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	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

(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		N 0000		
	This visit was an initial state licensure survey of a home health agency. Survey dates: 7/24/18-7/25/18 Facility ID: 014339 Patient census: 3 Home visits: 2			
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 the registered nurse documented his/ her efforts with coordination with the patient and the patient's physician related to continuity of wound care in 1 of 2 patients with wounds in a sample of 3 records reviewed. (#3) Findings include: 1. An agency policy, dated March 21, 2012, titled, "Plan of Treatment", stated, " .... 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 .... ". 2. Record review of patient number 3, certification period 7/9/18 to 9/6/18, included the diagnoses disruption of external operation (surgical) wound,	N 0486	During discussion of outlined findings between Administrator and Clinical Manager (CM), it was noted that coordination efforts were made however was substantiated by Administrator that no written communication was completed per policy. In correction of outlined findings, it is to be noted that late documentation entries have been completed to include care coordination with patient and MD/Surgeon. These entries include conversation with client, caregiver, MD, Area IV case manager and the surgeon overseeing surgical wound. The Administrator will provide an in-service to all internal employees by 08/08/2018, which refers to	08/08/2018

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

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	malignant neoplasm of colon, and type 2 diabetes mellitus with orders for visits from a skilled nurse and home health aide. A supplemental physician's order, dated 7/9/18, stated, "1. Evaluate for skilled nursing services for wound care. 2. Consult [physician] for wound care orders". The order was signed, timed, and dated by a registered nurse. A Comprehensive nursing admission assessment, dated 7/9/18, evidenced the rectal wound dressing was changed by the SN and that the physician was updated of the wound status. In the narrative notes, the SN stated, " .... MD [medical doctor] wishes to continue with orders for wound care daily. Client to return to office on 7/23/18". An additional supplemental physician's order, dated 7/9/18, stated, "Wound care to rectal wound via clean technique [sic] as follows: 1. Irrigate with normal saline, 2. Apply barrier cream to peri wound area, 3. Pack wound with normal saline moistened gauze, 4. Cover with folded gauze. Wound care daily by SN [skilled nurse] 2 days/ week and caregiver/ family trained by surgeon 5 days/ week". The order was signed, timed, and dated by a registered nurse. Record review evidenced SN visits on 7/13/18 and 7/16/18. There were no further visits made by the SN. 3. An interview with the clinical manager on 7/24/18 at 3:30 PM was conducted regarding the missed visits. The clinical manager stated, "That was more than we coud handle, the [family member] was never home for teaching" of wound care. We ended that care on Friday (7/20/18). The doctor wants the dressing changed 7 days per		Clinical Manager. The in-service will include specific review of outlined findings, review of missteps/omission and re-education of the noted plan of treatment policy. Evidenced by the executed in-service attendance log. Immediately, for the next 60 days, 100% of all changes in condition/additional service requests will be reported to the Administrator to allow for observation of the internal care coordination process to ensure the deficiency has been corrected. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client charts, or 20% - whichever is larger, to ensure services are being properly coordinated with all other health providers serving the patient, verifying this deficiency is corrected. Should any findings/trend 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.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

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	week so [patient] really needs a wound clinic." When asked if the patient was aware of this, the clinical manager stated, "her doctor is talking with her today." 4. A review of a 5/30/18 nursing note from the discharged record that was provided on 7/25/18 at 2:00 PM, indicated the family was observed providing the same treatment that was currently ordered without problems and the patient declined skilled nursing services due to he/ she felt the current system in place was sufficient. 5. An interview on 7/25/18 at 3:00 PM, the clinical manager confirmed the last skilled nurse visit was on 7/16/18 due to the patient had physician appointments on 7/20, 7/23, and 7/24/18. When voiced concerns for the patient's wound, the clinical manager stated "I haven't heard from the patient but I left a message." The clinical manager then stated that the physician wanted the patient to have a wound vac [vacuum assisted closure of a wound] and he/ she had a "long conversation" with the patient on Thursday, 7/19/18, "to try and talk [the patient] into the wound vac and to seek care at a wound clinic". The clinical record failed to evidence documenation of conversations between the clinical manager, the patient, and the patient's physician regarding future care of the patient's wound.			
N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.			

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ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

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	Based on record review and interview, the agency failed to ensure that patients were accepted for treatment with the expectation that their needs would be met in their residence in 1 of 2 patient records with wounds in a sample of 3. (#3) Findings include: 1. An agency policy, dated March 21, 2012, titled, "Admission Criteria", stated, " ... 1. Clients are accepted for Home Health Services based on a reasonable expectation that the client's health care needs can be met adequately by the home health agency in the client's residence. ... c. An initial health assessment must be performed in the client's residence by a Registered Nurse 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. Record review of patient number 2 contained a plan of care for certification period 6/4/18 to 8/2/18 with orders for, "HHA [home health aide] to provide 3 hours a day/2 days per week, not to exceed 6 hours per week throughout the certification period". A physician's order, dated 6/6/18, stated, " .... Starting 6/11/18 client's HHA schedule to change to 3 hours/day/week not to exceed 9 hours/week per family request .... ". Clinical records evidenced one (1) aide visit during the week of 7/1 to 7/7/18, one (1) visit during the week of 7/8 to 7/14/18, and two (2) visits during the week of 7/15 to 7/21/18. HHA services were provided on 7/4/18, 7/13/18, 7/16/18, and 7/18/18 only. The aide failed to follow the updated plan of care.	N 0520	The Administrator will provide an in-service to all internal employees by 08/08/2018, which refers to Clinical Manager. The in-service will include specific review of outlined findings, review of missteps/omission and re-educations of noted admission criteria policy. Additional re-education provided that if frequency isn't followed MD is to be notified and documented in patient chart. Evidenced by the executed in-service attendance log. Ongoing, Clinical Manager/designee will ensure orientation of newly hired RNs will include instruction on documenting all conversations with MD in patient chart. Clinical Manager/designee will instruct RNs on need to notify MD immediately when agency is unable to meet patient's needs/missed visits and document in patient chart. Clinical Manager/designee will ensure orientation of newly hired RNs includes instruction on need to notify MD when agency is unable to meet patient's needs/missed visits and document in patient chart. Any RN found to not be in compliance with notifying MD on agency's inability to meeting patient needs/missed visits will be re-instructed within five (5) business days. Immediately, Clinical	08/08/2018

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

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	During an interview on 7/24/18 at 2:30 PM, the clinical manager stated, "The aide was sick that week" in relation to the missed visits between 7/5 to 7/12/18. The clinical manager stated the agency only has one aide and they were unable to staff the missed visits. 3. Record review of patient number 3 contained an updated plan of care, start of care 7/9/18, for certification period 7/9/18 to 9/6/18, and included diagnoses disruption of external operation (surgical) wound, malignant neoplasm of colon, and type 2 diabetes mellitus. The plan of care included orders for visits from a skilled nurse (SN) visits 2 times a week for wound care and home health aide visits 3 hours a day 2 days a week. The agency failed to ensure patient #3 was accepted for treatment with the expectation that his/ her needs would be met as evidenced by: A supplemental unsigned physician's order, dated 7/9/18 at 10:00 AM, stated "OK for RN to assess the client in the home to determine medical necessity for SN PA (prior authorization for medicaid) services, which includes wound care for rectal surgical wound, in addition to HHA PA services ... If client meets eligibiity, they will be admitted for services." The order was signed, timed, and dated by a registered nurse. A Comprehensive nursing admission assessment dated 7/9/18, evidenced the rectal wound dressing was changed by the SN and that the physician was updated of the wound status. In the narrative notes, the SN stated, " .... MD [medical doctor] wishes to continue with orders for wound care daily. Client to return to office on 7/23/18". A supplemental unsigned physician's order, dated 7/9/18 at 12:20 PM, stated, "Wound care to rectal		Manager/designee will audit 100% of patient charts weekly to ensure compliance with notifying MD of inability to meet patient needs/missed visits. Once 100% compliance is achieved, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client charts, or 20% - whichever is larger, to ensure ongoing compliance and that 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.	

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	wound via clean technique [sic] as follows: 1. Irrigate with normal saline, 2. Apply barrier cream to peri wound area, 3. Pack wound with normal saline moistened gauze, 4. Cover with folded gauze. Wound care daily by SN [skilled nurse] 2 days/ week and caregiver/ family trained by surgeon 5 days/ week". The order was signed, timed, and dated by a registered nurse. A supplemental unsigned physician's order dated 7/9/18 at 4:00 PM, stated skilled nursing 1 hour a day, 2 days a weekto include wound care after hower and home health aide services 3 hours a day, 4 days a week. A skilled nursing visit note dated 7/16/18, indicated wound care would be provided after shower on home health aide days due to a family member was not available. Record review evidenced additional SN visit on 7/13/18. There were no further visits made by the SN. Record review evidenced one (1) aide visit during the week of 7/9/18 to 7/14/18 and two (2) aide visits during the week of 7/15/18 to 7/20/18. HHA services were provided on 7/13/18, 7/16/18, and 7/20/18 only. The home health aide failed to follow the updated medical plan of care. 4. An interview with the clinical manager on 7/24/18 at 3:30 PM was conducted regarding the missed visits. The clinical manager stated, "That was more than we coud handle, the [family member] was never home for teaching" of wound care. We ended that care on Friday (7/20/18). The doctor wants the dressing changed 7 days per week so [patient] really needs a wound clinic." When asked if the patient was aware of this, the			

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	clinical manager stated, "her doctor is talking with her today." 5. A review of a 5/30/18 nursing note from the discharged record that was provided on 7/25/18 at 2:00 PM, indicated the family was observed providing the same treatment that was currently ordered without problems and the patient declined skilled nursing services due to he/ she felt the current system in place was sufficient. 6. An interview on 7/25/18 at 3:00 PM, the clinical manager confirmed the last skilled nurse visit was on 7/16/18 due to the patient had physician appointments on 7/20, 7/23, and 7/24/18. When voiced concerns for the patient's wound, the clinical manager stated "I haven't heard from the patient but I left a message." The clinical manager then stated that the physician wanted the patient to have a wound vac [vacuum assisted closure of a wound] and he/ she had a "long conversation" with the patient on Thursday, 7/19/18, "to try and talk [the patient] into the wound vac and to seek care at a wound clinic". 6. At the exit conference on 7/25/18 at 4:00 PM the staff had no further information to add.			
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 record review and interview, the agency failed to ensure that the home health aide followed the plan of care in 1 of 2 records reviewed (#2) of patients receiving home health aide with skilled	N 0522	In correction of findings, 100% of patient charts have been audited and all outstanding HHA visit notifications have been sent to MD and placed in charts. MD has	08/08/2018

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	services and the skilled nurse failed to followed the plan of care in 1 of 2 patient records reviewed of patient with skilled nursing in a sample of 3. (#3) Findings included: 1. An agency policy, dated March 21, 2012, titled, "Plan of Treatment", stated, " .... Medical care shall follow a written medical plan of care established and periodically reviewed by the physician .... ". 2. Record review of patient number 3 contained an updated plan of care, start of care 7/9/18, for certification period 7/9/18 to 9/6/18, and included diagnoses Disrupt of external operation (surgical) wound, Malignant neoplasm of colon, and Type 2 diabetes mellitus. The plan of care included orders for wound care to be provided by a SN [skilled nurse] 2 days/ week and HHA 3 hours a day, 2 days a week. The skilled nurse and home health aide failed to follow the updated plan of care as evidenced by: A supplemental unsigned physician's order dated 7/9/18 at 4:00 PM, stated skilled nursing 1 hour a day, 2 days a week to include wound care after shower and home health aide services 3 hours a day, 4 days a week. Record review evidenced additional SN visits were made on 7/13, and 7/16/18. The record failed to evidence any further visits made by the SN. Record review evidenced one (1) aide visit during the week of 7/9/18 to 7/14/18 and two (2) aide visits during the week of 7/15/18 to 7/20/18. HHA services were provided on 7/13/18, 7/16/18, and 7/20/18 only. The record failed to evidence any		been notified and missed SN visits, including correction order, was generated and sent. All logged clarifying communications surrounding missed visits have also been printed and placed in patient charts. The Administrator will provide an in-service to all internal employees by 08/08/2018, which refers to Clinical Manager. The in-service will include specific review of outlined findings, review of missteps/omissions and re-education on the noted plan of treatment policy. Evidenced by the executed in-service attendance log. Specifically, time was spent in re-education to RN staff on need to follow MD ordered frequency. If frequency isn't followed, MD is to be notified and documented in patient chart. RNs re-educated on need to document conversations with MD in patient chart. Ongoing, Clinical Manger/designee will ensure orientation of newly hired RNs will include instruction on documenting all conversations with MD in patient chart. Clinical Manager/designee will instruct RNs on need to notify MD immediately when agency is unable to meet patient's needs/missed visits and document in patient chart. Clinical Manager/designee will ensure orientation of newly hired RNs	

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	further visits made by the HHA. On 7/25/18 at 3:00 PM, the clinical manager stated the reason for missed SN visits, "The patient had a doctor's appointment on 7/20/18, 7/23/18, and 7/24/18". The clinical manager stated, "I haven't heard from the patient but I left a message". 3. No further information was offered during the exit conference on 7/25/18 at 4:00 PM.		includes instruction on need to notify MD when agency is unable to meet patient's needs/missed visits and document in patient chart. Any RN found to not be in compliance with notifying MD on the agency's inability to meet patient needs/missed visits will be re-instructed within five (5) business days. Ongoing, in the case of missed visits due to illness or otherwise, the Agency will work to send a replacement home health aide (HHA) if one is available. If no replacement HHA is available for the regularly scheduled visit, the Agency will work to reschedule the missed visit with the family when appropriate and within the guidelines of the payer (when applicable). In an extreme circumstance, at the determination of the Clinical Manager (CM), the HHA visit may be provided by the CM to ensure ongoing patient safety is maintained. If neither solution is available and/or applicable, the Agency will follow the missed visit practice outlined above. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client charts, or 20% - whichever is larger, to ensure 100% compliance is being maintained. Should any findings/trends occur, they will be reported to the Administrator to be entered into	

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			the QAPI data cycle to determine necessity of internal plan of correction and/or heightened monitoring.	
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) 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. (b) 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. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. Based on record review and interview, the agency failed to ensure that the home health aide followed the nursing plan of care in 1 of 1 record reviewed of patients receiving home health aide only services (#2) in a sample of 3. Findings included: 1. Record review of patient number 2 contained a	N 0533	In correction of findings, specifically the noted record, the signed MD order was received on 07/26/18. Missed visit notification was sent to the MD on 07/25/18, returned executed on 07/26/18. Both were placed in the patient chart on 07/28/18. The Administrator was able to substantiate the noted lack of	08/08/2018

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	plan of care for certification period 6/4/18 to 8/2/18 with orders for, "HHA [home health aide] to provide 3 hours a day/ 2 days per week, not to exceed 6 hours per week throughout the certification period". The skilled nurse and home health aide failed to follow the updated plan of care as evidenced by: An unsigned physician's order, dated 6/6/18, stated, " .... Starting 6/11/18 client's HHA schedule to change to 3 hours/ day, 3 days/ week not to exceed 9 hours/ week per family request .... " Clinical records evidenced one (1) aide visit during the week of 7/1 to 7/7/18, one (1) visit during the week of 7/8 to 7/14/18, and two (2) visits during the week of 7/15 to 7/21/18. HHA services were provided on 7/4/18, 7.13.18, 7/16/18, and 7/18/18. The record failed to evidence any further visits made by the HHA. 2. During an interview on 7/24/18 at 2:30 PM, the clinical manager stated, "The aide was sick that week" in relation to the missed visits between 7/5 to 7/12/18. The clinical manager stated the agency only has one aide and they were unable to staff the missed visits.		coordination specific to HHA availability and coordination. Missed visit notifications will now be addressed on the date the missed visit occurs, agencies first knowledge, rather than waiting until the end of week leaving a potential to miss the notification. After being send to MD, missed visits forms will be placed in the patient chart. The Administrator will provide an in-service to all internal employees by 08/08/18, which refers to Clinical Manager. The in-service will include specific review of outlined findings, review of missteps/omissions and re-education on the noted plan of treatment policy and home health aide care plan policy. Evidenced by the executed in-service attendance log. Clinical Manager/designee will ensure orientation/instruction of newly hired RNs on care coordination efforts specific to missed visits – including documentation of MD conversation and subsequent charting requirements. Any RN found not to be in compliance with notifying MD regarding missed visits will be re-instructed within five (5) business days. Ongoing, in the case of missed visits due to illness or otherwise, the Agency will work to send a replacement home health aide (HHA) if one is available. If no	

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ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

(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
			replacement HHA is available for the regularly scheduled visit, the Agency will work to reschedule the missed visit with the family when appropriate and within the guidelines of the payer (when applicable). In an extreme circumstance, at the determination of the Clinical Manager (CM), the HHA visit may be provided by the CM to ensure ongoing patient safety is maintained. If neither solution is available and/or applicable, the Agency will follow the missed visit practice outlined above. Ongoing, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active client charts, or 20% - whichever is larger, to ensure 100% compliance is being maintained. 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 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on record review and interview, the agency failed to ensure the registered nurse followed the	N 0537	The Administrator will be provide an in-service to all internal employees by 08/08/18, which	08/08/2018

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		A. BUILDING 00 B. WING	07/25/2018

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ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

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	physician's orders on the plan of care in 1 of 2 patient records reviewed with skilled nursing in a sample of 3. (#3) Finding includes: 1. An agency policy, dated March 21, 2012, titled, "Plan of Treatment", stated, " .... Medical care shall follow a written medical plan of care established and periodically reviewed by the physician .... ". 2. Record review of patient number 3 contained an updated plan of care, start of care 7/9/18, for certification period 7/9/18 to 9/6/18, and included diagnoses Disrupt of external operation (surgical) wound, Malignant neoplasm of colon, and Type 2 diabetes mellitus. The plan of care included orders for wound care to be provided by a SN [skilled nurse] 2 days/ week and HHA 3 hours a day, 2 days a week. The skilled nurse and home health aide failed to follow the updated plan of care as evidenced by: A supplemental unsigned physician's order dated 7/9/18 at 4:00 PM, stated skilled nursing 1 hour a day, 2 days a week to include wound care after shower and home health aide services 3 hours a day, 4 days a week. Record review evidenced additional SN visits were made on 7/13, and 7/16/18. The record failed to evidence any further visits made by the SN. Record review evidenced one (1) aide visit during the week of 7/9/18 to 7/14/18 and two (2) aide visits during the week of 7/15/18 to 7/20/18. HHA services were provided on 7/13/18, 7/16/18, and 7/20/18 only. The record failed to evidence any further visits made by the HHA.		refers to Clinical Manger. The in-service will include specific review of outlined findings, review of missteps/omissions and re-education of noted plan of treatment policy. Specific re-education focus provided towards compliance in MD ordered frequency. Evidenced by the executed in-service attendance log. Ongoing, Clinical Manager/designee will ensure orientation of newly hired RNs will include instruction on need to notify MD when agency is unable to meet patient's needs/missed visits and the subsequent documentation. All communication to be placed into the patient chart. Any RN found to not be in compliance with notifying MD on agency's inability to meeting patient needs/missed visits will be re-instructed within five (5) business days. Ongoing, in the case of missed visits due to illness or otherwise, the Agency will work to send a replacement home health aide (HHA) if one is available. If no replacement HHA is available for the regularly scheduled visit, the Agency will work to reschedule the missed visit with the family when appropriate and within the guidelines of the payer (when applicable). In an extreme circumstance, at the determination of the Clinical	

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	On 7/25/18 at 3:00 PM, the clinical manager stated the reason for missed SN visits, "The patient had a doctor's appointment on 7/20/18, 7/23/18, and 7/24/18". The clinical manager stated, "I haven't heard from the patient but I left a message". 3. No further information was offered during the exit conference on 7/25/18 at 4:00 PM.		Manager (CM), the HHA visit may be provided by the CM to ensure ongoing patient safety is maintained. If neither solution is available and/or applicable, the Agency will follow the missed visit practice outlined above. Ongoing, quarterly chart audits will be conducted by the Nursing Supervisor/designee on 15 active client charts, or 20% - whichever is larger, to ensure ongoing compliance and that this 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 internal plan of correction and/or heightened monitoring.	
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 registered nurse failed to ensure his/ her efforts of coordination/ communication was documented with the patient and the patient's physician related to continuity of wound care in 1 of 2 patients with wounds in a sample of 3 records reviewed. (#3) Findings include:	N 0545	The Administrator will provide an in-service to all internal employees by 08/08/2018, which refers to Clinical Manager. The in-service will include specific review of the outlined findings, review of omissions and re-education on the noted plan of treatment policy. Evidenced by the executed in-service attendance log.	08/08/2018

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	1. An agency policy, dated March 21, 2012, titled, "Plan of Treatment", stated, " .... 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 .... ". 2. Record review of patient number 3, certification period 7/9/18 to 9/6/18, included the diagnoses disruption of external operation (surgical) wound, malignant neoplasm of colon, and type 2 diabetes mellitus with orders for visits from a skilled nurse and home health aide. A supplemental physician's order, dated 7/9/18, stated, "1. Evaluate for skilled nursing services for wound care. 2. Consult [physician] for wound care orders". The order was signed, timed, and dated by a registered nurse. A Comprehensive nursing admission assessment, dated 7/9/18, evidenced the rectal wound dressing was changed by the SN and that the physician was updated of the wound status. In the narrative notes, the SN stated, " .... MD [medical doctor] wishes to continue with orders for wound care daily. Client to return to office on 7/23/18". An additional supplemental physician's order, dated 7/9/18, stated, "Wound care to rectal wound via clean technique [sic] as follows: 1. Irrigate with normal saline, 2. Apply barrier cream to peri wound area, 3. Pack wound with normal saline moistened gauze, 4. Cover with folded gauze. Wound care daily by SN [skilled nurse] 2 days/ week and caregiver/ family trained by surgeon 5 days/ week". The order was signed, timed, and dated by a registered nurse.		Additionally, instruction was provided specific ensuring MD disciplines/frequencies are being followed and care coordination is occurring with all parties involved in the care continuum. Ongoing, Clinical Manager/designee will ensure orientation of newly hired RNs will include instruction on documenting all conversations with MD in patient chart. Clinical Manager/designee will instruct RNs on need to notify MD immediately when agency is unable to meet patient's needs/missed visits and document in patient chart. Clinical Manager/designee will ensure MD disciplines and frequencies are being followed as ordered. Clinical Manager/designee will ensure orientation of newly hired RNs includes instruction on need to notify MD when agency is unable to meet patient's needs/missed visits and document in patient chart. Any RN found to not be in compliance with notifying MD on agency's inability to meeting patient needs/missed visits will be re-instructed within five (5) business days. 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%	

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	Record review evidenced SN visits on 7/13/18 and 7/16/18. There were no further visits made by the SN. 3. An interview with the clinical manager on 7/24/18 at 3:30 PM was conducted regarding the missed visits. The clinical manager stated, "That was more than we coud handle, the [family member] was never home for teaching" of wound care. We ended that care on Friday (7/20/18). The doctor wants the dressing changed 7 days per week so [patient] really needs a wound clinic." When asked if the patient was aware of this, the clinical manager stated, "her doctor is talking with her today." 4. A review of a 5/30/18 nursing note from the discharged record that was provided on 7/25/18 at 2:00 PM, indicated the family was observed providing the same treatment that was currently ordered without problems and the patient declined skilled nursing services due to he/ she felt the current system in place was sufficient. 5. An interview on 7/25/18 at 3:00 PM, the clinical manager confirmed the last skilled nurse visit was on 7/16/18 due to the patient had physician appointments on 7/20, 7/23, and 7/24/18. When voiced concerns for the patient's wound, the clinical manager stated "I haven't heard from the patient but I left a message." The clinical manager then stated that the physician wanted the patient to have a wound vac [vacuum assisted closure of a wound] and he/ she had a "long conversation" with the patient on Thursday, 7/19/18, "to try and talk [the patient] into the wound vac and to seek care at a wound clinic". The clinical record failed to evidence documenation conversations between the clinical		-whichever is larger, to ensure compliance of MD discipline/frequency orders and 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	

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	manager, the patient, and the patient's physician regarding future care of the patient's wound.			
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 record review and interview, the agency failed to ensure a patient's clinical record was clear and contained all pertinent information in 1 of 1 patients who was hospitalized and readmitted in a sample of 3. (#3) Finding includes: 1. An agency policy, dated March 21, 2012, titled, "Clinical Records", stated, " .... A clinical record containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient receiving home health care services .... ".	N 0608	The Administrator will provide an in-service to all internal employees by 08/08/2018, which refers to Clinical Manager. The in-service will include specific review of the outlined findings, review of omissions and re-education on the noted clinical records policy. Including needs for discharged patients to have discharge order, discharge summary and discharge assessment as appropriate. Evidenced by the executed in-service attendance log. In regards to the corrections to	08/08/2018

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	2A. Record review of a discharged record for patient number 3, inital SOC (start of care) 5/30/18, contained an unsigned plan of care for the certification period of 5/30/18 to 7/28/18. The discharged record evidenced an unsigned physician order dated 6/16/18, indicating the patient was transferred into the hospital for an ileus and urinary tract infection. The discharged record evidenced a transfer summary report dated 6/16/18, indicating the patient had severe abdominal pain, vomiting, and little output from his/ her colostomy. The discharged record evidenced an unsigned physician order dated 6/26/18, indicating the patient returned home from the hospital on 6/23/18, and for services to resume. The clinical record also evidenced a resumption of care comprehensive assessment dated 6/26/18. HHA visits were provided on 6/29, 7/2, and 7/6/18. No further SN visits were provided. The clinical manager was interviewed on 7/25/18 at 2:00 PM. When asked about the reason for the discharge and readmission, the clinical manager stated the agency discharged and readmitted because the SN visits were added and wanted to be consistent with the OASIS, even though this was a survey for state license only. The discharged record failed to evidence a discharge order, discharge assessment, discharge summary, or documentation for the reason of the discharge and readmission. The clinical record also failed to evidence a physician signature had been obtained for the 5/30 to 7/28/18 plan of care, 6/16/18 and 6/26/18 physician orders.		record(s) in question the client was put on hold for hospitalization, received a resumption of care, then was discharged from HHA and readmitted to include SN. This process was completed per internal guidance, however after surveyor and reviewer remarks it is substantiated that this discharge/readmit did not need to occur and the process will be looked at moving forward. All orders for hold, resumption and discharge have been signed by the MD and placed in to the chart. Ongoing, Clinical Manager will review all potential admissions/discharges or any changes in services with the Administrator to ensure appropriateness in actions and effectiveness in communication. In correction and ongoing, (1) the Clinical Manager (CM)/designee will ensure all MD orders for charts cited in this survey have been signed. Any orders not signed will be sent to MD for signature. (2) All discharged charts will be audited by CM/designee to ensure all MD orders are signed. Once 100% compliance is achieved, all client discharges will have a chart audited completed by CM/designee prior to chart deconstruction to ensure this deficiency remains corrected. (3) All charts will be reviewed by CM/designee to ensure any orders outside of thirty (30) days get	

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	2B. Record review of the current clinical record for patient #3 evidenced a referral, start of care orders, new admission comprehensive assessment, and plan of care indicating a start of care for 7/9/18 and a certification period of 7/9/18 to 9/6/18, included the diagnoses disruption of external operation (surgical) wound, malignant neoplasm of colon, and type 2 diabetes mellitus with orders for visits from a skilled nurse and home health aide. A supplemental unsigned physician's order dated 7/9/18 at 10:00 PM, stated, "1. Evaluate for skilled nursing services for wound care. 2. Consult [physician] for wound care orders". The order was signed, timed, and dated by a registered nurse. A supplemental unsigned physician's order, dated 7/9/18 at 12:20 PM, stated, "Wound care to rectal wound via clean technique [sic] as follows: 1. Irrigate with normal saline, 2. Apply barrier cream to peri wound area, 3. Pack wound with normal saline moistened gauze, 4. Cover with folded gauze. Wound care daily by SN [skilled nurse] 2 days/ week and caregiver/ family trained by surgeon 5 days/ week". The order was signed, timed, and dated by a registered nurse. A Comprehensive nursing admission assessment dated 7/9/18 from 2:15 to 3:10 PM, evidenced the rectal wound dressing was changed by the SN and that the physician was updated of the wound status. In the narrative notes, the SN stated, " .... MD [medical doctor] wishes to continue with orders for wound care daily. Client to return to office on 7/23/18". Record review evidenced additional SN visits on		signed and placed into chart. (4) CM/designee will implement a tracking system for MD orders to ensure they are returned with MD signature within thirty (30) days as required. (5) CM/designee will audit all outstanding orders daily, business days, to ensure ongoing compliance. (6) Newly hired RNs will be instructed on MD order tracking system by CM/designee. (6) CM/designee will ensure orientation of newly hired RNs includes need for discharged patient's to have a discharge order, discharge summary and discharge assessment as appropriate. (7) CM/designee will audit all discharged charts to ensure they have discharge order, discharge assessment and discharge summary as appropriate. Once 100% compliance is achieved, all client discharges will have a chart audit completed by CM/designee prior to chart deconstruction to ensure this deficiency remains corrected. (8) Any RN not found to be compliant with the discharge process will be re-instructed within five (5) business days by the CM/designee. Additionally, (9) CM/designee will ensure orientation of newly hired RNs includes instruction on documenting all conversations with MD in patient chart, including those to notify MD when agency is unable to meet patient's	

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	7/13/18 and 7/16/18. There were no further visits made by the SN. An interview with the clinical manager on 7/24/18 at 3:30 PM was conducted regarding the missed visits. The clinical manager stated, "That was more than we coud handle, the [family member] was never home for teaching" of wound care. We ended that care on Friday (7/20/18). The doctor wants the dressing changed 7 days per week so [patient] really needs a wound clinic." When asked if the patient was aware of this, the clinical manager stated, "her doctor is talking with her today." A review of a 5/30/18 nursing note from the discharged record that was provided on 7/25/18 at 2:00 PM, indicated the family was observed providing the same treatment that was currently ordered without problems and the patient declined skilled nursing services due to he/ she felt the current system in place was sufficient. An interview on 7/25/18 at 3:00 PM, the clinical manager confirmed the last skilled nurse visit was on 7/16/18 due to the patient had physician appointments on 7/20, 7/23, and 7/24/18. When voiced concerns for the patient's wound, the clinical manager stated "I haven't heard from the patient but I left a message." The clinical manager then stated that the physician wanted the patient to have a wound vac [vacuum assisted closure of a wound] and he/ she had a "long conversation" with the patient on Thursday, 7/19/18, "to try and talk [the patient] into the wound vac and to seek care at a wound clinic". The clinical record failed to include documentation of any changes in care, orders to stop skilled nursing services, physician		needs/missed visits. (10) Any RN found to not be in compliance with notifying MD of agency's inability to meet patient needs/missed visits will be re-instructed within five (5) business days by the CM/designee. (11) CM/designee will instruct RNs o need to notify patient/caregiver of their being discharged, doing the appropriate documentation (appropriate time notification, MD order, discharge assessment, discharge summary) and documenting these things. (12) CM/designee will ensure orientation of newly hired RNs includes instruction on need to notify patient/caregiver on their being discharged, doing the appropriate documentation (appropriate time notification, MD order, discharge assessment, discharge summary) and documenting these things. (13) CM/designee will audit 100% of all discharges to ensure proper documentation and time frames are followed. (14) Any RN found not following proper discharge time frames and documentation will be re-instructed within five (5) business days by CM/designee. (15) RNs will be re-instructed on documenting clearly what the patients/caregivers needs are regarding their ability to provide/execute the care ordered by the MD. (16) CM/designee will ensure orientation of newly hired RNs will include training on	

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	notification of missed visits, conversations that was reported by the clinical manager, or information regarding the surgery that prompted dressing changes.		documenting clearly what the patient/caregivers needs are regarding their ability to provide/execute care ordered by MD. (17) CM/designee will audit 100% of clinical documentation to ensure compliance with documenting clearly what needs, if any, patient/caregiver has with providing the care ordered by the MD. Immediately, the corrective action steps listed above have been completed. Ongoing, Clinical Manager will continue to track MD orders on a weekly basis. Additionally, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active clinical records, or 20% - whichever is larger, to ensure ongoing compliance and 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 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the agency	N 0610	The Administrator will provide an in-service to all internal employees	08/08/2018

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ADAPTIVE NURSING AND HEALTHCARE SERVICES - LAFAYE	938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905

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	failed to ensure physician orders were signed and dated within 30 days in 1 out of 3 active records reviewed and 1 out of 1 discharged record reviewed. (Patient #2 and 3) Findings include: 1. The clinical record for patient number 2 contained a plan of care for the certification period of 6/4/18 to 8/2/18. The plan of care failed to be signed and dated by the ordering physician listed on the plan of care. The clinical manager was interviewed on 7/24/18 at 3:20 PM, in which the clinical manager acknowledge the plan of care had not been signed and stated he/ she had just recently sent a 3rd request for signature. 2. The discharged record of patient number 3 contained a plan of care for the certification period of 5/30/18 to 7/28/18. The plan of care failed to be signed and dated by the ordering physician listed on the plan of care. The clinical record evidenced two physician orders dated 6/16/18 and 6/26/18. Both orders failed to be signed and dated by the ordering physician listed on the order.		by 08/08/2018, which refers to Clinical Manager. The in-service will include specific review of the outlined findings, review of omissions and re-education on the noted clinical records policy. Evidenced by the executed in-service attendance log. In correction and ongoing, (1) the Clinical Manager (CM)/designee will ensure all MD orders for charts cited in this survey have been signed. Any orders not signed will be sent to MD for signature. (2) All charts will be reviewed by CM/designee to ensure any orders outside of thirty (30) days get signed and placed into chart. (3) CM/designee will implement a tracking system for MD orders to ensure they are returned with MD signature within thirty (30) days as required. (4) CM/designee will audit all outstanding orders daily, business days, to ensure ongoing compliance. (5) Newly hired RNs will be instructed on MD order tracking system by CM/designee. Immediately, the corrective action steps listed above have been completed. Ongoing, Clinical Manager will continue to track MD orders on a weekly basis as outlined above. Additionally, quarterly chart audits will be conducted by Nursing Supervisor/designee on 15 active clinical records, or 20% - whichever is larger, to ensure ongoing compliance and verifying	

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	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			this 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 internal plan of correction and/or heightened monitoring.	