment conducted on 5/31/18 was reviewed. The following note was documented by Employee E, "Patient hospitalized x 7 days for GI bleed. Discharged 5/30/18 to home. Denies any pain at this time. No order changes at this time. Is to follow up with PCP (Primary Care Physician) on 6/5/18." The clinical record failed to include orders to up date the plan of care for the patient's transfer to the hospital 5/23/18, hold orders for services from 5/25/18 to 5/30/18 and resumption of services 5/31/18. Employee E was interviewed on 6/7/18 at 11:00 AM, and reported there were no orders obtained.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	(ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, record review and interview the agency failed to ensure the medical plan of care contained all pertinent diagnoses, equipment required, frequency and duration of visits, and all current medications for 3 of 3 clinical records reviewed. (Patients # 1, 2, and 3). Findings Include: 1. An agency policy titled, "Plan of Treatment" was reviewed and stated, "The plan of treatment shall be developed in consultation with the agency staff and shall cover pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral and other appropriate items ... The health care professional staff of the home health agency shall promptly alert the person responsible for the medical	N 0524	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Plan of Treatment policy. Evidenced by the executed in-service attendance log. Corrective actions have been completed regarding all three listed patients, including the following; Patient #1: Discharge instructions obtained from the hospital on 06/13/18 after obtaining a signed RHI from patient, order placed for removal of Atorvastatin and sent to the MD for signature, order written and POC updated to add insulin pen needles to DME, order written to add GI bleed to diagnosis list,	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	component of the patient's care to any changes that suggest a need to alter the medical plan of care ... Nursing Plan of Care ... A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The nursing plan of care must contain the following: 1. A plan of care and appropriate patient identifying information, 2. The name of the patient's physician 3. Services to be provided 4. the frequency and duration of visits, 5. Medications, diet and activities 6. Signed and dated clinical notes from all personnel providing services ...." 2. The clinical record of Patient # 1 with a start of care date of 5/18/18 and a hospitalized from 5/23/18 to 5/30/18 was reviewed with the following findings The plan of care dated 5/18/18 was reviewed and included the following medication: Atrovastatin Calcium (Lipitor) 40 mg 1 tablet daily by mouth at bedtime (medication to reduce cholesterol). An interview was conducted with Patient # 1 during a home visit observation on 6/6/18 at 2:08 PM. The patient reported the Atrovastatin Calcium had been discontinued when he/she was discharged from the hospital on 5/30/18. The clinical record failed to include orders to discontinue the Atrovastatin Calcium to update the plan of care. The plan of care included the following (DME) durable medial equipment and supplies: "OSHA kit, CPR shield, gloves, hand sanitizer, oxygen concentrator and supplies, nebulizer, glucometer and supplies, shower chair, wheeled walker." The plan of care failed to include needles and/or syringes for insulin injections.		orders written to hold/resume services due to hospitalization and sent to MD for signature. Patient #2: Order written to add wheelchair (which is normally stored in the garage) and raised toilet seat (which is new as of 06/01/18) to the DME, care coordinated with behavior health physician (manages bipolar diagnosis) and PCP – order written to add bipolar to diagnosis list, HHA visits were not started until the following week per patient request which was documented on the comprehensive assessment. HHA visit (documentation provided) was provided on day of admission in which the HHA assisted with toileting and bed repositioning. Order written for POC clarification regarding delaying the start of HHA services until the following week. Patient #3: Order written to add insulin pen needles to DME. SOC was on 05/03/18 with visit that day. Patient requested services on M/W/Th, as such the next HHA visit was not until the following Monday. Per Patient instruction, she wanted to stay with those days only. Missed visit notifications were sent to the MD. CM will send out missed visit notifications weekly. HHA and patient were educated on the need to notify the office of any changes to the schedule and to document said changes. Patient was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	The diagnosis on the POC for 5/18/18 included: Cerebral infarction due to embolism of unspecified cerebral artery, Type 2 diabetes mellitus with diabetic neuropathic arthorpathey, Chronic obstructive pulmonary disease, dependence of supplemental oxygen. The admission summary included the following diagnosis not listed: open heart surgery, foot fracture, GERD (gastric reflux) gout, seasonal allergies. There was no updated order to add the current new diagnosis of GI bleed that occurred on 5/23/18. The frequency of visits listed for the plan of care included: SN (skilled nurse) every 30 days for supervisory visits and HHA (home health aide) 3 hours a day /2 days per week , not to exceed 6 hours. The HHA services began on 5/23/18 and orders obtained for services 5/25/18. Employee E was interviewed at time of home visit observation on 6/6/18 at 2:08 PM and reported he/ she had not obtained discharge orders from the hospital and was not aware of the change in medication orders. Employee E was interviewed on 6/7/19 at 11:00 AM and reported he/ she had not updated the plan of care to include transfer orders to the hospital 5/23/18, hold orders for services from 5/25/18 to 5/30/18 and resumption of services on 5/31/18. 3. The clinical record of Patient # 2, with a start of care date of 5/16/18 was reviewed with the following finding: The DME on the POC included : pain pump, oxygen , 2 wheeled walker, glucometer, testing supplies, insulin, needles and syringes, nebulizer,		educated on the need to notify the office of any changes she requests of the POC. Immediately 100% review of active client charts has been completed with the corrective actions listed above. Ongoing, medical record reviews will be completed per client upon admission, recertification and/or resumption of care by the Administrator/Nursing Supervisor/Designee. Lastly, quarterly chart audits will be conducted by Nursing Supervisor or designee on 15 active client charts, or 20% - whichever is larger, to ensure the medical plan of care contains all pertinent diagnoses, equipment required, frequency and duration of visits and all current medications, verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	CPAP (machine for sleep apnea), shower chair. The plan of care failed to include the a wheel chair and raised toilet seat observed during a home visit conducted on 6/6/18 at 12:58 AM. Employee E reported at the time of the home visit he/ she had not noticed the wheelchair or raised toilet seat in the home. The diagnosis on the POC included: Malignant neoplasm of unspecific site of unspecified female breast, pathological fracture/ neoplastic disease, left femur, chronic obstructive pulmonary disease, Type 2 diabetes mellitus with diabetic nephropathy. The admission summary listed the following diagnosis not listed on the plan of care: oxygen dependence, bipolar, hypertension, GERD, presence of pain pump, obesity. The frequency of visits listed for the plan of care included: HHA 3 hours/ 2 days week. The aide services did not begin until the second week on 5/22/18. There were no orders to update the plan of care regarding the omission of 2 HHA visits on week 1 of the POC. The findings was reviewed with Employee E on 6/5/18 at 4:40 PM. Employee E was unable to provide any further information/ documentation upon request. 4. The clinical record of Patient # 3, with a start of care date of 5/3/18 was reviewed with the following findings: The DME on the POC included: rolling walker, nebulizer, glucometer, testing strips. The patient's plan of care medication orders included: Humalog 100 units/ml inject sliding scale dosage subcutaneous three times daily with meals. The DME failed to include needles and/or syringes to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	inject the insulin. The frequency of visits listed for the plan of care included : HHA 4 hours a day/ 3 days per week, not to exceed 12 hours week. The aide services began on week 5/7/18. There were no orders to update the plan of care regarding the omission of 2 HHA visits on week 1 of the POC. On 5/30/18 (week 5 of the POC) the HHA visit was 6 hours and there were no other visits that week. There were not orders to update the plan of care to change the length of the visit or omission of the second visit that week. Employee E was interviewed on 6/5/18 at 4:40 PM regarding the plan of care and HHA frequency. He/ she reported there was no further documentation to be provided.			
N 0540 Bldg. 00	410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on record review and interview, the RN (registered nurse) failed to conduct an initial assessment for 1 of 3 records reviewed. (Patient # 2). 1. An agency policy titled, "Admission Criteria" dated 3/21/12 was reviewed and stated, "The agency will evaluate each individual for the appropriateness of admission ... Procedure ....1. Clients are accepted for home health services based on a reasonable expectation that the client's health care needs can be met adequately ... c. An	N 0540	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Admission Criteria policy. Evidenced by the executed in-service attendance log. In review, it was substantiated that the patient chart failed to contain	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	initial health assessment must be performed in the client's residence by a RN prior to or at the time that licensed home health services are initially provided to the client. The assessment must determine whether the agency has the ability to provide the necessary services ...." 2. The clinical record of Patient # 2 with admission date of 5/16/18 was reviewed. The document failed to include a initial assessment. 3. Employee E was unable to provide any further information or documentation upon request on 6/5/18 at 4:40 PM.		an initial assessment within it. However, the Clinical Manager (CM) was able to obtain/find it within her clip board – and it has since been placed in the client medical record. Re-education was provided during review that every patient has an initial assessment completed prior to admission to ensure appropriateness and safety of home care services. Immediately, Administrator/Nursing Supervisor conducted 100% review of active client charts to ensure inclusion of the completed initial assessment. Administrator/Nursing Supervisor will conduct 100% review of any new admission, for the next 60 days, to ensure inclusion of the completed initial assessment. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client records, or 20% - whichever is larger, to ensure the registered nurse (RN) has conducted an initial assessment per policy and that it has been placed in the medical record, verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	
N 0541	410 IAC 17-14-1(a)(1)(B) Scope of Services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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	Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review, observation and interview the nurse failed to regularly reevaluate the patient's nursing needs for 1 of 3 patients. (Patients # 3) Findings Include: 1. An agency policy titled, "Re-Assessment" and dated 3/29/18 was reviewed and stated, "... Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients. Clients who are not receiving skilled services under the Medicare or Medicaid program will be assessed using the OASIS tool or an alternative form identified by the agency. Reassessments must be done at least ... 3. Within forty-eight(48)hours of (or knowledge of) discharge or transfer ... Special Instructions ... 6. The RN (Registered Nurse)/Therapist is responsible for reassessing the need for HHA(Home Health Aide) 2. The clinical record of Patient # 3 with a start of care date of 5/3/18 was reviewed with the following findings : 3. A HHA daily record note signed by Employee A and dated 5/14/18 was reviewed and stated, " ... [patient #3] informed me of a rash on lower back area, lower abdomen, right hip and small area; on both of his/ her legs. He/ she states that he/ she is using cream that his/ her Dr. ordered but it is not working .... "	N 0541	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Re-Assessment policy. Evidenced by the executed in-service attendance log. In review of findings, the Administrator reviewed documentation policy and expectation with Home Health Aide (HHA) and Clinical Manager (CM). HHA will report via weekly note, all refusals of care by the patient – if refusals trend throughout the week, HHA is to call the CM to report the continued refusal. CM will follow up with patient initially with a phone call and potential visit. CM will review HHA daily visit notes on a weekly basis and clarify any unusual findings. The Administrator also reviewed communication expectation with HHA and CM. HHA will report any unusual findings or changes in patient's condition or habits to CM and document the reporting on the	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	An interview was conducted with Employee A on 6/5/18 at 3:00 PM. Employee A reported he/ she informed the nurse on 5/14/18 of the rash, but didn't document the call. He/ she reported patient # 3 refused personal care. 4. A skilled visit note, signed by Employee E and dated 5/17/18 at 2:30 PM was reviewed and failed to assess or document the rash reported on 5/14/18. 5. RN supervisory visits notes for visits conducted on 5/17/18 and 5/31/18 by Employee E were reviewed and indicated the "current plan of care in chart and reviewed : Yes" An interview was conducted with Employee E on 6/5/18 at 3:50 PM regarding personal care not being provided as assigned by the HHA. Employee E reported he/ she would review aide assignment notes when he/ she was at the agency and "tries to get here (at the agency) at least weekly". Employee E reported she was not aware of the patient not getting a bath or personal hygiene care by the aide and he/ she expected the aide would have reported this to him/ her. Employee E reported the aide had called and only reported the rash. Employee E validated there was no documentation of the rash in the skin assessment in the next RN visit note dated 5/17/18.		daily visit note. CM will follow up with call/visit with patient to assess changes/findings, CM will document into medical record. All findings will be documented, even if it is a chronic condition that is normal for the patient. Immediately, for next 60 days, Nursing Supervisor will review 100% of HHA weekly notes to ensure communication channels are working appropriately and deficiency is corrected. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client records, or 20% - whichever is larger, to ensure registered nurse (RN) properly and regularly reevaluate's the patient's nursing needs per policy, verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	(C) Initiate the plan of care and necessary revisions. Based on observation, record review, and interview, the Registered Nurse failed to ensure the medical plan of care contained all pertinent diagnoses, equipment required, frequency and duration of visits, and all current medications for 3 of 3 clinical records reviewed. (Patients # 1, 2, and 3). Findings Include: 1. An agency policy titled, "Plan of Treatment" was reviewed and stated, "The plan of treatment shall be developed in consultation with the agency staff and shall cover pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral and other appropriate items ... The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care ... Nursing Plan of Care ... A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The nursing plan of care must contain the following: 1. A plan of care and appropriate patient identifying information, 2. The name of the patient's physician 3. Services to be provided 4. the frequency and duration of visits, 5. Medications, diet and	N 0542	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Plan of Treatment policy. Evidenced by the executed in-service attendance log. In review of findings, the following course of action will be completed to ensure RN will include all pertinent diagnosis(es), equipment, frequencies, duration and medications on the plan of care. Immediately, 1) Administrator/designee will re-instruct RN on what must be included in a plan of care, including any new orders as they occur. 2) Nursing Supervisor/designee will audit 100% of all active client POC to ensure they include all required information until 100% compliance achieved. Once achieved, will follow ongoing audit structure below. Any clinician found not completing POC with all required information will be re-instructed within 5 business days by Nursing Supervisor/designee. 3) Administrator/designee will instruct RN on need to obtain orders from MD/hospital when	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	activities 6. Signed and dated clinical notes from all personnel providing services ...." 2. The clinical record of Patient # 1 with a start of care date of 5/18/18 and a hospitalized from 5/23/18 to 5/30/18 was reviewed with the following findings The plan of care dated 5/18/18 was reviewed and included the following medication: Atrovastatin Calcium (Lipitor) 40 mg 1 tablet daily by mouth at bedtime (medication to reduce cholesterol). An interview was conducted with Patient # 1 during a home visit observation on 6/6/18 at 2:08 PM. The patient reported the Atrovastatin Calcium had been discontinued when he/she was discharged from the hospital on 5/30/18. The clinical record failed to include orders to discontinue the Atrovastatin Calcium to update the plan of care. The plan of care included the following (DME) durable medial equipment and supplies: "OSHA kit, CPR shield, gloves, hand sanitizer, oxygen concentrator and supplies, nebulizer, glucometer and supplies, shower chair, wheeled walker." The plan of care failed to include needles and/or syringes for insulin injections. The diagnosis on the POC for 5/18/18 included: Cerebral infarction due to embolism of unspecified cerebral artery, Type 2 diabetes mellitus with diabetic neuropathic arthorpathey, Chronic obstructive pulmonary disease, dependence of supplemental oxygen. The admission summary included the following diagnosis not listed: open heart surgery, foot fracture, GERD (gastric reflux) gout, seasonal allergies. There was no updated order to add the current new diagnosis of GI bleed that occurred on 5/23/18.		patient is being admitted to or resumed by agency to ensure RN has current orders and information. 4) Nursing Supervisor/designee will audit 100% of admits/resumptions to ensure there is copy of MD/hospital orders include medications, diagnoses. Once achieved, will follow ongoing audit structure below. Any admit or resumption found to not have the required MD/hospital orders will result in involved RN being re-educated within 5 business days by Nursing Supervisor/designee. 5) Nursing Supervisor/designee will ensure all new orders are added to patient plan of care via chart audit. Once 100% compliance is achieved, will follow ongoing audit structure below. 6) Administrator/designee will re-instruct RN on need to obtain MD for HHA visit that exceeds ordered frequency and to notify MD of missed visits. 7) Nursing Supervisor/designee will audit 100% of active charts to ensure any visits that do not match frequency or duration have orders/missed visit report. Once achieved, will follow ongoing audit structure below. Any clinician found not to be in compliance with obtaining MD order or sending missed visit report will be re-educated within 5 business days by Nursing Supervisor/designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	The frequency of visits listed for the plan of care included: SN (skilled nurse) every 30 days for supervisory visits and HHA (home health aide) 3 hours a day /2 days per week , not to exceed 6 hours. The HHA services began on 5/23/18 and orders obtained for services 5/25/18. Employee E was interviewed at time of home visit observation on 6/6/18 at 2:08 PM and reported he/ she had not obtained discharge orders from the hospital and was not aware of the change in medication orders. Employee E was interviewed on 6/7/19 at 11:00 AM and reported he/ she had not updated the plan of care to include transfer orders to the hospital 5/23/18, hold orders for services from 5/25/18 to 5/30/18 and resumption of services on 5/31/18. 3. The clinical record of Patient # 2, with a start of care date of 5/16/18 was reviewed with the following finding: The DME on the POC included : pain pump, oxygen , 2 wheeled walker, glucometer, testing supplies, insulin, needles and syringes, nebulizer, CPAP (machine for sleep apnea), shower chair. The plan of care failed to include the a wheel chair and raised toilet seat observed during a home visit conducted on 6/6/18 at 12:58 AM. Employee E reported at the time of the home visit he/ she had not noticed the wheelchair or raised toilet seat in the home. The diagnosis on the POC included: Malignant neoplasm of unspecific site of unspecified female breast, pathological fracture/ neoplastic disease, left femur, chronic obstructive pulmonary disease, Type 2 diabetes mellitus with diabetic		Moving Forward, 1)Nursing Supervisor/designee will ensure orientation of new RN's includes training on what must be included in a plan of care. This includes asking about any DME, new or changed medications, diagnoses. 2) Nursing Supervisor/designee will ensure orientation of new RN's includes training on need to obtain orders from MD/hospital when patient is being admitted to or resumed by agency to ensure RN has current orders and information. 3) Nursing Supervisor/designee will ensure newly hired RN's are instructed on need to include any new orders on plan of care as they occur. 4) Clinical Manager/designee will ensure orientation of newly hired RN's includes training on need to obtain MD for HHA visit that exceeds ordered frequency and to notify MD of missed visits. Ongoing, medical record reviews will be completed per client upon admission, recertification and/or resumption of care by the Nursing Supervisor/Designee. Lastly, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client records, or 20% - whichever is larger, to ensure the medical plan of care contains all pertinent diagnoses, required equipment, frequency and duration of visits and all current medications, verifying this deficiency is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	nephropathy. The admission summary listed the following diagnosis not listed on the plan of care: oxygen dependence, bipolar, hypertension, GERD, presence of pain pump, obesity. The frequency of visits listed for the plan of care included: HHA 3 hours/ 2 days week. The aide services did not begin until the second week on 5/22/18. There were no orders to update the plan of care regarding the omission of 2 HHA visits on week 1 of the POC. The findings was reviewed with Employee E on 6/5/18 at 4:40 PM. Employee E was unable to provide any further information/ documentation upon request. 4. The clinical record of Patient # 3, with a start of care date of 5/3/18 was reviewed with the following findings: The DME on the POC included: rolling walker, nebulizer, glucometer, testing strips. The patient's plan of care medication orders included: Humalog 100 units/ml inject sliding scale dosage subcutaneous three times daily with meals. The DME failed to include needles and/or syringes to inject the insulin. The frequency of visits listed for the plan of care included : HHA 4 hours a day/ 3 days per week, not to exceed 12 hours week. The aide services began on week 5/7/18. There were no orders to update the plan of care regarding the omission of 2 HHA visits on week 1 of the POC. On 5/30/18 (week 5 of the POC) the HHA visit was 6 hours and there were no other visits that week. There were not orders to update the plan of care to change the length of the visit or omission of the second visit that week.		corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Employee E was interviewed on 6/5/18 at 4:40 PM regarding the plan of care and HHA frequency. He/ she reported there was no further documentation to be provided.			
N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the RN (registered nurse) failed to coordinate services with the Physical Therapist and the Physician for 2 of 3 clinical records reviewed. Patients # 1 and 2) Findings Included: 1. An agency policy titled, "Coordination of Care" dated 3/29/18 was reviewed and stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete current care plans and written and verbal interactions ... Purpose ... to ensure services are coordinated between members of the interdisciplinary team ... to establish effective interchange, reporting and coordination of client care does occur ... to modify the plan to reflect needs or changes identified by members of the team ... to identify needs to modify the plan of care ... to provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided ... Special	N 0545	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Coordination of Care, Home Health Aide Supervision and Plan of Treatment policies. Evidenced by the executed in-service attendance log. In corrective action review, the Nursing Supervisor has placed an order for removal of Atorvastatin and it was sent to the MD for signature. Additionally, the Nursing Supervisor completed a care coordination note on 06/11/2018 regarding the noted PT provider (Great Lakes Caring). The care coordination note and Adaptive POC was faxed to Great Lakes Caring on 06/11/2018. A POC from Great Lakes Caring	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Instructions ... The primary nurse will assume responsibility for update/changing the care plan and communicating charges to caregivers ...the physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in client conditions ... client care will be coordinated with other agencies in the home ... this will be documented in the client records .... " 2. A policy titled, "Home Health Aide Supervision" was reviewed and stated, " Policy ... Agency shall provide HHA (Home Health Aide) services under the direction and supervision of a (RN) Registered Professional Nurse/ Therapist ... Purpose ... To provide the aide with the opportunity for direct interaction with nurse and client as it relates to the current plan of care ... Special Instructions ... The aide visit record is reviewed by the supervising nurse/therapist to assure services are being provided according to the care plan." 3. An agency policy titled, "Plan of Treatment" was reviewed and stated, "The plan of treatment shall be developed in consultation with the agency staff and shall cover pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral and other appropriate items ... The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care ... Nursing Plan of Care ... A nursing plan of care must be developed by a registered nurse for		(PT) was requested in return, still awaiting receipt. Moving forward, RN will continue to coordinate with all providers serving the patient – provide Adaptive POC and request outside POC in return. All communication surrounding this activity will be documented on care coordination note and placed within the medical record. Immediately, 100% review was conducted on active clients and corrective actions were taken as noted above. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client records, or 20% -whichever is larger, to ensure coordination of care with all providers serving the patient, verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The nursing plan of care must contain the following: 1. A plan of care and appropriate patient identifying information, 2. The name of the patient's physician 3. Services to be provided 4. the frequency and duration of visits, 5. Medications, diet and activities 6. Signed and dated clinical notes from all personnel providing services ...." 4. The clinical record of Patient # 1 with a start of care date of 5/18/18 and a hospitalized from 5/23/18 to 5/30/18 was reviewed with the following findings The plan of care dated 5/18/18 was reviewed and included the following medication: Atrovastatin Calcium (Lipitor) 40 mg 1 tablet daily by mouth at bedtime (medication to reduce cholesterol). An interview was conducted with Patient # 1 during a home visit observation on 6/6/18 at 2:08 PM. The patient reported the Atrovastatin Calcium had been discontinued when he/she was discharged from the hospital on 5/30/18. The clinical record failed to include orders to discontinue the Atrovastatin Calcium to update the plan of care. Employee E was interviewed at time of home visit observation on 6/6/18 at 2:08 PM and reported he/ she had not obtained discharge orders from the hospital and was not aware of the change in medication orders. Employee E was interviewed on 6/7/19 at 11:00 AM and reported he/ she had not communicated with the physician to update the plan of care to include transfer orders to the hospital 5/23/18, hold orders for services from 5/25/18 to 5/30/18			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	and resumption of services on 5/31/18. 5. The clinical record of patient # 2 was reviewed with the following findings: A skilled nurse note dated 5/23/18 was reviewed and stated, "Patient has PT (physical therapy) eval through [another agency name] scheduled for tomorrow." The clinical record failed to provide documentation of care coordination between other agency's physical therapist and Employee E. An interview was conducted with Employee E on 6/5/18 at 1:45 PM. Employee E validated there was no documentation of care coordination with the PT from other agency for Patient # 2.			
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview, the Registered Nurse failed to ensure services were coordinated with other health providers serving the patient for 2 of 3 clinical records reviewed. (Patients 1 and 2) (Employee E) Findings include:	N 0546	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	1. An agency policy titled, "Coordination of Care" dated 3/29/18 was reviewed and stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete current care plans and written and verbal interactions ... Purpose ... to establish effective interchange, reporting and coordination of client care does occur ... to modify the plan to reflect needs or changes... to identify needs to modify the plan of care ... to provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided ... Special Instructions ... The primary nurse will assume responsibility for update/changing the care plan and communicating charges to caregivers ...the physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in client conditions ... client care will be coordinated with other agencies in the home ... this will be documented in the client records .... " 2. A policy titled, "Client Transfer" was reviewed and stated, "... A transfer summary/ Form shall be completed by the clinical manager and communicated/faxed to the receiving agency / facility ... This summary will be based on data collected on the last visit, and shall include documentation of services received, reason for transfer... the client's physical and psychosocial status, current medications, continuing symptom management needs ... A copy of the most recent POC (plan of care), updated medication profile, and any advance directives/ code status forms will also be sent with the transfer summary .... " 3. The clinical record of patient # 1 was reviewed		Coordination of Care and Client Transfer policies. Evidenced by the executed in-service attendance log. In review, Administrator discussed transfer policy and coordination of care with Clinical Manager (CM). With a transfer to a facility for placement greater than 24 hours, CM will call in a verbal report to receiving nurse as well as fax transfer summary, current POC, medication list and advanced directives to receiving facility. In coordinating services with an outside agency, CM will fax current POC and request copy of their POC in return – and speak with a representative to discuss specifics in the care delivery. CM will document all care coordination on the patient care coordination note and place in medical record. Immediately, for the next 60 days, 100% of all client hospitalizations/hospital admissions will be report to the Administrator to allow for observation of the client transfer process / communication to ensure the deficiency has been corrected. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor or designee on 15 active clients charts, or 20% - whichever is larger, to ensure services are being properly coordinated with all other health providers serving the patient, verify this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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 the following findings: A resumption of care Comprehensive Nursing Assessment dated 5/31/18 was reviewed and stated, "Patient hospitalized x 7 days for GI bleed. Discharged 5/30/18 to home. No order changes at this time." The clinical record failed to have documentation of a transfer summary sent to the hospital. An interview was conducted with the Employee E on 6/7/18 at 11:00 AM. Employee E validated no transfer papers were sent to the hospital from the agency for Patient #1. 4. The clinical record of patient # 2 was reviewed with the following findings: A skilled nurse note dated 5/23/18 was reviewed and stated, "Patient has PT (physical therapy) eval through [another agency name] scheduled for tomorrow." The clinical record failed to provide documentation of care coordination between the other home health care agency or the physical therapist and Employee E. An interview was conducted with Employee E on 6/5/18 at 1:45 PM. Employee E validated there was no documentation of care coordination with the other home health care agency or the physical therapist for Patient # 2.		Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	
N 0584 Bldg. 00	410 IAC 17-14-1(g) Scope of Services Rule 14 Sec. 1(g) Home health aides shall be supervised by a health care professional to ensure competent provision of care. Supervision of services must be within the scope of practice of the health care professional providing the supervision.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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 record review and interview the (RN) Registered Nurse failed to provide adequate supervision of the (HHA) Home Health Aide (Employee E and Employee A) for 1 of 1 agency. Findings include: 1. An agency policy titled, "Coordination of Care" dated 3/29/18 was reviewed and stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete current care plans and written and verbal interactions ... Purpose ... to ensure services are coordinated between members of the interdisciplinary team ... to establish effective interchange, reporting and coordination of client care does occur ... to modify the plan to reflect needs or changes identified by members of the team ... to identify needs to modify the plan of care ... to provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided ... Special Instructions ... The primary nurse will assume responsibility for update/changing the care plan and communicating charges to caregivers ...the physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in client conditions ... client care will be coordinated with other agencies in the home ... this will be documented in the client records .... " 2. A policy titled, "Home Health Aide Supervision" was reviewed and stated, " Policy ... Agency shall provide HHA (Home Health Aide) services under the direction and supervision of a (RN) Registered Professional Nurse/ Therapist ...	N 0584	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Coordination of Care and Home Health Aide Supervision policies. Evidenced by the executed in-service attendance log. In review of findings, the Administrator reviewed coordination of care and home health aide supervision expectations with Home Health Aide (HHA) and Clinical Manager (CM). HHA will report all refusals of care by the patient, via the weekly note. If the refusals trend throughout the week, the HHA is to call the CM to report the continued refusal. CM will follow up with the patient initially via phone and potentially a visit. CM will review HHA notes weekly and clarify any unusual findings. The HHA will report any unusual findings or changes in patient's condition, behaviors or habits to the CM and document the reporting on the daily visit note. CM will follow up with call/visit with patient to assess changes, CM will document into medical record. All findings will be documented, even if it is a chronic condition that is normal for the patient.	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Purpose ... To provide the aide with the opportunity for direct interaction with nurse and client as it relates to the current plan of care ... Special Instructions ... The aide visit record is reviewed by the supervising nurse/therapist to assure services are being provided according to the care plan." 3. The clinical record of patient # 1 was reviewed with the following findings: The HHA (home health aide) plan of care developed by the Employee E on 5/18/18 was reviewed. The HHA care plan was not updated after the patient's hospitalization and resumption of care nursing assessment on 5/31/18. A HHA note dated 6/1/18 failed to include bathing, dressing, skin care, oral care or skin assessment as assigned by the nurse. The note failed to have documentation of the patient's refusal of care reason for omission or documentation the nurse was informed. An interview was conducted with the Employee E on 6/7/18 at 11:00 AM. Employee E reported the HHA had not informed him/ her of the change in the services provided to patient # 1 on 6/1/18. 4. The clinical record of patient # 2 was reviewed with the following findings: A home health aide note by Employee A, dated 5/4/18 was reviewed and stated, "right side on top of his/her scalp there is a raised lump that is the size of a dime. He/she will be having his/her Dr. look at it on his/her next visit which is June 10th, 2018 at PM." There was no documentation the nurse was informed. An interview was conducted with Employee E on		RN will observe HHA providing care for patient every 30 days for supervisory visits and 56-60 for recertification visits. RN will discuss plan of care and any changes made/needed with HHA present. If HHA is not present, CM will place a call to the HHA involved in care delivery. This action is true on regular supervisory visits, updates throughout the certification period, any transfer periods due to change of condition, resumption of care visits prior to care delivery, and so on. All communication by HHA and CM to be documented on daily visit note or within medical record respectively. Immediately for next 60 days, Nursing Supervisor will review 100% of HHA weekly note to ensure communication channels are working appropriately. Immediately, for next 60 days, any resumption of care visit will be reported to the Administrator to observe appropriate HHA supervision and coordination. Ongoing, Nursing Supervisor/designee will note any refusal of care trends while processing weekly notes and report to Nursing Supervisor. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client charts, or 20% - whichever is larger, to ensure continuation of proper/adequate supervision of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	6/5/18 at 1:45 PM. Employee E reported the HHA did not inform him/ her of lump on scalp and his/her expectation was that the HHA will report new observation and changes. 5. The clinical record of patient # 3 was reviewed with the following findings: A HHA care plan developed by Employee E, and dated 5/3/18 was reviewed. The RN assigned the HHA to do the following at each visit: shower, assist with dressing, hair care/shampoo, skin care, foot care, nail care. The HHA notes completed and signed by Employee A and dated 5/3/18, 5/7/18, 5/9/18, 5/10/18, 5/14/18, 5/16/18, 5/17/18, 5/21/18, 5/23/18, 5/30/18, 5/31/18, were reviewed. The notes failed to have documentation the personal care assigned was provided, the patient's refusal of care, reason for omission or that the nurse was informed. A HHA note dated 5/14/18 was reviewed and stated, "[Patient name] informed me of a rash on lower back area, lower abdomen, right hip and small areas on both of his/her legs. He/She states that he/she is using cream that his/her doctor ordered but is not working." The note failed to include documentation the nurse was notified of rash and patient's complaints. An interview was conducted with Employee A on 6/5/18 at 3:00 PM. Employee A reported he/ she informed the nurse on 5/14/18 of the rash, but didn't document the call but, reported patient # 3 refused personal care. An interview was conducted with Employee E on 6/5/18 at 3:50 PM regarding personal care not being provided as assigned by the HHA.		home health aide (HHA), verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Employee E reported he/ she would review aide assignment notes when he/ she was at the agency and "tries to get here (at the agency) at least weekly". Employee E reported she was not aware of the patient not getting a bath or personal hygiene care by the aide and he/ she expected the aide would have reported this to him/ her. Employee E reported the aide had called and only reported the rash.			
N 0604 Bldg. 00	410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist. Based on record review and interview, the HHA (Home Health Aide) failed to report changes observed in the patient's condition and needs to the supervisory nurse for 1 of 1 HHA (Employee A) and involving 3 of 3 patients (Patient # 1, 2, and 3) Findings include: 1. An agency policy titled, "Coordination of Care" dated 3/29/18 was reviewed and stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete current care plans and written and verbal interactions ... Purpose ... to ensure services are coordinated between members of the interdisciplinary team ... to establish effective interchange, reporting and coordination of client care does occur ... to modify the plan to reflect needs or changes identified by members of the	N 0604	The Administrator will provide an in-service to all external employees by 07/06/2018, which refers to Home Health Aide(s), including the employee mentioned within the findings. The in-service will include specific review of the outlined findings, review of omissions and re-education of the noted Coordination of Care policy. Evidenced by the executed in-service attendance log. In review of findings, the Administrator reviewed documentation policy and communication expectations with the Home Health Aide (HHA). HHA report, via weekly note, all refusals of care by the patient – if refusals trend throughout the week – HHA is to call the Clinical Manager (CM) to report the continued refusals. Administrator also reviewed that HHA will report	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	team ... to identify needs to modify the plan of care ... to provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided ... Special Instructions ... The primary nurse will assume responsibility for update/changing the care plan and communicating charges to caregivers ...the physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in client conditions ... client care will be coordinated with other agencies in the home ... this will be documented in the client records ... 2. An agency job description signed by Employee A and dated 2/16/18 and titled: Position: "HHA, Home Health Aide" Reports To : Nursing Supervisor/Administrator was reviewed and stated, "Responsibilities/essential functions: ...1. Follow the instructions of the nursing supervisor ... 3. Observe and report any safety hazards found in the client's home or any significant observations regarding the client ...4. Observe, report, and document patient status and the care or services furnished ... 3. The clinical record of Patient # 1 with a start of care date of 5/18/18 was reviewed with the following findings: A document titled "Aide Care Plan" signed by Employee E and dated 5/18/18 was reviewed with the following personal care instructions for each visit 2 times weekly: Shower, assist with dressing, shampoo/ hair care, skin care, foot care, nail care. A HHA daily record note dated 6/1/18 and signed by Employee A failed to include documentation the RN instructions for personal care were provided by the HHA. The document failed to include reason for omission of care or that the RN		any unusual findings and/or changes in patient's condition, behaviors or habits to the CM and document the reporting call on the daily visit note. If CM is not directly available in office, HHA was instructed to call office location to speak with member of internal team so they may triage the call to another internal RN. Immediately, for next 60 days, 100% of HHA weekly notes will be reviewed by the Nursing Supervisor to ensure adherence to corrective action – including the documentation verification of any HHA call to report findings and/or changes of condition. Ongoing, Nursing Supervisor/designee will note any refusal of care trends while processing weekly notes. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor or designee on 15 active client charts, or 20% - whichever is larger, to ensure the home health aide (HHA) appropriately reports any/all changes observed in the patient's condition and needs to the supervisory nurse, verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	had been informed. An interview was conducted with Employee E on 6/6/18 at 4:30 PM and he/ she reported not being aware personal care was not done on 6/1/18 by the HHA. 4. The clinical record of patient # 2 was reviewed with the following findings: A home health aide note by Employee A, dated 5/4/18 was reviewed and stated, "right side on top of his/her scalp there is a raised lump that is the size of a dime. He/ she will be having his/ her Dr. look at it on his/her next visit which is June 10th, 2018 at PM." There was no documentation the nurse was informed. An interview was conducted with Employee E on 6/5/18 at 1:45 PM. Employee E reported the HHA did not inform him/her of lump on scalp and his/ her expectation was that the HHA will report new observation and changes. 6. The clinical record of patient # 3 was reviewed with the following findings: A HHA care plan developed by Employee E, and dated 5/3/18 was reviewed. The RN assigned the HHA to do the following at each visit: shower, assist with dressing, hair care/shampoo, skin care, foot care, nail care. The HHA notes completed and signed by Employee A and dated 5/3/18, 5/7/18, 5/9/18, 5/10/18, 5/14/18, 5/16/18, 5/17/18, 5/21/18, 5/23/18, 5/30/18, 5/31/18, were reviewed. The notes failed to have documentation that the personal care assigned was provided, the patient's refusal of care, reason for omission or that the nurse was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	informed. An interview was conducted with Employee E on 6/5/18 at 3:50 PM regarding personal care not being provided as assigned by the HHA. Employee E reported she was not made aware that the patient wasn't getting a bath or was not receiving personal hygiene care by the aide and he/ she expected the aide would have reported this to him/ her.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on observation , record review and interview, the agency failed to ensure the Medical Plan of Care included all DME (durable medical equipment), diagnosis, medications, and current activity orders for 3 of 3 clinical records reviewed. (Patients # 1, 2, and 3)	N 0608	The Administrator will provide an in-service to all internal employees by 07/06/2018, which refers to Clinical Manager(s). The in-service will include specific review of the outlined findings, review of omissions and	07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Findings Include: 1. An agency policy titled, "Plan of Treatment" was reviewed and stated, "The plan of treatment shall be developed in consultation with the agency staff and shall cover pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral and other appropriate items ... The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care ... Nursing Plan of Care ... A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The nursing plan of care must contain the following: 1. A plan of care and appropriate patient identifying information, 2. The name of the patient's physician 3. Services to be provided 4. the frequency and duration of visits, 5. Medications, diet and activities 6. Signed and dated clinical notes from all personnel providing services ...." 2. The clinical record of Patient # 1 with a start of care date of 5/18/18 and a hospitalized from 5/23/18 to 5/30/18 was reviewed with the following findings: The plan of care dated 5/18/18 was reviewed and included the following medication: Atrovastatin		re-education of the noted Plan of Treatment policy. Evidenced by the executed in-service attendance log. Immediately, 100% review of active client charts was completed with the previously outlined corrective actions (N-0524) to ensure 100% compliance. Medical record reviews will be completed per client upon admission, recertification and/or resumption of care by the Administrator/Nursing Supervisor/Designee. Ongoing, quarterly chart reviews will be conducted by Nursing Supervisor/designee on 15 active clients records, or 20% - whichever is larger, to ensure the plan of care includes all DME, diagnosis, medication and current activity orders for the patient, verifying this deficiency is corrected. Should any findings/trends occur, they will be reported to the Administrator to be entered into the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	Calcium (Lipitor) 40 mg 1 tablet daily by mouth at bedtime (medication to reduce cholesterol). An interview was conducted with Patient # 1 during a home visit observation on 6/6/18 at 2:08 PM. The patient reported the Atrovastatin Calcium had been discontinued when he/she was discharged from the hospital on 5/30/18. The clinical record failed to include orders to discontinue the Atrovastatin Calcium to update the plan of care. Employee E was interviewed at time of home visit observation on 6/6/18 at 2:08 PM and reported he/she had not obtained discharge orders from the hospital and was not aware of the change in medication orders. Employee E was interviewed on 6/7/19 at 11:00 AM and reported he/she had not communicated with the physician to update the plan of care to include transfer orders to the hospital 5/23/18, hold orders for services from 5/25/18 to 5/30/18 and resumption of services on 5/31/18. The plan of care included the following (DME) durable medial equipment and supplies: "OSHA kit, CPR shield, gloves, hand sanitizer, oxygen concentrator and supplies, nebulizer, glucometer and supplies, shower chair, wheeled walker." The plan of care failed to include needles and/or syringes for insulin injections. The diagnosis on the POC for 5/18/18 included : Cerebral infarction due to embolism of unspecified cerebral artery, Type 2 diabetes mellitus with diabetic neuropathic arthorpathey, Chronic obstructive pulmonary disease, dependence of supplemental oxygen. The admission summary included the following diagnosis not listed: open heart surgery, foot fracture, GERD (gastric reflux) gout, seasonal allergies. There was no updated order to add the current new diagnosis of GI bleed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	that occurred on 5/23/18. The frequency of visits listed for the plan of care included: SN (skilled nurse) every 30 days for supervisory visits and HHA (home health aide) 3 hours a day /2 days per week , not to exceed 6 hours. The HHA services began on 5/23/18 and orders obtained for services 5/25/18. Employee E was interviewed at time of home visit observation on 6/6/18 at 2:08 PM and reported he/ she had not obtained discharge orders from the hospital and was not aware of the change in medication orders. Employee E was interviewed on 6/7/19 at 11:00 AM and reported he/ she had not updated the plan of care to include transfer orders to the hospital 5/23/18, hold orders for services from 5/25/18 to 5/30/18 and resumption of services on 5/31/18. 3. The clinical record of Patient # 2, with a start of care date of 5/16/18 was reviewed with the following finding: The DME on the POC included : pain pump, oxygen , 2 wheeled walker, glucometer, testing supplies, insulin, needles and syringes, nebulizer, CPAP (machine for sleep apnea), shower chair. The plan of care failed to include the a wheel chair and raised toilet seat observed during a home visit conducted on 6/6/18 at 12:58 AM. Employee E reported at the time of the home visit he/she had not noticed the wheelchair or raised toilet seat in the home. The diagnosis on the POC included: Malignant neoplasm of unspecific site of unspecified female breast, pathological fracture / neoplastic disease,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	left femur, chronic obstructive pulmonary disease, Type 2 diabetes mellitus with diabetic nephropathy. The admission summary listed the following diagnosis not listed: oxygen dependence, bipolar, hypertension, GERD, presence of pain pump, obesity. The frequency of visits listed for the plan of care included: HHA 3 hours/ 2 days week. The aide services did not begin until the second week on 5/22/18. There were no orders to update the plan of care regarding the omission of 2 HHA visits on week 1 of the POC. An interview was conducted with Employee E on 6/5/18 at 4:40 PM. There was not further documentation to be provided. 4. The clinical record of Patient # 3, with a start of care date of 5/3/18 was reviewed with the following findings: The DME on the POC included: rolling walker, nebulizer, glucometer, testing strips. The patient's plan of care medication orders included: Humalog 100 units/ml inject sliding scale dosage subcutaneous three times daily with meals. The DME failed to include needles and/ or syringes to inject the insulin. Employee E was interviewed on 6/5/18 at 4:40 PM and reported there was not further documentation to be provided. The frequency of visits listed for the plan of care included : HHA 4 hours a day/ 3 days per week, not to exceed 12 hours week. The aide services began on week 5/7/18. There were no orders to update the plan of care regarding the omission of 2 HHA visits on week 1 of the POC. On 5/30/18 (week 5 of the POC) the HHA visit was 6 hours and there were no other visits that week. There			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - MUNCIE	400 W AIRPARK DRIVE MUNCIE, IN 47303

(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
	were not orders to update the plan of care to change the length of the visit or omission of the second visit that week. Employee E was interviewed on 6/5/18 at 4:40 PM regarding the plan of care and HHA frequency. He/ she reported there was no further documentation to be provided.			