STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157557	A. BUILDING 00 B. WING	07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADARNA HOME HEALTH CARE SERVICES INC	1400 EAST JOLIET STREET CROWN POINT, IN 46307

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E 0000 Bldg. 00	An Emergency Preparedness survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.22. Survey dates: 7/19/18 - 7/24/18 Facility ID: 004058 Provider #: 157557 Census: 81 unduplicated skilled patients for past year At this Emergency Preparedness survey, Adarna Home Health Services, LLC was found to be out of compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.22.	E 0000	The Clinical Manager, Amy Nitz, RN, will complete all initial assessments to determine the immediate care and support needs of new patient referrals, homebound eligibility and home health benefit (if a Medicare patient) within 48 hours of referral, or within 48 hours of patient's return home, or on the physician ordered start of care date. Comprehensive Assessments (Oasis) will be completed within 5 days. Clinical Supervisor to ensure on-going compliance. ***See Exhibit A & Exhibit A.1*** The Policy titled "Exposure Control Plan: OSHA Regulations", revised March 18, 2018 will be handed out to all Staff at an in-service meeting August 6th, 2018 and will be followed in the patient homes. Annual on-going competencies will be done with all staff annually to ensure compliance. Clinical Supervisor to oversee on-going compliance. ***See Exhibit C*** All current staff and new hires will sign the policy titled "Computer Key/Password Statement", revised March 2018. An in-service will be held August 6th, 2018 in the office where the forms will be distributed and signed by all staff including	

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

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			office personnel to ensure that no one else is allowed to use his/her computer key password. This statement will be filed in the employee personnel file. All employees will be oriented to their duties and position, including the importance of HIPAA compliance, given appropriate job descriptions, and applicable expanded criminal history searches. All employees will have timely annual evaluations that are dated and signed by employee and supervisor. ***See Exhibit B*** Human Resource person to ensure compliance with Administrator overseeing. All Discharge Oasis will have a scheduled Discharge Summary will be completed with the Oasis. Director of Nursing to ensure on-going compliance. ***See Exhibit D*** All electronic health records containing amendments, corrections or delayed (late) entries will be distinctly identified by the authorized discipline in the form of a Communication Note. All comprehensive assessments will be completed within 5 days of the Initial Eval or 5 days within the end of the episode (Recert). All physician orders will be dated and authenticated, with	

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			late entry noted, if applicable. All Therapists will submit orders when received and will be encompassed on the Plan of Care. All missed visits will be audited by skilled personnel and will be returned to the authoring discipline, if applicable. This will be discussed and reinforced at the in-service August 6th, 2018. Clinical Supervisor will ensure on-going compliance.	
E 0006 Bldg. 00	Based on record review and interview, the agency failed to evidence a full scale community - based drill was completed for 1 of 1 agency's emergency preparedness plan reviewed. The findings include: 1. The policy titled "Testing Program for Emergency Operations Plan" revised March 2018 stated, "The agency will conduct exercises to test the EOP [emergency operations plan] at least annually. The agency will do the following: Participate in a full - scale exercise that is community - based or when a community - based exercise is not accessible, an individual, facility - based exercise. The agency is encouraged to seek out local state emergency agencies and health care coalitions to participate in a full - scale exercise, community - based exercise ... Conduct an additional exercise that may include, but is not limited to the following: a second full - scale exercise that is community - based or individual,	E 0006	Agency will be participating in a full scale exercise with Homeland Security of Lake County, Indiana, on November 7th, 2018. All staff will be required to attend the exercise. DON & Office Manager will attend meetings August 15th, 2018 & September 19th, 2018 for additional training. Annual exercises will be held. Clinical Supervisor to monitor for compliance. This will be discussed at the in-service August 6th, 2018. See Exhibit F	11/07/2018

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	facility - based. A table top exercise that include a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages or prepared questions designed to challenge the EOP ... " 2. A review of the Emergency Preparedness Plan on 7/23/18 and 7/24/18 failed to show a second additional exercise such as a full scale exercise had been completed. The agency failed to evidence that a full scale community - based drill had been completed. This was evidenced by the following: A document in the emergency preparedness plan dated 11/30/17 evidenced an emergency operations plan / evaluation analysis. This document stated, "Date: 11/30/17. Site: Adarna Home Health. Type of Actual emergency: Critical Power Failure. Planned table top exercise: yes. Type: Critical Power Failure. 1. Who declared the emergency exercise or actual implementation of plan: [the alternate administrator / director of nursing] ... Staff involved in analysis / evaluation: all meeting attendees." This document was signed by Employee B, office manager. 3. During an interview on 7/24/18 at 4:15 PM, the alternate administrator / director of nursing indicated the agency had completed a Table Top exercise in November 2017. No other exercise had been completed yet.			
G 0000 Bldg. 00	This was a Federal Home Health Recertification survey.	G 0000	The Clinical Manager, Amy Nitz, RN, will complete all initial assessments to determine the	

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	Survey dates: 7/19/18 - 7/24/18 Facility ID: 004058 Provider #: 157557 Census: 81 unduplicated skilled patients for past year		immediate care and support needs of new patient referrals, homebound eligibility and home health benefit (if a Medicare patient) within 48 hours of referral, or within 48 hours of patient's return home, or on the physician ordered start of care date. Comprehensive Assessments (Oasis) will be completed within 5 days. Clinical Supervisor to ensure on-going compliance. ***See Exhibit A & Exhibit A.1*** The Policy titled "Exposure Control Plan: OSHA Regulations", revised March 18, 2018 will be handed out to all Staff at an in-service meeting August 6th, 2018 and will be followed in the patient homes. Annual on-going competencies will be done with all staff annually to ensure compliance. Clinical Supervisor to oversee on-going compliance. ***See Exhibit C*** All current staff and new hires will sign the policy titled "Computer Key/Password Statement", revised March 2018. An in-service will be held August 6th, 2018 in the office where the forms will be distributed and signed by all staff including office personnel to ensure that no one else is allowed to use his/her computer key password. This statement will be filed in the employee personnel file. All employees will be	

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			oriented to their duties and position, including the importance of HIPAA compliance, given appropriate job descriptions, and applicable expanded criminal history searches. All employees will have timely annual evaluations that are dated and signed by employee and supervisor. ***See Exhibit B*** Human Resource person to ensure compliance with Administrator overseeing. All Discharge Oasis will have a scheduled Discharge Summary will be completed with the Oasis. Director of Nursing to ensure on-going compliance. ***See Exhibit D*** All electronic health records containing amendments, corrections or delayed (late) entries will be distinctly identified by the authorized discipline in the form of a Communication Note. All comprehensive assessments will be completed within 5 days of the Initial Eval or 5 days within the end of the episode (Recert). All physician orders will be dated and authenticated, with late entry noted, if applicable. All Therapists will submit orders when received and will be encompassed on the Plan of Care. All missed visits will be audited by skilled personnel and	

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			will be returned to the authoring discipline, if applicable. This will be discussed and reinforced at the in-service August 6th, 2018. Clinical Supervisor will ensure on-going compliance.	
G 0514 Bldg. 00	Based on record review and interview, the agency failed to evidence documentation that the patient had an initial assessment to determine the patients immediate care and support needs and notified the responsible physician managing the patient's care prior to conducting the comprehensive assessment.for 7 of 7 patients whose clinical records were reviewed (#1 - 7). The findings include: 1. Review of the policy titled "Initial Assessments / Comprehensive Assessments" revised December 2018 stated, "Policy: Each patient admitted by the agency will have appropriate initial assessments performed and documented ... Procedure 1. Each patient admitted will receive a comprehensive assessment. The assessment will reflect the patient's current health status and include information to demonstrate the patient's progress toward achievement of desired outcomes ... Initial assessment and time frame: A RN, PT or SLP must conduct the initial assessment visit within 48 hours of referral, within 48 hours of the patient's home or on the physician - ordered start of care date. The initial assessment is conducted to determine the immediate care and support needs of the patient. In the absence of the a	G 0514	Initial Visit will be completed before Comprehensive Assessment on every admission with 100% review weekly until 100% compliance is met. Then, 10% of all new admissions will be monitored monthly until September 2019. The Clinical Manager, will complete all initial assessments to determine the immediate care and support needs of new patient referrals, homebound eligibility and home health benefit (if a Medicare patient) within 48 hours of referral, or within 48 hours of patient's return home, or on the physician ordered start of care date. Comprehensive Assessments (Oasis) will be completed within 5 days. Clinical Supervisor to ensure on-going compliance. In the absence of the Clinical Manager, the Alternate Clinical Manager will monitor for compliance. Referral date will be audited by the Clinical Supervisor on 100% of referrals weekly until 100% compliance is met, then 10% of	09/24/2018

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	physician - specified start of care date, the initial assessment is conducted within 48 hours of the referral ... Completion of the comprehensive assessment: must be completed in a timely manner consistent with the patient's needs, but no later than 5 calendar days after the start of care, RN must complete the comprehensive assessment and determine eligibility for home health benefit [for Medicare patients] including homebound status when skilled nursing is ordered ..." 2. The policy titled "Assessment and Reassessment Guidelines" revised March 2018 stated, "The Registered Nurse ... will perform the initial assessment for all nursing patients. Reassessments for nursing may be conducted by RNs and LPNs during nursing visits. Only RNs or registered therapists can conduct initial and reassessments for home health aide patients. Only registered therapists can perform initial assessment for therapy services." 3. Review of the clinical record of patient #1, start of care (SOC) date of 1/3/18, failed to evidence documentation an initial assessment had been performed to determine patient #1's immediate care and support needs and was completed within 48 hours of referral as evidenced by: A document titled "Patient Referral Form" with a blank date evidenced patient #1's name, address, date of birth, gender, social security number, and home phone number. Also listed was the name of the contact person and relationship to patient and phone number. The source of payment was listed as Medicare and private insurance. The physician was listed with the physician's contact information. The diagnoses for patient #1 was listed as muscle weakness and cerebral infarction. Below a dotted line was information that the		referrals will be audited/monitored monthly until Sept 24, 2019. This will discussed at an in-service August 6th, 2018. See Exhibit A & Exhibit A.1, & A.2	

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	assignment was accepted by Employee I, Registered Nurse, on 1/3/18. Circled services included skilled nurse, physical therapy, speech therapy, home health aide, and occupational therapy. Review of a SOC OASIS comprehensive assessment dated 1/3/18, failed to evidence documentation that the patient had an initial assessment, qualified for home health services, notified the responsible physician managing the patient's care, prior to conducting the comprehensive assessment. During an interview on 7/20/18 at 11:25 AM, the alternate administrator / director of nursing indicated the referral document lacked a date on the referral part of the form. During an interview on 7/20/18 at 11:55 AM, the alternate administrator /director of nursing indicated "We are only doing start of care assessments." 4. A review of the clinical record of patient #2, start of care date of 6/27/18, failed to evidence documentation an initial assessment had been performed to determine patient #2's immediate care and support needs and was completed within 48 hours of referral as evidenced by: A document titled "Patient Referral Form" with a blank date evidenced patient #2's name, address, date of birth, gender, social security number, and home phone number. Also listed was the name of the contact person and relationship to patient and phone number. The source of payment was listed as Medicare. The physician was listed with the physician's contact information. The diagnoses for patient #2 were listed as pneumonia ... acute			

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	cystitis. Below a dotted line was information that the assignment was accepted by Employee H, Registered Nurse, on 6/25/18. Circled services included physical therapy and occupational therapy. Review of a SOC OASIS comprehensive assessment dated 6/27/18, failed to evidence documentation that the patient had an initial assessment, qualified for home health services, notified the responsible physician managing the patient's care, prior to conducting the comprehensive assessment. 5. A review of the clinical record of patient #3, start of care date of 6/13/16, failed to evidence documentation an initial assessment had been performed to determine patient #3's immediate care and support needs as evidenced by: Review of a SOC OASIS comprehensive assessment dated 6/13/16, failed to evidence documentation that the patient had an initial assessment, qualified for home health services, notified the responsible physician managing the patient's care, prior to conducting the comprehensive assessment. 6. A review of the clinical record of patient #4, start of care date of 10/28/17 , failed to evidence documentation an initial assessment had been performed to determine patient #5's immediate care and support needs as evidenced by: Review of a SOC OASIS comprehensive assessment dated 10/28/17, failed to evidence documentation that the patient had an initial assessment, qualified for home health services, notified the responsible physician managing the patient's care, prior to conducting the			

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	comprehensive assessment. During an interview on 7/24/18 at 4:15 PM, the alternate administrator / director of nursing indicated the start of care assessment is combined with the initial assessment. 7. A review of the clinical record of patient #5, start of care date of 11/18/17 , failed to evidence documentation an initial assessment had been performed to determine patient #5's immediate care and support needs as evidenced by: Review of a SOC OASIS comprehensive assessment dated 11/18/17, failed to evidence documentation that the patient had an initial assessment, qualified for home health services, notified the responsible physician managing the patient's care, prior to conducting the comprehensive assessment. 8. A review of the clinical record of patient #6, start of care 11/4/17, failed to evidence documentation an initial assessment had been performed to determine patient #6's immediate care and support needs as evidenced by: A document titled "Patient Referral Form" with a blank date evidenced patient #6's name, address, date of birth, gender, social security number, and home phone number. The source of payment was listed as Medicare. The physician was listed with the physician's contact information. Below a dotted line was information that the assignment was accepted by Employee Q, Registered Nurse, on 11/4/17. Review of a SOC OASIS comprehensive assessment dated 11/4/17, failed to evidence documentation that the patient had an initial			

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	assessment, qualified for home health services, notified the responsible physician managing the patient's care, prior to conducting the comprehensive assessment. 9. A review of the clinical record of patient #7, start of care 5/17/18, failed to evidence documentation an initial assessment had been performed to determine patient #7's immediate care and support needs as evidenced by: A document titled "Patient Referral Form" with a blank date evidenced patient #7's name, address, date of birth, gender, social security number, and home phone number. The contact name and phone number were listed. The source of payment was listed as Medicare. The physician was listed with the physician's contact information. Below a dotted line was information that the assignment was accepted by Employee I, Registered Nurse, on 5/17/18. Review of a SOC OASIS comprehensive assessment dated 5/17/18, failed to evidence documentation that the patient had an initial assessment, qualified for home health services, notified the responsible physician managing the patient's care, prior to conducting the comprehensive assessment. During an interview on 7/20/18 at 4:00 PM, the alternate administrator / director of nursing indicated the start of care assessment is combined with the initial assessment.			
G 0682 Bldg. 00	Based on observation, record review, and	G 0682	Hand Washing & Bag Technique: Clinical Manager & Therapist	09/24/2018

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	interview, the home health agency failed to follow infection control guidelines in 1 of 2 home visits (#2) with a Registered Nurse (#H). The findings include: 1. The agency policy titled "Exposure Control Plan: OSHA Regulations" revised March 2018 stated, "Nurse, Home Health Aide and other Staff Bags 1. Bags used by nurses, home health aides and other staff which contain equipment, e.g. a thermometer, stethoscope, blood pressure cuff, etc., and are brought into the home are classified as clean on the inside. The outside of the bag, because it is exposed to all environments, is considered 'soiled' ... upon entering the home, place the bag on a clean surface; paper towels or plastic bag may be used to create a clean area if indicated. Open the bag near the care area and, if possible, near the water supply. Wash hands thoroughly with bacteriostatic foam / liquid / gel . remove all items needed for the visit. Place items on one of the paper towels. Close the bag and give the patient care. If additional items are needed after care has started, wash hands before re - entering bag ..." 2. The agency policy titled "Hand Hygiene Policy and Compliance Program" revised March 2018 stated, "Indications for staff performing hand hygiene are : before re-entering nursing bag or patient's clean supplies ...the agency will follow the Centers for Disease Control and Prevention [CDC] guidelines for hand hygiene: CDC Hand Hygiene Guidelines ... Recommendations: 1. Indications for handwashing and hand antisepsis ... after removing gloves." 3. During an observation at a home visit on 7/24/18 at approximately 9:45 AM, Employee H,		Coordinator will perform home visits monthly to monitor to audit hand washing technique until 100% compliance is obtained, then 10% monthly monitoring/auditing will occur until Sept 24, 2019. The Policy titled “Exposure Control Plan: OSHA Regulations”, revised March 18, 2018 will be handed out to all Staff at an in-service meeting August 6th, 2018 and will be followed in the patient homes. Monthly in-service training will be held with all Field Staff for on-going education until October 2019. New hires will be orientated before and upon 1st patient contact. Annual on-going competencies will be done with all staff annually to ensure compliance. Clinical Supervisor to oversee on-going compliance. ***See Exhibit C & C.1***	

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	was observed to complete wound care with patient #2. Employee H cleansed a wound with gauze and wound cleanser on the patient's left arm and then took gloves off and did not wash hands or sanitize hands with hand sanitizer gel. Employee H opened Border Island Gauze and applied bacitracin ointment to the dressing. She applied a glove to the right hand and not to the left and continued with wound care. Employee H proceeded to take vital signs. Employee H did not gel / sanitize / wash her hands before pulling out the blood pressure cuff or stethoscope. After taking the patient #2's blood pressure with the stethoscope and blood pressure cuff, Employee H reached into the bag and pulled out disinfecting wipes. Employee H did not cleanse her hands before she reached into the bag at this time. 4. During an interview on 7/24/18 at 10:27 AM, Employee I, was silent when questioned about the observations of the infection control concerns at the above visit.			
G 0948 Bldg. 00	Based on record review and interview, the administrator failed to organize and direct the agency's ongoing functions for 1 of 1 agency. The findings include: 1. The policy titled "Computer Key / Password" revised March 2018 stated, "The agency will maintain confidentiality and security of patient data that is entered and stored on computer systems. Purpose: To ensure confidentiality of patient data within computer systems ... At time of employment each individual who is authenticating	G 0948	All current staff and new hires will sign the policy titled “Computer Key/Password Statement”, revised March 2018. An in-service will be held August 6th, 2018 in the office where the forms will be distributed and signed by all staff including office personnel to ensure that no one else is allowed to use his/her computer key password. This statement will be filed in the employee personnel file. Employee files will be monitored monthly to ensure compliance.	08/06/2018

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	157557	A. BUILDING 00 B. WING	07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADARNA HOME HEALTH CARE SERVICES INC	1400 EAST JOLIET STREET CROWN POINT, IN 46307

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	medical record entries by computer will sign a statement that no one else is allowed to use his / her computer key / password. This statement will be filed in the agency's administrative offices. The individual employee is responsible for maintaining the security of his / her computer key / password." 2. The agency form titled "Computer Key / Password Statement" revised October 2017 evidenced a blank line for the employee's signature and blank line for the date. The form stated, "I understand the need and responsibility to maintain a high level of security with computer access. I will not allow anyone to use my computer key / password and accept full responsibility for the security of my computer key / password. 3. The agency policy titled "Employee Orientation" revised March 2018 stated, "To provide a mechanism whereby all employees are oriented to and become acquainted with the agency policies and procedures Procedure 1. Orientation for all employees will be coordinated, performed, and documented by supervisory staff, peers, and / or preceptors. The Orientation checklist will be used to document orientation for all staff, including contract staff ... Additional ACHC requirements 1. Orientation for each employee will minimally include ... confidentiality and privacy of Protected Health Information ... " 4. A review of the agency policy titled "Personnel Records" revised March 2018 stated, "Personnel files will be established and maintained for all staff ... The personnel record or personnel information for an employee will include, but not be limited to, the following ... performance appraisal / forms ... agency employee orientation ... criminal history		All employees will be oriented to their duties and position, including the importance of HIPAA compliance, given appropriate job descriptions, and applicable expanded criminal history searches. Employee files will be monitored monthly to ensure compliance. All employees will have timely annual evaluations that are dated and signed by employee and supervisor. Employee files will be monitored monthly to ensure compliance. Human Resource person to ensure compliance with Administrator overseeing. ***See Exhibit B***	

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	check, if required by law ... job description: reviewed and signed by employee." 5. The Orientation checklist revised October 2017 stated, "Orientation to ... Confidentiality of patient information / HIPAA policies and practices." 6. The agency policy titled "Patient Confidentiality" revised March 2018 stated, "All information to provision of home care for specific patient is treated confidential, including home care records. The administrator is responsible for ensure that the confidentiality and privacy policies and procedures are adopted and followed. At all times, the agency and staff will comply with the current regulations for the Health Information Portability and Accountability Act [HIPAA] for protected health information [PHI] ... The agency will comply with applicable HIPAA rules and regulations ..." Regarding a confidentiality of patient information / HIPAA policies and practices and computer key / password statement not signed or maintained in administrative records 7. A review of 14 employee files evidenced a lack of the Computer Key Statement in all files reviewed. Employee F lacked orientation documentation including HIPAA policy review. This was evidenced by the following: A review of the file for Employee A, C, D, E, F, G, H, I, K, L , M, N, O, and P, failed to evidence the "Computer Key / Password statement. A review of the file for Employee F, Information Technology, failed to evidence the "Computer Key / Password statement. This Employee had not had an orientation and lacked the HIPAA /			

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	patient confidentiality orientation. During an interview on 7/24/18 at 2:50 PM ,the office manager indicated no employees had ever completed the above form noted in finding #2 and the agency maintained electronic medical records for each patient. Employee F was completing OASIS transmissions for the agency. Employee F lacked orientation including HIPAA. Regarding Personnel Files lacking agency job descriptions, performance evaluations, orientations, and a limited criminal history background checks 8. A review of the file of Employee C, administrator, hire date 4/1/04, failed to evidence a performance evaluation had been completed. In the file was a document titled "Performance Appraisal / Evaluation" with no date and included the signature of the administrator. The document had check marks showing the administrator had met standards or exceeded standards for the job reviewed. There was no signature / date of a supervisor signature. This was left blank. During an interview on 7/24/17 at 2:35 PM, Employee B, office manager, indicated the personnel file was lacking the performance evaluation completed and dated. 9. A review of the file of Employee F, information technology, hire date 4/1/04, failed to evidence an orientation, signed job description, limited criminal history check, or annual performance evaluation. All that was in the file was a job application document dated 4/1/04. During an interview on 7/23/18 at 12 noon, Employee B indicated the file only contained the			

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	application. 10. A review of the file of Employee N, occupational therapist, hire date 4/11/7 and first patient contact date 4/12/17, failed to evidence a performance evaluation had been completed. During an interview on 7/24/17 at 3 PM, Employee B, office manager, indicated the personnel file was lacking the performance evaluation. 11. A review of the file of Employee P, speech therapist, hire date 4/24/17 and first patient contact date 4/24/17, failed to evidence a signed job description or performance evaluations was in the personnel file for this employee. During an interview on 7/24/18 at 2:30 PM, Employee B, office manager, indicated the personnel file was missing the performance evaluation and job description.			
G 1022 Bldg. 00	Based on record review and interview, the agency failed to ensure the clinical record included a completed discharge summary for 1 of 2 closed records reviewed (#4). The findings include: 1. The agency policy titled "Discharge Summary" revised March 2018 stated, "A discharge summary will be completed for all patients discharged from the agency." 2. A review of clinical record #7, a closed record, failed to evidence a discharge summary in the	G 1022	All DC charts from January 13, 2018 until the present will be monitored/audited for missing DC Summaries. All charts that are missing DC Summaries will have one added to be in compliance. This will be done by September 24, 2018. The Clinical Supervisor will monitor 100% of Discharge Summaries every week until 100% compliance is met and then 10% every month. All Discharge Oasis will have a scheduled Discharge Summary that will be completed with the	09/24/2018

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	record. 3. During an interview on 7/20/18 at 4 PM, the alternate administrator / director of nursing indicated the discharge summary was not documented.		Oasis and QA'd with the DC OASIS. Discharge summaries were immediately scheduled to all upcoming Discharge patients in Axxess by the scheduler upon Surveyor findings. Clinical Manager & Clinical Supervisor will continuously monitor to ensure compliance. ***See Exhibit D & D.1***	
G 1024 Bldg. 00	Based on record review and interview, the agency failed to ensure clinical records reviewed included entries which were authentic and appropriately dated / timed for 3 of 4 active records reviewed (#1, #2, #3). The findings include: 1. The agency policy titled "Information Confidentiality, Security and Data Integrity" revised March 2018 stated, "Electronic health records containing amendments, corrections or delayed [late] entries must distinctly identify any amendment, correction, or delayed [late] entry, provide a reliable means to clearly identify the original content, the modified content and the date and author for each modification of the record." 2. The agency policy titled "Initial Assessments / Comprehensive Assessments" revised March 2018 stated, "Each patient admitted will receive a comprehensive assessment ... Completion of the comprehensive assessment: Must be completed in a timely manner consistent with the patient's	G 1024	100% of orders written from Jan 1st, 2018 will be audited and late entry orders will be completed as needed. 100% auditing of orders weekly until compliance is met, then 10% every week until Sept 24, 2019 by Clinical Supervisor. Upon discovery of Employee D mishandling and editing orders, missed visits and POC's, all of her permissions in the Axxess system that previously allowed her to access this information were removed from her August 10th, 2018. All of these documents were corrected and denoted with Late Entry. POC for Patient # 3 was discovered to have wrong signature date by MD. All electronic health records containing amendments, corrections or delayed (late) entries will be distinctly identified by the authorized skilled discipline.	09/24/2018

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	needs, but no later than 5 calendar days after the start of care." 3. The agency policy titled "Plan of Care - CMS #485 and Physician Orders" revised March 2018 stated, "Physicians should complete the certification when the plan of care is established or as soon as possible thereafter ... verbal orders are accepted only by personal authorized to do so by applicable state laws and regulations and agency policy. Verbal orders are put in writing, signed, timed and dated with the receipt by a RN or therapist responsible for furnishing or supervising ordered services..." 4. The agency policy titled "Timely submission of Patient Documentation" revised October 2017 stated, "To comply with state / federal laws and regulations related to timely submission of all patient documentation ... Physicians' orders must be submitted to Agency within 3 business days after receipt. 2. Itineraries, with all visit notes attached, must be submitted the next scheduled work day, not exceeding three business days." 5. The agency policy titled "Medical Record Entries and Authentication" revised March 2018 stated, "All medical record entries will be dated and authenticated." 6. A review of a physician order in clinical record #1 failed to show late entry documentation had occurred on the clinical record documents reviewed as evidenced by the following: A review of a physician order dated 7/2/18 at 11:35 AM evidenced patient #1's name and birthdate and the name of the attending physician, address, phone number, fax number and NPI. The order was dated 7/2/18 at 11:35 AM. The order stated,		All OASIS will be QA'd & monitored twice weekly for timeliness of submission until compliance is met be the Clinical Manager & orders will be monitored/QA'd by Clinical Supervisor. Initial Visit will be completed before Comprehensive Assessment on every admission with 100% review weekly until 100% compliance is met. Then, 10% of all new admissions will be monitored monthly until September 2019. The Clinical Manager, will complete all initial assessments to determine the immediate care and support needs of new patient referrals, homebound eligibility and home health benefit (if a Medicare patient) within 48 hours of referral, or within 48 hours of patient's return home, or on the physician ordered start of care date. Comprehensive Assessments (Oasis) will be completed within 5 days. Clinical Supervisor to ensure on-going compliance. In the absence of the Clinical Manager, the Alternate Clinical Manager will monitor for compliance. Referral date will be audited by the Clinical Supervisor on 100% of referrals weekly until 100% compliance is met, then 10% of referrals will be audited/monitored monthly until Sept 24, 2019. This will discussed at an in-service August 6th, 2018.	

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	"PT order to continue for 2 X / WK [week] for therapeutic exercise, therapy." An activity log for the order above in finding evidenced the order was created on 7/20/18 at 11:35 AM by the office staff, Employee D. Employee P, physical therapist, submitted the order at 7/20/18 at 11:36 AM. This order was sent to the physician manually on 7/20/18 at 4:31 PM. During an interview on 7/20/18 at 11:55 AM, the alternate administrator / director of nursing indicated physical therapy orders were lacking. 7. A review of the clinical record note from record #2 failed to show late entry documentation had occured on the clinical record documents reviewed as evidenced by the following: A review of a missed visit note evidenced Employee N completed the document on 6/27/18. An activity log for the note evidenced the note was not completed until 7/20/18 at 7:51 AM by Employee N. There was no note on this document indicating that a late entry documentation had been completed. A review of a document titled "Missed Visit" dated 6/27/18 stated, "Patient Unable to Answer Door." This was electronically signed by Employee N, Occupational Therapist on 6/27/18. An activity log dated 7/23/18 evidenced the note's activity history. The note was updated and created on 7/11/18 by Employee D, office staff. On 7/20/18 at 7:51 AM, the activity log stated, "Status changed. [Documented as a missed visit by [Occupational Therapist, Employee N]. The note was completed on 7/23/18 at 10:31 AM by the office staff, Employee D.		See Exhibit A & Exhibit A.1, & A.2 All physician orders will be dated and authenticated, with late entry noted, if applicable. All Therapists will submit orders when received and will be encompassed on the Plan of Care. All missed visits will be audited by skilled personnel and will be returned to the authoring discipline for corrections, if applicable. This will be discussed and reinforced at the in-service August 6th, 2018. Clinical Supervisor & Clinical Manager will monitor to ensure on-going compliance.	

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	8. A review of a clinical record #3 evidenced a Recertification assessment and plan of care that failed to show late entry and authentic documentation. This was evidenced by the following: A review of an OASIS - C2 Recertification assessment evidenced Employee I signed the document on 6/1/18. A review of an activity log note dated 7/23/18 and printed by Employee B on that date at 10:50 AM, evidenced activity log notes of the OASIS - C2 Recertification assessment above in finding #A. This log stated, "[Employee B] Created 4/6/18; [Employee B] Reassigned [from Employee I, RN to Employee R, RN] on 5/29/18 at 9:32 AM; [Employee B] Reassigned [from Employee R to Employee I] 6/14/18 at 12:17 PM; [Employee I] Saved 6/14/18 at 2:20 PM ... [Employee I] saved on 6/14/18 at 2:49 PM ... completed 6/14/18 2:49 PM." A review of patient #3's Home Health Certification and Plan of Care for the certification period of 6/3/18 - 8/1/18 evidenced a physician's electronic signature dated 6/11/18 and second Home Health Certification and Plan of care for the same certification period evidenced a physician signature with an illegible date and received on 6/14/18 stamped on page 3 of this document also evidenced a physician signature. A review of an activity log note dated 7/23/18 at 10:50 AM and printed by Employee B evidenced the document had been saved on 6/14/18 and submitted [pending QA review] on 6/14/18 at 2:48 PM. The note also stated, "[employee I] to be sent to physician [approved by (Employee I) 6/14/18 2:49 PM.]; and [Employee D] Sent to physician [manually] on 6/21/18 at 11:25 AM. Returned with physician signature 7/19/18."			

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N 0000 Bldg. 00	During an interview on 7/23/18 at 11 AM, Employee I was asked why the plan of care was completed after the date on the plan of care with the physician signature. Employee I stated, "I get behind a lot with QA and supervisory visits." Employee I indicated the notes were completed late and not appropriately marked as late entries. During an interview on 7/23/18 at 11:10 AM, the alternate administrator / director of nursing indicated the Recertification visit was not completed on time. This was a state home relicensure survey. Survey dates: 7/19/18 - 7/24/18 Facility ID: 004058 Provider #: 157557 Census: 81 unduplicated skilled patients for past year	N 0000	The Clinical Manager, Amy Nitz, RN, will complete all initial assessments to determine the immediate care and support needs of new patient referrals, homebound eligibility and home health benefit (if a Medicare patient) within 48 hours of referral, or within 48 hours of patient's return home, or on the physician ordered start of care date. Comprehensive Assessments (Oasis) will be completed within 5 days. Clinical Supervisor to ensure on-going compliance. ***See Exhibit A & Exhibit A.1*** The Policy titled "Exposure Control Plan: OSHA Regulations", revised March 18, 2018 will be handed out to all Staff at an in-service meeting August 6th, 2018 and will be followed in the patient homes. Annual on-going	

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			competencies will be done with all staff annually to ensure compliance. Clinical Supervisor to oversee on-going compliance. ***See Exhibit C*** All current staff and new hires will sign the policy titled “Computer Key/Password Statement”, revised March 2018. An in-service will be held August 6th, 2018 in the office where the forms will be distributed and signed by all staff including office personnel to ensure that no one else is allowed to use his/her computer key password. This statement will be filed in the employee personnel file. All employees will be oriented to their duties and position, including the importance of HIPAA compliance, given appropriate job descriptions, and applicable expanded criminal history searches. All employees will have timely annual evaluations that are dated and signed by employee and supervisor. ***See Exhibit B*** Human Resource person to ensure compliance with Administrator overseeing. All Discharge Oasis will have a scheduled Discharge Summary will be completed with the Oasis. Director of Nursing to ensure on-going compliance. ***See Exhibit D***	

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			All electronic health records containing amendments, corrections or delayed (late) entries will be distinctly identified by the authorized discipline in the form of a Communication Note. All comprehensive assessments will be completed within 5 days of the Initial Eval or 5 days within the end of the episode (Recert). All physician orders will be dated and authenticated, with late entry noted, if applicable. All Therapists will submit orders when received and will be encompassed on the Plan of Care. All missed visits will be audited by skilled personnel and will be returned to the authoring discipline, if applicable. This will be discussed and reinforced at the in-service August 6th, 2018. Clinical Supervisor will ensure on-going compliance.	
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.			

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	Based on record review and interview, the administrator failed to organize and direct the agency's ongoing functions for 1 of 1 agency. The findings include: Regarding a confidentiality of patient information / HIPAA policies and practices and computer key / password statement not signed or maintained in administrative records 1. The policy titled "Computer Key / Password" revised March 2018 stated, "The agency will maintain confidentiality and security of patient data that is entered and stored on computer systems. Purpose: To ensure confidentiality of patient data within computer systems ... At time of employment each individual who is authenticating medical record entries by computer will sign a statement that no one else is allowed to use his / her computer key / password. This statement will be filed in the agency's administrative offices. The individual employee is responsible for maintaining the security of his / her computer key / password." 2. The agency form titled "Computer Key / Password Statement" revised October 2017 evidenced a blank line for the employee's signature and blank line for the date. The form stated, "I understand the need and responsibility to maintain a high level of security with computer access. I will not allow anyone to use my computer key / password and accept full responsibility for the security of my computer key / password. 3. The agency policy titled "Employee Orientation" revised March 2018 stated, "To	N 0444	All current staff and new hires will sign the policy titled “Computer Key/Password Statement”, revised March 2018. An in-service will be held August 6th, 2018 in the office where the forms will be distributed and signed by all staff including office personnel to ensure that no one else is allowed to use his/her computer key password. This statement will be filed in the employees personnel files. Employee files will be monitored monthly to ensure compliance. All employees will be oriented to their duties and position, including the importance of HIPAA compliance, given appropriate job descriptions, and applicable expanded criminal history searches. Employee files will be monitored monthly to ensure compliance. All employees will have timely annual evaluations that are dated and signed by employee and supervisor. Employee files will be monitored monthly to ensure compliance. This will be discussed and reinforced at the in-service August 6th, 2018. Human Resources to monitor for on-going compliance. ***See Exhibit B***	08/06/2018

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	157557	A. BUILDING 00 B. WING	07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADARNA HOME HEALTH CARE SERVICES INC	1400 EAST JOLIET STREET CROWN POINT, IN 46307

(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
	provide a mechanism whereby all employees are oriented to and become acquainted with the agency policies and procedures Procedure 1. Orientation for all employees will be coordinated, performed, and documented by supervisory staff, peers, and / or preceptors. The Orientation checklist will be used to document orientation for all staff, including contract staff ... Additional ACHC requirements 1. Orientation for each employee will minimally include ... confidentiality and privacy of Protected Health Information ... " 4. The Orientation checklist revised October 2017 stated, "Orientation to ... Confidentiality of patient information / HIPAA policies and practices." 5. The agency policy titled "Patient Confidentiality" revised March 2018 stated, "All information to provision of home care for specific patient is treated confidential, including home care records. The administrator is responsible for ensure that the confidentiality and privacy policies and procedures are adopted and followed. At all times, the agency and staff will comply with the current regulations for the Health Information Portability and Accountability Act [HIPAA] for protected health information [PHI] ... The agency will comply with applicable HIPAA rules and regulations ..." 6. During an interview on 7/24/18 at 2:50 PM ,the office manager indicated no employees had ever completed the above form noted in finding #2 and the agency maintained electronic medical records for each patient. Employee F lacked orientation including HIPAA. Employee F was completing OASIS transmissions for the agency. 7. A review of 14 employee files evidenced a lack of the Computer Key Statement in all files			

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	reviewed. Employee F lacked orientation documentation including HIPAA policy review. This was evidenced by the following: A. A review of the file for Employee A, alternate administrator and director of nursing, failed to evidence the "Computer Key / Password statement. B. A review of the file for Employee C, administrator, failed to evidence the "Computer Key / Password statement. C. A review of the file for Employee D, office staff and home health aide, failed to evidence the "Computer Key / Password statement. D. A review of the file for Employee E, alternate director of nursing, failed to evidence the "Computer Key / Password statement. E. A review of the file for Employee F, Information Technology, failed to evidence the "Computer Key / Password statement. This Employee had not had an orientation and lacked the HIPAA / patient confidentiality orientation. F. A review of the file for Employee G, Home Health Aide, failed to evidence the "Computer Key / Password statement. G. A review of the file for Employee H, Registered Nurse, failed to evidence the "Computer Key / Password statement. H. A review of the file for Employee I, Registered Nurse, failed to evidence the "Computer Key / Password statement. I. A review of the file for Employee K, Home			

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	Health Aide, failed to evidence the "Computer Key / Password statement. J. A review of the file for Employee L, Licensed Practical Nurse, failed to evidence the "Computer Key / Password statement. K A review of the file for Employee M, Licensed Practical Nurse, failed to evidence the "Computer Key / Password statement. L. A review of the file for Employee N, Occupational Therapy, failed to evidence the "Computer Key / Password statement. M. A review of the file for Employee O, Physical Therapy, failed to evidence the "Computer Key / Password statement. N. A review of the file for Employee P, Speech Therapy, failed to evidence the "Computer Key / Password statement." Regarding Personnel Files lacking agency job descriptions, performance evaluations, orientations, and a limited criminal history background checks 8. A review of the agency policy titled "Personnel Records" revised March 2018 stated, "Personnel files will be established and maintained for all staff ... The personnel record or personnel information for an employee will include, but not be limited to, the following ... performance appraisal / forms ... agency employee orientation ... criminal history check, if required by law ... job description: reviewed and signed by employee." 9. A review of the file of Employee C, administrator, hire date 4/1/04, failed to evidence a			

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	performance evaluation had been completed. In the file was a document titled "Performance Appraisal / Evaluation" with no date and included the signature of the administrator. The document had check marks showing the administrator had met standards or exceeded standards for the job reviewed. There was no signature / date of a supervisor signature. This was left blank. During an interview on 7/24/17 at 2:35 PM, Employee B, office manager, indicated the personnel file was lacking the performance evaluation completed and dated. 10. A review of the file of Employee F, information technology, hire date 4/1/04, failed to evidence an orientation, signed job description, limited criminal history check, or annual performance evaluation. All that was in the file was a job application document dated 4/1/04. During an interview on 7/23/18 at 12 noon, Employee B indicated the file only contained the application. 11. A review of the file of Employee N, occupational therapist, hire date 4/11/7 and first patient contact date 4/12/17, failed to evidence a performance evaluation had been completed. During an interview on 7/24/17 at 3 PM, Employee B, office manager, indicated the personnel file was lacking the performance evaluation. 12. A review of the file of Employee P, speech therapist, hire date 4/24/17 and first patient contact date 4/24/17, failed to evidence a signed job description or performance evaluations was in the personnel file for this employee.			

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	During an interview on 7/24/18 at 2:30 PM, Employee B, office manager, indicated the personnel file was missing the performance evaluation and job description.			
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 to ensure personnel files contained agency job descriptions, performance evaluations, orientations, and a limited criminal history background checks for 4 of 14 personnel files reviewed (C, F, N, P). The findings include: 1. A review of the agency policy titled "Personnel Records" revised March 2018 stated, "Personnel files will be established and maintained for all staff ... The personnel record or personnel information	N 0458	All current staff and new hires will sign the policy titled “Computer Key/Password Statement”, revised March 2018. An in-service will be held August 6th, 2018 in the office where the forms will be distributed and signed by all staff including office personnel to ensure that no one else is allowed to use his/her computer key password. This statement will be filed in the employees personnel files. Employee files will be monitored monthly to ensure these	08/06/2018

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	for an employee will include, but not be limited to, the following ... performance appraisal / forms ... agency employee orientation ... criminal history check, if required by law ... job description: reviewed and signed by employee." 2. A review of the file of Employee C, administrator, hire date 4/1/04, failed to evidence a performance evaluation had been completed. In the file was a document titled "Performance Appraisal / Evaluation" with no date and included the signature of the administrator. The document had check marks showing the administrator had met standards or exceeded standards for the job reviewed. There was no signature / date of a supervisor signature. This was left blank. During an interview on 7/24/17 at 2:35 PM, Employee B, office manager, indicated the personnel file was lacking the performance evaluation completed and dated. 3. A review of the file of Employee F, information technology, hire date 4/1/04, failed to evidence an orientation, signed job description, limited criminal history check, or annual performance evaluation. All that was in the file was a job application document dated 4/1/04. 4. A review of the file of Employee N, occupational therapist, hire date 4/11/7 and first patient contact date 4/12/17, failed to evidence a performance evaluation had been completed. During an interview on 7/24/17 at 3 PM, Employee B, office manager, indicated the personnel file was lacking the performance evaluation. 5. A review of the file of Employee P, speech therapist, hire date 4/24/17 and first patient		documents are in all personnel files. All employees will be oriented to their duties and position, including the importance of HIPAA compliance, given appropriate job descriptions, and applicable expanded criminal history searches. Employee files will be monitored monthly to ensure these documents are in all personnel files. All employees will have timely annual evaluations that are dated and signed by employee and supervisor. Employee files will be monitored monthly to ensure these documents are in all personnel files. This will be discussed and reinforced at the in-service August 6th, 2018. Human Resources & Administrator to monitor monthly for on-going compliance. ***See Exhibit B***	

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	contact date 4/24/17, failed to evidence a signed job description or performance evaluations was in the personnel file for this employee. During an interview on 7/24/18 at 2:30 PM, Employee B, office manager, indicated the personnel file was missing the performance evaluation and job description.			
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: (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			

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	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 2 of 10 employee files (Employee K, P) of employees with direct patient contained had a baseline two-step tuberculin skin test, a tuberculin test during the previous twelve months or a chest x-ray with an annual TB risk assessment. The findings include: 1. A review of the agency policy titled "Personnel Records" revised March 2018 stated, "The personnel record or personnel information for an employee will include, but not be limited to, the following ... the health record for applicable employees will include: PPD Tests or chest x ray	N 0464	Personnel files were audited on July 30th, 2018 & zero deficiencies found. Personnel files will be monitored 100% monthly to ensure compliance by the Office Manager. Upon investigation at the time of the survey, Employee P had been on Medical Leave and had not seen patients after her TB expired and the other employee missing 2nd step TB had resigned and had no patients. Office Manager will monitor that all new hires have had a previous TB Test within the last 12 months and will receive a TB test upon hire, unless a chest X-RAY is available. If a	09/24/2018

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	results based on Agency's TB risk assessment ... initial PPD or x ray screening and annual verification of PPD or TB symptom screening tool for all direct care staff." 2. A review of the agency policy titled "Occupational Exposure Prevention of Transmission of TB plan" revised March 2018 stated, "For employees who have not had a documented negative PPD during the preceding 12 months, the baseline PPD testing will include the two - step method ... PPD negative employees will undergo PPD testing at regular intervals [but at least annually] as determined by the risk assessment." 3. A review of Employee K's file, Home Health Aide, with hire date of 3/1/18 and first patient contact 3/5/18, failed to evidence a two step PPD as required by agency policy. A review of a Tuberculosis screening for Employee K evidenced a PPD was given on 2/26/18 and read on 3/1/18 at a health clinic. There was not a second step noted on this form or in the file. 4. A review of Employee P's file, Speech Therapist, with hire date of 4/24/17 and first patient contact 4/27/17, failed to evidenced an annual PPD test, annual risk assessment, or chest x - ray was completed per policy. A document titled "Tuberculin Skin Test" evidenced Tuberculin skin test completed on 4/24/17 and read on 4/26/17. A second step PPD was not completed. An annual PPD was not completed in 2018. There was no annual risk assessment completed.		new hire is unable to produce a previous TB, the a 2 Step TB will be given. All new hires will have a 2 step TB test or applicable Chest X-Ray, and a TB risk assessment and will undergo regular TB testing and risk assessments annually. This will be discussed and reinforced at an in-service August 6th, 2018. Clinical Supervisor & Clinical Manager to monitor compliance. See Exhibit I (Annual TB Risk Assessment)	

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	5. During an interview on 7/24/18 at 3:30 PM, Employee B, office manager, indicated the TB policy had not been followed.			
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 follow infection control guidelines in 1 of 2 home visits (#2) with a Registered Nurse (#H). The findings include: 1. The agency policy titled "Exposure Control Plan: OSHA Regulations" revised March 2018 stated, "Nurse, Home Health Aide and other Staff Bags 1. Bags used by nurses, home health aides and other staff which contain equipment, e.g. a thermometer, stethoscope, blood pressure cuff, etc., and are brought into the home are classified as clean on the inside. The outside of the bag, because it is exposed to all environments, is considered 'soiled' ... upon entering the home, place the bag on a clean surface; paper towels or plastic bag may be used to create a clean area if indicated. Open the bag near the care area and, if possible, near the water supply. Wash hands thoroughly with bacteriostatic foam / liquid / gel . remove all items needed for the visit. Place items on one of the paper towels. Close the bag and give the patient care. If additional items are needed after care has started, wash hands before re - entering bag ..."	N 0470	Hand Washing & Bag Technique: Clinical Manager & Therapist Coordinator will perform home visits monthly to monitor to audit hand washing technique until 100% compliance is obtained, then 10% monthly monitoring/auditing will occur until Sept 24, 2019. The Policy titled “Exposure Control Plan: OSHA Regulations”, revised March 18, 2018 will be handed out to all Staff at an in-service meeting August 6th, 2018 and will be followed in the patient homes. Monthly in-service training will be held with all Field Staff for on-going education until October 2019. New hires will be orientated before and upon 1st patient contact. Annual on-going competencies will be done with all staff annually to ensure compliance. Clinical Supervisor to oversee on-going compliance. ***See Exhibit C & C.1***	09/24/2018

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	2. The agency policy titled "Hand Hygiene Policy and Compliance Program" revised March 2018 stated, "Indications for staff performing hand hygiene are : before re-entering nursing bag or patient's clean supplies ...the agency will follow the Centers for Disease Control and Prevention [CDC] guidelines for hand hygiene: CDC Hand Hygiene Guidelines ... Recommendations: 1. Indications for handwashing and hand antisepsis ... after removing gloves." 3. During an observation at a home visit on 7/24/18 at approximately 9:45 AM, Employee H, was observed to complete wound care with patient #2. Employee H cleansed a wound with gauze and wound cleanser on the patient's left arm and then took gloves off and did not wash hands or sanitize hands with hand sanitizer gel. Employee H opened Border Island Gauze and applied bacitracin ointment to the dressing. She applied a glove to the right hand and not to the left and continued with wound care. Employee H proceeded to take vital signs. Employee H did not gel / sanitize / wash her hands before pulling out the blood pressure cuff or stethoscope. After taking the patient #2's blood pressure with the stethoscope and blood pressure cuff, Employee H reached into the bag and pulled out disinfecting wipes. Employee H did not cleanse her hands before she reached into the bag at this time. 4. During an interview on 7/24/18 at 10:27 AM, Employee I, was silent when questioned about the observations of the infection control concerns at the above visit.			
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency			

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	must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the agency failed to develop and implement a policy / procedure requiring a notice of discharge of service at least fifteen calendar days before the services are stopped for 1 of 1 agency. The findings include: 1. The agency policy titled "Discharge Criteria" dated March 2018 stated, "The patient is informed	N 0488	Policy updated to notify patients of discharge of services at least 15 calendar days prior before the services are discontinued. Clinical Supervisor to monitor for compliance. See Exhibit H	08/06/2018

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	of discharge plan in a timely manner and acknowledges understanding reason." 2. During an interview on 7/20/18 at 4 PM, the alternate administrator / director of nursing indicated the discharge policy did not state 15 days for the discharge notice.			
N 0529 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure a written summary was completed and sent to the physician every 60 days for 4 of 5 records reviewed of active patients on service more than 60 days (#1, #3, #4, #5). The findings include: 1. Clinical record #1, start of care 1/3/18 and diagnosis of difficulty in walking, included plans of care for the certification periods of 1/3/18 - 3/3/18, 3/4/18 - 5/2/18, 5/3/18 - 7/1/18, and 7/2/18 - 8/30/18. The clinical record failed to evidence that a 60 day summary completed for this patient or sent to the physician for this time frame. During an interview on 7/20/18 at 11:55 AM, the alternate administrator / director of nursing indicated there was no 60 day summary. 2. Clinical record #3, start of care 6/13/16 and	N 0529	All active records were audited for 60 day summaries. All charts without 60 day summaries had summaries scheduled and will be completed by Discipline assigned to Recertification and will be monitored every week until September 24, 2019 to ensure compliance. Clinical Manager will monitor and audit weekly form timely completion along with recert OASIS. All patients will have a 60 day summary completed at the end of every episode (every 2 months) that will sent out to the physician, dentist, chiropractor, optometrist, or podiatrist. Clinical Supervisor to monitor for compliance. This will be discussed in an in-service August	09/24/2018

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	diagnosis of generalized muscle weakness, included plans of care for the certification periods of 4/4/18 - 6/2/18 and 6/3/18 - 8/1/18. The clinical record failed to evidence that a 60 day summary completed for this patient or sent to the physician for this time frame. During an interview on 7/20/18 at 4 PM, the alternate administrator / director of nursing indicated there was no 60 day summary. 3. Clinical record #4, start of care 10/28/17 and diagnosis of pyelitis cystica, included plans of care for the certification periods of 4/26/18 - 6/24/18 and 6/25/18 - 8/23/18. The clinical record failed to evidence that a 60 day summary completed for this patient or sent to the physician for this time frame. 4. Clinical record #5, start of care 11/18/17 and diagnosis of essential hypertension, included plans of care for the certification periods of 3/18/18 - 5/16/18, 5/17/18 - 7/15/18, and 7/16/18 - 9/13/18. The clinical record failed to evidence that a 60 day summary completed for this patient or sent to the physician for this time frame. 5. During an interview on 7/24/18 at 4:20 PM, the alternate administrator / director of nursing indicated the plan of care is where the 60 day summary is and this goes to the physician.		6th, 2018. See Exhibit G	
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			

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	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 the clinical record included a completed discharge summary for 1 of 2 closed records reviewed (#4). The findings include: 1. The agency policy titled "Discharge Summary" revised March 2018 stated, "A discharge summary will be completed for all patients discharged from the agency." 2. A review of clinical record #7, a closed record, failed to evidence a discharge summary in the record. 3. During an interview on 7/20/18 at 4 PM, the alternate administrator / director of nursing indicated the discharge summary was not documented.	N 0608	All DC charts from January 13, 2018 until the present will be monitored/audited for missing DC Summaries. All charts that are missing DC Summaries will have one added to be in compliance. This will be done by September 24, 2018. The Clinical Supervisor will monitor 100% of Discharge Summaries every week until 100% compliance is met and then 10% every month. All Discharge Oasis will have a scheduled Discharge Summary that will be completed with the Oasis and QA'd with the DC OASIS. Discharge summaries were immediately scheduled to all upcoming Discharge patients in Axxess by the scheduler upon Surveyor findings. Clinical Manager & Clinical Supervisor will continuously monitor to ensure compliance. ***See Exhibit D & D.1***	09/24/2018

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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 failed to ensure clinical records reviewed included entries which were authentic and appropriately dated / timed for 3 of 4 active records reviewed (#1, #2, #3). The findings include: 1. The agency policy titled "Information Confidentiality, Security and Data Integrity" revised March 2018 stated, "Electronic health records containing amendments, corrections or delayed [late] entries must distinctly identify any amendment, correction, or delayed [late] entry, provide a reliable means to clearly identify the original content, the modified content and the date and author for each modification of the record." 2. The agency policy titled "Initial Assessments / Comprehensive Assessments" revised March 2018 stated, "Each patient admitted will receive a comprehensive assessment ... Completion of the comprehensive assessment: Must be completed in a timely manner consistent with the patient's needs, but no later than 5 calendar days after the start of care." 3. The agency policy titled "Plan of Care - CMS #485 and Physician Orders" revised March 2018 stated, "Physicians should complete the certification when the plan of care is established	N 0610	100% of orders written from Jan 1st, 2018 will be audited and late entry orders will be completed as needed. 100% auditing of orders weekly until compliance is met, then 10% every week until Sept 24, 2019 by Clinical Supervisor. Upon discovery of Employee D mishandling and editing orders, missed visits and POC's, all of her permissions in the Axxess system that previously allowed her to access this information were removed from her August 10th, 2018. All of these documents were corrected and denoted with Late Entry. POC for Patient # 3 was discovered to have wrong signature date by MD. All electronic health records containing amendments, corrections or delayed (late) entries will be distinctly identified by the authorized skilled discipline. All OASIS will be QA'd & monitored twice weekly for timeliness of submission until compliance is met be the Clinical Manager & orders will be monitored/QA'd by Clinical Supervisor.	09/24/2018

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	or as soon as possible thereafter ... verbal orders are accepted only by personal authorized to do so by applicable state laws and regulations and agency policy. Verbal orders are put in writing, signed, timed and dated with the receipt by a RN or therapist responsible for furnishing or supervising ordered services..." 4. The agency policy titled "Timely submission of Patient Documentation" revised October 2017 stated, "To comply with state / federal laws and regulations related to timely submission of all patient documentation ... Physicians' orders must be submitted to Agency within 3 business days after receipt. 2. Itineraries, with all visit notes attached, must be submitted the next scheduled work day, not exceeding three business days." 5. The agency policy titled "Medical Record Entries and Authentication" revised March 2018 stated, "All medical record entries will be dated and authenticated." 6. A review of a physician order in clinical record #1 failed to show late entry documentation had occurred on the clinical record documents reviewed. This was evidenced by the following: A review of a physician order dated 7/2/18 at 11:35 AM evidenced patient #1's name and birthdate and the name of the attending physician, address, phone number, fax number and NPI. The order was dated 7/2/18 at 11:35 AM. The order stated, "PT order to continue for 2 X / WK [week] for therapeutic exercise, therapy." An activity log for the order above in finding evidenced the order was created on 7/20/18 at 11:35 AM by the office staff, Employee D. Employee P, physical therapist, submitted the		Initial Visit will be completed before Comprehensive Assessment on every admission with 100% review weekly until 100% compliance is met. Then, 10% of all new admissions will be monitored monthly until September 2019. The Clinical Manager, will complete all initial assessments to determine the immediate care and support needs of new patient referrals, homebound eligibility and home health benefit (if a Medicare patient) within 48 hours of referral, or within 48 hours of patient's return home, or on the physician ordered start of care date. Comprehensive Assessments (Oasis) will be completed within 5 days. Clinical Supervisor to ensure on-going compliance. In the absence of the Clinical Manager, the Alternate Clinical Manager will monitor for compliance. Referral date will be audited by the Clinical Supervisor on 100% of referrals weekly until 100% compliance is met, then 10% of referrals will be audited/monitored monthly until Sept 24, 2019. This will discussed at an in-service August 6th, 2018. See Exhibit A & Exhibit A.1, & A.2 All physician orders will be dated and authenticated, with late entry noted, if applicable. All Therapists will submit orders when received and will be	

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	order at 7/20/18 at 11:36 AM. This order was sent to the physician manually on 7/20/18 at 4:31 PM. During an interview on 7/20/18 at 11:55 AM, the alternate administrator / director of nursing indicated physical therapy orders were lacking. 7. A review of the clinical record note from record #2 failed to show late entry documentation had occured on the clinical record documents reviewed. The was evidenced by the following: A review of a missed visit note evidenced Employee N completed the document on 6/27/18. An activity log for the note evidenced the note was not completed until 7/20/18 at 7:51 AM by Employee N. There was no note on this document indicating that a late entry documentation had been completed. A review of a document titled "Missed Visit" dated 6/27/18 stated, "Patient Unable to Answer Door." This was electronically signed by Employee N, Occupational Therapist on 6/27/18. An activity log dated 7/23/18 evidenced the note's activity history. The note was updated and created on 7/11/18 by Employee D, office staff. On 7/20/18 at 7:51 AM, the activity log stated, "Status changed. [Documented as a missed visit by [Occupational Therapist, Employee N]. The note was completed on 7/23/18 at 10:31 AM by the office staff, Employee D. 8. A review of a clinical record #3 evidenced a Recertification assessment and plan of care that failed to show late entry and authentic documentation. This was evidenced by the following: A review of an OASIS - C2 Recertification		encompassed on the Plan of Care. All missed visits will be audited by skilled personnel and will be returned to the authoring discipline for corrections, if applicable. This will be discussed and reinforced at the in-service August 6th, 2018. Clinical Supervisor & Clinical Manager will monitor to ensure on-going compliance.	

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	assessment evidenced Employee I signed the document on 6/1/18. A review of an activity log note dated 7/23/18 and printed by Employee B on that date at 10:50 AM, evidenced activity log notes of the OASIS - C2 Recertification assessment above in finding #A. This log stated, "[Employee B] Created 4/6/18; [Employee B] Reassigned [from Employee I, RN to Employee R, RN] on 5/29/18 at 9:32 AM; [Employee B] Reassigned [from Employee R to Employee I] 6/14/18 at 12:17 PM; [Employee I] Saved 6/14/18 at 2:20 PM ... [Employee I] saved on 6/14/18 at 2:49 PM ... completed 6/14/18 2:49 PM." A review of patient #3's Home Health Certification and Plan of Care for the certification period of 6/3/18 - 8/1/18 evidenced a physician's electronic signature dated 6/11/18 and second Home Health Certification and Plan of care for the same certification period evidenced a physician signature with an illegible date and received on 6/14/18 stamped on page 3 of this document also evidenced a physician signature. A review of an activity log note dated 7/23/18 at 10:50 AM and printed by Employee B evidenced the document had been saved on 6/14/18 and submitted [pending QA review] on 6/14/18 at 2:48 PM. The note also stated, "[employee I] to be sent to physician [approved by (Employee I) 6/14/18 2:49 PM.]; and [Employee D] Sent to physician [manually] on 6/21/18 at 11:25 AM. Returned with physician signature 7/19/18." During an interview on 7/23/18 at 11 AM, Employee I was asked why the plan of care was completed after the date on the plan of care with the physician signature. Employee I stated, "I get behind a lot with QA and supervisory visits." Employee I indicated the notes were completed late and not appropriately marked as late entries.			

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	During an interview on 7/23/18 at 11:10 AM, the alternate administrator / director of nursing indicated the Recertification visit was not completed on time.			