STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K173	A. BUILDING _____ B. WING _____	R-C 03/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS This was the first post condition revisit (PCR) for the Federal and State home health recertification survey origionally completed on December 28, 2020. Survey Date: March 29, 30, 31; April 1, 5, 6, 7, 2021 Facility Number: 014339 Provider Number: 15K173 Unduplicated Admissions for Last 12 Months: 66 Active Census: 86 Skilled Patients Only: 4 Home Health Aide Only Patients: 82 Personal Service Only Patients: 0 During this survey, 5 condition level deficiency were found corrected, 12 standard level deficiencies were found corrected, 1 condition level deficiency was re-cited, 12 standard level deficiencies were re-cited, and 3 new standard level deficiencies were cited. Adaptive Nursing and Healthcare Services - Lafayette continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning December 28, 2020 and continuing through December 28, 2022, for being found out of compliance with the Condition of Participation 42 CFR 484.60 Care Planning, coordination, quality of care. These deficiencies reflects State Findings cited in accordance with 410 IAC 17.	{G 000}		
{G 528}	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1)	{G 528}		

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

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{G 528}	Continued From page 1 The patient's current health, psychosocial, functional, and cognitive status; This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment contained a complete and thorough health, mental, cognitive, and psychosocial status for 3 of 3 active records reviewed (#1, 23, 24), in a total sample of 24 records. Findings include: 1. An agency policy titled "Comprehensive Client Assessment," revised 4/29/2020, stated " ... A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed ... Special Instructions: ... 3. In addition to general health status/system assessment, the agency comprehensive assessment will include: ... e. Respiratory status ... g. Formal Pain Assessment, pain intervention and management. h. Elimination status. i. Sensory status. j. Integumentary status ... l. Neuro/emotional/behavioral status ... 5. Nutritional status is assessed ...." 2. An agency document titled "Change of Condition In-Service," dated 3/8/21, stated " ... Mouth: Any issues must be addressed including loss of teeth. [Is the patient] able to chew food without issue? ... Pain: ... What is the client's pain goal? ... Endocrine: All issues must be addressed. If the client has thyroid issues are they being treated with meds? ... Integumentary: ... We must describe any skin conditions we find thoroughly. We need to measure the areas [of wounds or other skin abnormalities]. We need to note any odors, any exudate, color around the	{G 528}		

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{G 528}	Continued From page 2 area, does the skin around the area blanche [turn white when a finger is pressed into the skin] ... Respiratory: We need to get the heigh and weight as close as we can. If there is no scale we can get it from the MD's office if possible or the client but we need to document how we got the weight ... Cardiac: We will need to address the vitals again here and make sure the heart rate is normal with no irregular beats ... We need to ask if they have any palpitations ... any episodes of dizziness ... chest pain ... Psychological: ... [Is the patient] angry, withdrawn, discouraged, depressed. What is their affect like ... Mental Status: Is the client alert, oriented. Do they have behaviors. Are they forgetful, depressed, disoriented ... Musculoskeletal: ... Do they have ... any [history] of falls ... and if they do when was last fall ...." 3. An agency document titled "Lafayette Plan of Correction Training Attestation," dated 2/25/21, stated " ... Comprehensive Assessment to include: Patient current status. Psychosocial, functional, and cognitive status ...." 4. An agency document titled "Plan of care meeting agency [2/18/21]," dated 2/18/21, stated " ... Meeting discussion: ... Assessments must include: A complete [and] thorough assessment of all body systems ... Pain assessment to be thorough including: Where the pain is located, what mitigates the pain, what is the patient's established pain goal, what is the normal range of pain 1 - 10 ...." 5. The clinical record of Patient #1 was reviewed on 3/29/21 and 4/2/21 and indicated a start of care date of 1/26/2021, with patient diagnoses including but not limited to: Parkinson's Disease, systemic lupus erythematosus (autoimmune	{G 528}		

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{G 528}	Continued From page 3 disease which results in damage to organs and tissues of the body), legal blindness, SICCA syndrome (dryness of the eyes and mouth, often caused by Sjogren's syndrome), incontinence (inability to control the bowels or bladder), anxiety, hallucinations, inguinal hernia (bulging of abdomen into the groin), and presence of a pressure ulcer (type of wound caused by prolonged pressure to the body site). The record included a comprehensive assessment, completed on 3/23/2021 by Registered Nurse (RN) #1, for the certification period 3/27/2021 - 5/25/2021. The assessment failed to evidence an assessment of the patient's Parkinson's disease, lupus, SICCA syndrome, anxiety, hallucinations, and inguinal hernia. The comprehensive assessment included a section titled "Integumentary," which indicated the patient had a pressure ulcer to his "top of [left] foot." The assessment stated the wound's "Size (LxWxD [Length by Width by Depth]): 4 cm [centimeters] in diameter. Description: Patient has a circular wound on the top of his L [left] foot ... Wound care as follows: [Family Member #1] to change dressing every other day ...." The assessment failed to evidence a complete and thorough wound assessment (length, width, and depth of the patient's wound, the color of the wound and surrounding tissue, the presence or absence of drainage or odor, the type of dressing used to cover the wound, etc). The plan of care for the certification period 3/27/2021 - 5/25/2021 indicated the patient's mental status was "Forgetful," and the patient's cognitive and psychosocial status was "confusion at times." The comprehensive assessment included a section titled "Mental Status," which indicated the patient was "Alert. Oriented [to]	{G 528}		

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{G 528}	Continued From page 4 Person, Place, Time [Patient was aware of who he was, where he was, and the date] ...." The comprehensive assessment also included a section titled "Psychological," which stated " ... Other: Patient does not speak very much. However, patient was able to answer RNs questions correctly and would laugh at RN's stories and jokes ...." The comprehensive assessment failed to evidence a complete and thorough assessment of the patient's mental, cognitive, and psychosocial status which aligned with the plan of care. The comprehensive assessment included a "Medication Report" reviewed and signed by 3/24/21 by RN #1. The medication list included the medications "Quetiapine ... for sleep delusions ... donepezil ... for Memory ...." The comprehensive assessment failed to evidence diagnoses or conditions, as well as assessments, related to these medications. 6. The clinical record of Patient #23 was reviewed on 4/6/21, and indicated a start of care of 1/21/21, with patient diagnoses including but not limited to: COPD (Chronic Obstructive Pulmonary Disorder), history of falls, Diabetes, amnesia, history of venous thrombosis and embolism, GERD (Gastroesophageal Reflux Disease), depression, eczema, and mild dementia. The record included a comprehensive assessment completed on 3/17/21 by RN #1 for the recertification period 3/22/21 - 5/20/21. The comprehensive assessment failed to evidence an assessment of the patient's diagnoses of GERD, depression, and eczema. The comprehensive assessment included the patient's vital signs (group of measurements that help to assess the general health of the patient),	{G 528}		

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{G 528}	Continued From page 5 which indicated the patient's heart rhythm was "irregular." The comprehensive assessment also included a section titled "Cardiovascular," which indicated the patient's heart tones were "Regular." The comprehensive assessment failed to evidence an assessment of the patient's heart rhythm and tones which was not conflicting. The comprehensive assessment included a section titled "Mental Status," which indicated Patient #1 was "Alert. Oriented [to] Person, Place, Time." The clinical record also included a plan of care for the certification period 3/22/21 - 5/20/21. The plan of care stated " ... 60 - Day Summary: 3/17/21," which stated " ... Patient continues to have memory issues and lower cognitive level ... Mental Status: Oriented, Forgetful, and Depressed. Cognitive / Psychosocial Status: Memory Deficit ...." The comprehensive assessment failed to evidence a thorough and complete mental, cognitive, and psychosocial status. The comprehensive assessment included a section titled "Nutrition/Hydration Status," which stated " ... Diet: ... Restricted/type: Low carb ... Difficulty chewing/swallowing ...." The plan of care stated " ... Nutritional Requirements: ... No teeth, no dentures, soft food by mouth ...." The comprehensive assessment failed to evidence a complete and thorough assessment of the patient's nutritional status and dietary requirements. 7. The clinical record of Patient #24 was reviewed on 4/6/21 and 4/7/21, and indicated a start of care 1/19/21, with patient diagnoses including but not limited to: COPD, essential hypertension (high blood pressure), diabetes type 2, bipolar disorder, major depressive disorder,	{G 528}		

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{G 528}	Continued From page 6 GERD, syncope (fainting), anxiety, angina (chest pain), hypothyroidism (underactive thyroid gland), and seborrheic dermatitis (skin condition of the scalp). The clinical record included a comprehensive assessment completed on 3/18/21 by the Alternate Clinical Manager for the recertification period 3/20/21 - 5/18/21. The assessment failed to evidence an assessment of the patient's bipolar disorder, depression, GERD, anxiety, angina, hypothyroidism, and seborrheic dermatitis. The comprehensive assessment included a "Medication Report," reviewed and signed by the Alternate Clinical Manager on 3/19/21. The medication list indicated Patient #24 was currently prescribed the medications Bumetanide (medication given to remove excess fluid retained in the body) and Hydrochlorothiazide-lisinopril (medication given to lower blood pressure, which in part does this by removing excess fluid retained in the body). The comprehensive assessment failed to evidence the patient's weight was obtained and assessed for any gain or loss. The comprehensive assessment included a section titled "Pain Assessment," which indicated the patient had chronic, constant, and generalized (all over the body) pain. Patient #24 had rated her pain as an "8" on a 0-10 numeric pain scale (method of subjectively assessing a patient's pain by having the patient rate their pain between 0-10, where "0" is no pain and "10" is the worst pain). The assessment stated " ... History of Pain Management: Patient #24] can tolerate pain ... Patient's pain goals: [Patient #24] would like to be stronger and walk outside without as much pain within 30 days ...." The comprehensive assessment failed to evidence a complete pain	{G 528}		

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{G 528}	Continued From page 7 assessment was completed (the patient's tolerable pain level based on the pain scale used, the patient's pain goal based on the pain scale used, etc). The clinical record included a plan of care for the recertification period 3/20/21 - 5/18/21. The plan of care included a 60-day summary which stated " ... [Patient #24] denies any recent ER visits or hospitalizations. She reports one fall about a month ago with no injury ...." The comprehensive assessment included a section titled "Musculoskeletal," which indicated the patient had a history of falls, and a section titled "Falls Risk Assessment," which indicated the patient had a "Prior history of falls within [past] 3 months." The assessment failed to evidence a complete assessment of the patient's history of falls was conducted (when was most recent fall, what was the cause, etc). 8. An interview was conducted on 4/5/21 at 3:47 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the comprehensive assessment should include the patient's current health and cognitive status. 17-14-1(a)(1)(B)	{G 528}		
{G 530}	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This Element is not met as evidenced by: Based on record review and interview, the home	{G 530}		

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{G 530}	Continued From page 8 health agency failed to ensure the comprehensive assessment included the patient's strengths for 3 of 3 active records reviewed (#1, 23, 24), in a total sample of 24 records. Findings include: 1. An agency policy titled "Comprehensive Client Assessment," revised 4/29/2020, stated " ... A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed ... Special Instructions ... 12. Client needs are assessed and care guidelines established based on the assessment data ...." 2. An agency document titled "Lafayette Plan of Correction Training Attestation," dated 2/25/21, stated " ... Comprehensive Assessment to include: ... Current strengths ...." 3. The clinical record of Patient #1 was reviewed on 3/29/21 and 4/2/21 and indicated a start of care date of 1/26/2021, with patient diagnoses including but not limited to: Parkinson's Disease, systemic lupus erythematosus (autoimmune disease which results in damage to organs and tissues of the body), legal blindness, SICCA syndrome (dryness of the eyes and mouth, often caused by Sjogren's syndrome), incontinence (inability to control the bowels or bladder), anxiety, hallucinations, inguinal hernia (bulging of abdomen into the groin), and presence of a pressure ulcer (type of wound caused by prolonged pressure to the body site). The record included a comprehensive assessment, completed on 3/23/2021 by Registered Nurse (RN) #1, for the certification period 3/27/2021 - 5/25/2021. The comprehensive assessment failed to evidence an assessment of the patient's	{G 530}		

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{G 530}	Continued From page 9 strengths. 4. The clinical record of Patient #23 was reviewed on 4/6/21, and indicated a start of care of 1/21/21, with patient diagnoses including but not limited to: COPD (Chronic Obstructive Pulmonary Disorder), history of falls, Diabetes, amnesia, history of venous thrombosis and embolism, GERD (Gastroesophageal Reflux Disease), depression, eczema, and mild dementia. The record included a comprehensive assessment, completed on 3/17/21 by RN #1, for the recertification period 3/22/21 - 5/20/21. The comprehensive assessment failed to evidence an assessment of the patient's strengths. 5. The clinical record of Patient #24 was reviewed on 4/6/21 and 4/7/21, and indicated a start of care 1/19/21, with patient diagnoses including but not limited to: COPD, essential hypertension (high blood pressure), diabetes type 2, bipolar disorder, major depressive disorder, GERD, syncope (fainting), anxiety, angina (chest pain), hypothyroidism (underactive thyroid gland), and seborrheic dermatitis (skin condition of the scalp). The clinical record included a comprehensive assessment completed on 3/18/21 by the Alternate Clinical Manager for the recertification period 3/20/21 - 5/18/21. The comprehensive assessment failed to evidence an assessment of the patient's strengths. 6. An interview was conducted on 4/5/21 at 3:47 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the comprehensive assessment should include the patient's strengths. 7. A follow up interview was conducted on 4/7/21	{G 530}		

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{G 530}	Continued From page 10 at 11:24 AM with the Administrator and Agency Consultant #1. During the interview, the Administrator indicated the nurse could determine the patient's strengths based on the findings documented within the assessment, such as the ADLs which the patient could complete independently or the patient's behavior towards staff, therefore the comprehensive assessment did contain the patient goals. The Administrator also indicated the assessment did not state outright the patient's strengths.	{G 530}		
{G 534}	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to evidence the patient's medical and nursing needs for 1 of 3 active records reviewed (#1), in a total sample of 24 records. Findings include: An agency policy titled "Comprehensive Client Assessment," revised 4/29/2020, stated " ... Policy: A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed ... Purpose: ... To identify clients medical, nursing ... needs ... Special Instructions: ... 3. In addition to general health status/system assessment, the agency comprehensive assessment will include: ... j. Integumentary status ...." An agency document titled "Lafayette Plan of Correction Training Attestation," dated 2/25/21, stated " ... Comprehensive Assessment to	{G 534}		

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{G 534}	Continued From page 11 include: ... Medical, nursing [patient needs] ...." The clinical record of Patient #1 was reviewed on 3/29/21 and 4/2/21 and indicated a start of care date of 1/26/2021, with patient diagnoses including but not limited to: Parkinson's Disease, systemic lupus erythematosus (autoimmune disease which results in damage to organs and tissues of the body), legal blindness, SICCA syndrome (dryness of the eyes and mouth, often caused by Sjogren's syndrome), incontinence (inability to control the bowels or bladder), anxiety, hallucinations, inguinal hernia (bulging of abdomen into the groin), and presence of a pressure ulcer (type of wound caused by prolonged pressure to the body site). The record included a comprehensive assessment, completed on 3/23/2021 by Registered Nurse (RN) #1, for the certification period 3/27/2021 - 5/25/2021. The comprehensive assessment included a section titled "Integumentary," which indicated the patient had a pressure ulcer to his "top of [left] foot." The assessment stated " ... Description: Patient has a circular wound on the top of his L [left] foot ... Wound care as follows: [Family Member #1] to change dressing every other day ...." The assessment failed to evidence the type of dressing used to cover the wound, measurements so the nurse could monitor for changes (length, width, and depth of the patient's wound), an assessment of the wound (the color of the wound and surrounding tissue, the presence or absence of drainage or odor), or an assessment of the caregiver's ability to accurately perform wound care. The comprehensive assessment included a section titled "DME [Durable Medical Equipment] Supplies," which stated "Wound Care Supplies. Incontinence supplies. Briefs. Pads. [Chux,	{G 534}		

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{G 534}	Continued From page 12 incontinence bed pads that can be disposable or reusable] ...." The clinical record included a plan of care for the certification period of 3/27/2021 - 5/25/2021. The plan of care indicated the patient's "DME / Supplies" included "OSHA kit, CPR shield, gloves, hand sanitizer, hospital bed, wheelchair, shower chair, sit to stand lift, grab bars, incontinence supplies." The comprehensive assessment failed to evidence a complete list of the patients DME and other needed medical supplies within the patient's home to assist the patient with rehabilitative needs. An interview was conducted on 4/5/21 at 3:47 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the comprehensive assessment should include the patient's medical and durable medical equipment needs 17-14-1(a)(1)(B)	{G 534}		
G 544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This Standard is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment was updated with a change in the patient's condition for 1 of 2 active record reviewed which indicated a change in the patient's condition (#1), in a total sample of 24 records.	G 544		

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

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G 544	Continued From page 13 Findings include: An agency policy titled "Comprehensive Client Assessment," revised 4/29/2020, stated " ... Special Instructions: ... 12. Client needs are assessed and care guidelines established based on the assessment data. Any unusual findings or additional assessment needed will be reported to the Clinical Manager to determine what additional consultation is needed ... 14. Reassessments are conducted based on client needs ...." An agency document titled "Change in Condition in-service," dated 3/8/21, stated " ... Any change in the client's condition must be conveyed to the physician. This includes but is not limited to: ... 3. Hospitalizations or ER visits ... 7. Any new wounds (including ... new surgical sites ...) ...." The clinical record of Patient #1 was reviewed on 3/29/21 and 4/2/21 and indicated a start of care date of 1/26/2021, with patient diagnoses including but not limited to: Parkinson's Disease, systemic lupus erythematosus (autoimmune disease which results in damage to organs and tissues of the body), legal blindness, SICCA syndrome (dryness of the eyes and mouth, often caused by Sjogren's syndrome), incontinence (inability to control the bowels or bladder), anxiety, hallucinations, inguinal hernia (bulging of abdomen into the groin), and presence of a pressure ulcer (type of wound caused by prolonged pressure to the body site). The record included a comprehensive assessment, completed on 3/23/2021 by Registered Nurse (RN) #1, for the certification period 3/27/2021 - 5/25/2021. The comprehensive assessment stated " ... Pertinent Health / Surgical History: ... [Family Member #1] reports that patient will have	G 544		

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G 544	Continued From page 14 surgery to remove a pin that is in his [left] foot on 3/24/21 ...." The clinical record included a "Communication" note documented on 3/26/21 by Program Manager (PM) #1. The note stated " ... I spoke with [Family Member #1] today ... She also let us know [Patient #1] had foot surgery and is feeling weak and they do have a doctors [sic] appointment this week. I have notified the nurse of this ...." The clinical record included a "Communication" note documented on 3/29/21 at 10:48 AM by RN #1. The note stated " ... RN called [patient's primary provider]'s office and spoke with [Office Nurse #1] ... [Office Nurse #1] aware that patient had surgery on 3/24[/21] for his foot ...." The clinical record included a "Communication" note documented on 3/29/21 at 10:50 AM by RN #1. The note stated " ... RN unable to speak with a staff member from [patient's surgeon]'s office at this time. RN to call back later to contact an RN at the office and verify wound care instructions for patient following surgery ...." The clinical record included a plan of care for the certification period of 3/27/21 - 5/25/21, revised on 3/29/21 to include the new physician order of "Care post foot procedure to remove pin: Do not remove dressing. Call MD if dressing comes off or becomes soiled. Keep area clean and dry. Elevate as much as possible. Follow-up with surgeon in 2 weeks ...." A home visit observation was conducted on 3/30/21 at 8:26 AM with Patient #1. During the visit, Patient #1 was observed to have a dressing to his left ankle, which Family Member #1	G 544		

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G 544	Continued From page 15 indicated was a surgical dressing placed after the patient had foot surgery on 3/24/21. Family Member #1 indicated the patient was to keep the dressing on for 2 weeks, so the surveyor was unable to observe the patient's wound or entire dressing. The exterior dressing included wrap gauze and an ACE bandage, which was wrapped from the patient's upper foot to mid-calf. The patient's toes were not covered by the dressing. Family Member #1 indicated no agency RN had conducted a home visit or called to follow up on the patient after his surgery. An interview was conducted on 4/5/21 at 3:47 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the comprehensive assessment should be updated with a change in patient status or condition. 17-14-1(a)(1)(B)	G 544		
{G 570}	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The	{G 570}		

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{G 570}	Continued From page 16 individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This Condition is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the plan of care contained the patient's mental, psychosocial, and cognitive status; supplies and equipment required, prognosis, rehabilitation potential, nutritional requirements, interventions for all the patient's risk factors for ED visits and hospitalization, measurable goals, and advance directive information (See Tag G574); failed to ensure the patient's medical provider was notified of a change in the patient's condition (See Tag G590), failed to ensure a list of the patient's medications, including a schedule and instructions for administration, was present in the home (See Tag G616); failed to ensure the patient's plan of care was present in the home (see Tag G618), and failed to ensure the patient's home binder included the name and contact information for the agency's clinical manager (See Tag G622). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care planning, coordination, and quality of care.	{G 570}		
{G 574}	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required;	{G 574}		

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{G 574}	Continued From page 17 (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the plan of care (POC) contained the patient's mental, psychosocial, and cognitive status; supplies and equipment required, prognosis, rehabilitation potential, nutritional requirements, interventions for all the patient's risk factors for ED visits and hospitalization, measurable goals, and advance directive information for 3 of 3 active records reviewed (#1, 23, 24), in a total sample of 24 records. Findings include: 1. An agency policy titled "Plan of Treatment," revised 4/10/2019, stated " ... Procedure: 1. As follows, the medical plan of care shall: ... C.	{G 574}		

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{G 574}	Continued From page 18 Include the following ... (ii) The patient's mental, psychosocial ... status (iii) Types of ... supplies and equipment required ... (v) Prognosis. (vi) Rehabilitation potential ... (ix) Nutritional requirements ... (xii) A description of patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors ... (xiv) ... measurable outcomes and goals identified by the [home health agency] and the patient (xv) Information related to any advance directives ...." 2. An agency document titled "Change of Condition In-Service," dated 3/8/21, stated " ... Psychological: ... [Is the patient] angry, withdrawn, discouraged, depressed. What is their affect like ... Mental Status: Is the client alert, oriented. Do they have behaviors. Are they forgetful, depressed, disoriented, lethargic ... agitated. This should all be listed on the POC as well ... Activities permitted: These should also be on the POC ... DME: this is a list of some DME that may be in home but please list any others they may have. These should be posted on the POC as well ... Rehab potential: This is listed as poor, fair, or good ... This will also be listed on the POC ... Goals: Goals must be individualized to the client and they must have a time frame attached ..." 3. An agency document titled "Plan of care meeting agency 2.18.21," dated 2/18/21, stated " ... Meeting discussion: Audit all charts to include: ... Hospital risk factor to be updated to include: Specific risks for hospitalizations and what we will be doing to mitigate that risk 4. The clinical record of Patient #1 was reviewed on 3/29/21 and 4/2/21 and indicated a start of care date of 1/26/2021, with patient diagnoses	{G 574}		

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{G 574}	Continued From page 19 including but not limited to: Parkinson's Disease, systemic lupus erythematosus (autoimmune disease which results in damage to organs and tissues of the body), legal blindness, SICCA syndrome (dryness of the eyes and mouth, often caused by Sjogren's syndrome), incontinence (inability to control the bowels or bladder), anxiety, hallucinations, inguinal hernia (bulging of abdomen into the groin), and presence of a pressure ulcer (type of wound caused by prolonged pressure to the body site). The record included a plan of care the recertification period 3/27/2021 - 5/25/2021. The POC indicated the patient's mental status was "Forgetful," and the patient's cognitive and psychosocial status was "confusion at times." The clinical record also included a comprehensive assessment completed on 3/23/2021 by Registered Nurse (RN) #1. The assessment included a section titled "Mental Status," which indicated the patient was "Alert. Oriented [to] Person, Place, Time [Patient was aware of who he was, where he was, and the date] ...." The comprehensive assessment also included a section titled "Psychological," which stated " ... Other: Patient does not speak very much. However, patient was able to answer RNs questions correctly and would laugh at RN's stories and jokes ...." The plan of care failed to evidence the patient's mental, cognitive, and psychosocial status which followed the comprehensive assessment. The POC included a section titled "DME / Supplies," which indicated the patient's supplies and equipment included " ... CPR shield, gloves, hand sanitizer, hospital bed, wheelchair, shower chair, sit to stand lift, grab bars, incontinence supplies." The comprehensive assessment included a section titled "DME [Durable Medical Equipment] Supplies," which stated "Wound Care	{G 574}		

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{G 574}	Continued From page 20 Supplies. Incontinence supplies. Briefs. Pads. [Chux, incontinence bed pads that can be disposable or reusable] ...." The plan of care failed to evidence a complete list of the patient's DME and other needed medical supplies which followed the comprehensive assessment. The POC included a section titled "Rehabilitation potential," which stated, "Rehab potential for above goals are good and attainable." The comprehensive assessment indicated the patient's rehabilitation potential was "Poor." The plan of care failed to evidence Patient #1's rehabilitation potential followed the comprehensive assessment. The POC included a section titled "Hospital Risk Factor" which stated "Moderate hospital risk related to dependence on others for all care, history of wounds, and high fall risk. HHA [Home Health Aide] to assist with all ADLs [Activities of Daily Living] and notify RN immediately of any concern. [Patient #1] is well cared for by his [family members]." The comprehensive assessment included a section titled "Risk for Hospitalization," which indicated the patient's risk factors for hospitalization were " ... Currently taking 5 or more medications ... Pt [Patient] at Risk - see additional notes for interventions / education provided. Additional notes regarding hospital risk / education: Patient has history of multiple chronic wounds that are slow to heal and present a risk for hospitalization if they are to be come infected." The plan of care failed to evidence a complete list of hospitalization risk factors which followed the comprehensive assessment and failed to evidence interventions specific to all the patient's ED visit and hospitalization risk factors.	{G 574}		

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{G 574}	Continued From page 21 5. The clinical record of Patient #23 was reviewed on 4/6/21, and indicated a start of care of 1/21/21, with patient diagnoses including but not limited to: COPD (Chronic Obstructive Pulmonary Disorder), history of falls, Diabetes, amnesia, history of venous thrombosis and embolism, GERD (Gastroesophageal Reflux Disease), depression, eczema, and mild dementia. The record included a plan of care for the recertification period 3/22/21 - 5/20/21. The plan of care stated " ... 60 - Day Summary: 3/17/21," which stated " ... Patient continues to have memory issues and lower cognitive level ... Mental Status: Oriented, Forgetful, and Depressed. Cognitive / Psychosocial Status: Memory Deficit ...." The clinical record also included a comprehensive assessment, completed on 3/17/21 by RN #1. The comprehensive assessment included a section titled "Mental Status," which indicated Patient #1 was "Alert. Oriented [to] Person, Place, Time." The plan of care failed to evidence the patient's mental, cognitive, and psychosocial status followed the comprehensive assessment. The POC included a section titled "Prognosis," which indicated the patient's prognosis was "Good." The comprehensive assessment stated the patient's prognosis was "Fair." The plan of care failed to evidence a patient prognosis which followed the comprehensive assessment. The POC included a section titled "Nutritional Requirements," which stated " ... No teeth, no dentures, soft food by mouth ...." The comprehensive assessment included a section titled "Nutrition/Hydration Status," which stated " ... Diet: ... Restricted/type: Low carb ... Difficulty chewing/swallowing ...." The plan of care failed to evidence the patient's nutritional requirements	{G 574}		

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{G 574}	Continued From page 22 followed the comprehensive assessment. The POC included a section titled "Hospital Risk Factor" which stated " ... Client is at risk for hospitalization due to multiple comorbidities including COPD, [Diabetes], Edema [swelling of an extremity], and high fall risk. HHA [Home Health Aide] will assist in ADLs including supervision of and assistance with ambulation utilizing walker and/or wheelchair, assistance with toileting/incontinence care to prevent skin breakdown, and give medication reminders to prevent missed doses and flair-ups ...." The comprehensive assessment included a section titled "Risk for Hospitalization" which indicated the patient's risk factors for ED visits and hospitalization were " ... History of falls ... Multiple hospitalizations ... Multiple emergency department visits ... Decline in mental, emotional, or behavioral status ... Additional notes regarding hospital risk and intervention/education: Patient educated on the importance of checking his legs for signs of inflammation (redness, rashes, skin hot to touch) as it could be early signs of returning cellulitis ...." The plan of care failed to evidence a complete list of hospitalization risk factors which aligned with the comprehensive assessment and failed to evidence interventions specific to all the patient's ED visit and hospitalization risk factors. The POC included a section titled "Advance Directives," which stated " ... Patient denies advance directives and wishes to be a full code ...." The POC's "Admission Summary completed on 1/21/2021" stated " ... Patient denies advance directives and wishes to be a full code ...," and the "60 Day Summary -3/17/21" stated " ... Patient has a DNR which can be found in patient's binder ...." The comprehensive	{G 574}		

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{G 574}	Continued From page 23 assessment included a section titled "Advance Directives," which indicated the patient's code status was "DNR [Do Not Resuscitate, the patient declined any life-saving measures in the event of cardiac or respiratory arrest]." The plan of care failed to evidence the patient's code status and presence or absence of advance directives followed the comprehensive assessment. 6. The clinical record of Patient #24 was reviewed on 4/6/21 and 4/7/21, and indicated a start of care 1/19/21, with patient diagnoses including but not limited to: COPD, essential hypertension (high blood pressure), diabetes type 2, bipolar disorder, major depressive disorder, GERD, syncope (fainting), anxiety, angina (chest pain), hypothyroidism (underactive thyroid gland), and seborrheic dermatitis (skin condition of the scalp). The clinical record included a plan of care for the recertification period 3/20/21 - 5/18/21. The plan of care included a section titled "Mental Status" which indicated the patient was "Oriented, Forgetful, Agitated, Depressed, and Lethargic." The clinical record included a comprehensive assessment completed on 3/18/21 by the Alternate Clinical Manager. The assessment included a section titled "Mental Status" which indicated the patient was "Alert. Oriented [to] Person, Place, Time." The plan of care failed to evidence the patient's mental status which followed the comprehensive assessment. The POC included a section titled "DME / Supplies," which indicated the patient's DME supplies included " ... CPR shield, gloves, hand sanitizer, wheelchair, walker, cane, shower bench, grab bar, incontinence pads, oxygen tubing, diabetic supplies ... oxygen supplies (tubing, concentrator)." The comprehensive assessment stated " ... Safety Measures ...	{G 574}		

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{G 574}	Continued From page 24 Contact Precautions [preventative measures, such as specific PPE, used to prevent the spread of transmissible diseases or infestations] ... Home Environment Safety: ... Insects / rodents ... Additional Notes / Narrative: Caregiver observed wearing gown, shoe coverings, hair net, gloves, and surgical mask ...." The plan of care failed to evidence the patient's requirement for contact precautions due to an insect infestation. The POC included a section titled "Prognosis," which indicated the patient's prognosis was "Good." The comprehensive assessment stated the patient's prognosis was "Fair." The plan of care failed to evidence the patient's prognosis followed the comprehensive assessment. The POC included a section titled "Hospital Risk Factors," which stated "Client is at a medium hospitalization risk due to multiple comorbidities. A HHA will assist client with ADLs to help prevent falls and hospitalizations as well [as] medication reminders to prevent missed doses." The comprehensive assessment included a section titled "Risk for Hospitalization," which indicated the patient's risk factors were " ... History of falls ... Currently taking 5 or more medications ...." The plan of care failed to evidence a complete list of the patient's risk factors for hospitalization and ER visits. The POC included a section titled "Goals" which stated " ... Patient will safely perform ADLs with assist of HHA as reported by HHA and patient ...." The plan of care failed to evidence goals which were measurable. 7. An interview was conducted on 4/5/21 at 3:47 PM with the Administrator and Alternate Administrator. During the interview, the	{G 574}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 574}	Continued From page 25 Administrator indicated the plan of care should follow the comprehensive assessment and should include all patient supplies required, all patient activities permitted, all patient nutritional needs, patient-specific interventions related to ED visits and hospitalization risk factors, measurable goals, and detailed information on the patient's advance directives, if present. 17-13-1(a)(1)(C)(i, ii, iv, v, xiii)	{G 574}		
{G 590}	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed ensure the patient's medical provider was notified of a change in the patient's condition for 3 of 3 records with a noted change in patient condition (#2, 16, 23), in a total sample of 24 records. Findings include: 1. An agency job description titled "Adaptive Nursing and Healthcare Services. Job Description. Position: Program Manager," revised 11/11/16, stated " ... Responsibilities/essential functions: 7. Rotate on-call service, which will include answering calls and staffing shifts ... 12. Report abnormal findings in the client's condition to the [Administrator] ...." 2. An agency document titled "Change in Condition In-Service," dated 3/8/21, stated " ... Any change in the client's condition must be	{G 590}		

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{G 590}	Continued From page 26 conveyed to the physician. This includes but is not limited to ... 3. Hospitalizations or ER visits ... 6. Any decline in the health status of the client ... 15. Any abnormal breathe [sic] sounds ... 16. Any significant weight gain ... All changes or issues [the nurse] find[s] during the visit should be called to the MD ..." 3. The agency's On-Call Log was reviewed on 4/5/21, and included a document titled "Daily On-Call Report," dated "3/12/21 - 3/15/21." The document indicated a call was placed to the agency's on-call line on 3/12/21 at 5:20 PM by HHA #2, and the "Reason for Call" stated "[HHA #2] called 911 because [Patient #16] was having trouble breathing and wasn't feeling well." The document also indicated a second call was placed to the agency's on-call line on 3/15/21 by HHA #3, and the "Reason for Call" stated "[HHA #3] calling about [Patient #16] being diagnosed with COVID-19." The document's "Follow - Up Needed" stated "[On-call receiving employee (not indicated on form)] emailed [Administrator] about the situation and informed [RN #3] ...." The clinical record of Patient #16 was reviewed on 4/6/21 and 4/7/21, and indicated a start of care date of 9/30/2020, with patient diagnoses including but not limited to: spinal stenosis, asthma, and fibromyalgia. The clinical record included a plan of care for the certification period 1/28/21 - 3/28/21, which included the service orders for HHA visits 4 hours per day, 5 days per week. The record included a "Daily Visit Sheet," dated 3/12/21 and documented by HHA #2. The aide visit note stated " ... Unusual Findings: [Patient #16] felt hot to the touch and was cold but when we checked her [temperature] it was 95.6 [degrees Fahrenheit] ...."	{G 590}		

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{G 590}	Continued From page 27 The record included a "Activity" note, documented on 3/15/21 at 10:01 AM by Operations Manager #1. The note stated " ... [Patient #16] tested positive for COVID-19 on 3/15/21. All caregivers who work with her need to be in full [Personal Protective Equipment] until 3/23/21 ...." The clinical record failed to evidence Patient #16's physician was notified of the patient's report of shortness of breath and need for agency staff to call 911 and failed to evidence the patient's physician was notified of the patient's diagnosis of COVID-19. 4. The clinical record of Patient #2 was reviewed on 3/30/21 and 3/31/21, and indicated a start of care of 4/9/2020, with patient diagnoses including but not limited to COPD (Chronic Obstructive Pulmonary Disorder), Diabetes Type 2, arthritis, GERD (Gastroesophageal Reflux Disease), urinary incontinence, and history of pacemaker placement. The record included a plan of care for the recertification period of 2/3/21 - 4/3/21, which contained service orders for home health aide (HHA) visits 3 hours a day, 5 days per week, not to exceed 15 hours per week. The clinical record included a "Note" on the visit calendar, documented on 3/12/21 by Program Manager #2, which stated "[Program Manager] received call from [Patient #2] at 1 PM cancelling shift due to her sugar acting being [sic] very high ... Client does have emergency contact to help in the absence of [HHA staff] ...." The clinical record failed to evidence Program Manager #2 notified the Administrator of the patient reporting elevated blood sugars per agency job description and failed to evidence the patient's medical provider was notified of the change in patient condition. A home visit observation was conducted on	{G 590}		

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{G 590}	Continued From page 28 3/30/21 at 1:06 PM with Patient #2 and RN #1. During the visit, Patient #2 reported to RN #1 she was "sick ... a few weeks ago [3/12/21]," and that her blood sugar readings were "300 - something." The patient reported she cancelled her HHA visit for the day due to not feeling well and "almost" went to the ED to be evaluated, but decided against it. Patient #1 reported her blood sugars improved and she felt better the next day. 5. The clinical record of Patient #23 was reviewed on 4/6/21 and 4/7/21, and indicated a start of care of 1/21/21, with patient diagnoses including but not limited to: COPD, history of falls, Diabetes, amnesia, history of venous thrombosis and embolism, GERD, depression, eczema, and mild dementia. The record included a comprehensive assessment completed on 3/17/21 by RN (Registered Nurse) #1 for the recertification period 3/22/21 - 5/20/21. The assessment indicated the patient's breathing was "shallow," he had nasal flaring (observation of a patient's nostrils widening during breathing, often indicating shortness of breath), and "crackles / rales ... wheeze" sounds (abnormal lung sounds which could indicate fluid or swelling in the lungs) heard on lung auscultation. The comprehensive assessment stated " ... Additional Notes / Narrative: ... During physical exam RN noted that patient had wheezing in bilateral [right and left] lungs, and crackles auscultated in R [right] lower lung. Patient has gained 20 lbs [pounds] since 3/5[/21] per wife. Patient had +3 pitting edema [swelling which results in indentation to the extremity, graded on a +1 to +4 scale] to the bilateral lower extremities. Patient's R toes were cool to touch with purple undertones. Cap refill [capillary refill] was > 3 seconds on R toe ...." The assessment indicated RN #1 called the patient's medical provider to notify them of the	{G 590}		

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{G 590}	Continued From page 29 abnormal assessment findings, however the assessment failed to evidence the date and time the RN contacted the patient's provider. The comprehensive assessment included a "Medication Report," reviewed and signed by RN #1 on 3/17/21. The medication list indicated the patient was taking furosemide (medication given to decrease excess swelling, also called Lasix) 40 milligrams (mg), 1 tablet once a day. A "Communication" note was documented on 3/18/21 at 10:53 AM by RN #1 which stated " ... Notes: RN spoke with [nurse for Patient #23's medical provider] and made her aware of physical assessment findings from yesterday (rapid weight gain, poor perfusion to R toes, edema to bilateral lower extremities, and crackles in R lung base) that suggests patient may be have CHF [Congestive Heart Failure] exacerbation ...." A "Communication" note was documented on 3/23/21 at 2:18 PM by RN #2 which stated " ... Note: [RN #2] with [nurse for Patient #23's medical provider] to report [Patient #23 was] taking two 40 mg Lasix when [the provider] had ordered one 40 mg tablet a day. The other [agency nurse, RN #1] saw [the patient] on 3/17/21 and reported crackles in both lung bases and a twenty-pound weight gain. [RN #1] did report it to [the provider on] 3/18/21. [RN #2] called [Family Member #2] to check on [the patient] today and [the family member] said that she increased [the patient's] Lasix from one 40mg tablet to two 40 mg tables, and [the patient] lost 5.5 pounds since 3/17/21. [The medical provider's nurse] said [Patient #23] should go back to one 40 mg tablet a day. [RN #2] told the nurse that [the patient] needed to be seen if [the medical provider's nurse] wanted [Patient #23] to	{G 590}		

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{G 590}	Continued From page 30	{G 590}		

decrease the Lasix. [The medical provider's nurse] agreed and stated she would call [the patient]."

A "Communication" note was documented on 3/23/21 at 3:00 PM by RN #2 which stated " ... Note: [RN #2] spoke with [Family Member #2] to explain [the] conversation with [the patient's medical provider's nurse]. The PCP [primary care provider] office had not called [the patient]. [RN #2] asked [Family Member #2] to call [the PCP's office] to get [Patient #23] in to be seen ASAP due to the fluid in his lungs. [Family Member #2] stated she will call and [RN #2] let [the family member] know [the RN] will call tomorrow to check [on the patient] ... [RN #2] will update accordingly." The clinical record failed to evidence any further documentation regarding the nurse following up on the patient's condition.

An interview was conducted on 4/7/21 at 1:21 PM with RN #1. During the interview, RN #1 indicated the assessment of Patient #23 on 3/17/21 was the first time she had met and assessed the patient. RN #1 stated the patient's wheezing and crackle lung sounds were "worse" than his baseline. The nurse was unsure of the patient's baseline pulses in his feet. RN #1 also stated she contacted Patient #23's medical provider while she was in the home with the patient, spoke with the medical provider's nurse to advise her of the abnormal assessment findings, recommended the patient be seen, and the office nurse reported she would call RN #1 back. RN #1 indicated she then reported the abnormal findings to RN #2, as RN #2 was Patient #23's case manager. RN #1 also indicated she did not follow up further on the patient's condition.

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{G 590}	Continued From page 31 An interview was conducted on 4/7/21 at 1:32 PM with Family Member #2. During the interview, Family Member #2 indicated when RN #2 was in the home on 3/17/21, the family member stated the nurse did not call the patient's medical provider to report her abnormal assessment findings while the nurse was in the home. Family Member #2 stated she asked RN #2 if the nurse was going to call the provider or if the family member should call, and the family member indicated RN #2 stated she would call the provider. Family Member #2 also indicated she did not hear anything back from RN #2, the home health agency, or the patient's medical provider for "a week and a half," so the family member decided to increase the patient's Lasix dosage to increase the amount of fluid removed. 6. A follow up interview was conducted on 4/7/21 at 11:24 AM with the Administrator and Agency Consultant #1. During the interview, the Administrator indicated the RN should notify the patient's physician of a change in patient condition "right away ... can be within 24 hours." The Administrator also indicated the Program Manager should immediately notify the administrator or RN of a patient report of illness. 17-13-1(a)(2)	{G 590}		
G 616	Patient medication schedule/instructions CFR(s): 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to	G 616		

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G 616	Continued From page 32	G 616		

ensure a list of the patient's medications, including a schedule and instructions for administration, was present in the home for 1 of 2 home visit observations (#1).

Findings include:

An agency policy titled "Plan of Treatment," revised 4/10/19, stated " ... Procedure: (1) As follows, the medical plan of care shall: ... (C) Include the following: ... (x) All medications and treatments ...."

An undated agency job description titled "Adaptive Nursing & Healthcare Services. Job Description. Position: Nursing Supervisor / Clinical Manager," stated " ... Essential Functions / Areas of Accountability: ... 2. Performs initial and ongoing client assessments ... to ensure effective and appropriate home care services ... 9. Manages / supervises a team ... to provide effective and quality home care services ...."

An agency document titled "Lafayette Plan of Correction Training Attestation," dated 2/23/21, stated " ... Home binder [should include] ... current POC [plan of care] ... Binder to be updated with any changes immediately ...."

A home visit observation was conducted on 3/30/21 at 8:26 AM with Patient #1 (start of care 1/26/2021). During the home visit, the surveyor requested to review the patient's home binder provided by the agency. Family Member #1 and HHA (Home Health Aide) #1 both attempted to find the home binder, but were unable to locate it. Family Member #1 stated "I don't have it." HHA #1 reported an agency nurse (she was unable to name a specific employee) had brought a visit schedule, aide care plan, and patient handbook

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G 616	Continued From page 33 to the patient's home "a few weeks ago," and had requested the family member or HHA place the items within the patient's home binder. Family Member #1 denied receiving a list of the patient's medications, including a schedule and instructions for administration, from the agency. An interview was conducted on 3/30/21 at 4:27 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the patient's home binder, which should include a medication list for the patient, should be present in the home.	G 616		
G 618	Treatments and therapy services CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the patient's plan of care was present in the home for 1 of 2 home visit observations (#1). Findings include: An undated agency job description titled "Adaptive Nursing & Healthcare Services. Job Description. Position: Nursing Supervisor / Clinical Manager," stated " ... Essential Functions / Areas of Accountability: ... 2. Performs initial and ongoing client assessments ... to ensure effective and appropriate home care services ... 9. Manages / supervises a team ... to provide effective and quality home care services ...." An agency document titled "Lafayette Plan of Correction Training Attestation," dated 2/23/21, stated " ... Home binder [should include] ...	G 618		

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G 618	Continued From page 34 current POC [plan of care] ... Binder to be updated with any changes immediately ...." A home visit observation was conducted on 3/30/21 at 8:26 AM with Patient #1 (start of care 1/26/2021). During the home visit, the surveyor requested to review the patient's home binder provided by the agency. Family Member #1 and HHA (Home Health Aide) #1 both attempted to find the home binder, but were unable to locate it. Family Member #1 stated "I don't have it." HHA #1 reported an agency nurse (she was unable to name a specific employee) had brought a visit schedule, aide care plan, and patient handbook to the patient's home "a few weeks ago," and had requested the family member or HHA place the items within the patient's home binder. Family Member #1 denied receiving the patient's plan of care from the agency. An interview was conducted on 3/30/21 at 4:27 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the patient's home binder, which should include a current plan of care, should be present in the home.	G 618		
{G 622}	Name/contact information of clinical manager CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the patient's home binder included the name and contact information for the agency's clinical manager for 2 of 2 home visit observations (#1, 2). Findings include:	{G 622}		

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{G 622}	Continued From page 35 1. An undated agency job description titled "Adaptive Nursing & Healthcare Services. Job Description. Position: Nursing Supervisor / Clinical Manager," stated " ... Essential Functions / Areas of Accountability: ... 2. Performs initial and ongoing client assessments ... to ensure effective and appropriate home care services ... 9. Manages / supervises a team ... to provide effective and quality home care services ...." 2. An agency document titled "Lafayette Plan of Correction Training Attestation," dated 2/23/21, stated " ... Home binder [should include] ... contact [information] of clinical manager and administrator ...." 3. A home visit observation was conducted on 3/30/21 at 8:26 AM with Patient #1 (start of care 1/26/2021). During the home visit, the surveyor requested to review the patient's home binder provided by the agency. Family Member #1 and HHA (Home Health Aide) #1 both attempted to find the home binder, but were unable to locate it. Family Member #1 stated "I don't have it." HHA #1 reported an agency nurse (she was unable to name a specific employee) had brought a visit schedule, aide care plan, and patient handbook to the patient's home "a few weeks ago," and had requested the family member or HHA place the items within the patient's home binder. The agency's patient handbook, titled "Patient Orientation for Home Health Care," included a section where the clinical manager's name and contact information could be written in, which was observed to be left blank. 4. A home visit observation was conducted on 3/30/21 at 1:06 PM with Patient #2 (start of care 4/9/2020). During the home visit, the patient's	{G 622}		

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{G 622}	Continued From page 36 home binder was reviewed. The home binder included the agency's patient handbook, which listed Former Employee #1 was as the Clinical Manager. The home binder failed to evidence the name of the Clinical Manager was updated to reflect the most current employee in the role (Administrator / Clinical Manager). 5. An interview was conducted on 3/30/21 at 4:27 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the patient's home binder should include the name and contact information of the clinical manager.	{G 622}		
{G 682}	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This Standard is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all employees followed agency infection control policies and procedures and standard precautions for 2 of 2 home visit observations (#1, 2). Findings include: 1. An agency policy titled "Handwashing policy," revised 5/15/20, stated " ... The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: ... After caring for a client ... The World Health Organization note that washing times of at least 45 seconds will remove most transient microorganisms from the skin ... Procedure ...	{G 682}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 682}	Continued From page 37 11. Wash hands ... for at least 45 seconds ... If hands are not visibly soiled, use an alcohol-based rub for routinely decontaminating hands and in the following situations: before and after having direct contact with patients ... between tasks and procedures on the same patient ... before moving from a contaminated body site to a clean body site during patient care. After removing gloves. Instant Hand Antiseptic Gel [procedure] A. Dispense the alcohol gel into the palm of the hand. B. Briskly rub hands together ... C. Continue rubbing hands together until the skin is dry ...." 2. An agency policy titled "OSHA Infection Control/Exposure Control Plan," revised 3/21/12, stated " ... Special Instructions: 1. Client infection control procedures shall include, but not limited to: a. Wearing and changing gloves as necessary during the delivery of client care ... c. Appropriate handling and disposal of waste products ... f. Frequent hand washing by home health care employees: Before and after the provision of direct client care ... After removing gloves ... i. Use of appropriate protective equipment including gloves, gowns, and masks when indicated ...." 3. A home visit observation was conducted on 3/30/21 at 8:26 AM with Patient #1 (start of care 1/26/2021) and Home Health Aide (HHA) #1. During the visit, HHA #1 was observed informing the patient he was to receive a bed bath, left the room to obtain supplies, and donned gloves. During the bed bath, HHA #1 cleaned the patient's scrotum and penis with a disposable bath wipe, obtained a new bath wipe, and began cleaning Patient #1's arms. After completing the patient's bath and transfer to the bedside commode, the aide removed her gloves, removed	{G 682}		

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{G 682}	Continued From page 38 soiled linens from the patient's bed, placed them in the laundry hamper, and washed her hands with soap and water, scrubbing for 31 seconds. After the patient had finished voiding, Patient #1 was transferred by bedside commode to the kitchenette area, where he had two grab bars installed on the wall. The aide applied new gloves, wiped the patient's rectum, removed her gloves, and HHA #1 and Family Member #1 assisted the patient with standing. HHA #1 then pulled up the patient's disposable adult brief and pants with ungloved hands. After the patient's brief and pants were appropriately positioned, he was assisted to sit in his wheelchair, and the aide readjusted her masks with her hands. HHA #1 and Family Member #1 completed dressing and positioning the patient, the aide performed hand hygiene using alcohol-based hand sanitizer (ABHS) by applying the hand sanitizer, rubbing it in her hands, then waving her arms back and forth to allow the sanitizer to dry. The HHA failed to perform hand hygiene prior to donning gloves twice, failed to change gloves and perform hand hygiene after cleaning the patient's perineal area and before moving to another area of the body to clean, failed to wear gloves when handling soiled linens, failed to perform hand washing technique according to agency policy, failed to perform hand hygiene after removing gloves twice, failed to perform patient dressing with gloved hands, and failed to perform hand hygiene with ABHS according to agency policy. 4. A home visit observation was conducted on 3/30/21 at 1:06 PM with Patient #2 (start of care 4/9/2020) and RN #1. During the home visit, RN #1 retrieved her tablet from her nursing bag, placed her tablet on a drape and opened it, applied ABHS to her hands, began to rub her hands together, started to chart on the tablet with	{G 682}		

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{G 682}	Continued From page 39 her hands, stopped to rub her hands together more to dry the ABHS, and repeated the step of charting on the tablet with her hands and stopping to rub her hands together once more. The RN failed to perform hand hygiene with ABHS according to agency policy. 5. An interview was conducted on 3/30/21 at 4:27 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated staff should perform hand hygiene prior to donning and after removing gloves, should change gloves after cleaning the perineal area and before moving to another area of the body to wash, and should wear gloves to handle soiled linen. The Administrator also indicated when performing hand hygiene with alcohol-based hand sanitizer, staff should rub their hands until dry prior to moving on to further tasks. 17-12-1(m)	{G 682}		
{G 706}	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This Element is not met as evidenced by: Based on observation, record review and interview, the Registered Nurse (RN) failed to conduct and document a complete and thorough assessment per professional and agency standards for 1 of 1 skilled nurse visit observations (#2). Findings include: 1. An agency job description titled "Adaptive Nursing and Healthcare Services. Job Description. Position: ... RN ...," revised 4/9/19,	{G 706}		

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{G 706}	Continued From page 40 stated " ... Responsibilities / Essential Functions: ... 2. Be able to regularly re-evaluate the needs of the patients. 3. Completes assessments ...." 2. An agency document titled "Change in Condition In-service," dated 3/8/21, stated " ... Genitourinary: Is the client incontinent [unable to hold their urine] of urine ... Are they having any burning with urination or pain? Are they having issues with hesitancy [difficulty starting urination] or nocturia [frequent urination at night]? ... Is there [sic] urine clear or cloudy, is there an odor, what is the color of the urine, is there any blood noted in the urine ... Please note we should notify the MD for any of the issues listed above ...." 3. Constantine, Salmon, & Maryniak (January 16, 2012). "Overview of Nursing Health Assessment." Retrieved 4/16/21 from RN.com. " ... Female Reproductive System. When examining the reproductive system, ask about the following: Do you urinate more than usual? ... Any pain or burning upon urination? Any difficulty starting or maintaining the stream of urine? Any blood in your urine? Any difficulty controlling your urine? ...." 4. A home visit observation was conducted on 3/30/21 at 1:06 PM with Patient #2 and RN #1. During the visit, RN #1 performed a comprehensive assessment of the patient. During the assessment, RN #1 asked Patient #1 what her urine color was, and the patient reported it was the normal color of urine, and had a "strong odor." RN #1 asked the patient was the odor of her urine was, but the patient was unable to distinguish the odor to her urine any further and stated again the odor was "strong." RN #1 failed to further the patient for the presence or absence of other abnormal urinary findings (burning or	{G 706}		

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{G 706}	Continued From page 41 pain with urination, blood in the urine, urinary incontinence, urinary hesitancy, urinary frequency, etc). Later during the visit, RN #1 called the patient's medical provider and reported the patient's complaint of strong urine. An interview of Patient #2 was conducted on 3/30/21 at 2:42 PM. During the interview, Patient #2 reported occasionally she has pressure in her abdomen with urination and "feel like I have to push out" the urine. Patient #2 denied burning with urination, pain in her back or flank, and stated "I don't have a UTI [urinary tract infection] ... I know those symptoms." 5. An interview was conducted on 3/30/21 at 4:27 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated if a patient reported strong odor to their urine the nurse should perform a focused assessment for signs and symptoms of a UTI. 6. A follow up interview was conducted on 3/30/21 at 4:39 PM with the Administrator. During the interview, the Administrator indicated she reviewed the findings from RN #1's home visit with Patient #2 with the nurse, and the nurse had reported she did perform a focused assessment of the patient for signs and symptoms of a UTI after the patient reported a strong odor. The surveyor informed the Administrator that both surveyors present at the home visit did not observe this assessment, and the surveyors had started to ask the patient if she had further symptoms of a UTI before the patient interrupted the surveyors to deny further symptoms. 17-12-2(g)	{G 706}		
{G 798}	Home health aide assignments and duties	{G 798}		

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{G 798}	Continued From page 42 CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This Standard is not met as evidenced by: Based on record review and interview, the Registered Nurse (RN) failed to develop a Home Health Aide (HHA) care plan which was patient-specific and detailed for 3 of 3 active records reviewed (#1, 23, 24), in a total sample of 24 records. Findings include: 1. The agency policy titled "Home Health Aide Care Plan," revised 8/1/12, which stated "Policy. A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... Special Instructions: 1. Following the initial nursing assessment and consultation with the client/caregiver, a written plan identifying personal care and supportive care services are prepared by a Registered Nurse ... 2. The Care Plan shall be developed in plain, non-technical lay terms and identify the duties to be performed such as, but not limited to: a. Personal Care. b. Ambulation ... c. Household services essential to health care at home. d. Assistance with medications that are ordinarily self-administered ...." 2. An agency job description titled "Adaptive	{G 798}		

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{G 798}	Continued From page 43 Nursing and Healthcare Services. Job Description. Position: Nursing Supervisor/Clinical Manager," revised 4/9/19, stated " ... Essential Functions/Areas of Accountability: ... 4. Collaborates with physicians, other health care professionals ... clients, and families in developing a comprehensive, coordinated plan for care ...." 3. An agency job description titled "Adaptive Nursing and Healthcare Services. Job Description. Position: HHA, Home Health Aide," revised 4/9/19, stated " ... Responsibilities/essential functions: ... 1. Follow the instructions of the nursing supervisor ... 3. Observe and report any safety hazards found in the client's home or any significant observations regarding the client ...." 4. The clinical record of Patient #1 was reviewed on 3/29/21 and 4/2/21 and indicated a start of care date of 1/26/2021, with patient diagnoses including but not limited to: Parkinson's Disease, systemic lupus erythematosus (autoimmune disease which results in damage to organs and tissues of the body), legal blindness, SICCA syndrome (dryness of the eyes and mouth, often caused by Sjogren's syndrome), incontinence (inability to control the bowels or bladder), anxiety, hallucinations, inguinal hernia (bulging of abdomen into the groin), and presence of a pressure ulcer (type of wound caused by prolonged pressure to the body site). The record included a plan of care for the recertification period 3/27/2021 - 5/25/2021, which contained orders for HHA services to be provided 5 hours per day, 5 days per week, not to exceed 25 hours per week. HHA tasks were to include "assist with all ADLs [Activities of Daily Living] such as bathing (showering/bed), hair care, dressing nail	{G 798}		

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{G 798}	Continued From page 44 care (no clipping), incontinence care, meal prep, medication reminders, light housekeeping, and transfers ...." The record included a "Plan of Care Service Plan," reviewed and signed by RN #1on 3/29/21, which contained the HHA tasks " ... Assist with Ambulation ... wheelchair only ... Mobility Assist ([with] transfers) ... per family only ... Bed Bath ... until shower chair and lift are repaired ... Partial Bath ... as needed and with incontinent care ... Assist with Elimination (Toileting) ... assist patient to toilet and perform [perineal] care as needed ...." The RN failed to ensure the aide care plan was detailed, patient-specific, and did not contain conflicting information regarding how the HHA was to ambulate and toilet the patient. 5. The clinical record of Patient #23 was reviewed on 4/6/21, and indicated a start of care of 1/21/21, with patient diagnoses including but not limited to: COPD (Chronic Obstructive Pulmonary Disorder), history of falls, Diabetes, amnesia, history of venous thrombosis and embolism, GERD (Gastroesophageal Reflux Disease), depression, eczema, and mild dementia. The record included a plan of care for the recertification period 3/22/21 - 5/20/21, which contained orders for HHA services to be provided 6 hours per day, 5 hours per week, not to exceed 30 hours per week. HHA tasks were to include " ... assist with all ADLs such as bathing (shower), hair care, dressing, nail care (no clipping), incontinence care, meal prep, medication reminders, light housekeeping, and transfers ...." The clinical record also included a "Plan of Care Service Plan," reviewed and signed by RN #1 on 3/18/21, which contained the HHA tasks " ... Skin Care ... non-prescription lotions / creams / powders ... Medication Reminder ... reminders only ...." The RN failed to ensure the aide care	{G 798}		

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{G 798}	Continued From page 45 plan was detailed and patient-specific. 6. The clinical record of Patient #24 was reviewed on 4/6/21 and 4/7/21, and indicated a start of care 1/19/21, with patient diagnoses including but not limited to: COPD, essential hypertension (high blood pressure), diabetes type 2, bipolar disorder, major depressive disorder, GERD, syncope (fainting), anxiety, angina (chest pain), hypothyroidism (underactive thyroid gland), and seborrheic dermatitis (skin condition of the scalp). The clinical record included a plan of care for the recertification period 3/20/21 - 5/18/21, which contained orders for HHA services to be provided 4 hours per day, 5 days per week, not to exceed 20 hours per week. HHA tasks were to include " ... assist with all ADLs such as bathing (shower), hair care, dressing, nail care (no clipping), incontinence care, meal prep, medication reminders, light housekeeping, and transfers ...." The plan of care also stated " ... Professional Service Orders ... HHA to inform office / RN if [blood] sugar < 60 or > 350 ... [Recertification] completed on 3/18/21 ... O2 [Oxygen] on 4 [liters per minute (L/min) per nasal cannula, continuous] ... Activities Permitted: Wheelchair, Walker, Up as Tolerated, and Cane ...." The clinical record also included a "Plan of Care Service Plan," reviewed and signed by the Alternate Clinical Manager on 3/25/21, which contained the aide tasks " ... Mobility Assist ([with] transfers) ... Assist with transfers to wheelchair or walker ... Assist with Ambulation ... Walker, wheelchair ... Other ... Observe for signs / symptoms of hypo [low] / hyperglycemia [elevated blood sugar] such as: pallor [paleness], sweating, confusion, nausea and vomiting. HHA to report these findings immediately to Office RN and in emergency situation call 911 ... Foot Care ... Apply non-medicated lotions ... Skin Care ...	{G 798}		

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{G 798}	Continued From page 46 Apply non-medication lotion as needed ... Other: Oxygen via nasal cannula continuously at 3 - 4 L/min [liters per minute, how oxygen is dosed] ... Medication Reminder ... Medication and blood sugar check reminders ...." The RN failed to ensure the aide care plan was detailed and patient-specific. 7. An interview was conducted on 4/5/21 at 3:47 PM with the Administrator and Alternate Administrator. During the interview, the Administrator indicated the aide care plan should be patient specific and detailed. 8. A follow up interview was conducted on 4/7/21 at 11:24 AM with the Administrator and Agency Consultant #1. During the interview, the Administrator indicated the HHA care plan task instructions "Apply non-medication lotion as needed" indicated the aide was to not apply medicated lotions or creams, and the aide care plan did not need to list the specific non-medicated lotions, creams, or powders the aide could administer. The administrator also indicated the aide care plan did not need to list the patient-specific times the HHA was to perform medication reminders. 17-13-2(a)	{G 798}		
{G 800}	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This Element is not met as evidenced by: Based on observation, record review, and	{G 800}		

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{G 800}	Continued From page 47 interview, the home health aide (HHA) failed to follow the aide care plan as written for 1 of 1 HHA home visit observations (#1). Findings include: The agency policy titled "Home Health Aide Care Plan," revised 8/1/12, which stated "Policy. A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... Special Instructions: 1. Following the initial nursing assessment and consultation with the client/caregiver, a written plan identifying personal care and supportive care services are prepared by a Registered Nurse ... 2. The Care Plan shall be developed in plan, non-technical lay terms and identify the duties to be performed such as, but not limited to: ... b. Ambulation ...." An agency job description titled "Adaptive Nursing and Healthcare Services. Job Description. Position: HHA, Home Health Aide," revised 4/9/19, stated " ... Responsibilities/essential functions: ... 1. Follow the instructions of the nursing supervisor ...." An undated agency document titled "HHA scope of practice and following the plan of care service plan" stated " ... Following the plan of care service plan: ... All tasks listed are ordered on the plan of care by physician based on patient need ...." A home visit observation was conducted on 3/30/21 at 8:26 AM with Patient #1 (start of care 1/26/2021) and Home Health Aide (HHA) #1. During the visit, HHA #1 was observed assisting Patient #1 to the bedside commode using a sit-to-stand lift with Family Member #1. After the patient had finished voiding, Patient #1 was	{G 800}		

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{G 800}	Continued From page 48	{G 800}		

transferred by bedside commode to the kitchenette area, where he had two grab bars installed on the wall. HHA #1 and Family Member #1 assisted the patient with standing, his disposable adult brief and pants were pulled up, and the aide and family member assisted the patient to sit back in his wheelchair.

The clinical record of Patient #1 was reviewed on 3/29/21 and 4/2/21 and indicated patient diagnoses including but not limited to: Parkinson's Disease, systemic lupus erythematosus (autoimmune disease which results in damage to organs and tissues of the body), legal blindness, SICCA syndrome (dryness of the eyes and mouth, often caused by Sjogren's syndrome), incontinence (inability to control the bowels or bladder), anxiety, hallucinations, inguinal hernia (bulging of abdomen into the groin), and presence of a pressure ulcer (type of wound caused by prolonged pressure to the body site). The record included a plan of care for the recertification period 3/27/2021 - 5/25/2021, which contained orders for HHA services to be provided 5 hours per day, 5 days per week, not to exceed 25 hours per week. HHA tasks were to include "assist with all ADLs [Activities of Daily Living] such as bathing (showering/bed), hair care, dressing nail care (no clipping), incontinence care, meal prep, medication reminders, light housekeeping, and transfers ...." The record included a HHA care plan, reviewed and signed by RN #1on 3/29/21, which contained the tasks " ... Assist with Ambulation ... wheelchair only ... Mobility Assist ([with] transfers) ... per family only ... All transfers to be completed by patient's [family members] until lift is repaired ...." HHA #1 failed to follow the aide care plan by assisting Family Member #1 with transferring the patient from the bed to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K173	A. BUILDING _____ B. WING _____	R-C 03/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 800}	Continued From page 49 bedside commode with the sit-to-stand and with assisting the patient to stand using grab bars and then into the wheelchair, when directed by the aide care plan for the family to complete all transfers until the lift was fixed. An interview was conducted on 3/31/21 at 4:27 PM with the Administrator. During the interview, the administrator indicated the home health aide should follow the aide care plan and not perform tasks that were not written within the aide care plan.	{G 800}		
{G 978}	Must have a written agreement CFR(s): 484.105(e)(2)(i-iv) An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure written agreements were in place which delineated the services each agency was to provide for 1 of 1 active record reviewed with another home health agency (#20), in a total sample of 24 records.	{G 978}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K173	A. BUILDING _____ B. WING _____	R-C 03/23/2021

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

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{G 978}	Continued From page 50 Findings include: An agency policy titled "Coordination of Care," revised 3/29/18, stated " ... Purpose: ... To establish effective interchange, reporting, and coordination of client care does occur ... avoid duplication of services ... To ensure continuity of care ... Special Instructions: ... 3. After the initial assessment, the admitting Registered Nurse/Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure: ... e. Need for other services and/or referral to community resources ... g. Coordination with other agencies and institutions, if the need arises ... 11. Client care will be coordinated with other agencies in the home, dialysis facilities, physicians, caregivers, in the home, family and the client. The plan of care will be provided to the others involved in the client's care and we will also request a copy of their plan of care. This will be documented in the client records ...." An agency job description titled "Adaptive Nursing and Healthcare Services. Job Description. Position: Nursing Supervisor / Clinical Manager," revised 4/9/19, stated " ... Essential Functions/Areas of Accountability ... 4. Collaborates with physicians, other health care professionals ..., clients, and families in developing a comprehensive, coordinated plan for care ... 8. Communicates with other disciplines/departments when required ...." An agency document titled "Coordination of Care In-service," dated 3/8/21, stated " ... Coordination of Care will be completed on all care provided by other entities other than Adaptive personnel. This includes any and all services and treatments provided to any Adaptive clients by another person or company ...."	{G 978}		

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	15K173	A. BUILDING _____ B. WING _____	R-C 03/23/2021

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{G 978}	Continued From page 51 A list of active patients who received home care services from at least one other agency was reviewed on 3/29/21. 7. The clinical record of Patient #20 was reviewed on 4/5/21, and indicated a start of care date 2/5/21, with patient diagnoses including but not limited to: spina bifida, dementia, essential hypertension, epilepsy, and pressure ulcer. The record included a plan of care for the certification period 2/5/21 - 4/5/21, which included service orders for home health visits 3 hours per day, 5 days per week. The plan of care stated " ...Admission Summary 2/5/21 ... [Patient #20] already has a pressure ulcer to his coccyx that is healing. [Home Health Entity #1] is managing the wound ...." The clinical record failed to evidence a shared patient agreement was enacted with Home Health Entity #1. An interview was conducted on 4/5/21 at 1:48 PM with the Administrator. During the interview, the Administrator indicated the agency had discussed enacting a shared patient agreement with Home Health Entity #1, and the home care entity was "still reviewing" the shared patient agreement. 17-12-2(d)	{G 978}		
{G 980}	Primary HHA is responsible for patient care CFR(s): 484.105(e)(3) The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure a shared patient agreement which indicated the primary agency was enacted for 1 of 1 active records reviewed	{G 980}		

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 CODE
ADAPTIVE NURSING AND HEALTHCARE SERVICES	938 MEZZANINE DRIVE. SUITE A LAFAYETTE, IN 47905

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{G 980}	Continued From page 52 with another home health agency (#20), in a total sample of 24 records. Findings include: A list of active patients who received home care services from at least one other agency was reviewed on 3/29/21. The clinical record of Patient #20 was reviewed on 4/5/21, and indicated a start of care date 2/5/21, with patient diagnoses including but not limited to: spina bifida, dementia, essential hypertension, epilepsy, and pressure ulcer. The record included a plan of care for the certification period 2/5/21 - 4/5/21, which included service orders for home health visits 3 hours per day, 5 days per week. The plan of care stated " ...Admission Summary 2/5/21 ... [Patient #20] already has a pressure ulcer to his coccyx that is healing. [Home Health Entity #1] is managing the wound ... [Patient #20] ...." The clinical record failed to evidence a shared patient agreement, which included designation of the primary agency, was enacted with Home Health Entity #1. An interview was conducted on 4/5/21 at 1:48 PM with the Administrator. The Administrator indicated the agency had discussed enacting a shared patient agreement with Home Health Entity #1, and the home care entity was "still reviewing" the shared patient agreement. 17-12-2(e)	{G 980}		