STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K121	A. BUILDING 00 B. WING	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEEWELL INC	6967 HILLSDALE COURT INDIANAPOLIS, IN 46250

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G 0000 Bldg. 00	This visit was a follow up Federal recertification survey. Dates of Survey: February 19 and 20, 2018 Facility ID #: 013425 Medicaid #: 201222410 Current Census: 13 (13 Skilled and 4 Home health aide only) BeeWell Home Health Agency continue to be precluded from providing its own training and competency evaluation program for a period of 2 years beginning February 20, 2018 to February 20, 2020 for being found out of compliance with the Conditions of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision, 484.30 Skilled Nursing Services, 484.36 Home Health Aide, and 484.48 Clinical Records.	G 0000		
G 0133 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Based on record review, the Administrator failed to ensure the home health agency met all the rules and regulations for continued licensure and	G 0133	The administrator provides on-site agency supervision on most business days and can be reached by phone, email, or	04/02/2018

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

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	certification by Centers for Medicaid and Medicare in 1 of 1 agency. Findings include: 1. The Administrator failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care. (See G 143) 2. The Administrator failed to ensure clinical staff follow the plan of care and the agency failed to ensure services were not provided until a physician's order could be obtained (See G 158); failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, failed to include goals for the next certification period, and failed to include discipline frequencies and duration specific to the certification period (See G 159); failed to ensure a physician was notified and orders obtained for the continuation of services upon recertification for additional 60 days (See G 160); failed to notify the physician when it was identified that there was a need to alter the plan of care (See G 164); and failed to put orders into writing (See G 166). 3. The Administrator failed to ensure clinical staff follow the plan of care and the agency failed to ensure services were not provided until a physician's order could be obtained (See G 170); failed to ensure that a skin assessment addressed		texting nearly 24/7. Administrator shall ensure the agency meets all rules and regulations through onsite supervision, increased monitoring, enhanced management staff training, and consultation with experienced, knowledgeable professionals in the home healthcare industry. DCS has been instructed in numerous areas to insure complete, accurate, and timely documentation. The deficiency report has been used for education by reviewing the findings and the correction plan. A well experience, competent, and well reputed agency consultant will provide no less than monthly expertise, advice, and audit services until audits show consistent agency compliance with rules and expectations. Consultation will then continue at least quarterly for another year. Increased and enhanced agency systems tracking methods have been developed and implemented to provide agency-wide accountability. The administrator will review these results monthly; the QAPI committee will review these results no less than quarterly in attempt to identify problems and trends before they become systemic issues.	

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	a skin impairment with each visit and failed to ensure skilled nursing identified and addressed a patient's behavior (See G 172); failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, and failed to include discipline frequencies and duration specific to the certification period (See G 173); failed to document if trach care, g-tube care, medications, flushes, blood sugar checks, the time the insulin was given had been provided (See G 174); failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care (See G 176); LPNs failed to ensure to documentation was in real time in relation to specifing what medications were administered, when the patient was suctioned, the amount, color and viscosity, the specific treatments provided to the trach and g-tube, as well as skin appearance of treatment sites, patient tolerance, results and reassessment after cpt use, intake and each output, and failed to document occurences of bed bug festation and equipment issues (See G 180); failed to ensure to specifically document all procedures and treatment that had been provided through out the day / visit (See G 181); and failed to instruct the caregiver in all aspects of trach care and equipment, diabetic management, proper technique for tube feeding / apsiration precautions / care of feeding tube site, instruct on seizure disorder as per the plan of care (See G 183).		Prevention: Agency tracking systems have been incorporated into the agency QAPI program to provide no less than quarterly compliance data. An outside consultant will provide monthly educational and audit visits until compliance has been achieved; quarterly visits for an additional year. Target date: April 2, 2018 Responsible party: Administrator	

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	4. The Administrator failed to ensure home health aide skills competency evaluations were conducted by an outside non-employee / contracted registered nurse (See G 207); failed to ensure the home health aide followed the home health aide care plan (See G 224); failed to follow the plan of care in regards to duration of hours spent inside the home (See G 225); and failed to conduct supervisory visits with the home health aide every 14 days (See G 229). 5. The Administrator failed to ensure orders were collaborated and co-signed by the collaborating / attending physician, failed to ensure communication notes were electronically signed by the visiting clinician, failed to ensure communication notes had accurate dates of visit, and failed to ensure clinical records contained complete and accurate information and failed to ensure visit notes were in the electronic medical record or in the office within a timely manner (See G 236). 6. The Administrator failed to ensure the medications listed on the medication profile was accurate, clarified by the physician, and authenticated by signature (See G 337). 7. The Administrator failed to ensure the correct OASIS recertification forms were completed within the last 5 days of a 60 day certification period and failed to ensure endocrine assessments included blood sugar ranges between certification periods (See G 339).			
G 0144 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of			

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	patient care does occur. Based on record review and interview, the agency failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care in 3 out of 3 records reviewed of patients being seen by more than 1 discipline / clinician in a sample of 4. (#1, 2, and 7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/18 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/10/17. The document only indicated the name of the case manager. B. Review of the skilled nursing visit notes, majority of the visit were made by 3 different licensed practical nurses. The case conference note failed to evidence participation of all clinicians involved in the patient's care. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. The clinical record included a plan of care for the certification period of 2/7/18 to 4/7/18, with orders for skilled nursing 1 time a month for supervisory visits and home health aide services 2 hours a day 5 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/4/17. The document only indicated the name of the case manager. The case conference note failed to evidence participation of	G 0144	Corrective Action: All direct care staff, RN's, aides, LPN's, will be educated on care coordination and participation in case conferences. The deficiency report will be used for education reviewing the findings and the correction plan. Minutes of the case conferences will evidence the effective interchange, reporting, and coordination of patient. The minutes of the case conferences as well as the patient's record documentation will evidence that all involved staff participated in the case conferences and the coordination of patient care. If staff that are not familiar with the patient's case is utilized, the RN Case Manager will report on the patient's condition and treatments with the as needed staff and document in the patient's record. An updated copy of the Plan of Care will be maintained and given to the as needed staff as well as available in the patient's home. The form "Coordination of Care" will be completed, all sections and required information be accurate and complete, by the RN Case Manager with input from all involved staff. Prevention: 100% active files will have a case conference completed by April 2, 2018. Case Conferences will be conducted at least every 60 days, unless the patient's condition warrants more	03/30/2018

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	the home health aide involved in the patient's care. 3. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. A. The electronic record evidenced a document titled "Coordination of Care" for the certification period of 12/1/17 to 1/29/18. The document was incomplete and failed to evidenced functinal limitations, patient condition, services provided, vital sign ranges, home bound status, and summary of care provided by the home health agency. B. On 2/20/18, at 9:30 a.m., provided another "Coordination of Care" document that included all the missing infomation with exception to summary of care provided by the agency and the author's signature and date of who completed the form and failed to evidenced participation of the home health aide involved in the patient's care. C. The clinical record was reviewed with the Administrator and the DOCS on 2/2/18 at 3:30 p.m. No further information was provided during this time.		frequently. Case Conferences will be tracked for completion by the Director of Clinical Services. 100% patient charts will be audited for compliance with this condition by April 6, 2018. 10% or at least 3 patient charts will be audited quarterly to insure no recurrence of the deficiency. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	
G 0156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on record review and interview, the agency failed to ensure clinical staff follow the plan of care and the agency failed to ensure services were not provided until a physician's order could be obtained (See G 158); failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to	G 0156	Corrective Action: Clinical staff will be educated on the following to insure agency wide knowledge and compliance: Services will be provided as directed by the plan of care. The physician will be informed of any reason that might or would indicate a need to modify the plan of care to meet the	04/02/2018

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	include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, failed to include goals for the next certification period, and failed to include discipline frequencies and duration specific to the certification period (See G 159); failed to ensure a physician was notified and orders obtained for the continuation of services upon recertification for additional 60 days (See G 160); failed to notify the physician when it was identified that there was a need to alter the plan of care (See G 164); and failed to put orders into writing (See G 166). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patient, Plan of Care and Medical Supervision. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.		patient's assessed needs. The agency will not admit any one to services unless the agency has a reasonable expectation of meeting the patient's assessed needs. The Plan of Care in consultation with the physician will be completed after the comprehensive assessment is completed and the patient's home health needs are identified. The plan of care will be complete with the required information, including all prescribed medications and treatments, and sent to the physician for signature. Care Coordination and outside providers will be included in the plan of care. If continuation of care services is required, the physician will be contacted for orders to continue care. Those orders will be put into writing and sent to the physician for signature. 484.18 and the deficiency report will serve as the basis for clinical staff education instructing on the findings and the correction plan and compliance. Education and compliance of the clinical staff will insure the systemic problem will be resolved and not recur. Compliance will be tracked through the QAPI program. Prevention: QAPI program will be developed with tracking and auditing of the compliance issues. 100% of active charts will be audited for compliance, then 10%	

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			of charts will be audited to insure and compliance and that this deficiency does not recur. Responsible Person: Director of Clinical Services Target Date: April 2, 2018	
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on record review and interview, the agency failed to ensure clinical staff follow the plan of care in 2 out of 3 records reviewed (#1 and 7) of patient receiving skilled nursing services and 1 out of 2 records reviewed (#7) of patients receiving home health aide services in a sample of 4 and the agency failed to ensure services were not provided until a physician's order could be obtained in 1 out of 4 records reviewed. (#7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week to "change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage,	G 0158	Corrective Action: Patient #1 was transferred to Skilled LTC facility and was discharged from BeeWell services March 13, 2018 insuring the patient's needs and level of required care are met. The RN's and LPN's will be educated that every patient requires an updated, complete, and accurate Plan of Care and that care is only provided with physician's orders. Clinical staff will provide services only as directed by the physician on the Plan of Care and subsequent orders. The physician will be notified if the clinical staff cannot implement the physician's orders as directed. As needed staff will be educated on this compliance issue as well and will be given report regarding the patient's	04/02/2018

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	remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD ... SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80." Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin] 40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. The narrative notes for both 2/5 and		orders and condition prior to providing care. The patient record will reflect this exchange of information. Prevention: Audit all 100% of active charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	2/7/18 failed to include documentation of the patient being repositioned after 1:30 p.m. B. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. C. Review of the skilled nursing visits in the electronic medical record, visit dates 2/6, 2/8, 2/10, 211, 2/12, 2/14, 2/16 and 2/17/18 failed to evidenced documentation that skilled nursing visits had taken place. Review of the skilled nursing visits in the electronic medical record, the visits notes dated 2/9, 2/13, and 2/15/18 did not equal to 15 hours. i. The DOCS was interviewed on 2/19/18 at 1:20 p.m. When queried on why the patient's visits were not per the plan of care, the DOCS indicated Employee B had a death in the family and was off all of 2/12 to 2/16, Employee A would not pick up extra visits, Employee F worked another full time job, Employee E had responsibilities with the adjoining agency and as for herself, she was not able to move a 200+			

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	pound patient on top of her injury she acquired on 2/12/18. The DOCS indicated they have difficulty with interviewees showing up for scheduled interviews. The Administrator entered the office and indicated there were no missed visits, some staff has had problems with entering visit notes, there were scheduled visits 3 times a day to make sure the patient received his / her insulin in the morning, 3:00 p.m. and 10:00 p.m. The Administrator indicated that the Direct Care Professionals from the disability waiver through the FSSA program had been staying with the patient when skilled nursing was not present. ii. On 2/19/18 at 2:40 p.m., the Director of Clinical Services (DOCS) was informed of the missing documentation between 2/5 and 2/17/18. The DOCS was requested to have all visit notes printed from the EMR during this time frame. The DOCS indicated that the staff was informed that all visit notes must be in the EMR. The Administrator had indicated she thought all the days had been covered. Also expressed problems with their computer program since the new updates. iii. At 3:25 p.m., the Employee E provided hand written notes for 2/13 and 2/15/18, expressed problems with the computer as for not having the notes entered in the EMR. Employee E indicated she would have the notes in the EMR by 2/20/18. iv. On 2/20/18 at 11:30 a.m., the Employee E provided two electronic visit notes that she had conducted on 2/13/18 from 8:00 a.m. to 10:30 a.m. and 2/15/18 from 8:00 p.m. to 9:45 p.m. D. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits			

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	were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen through the payroll and could not provide the actual visit notes. The agency failed to ensure the skilled nurses followed the plan of care as evidenced by the following: i. On 2/9/18, skilled nursing was provided at 7:55 a.m. to 8:55 a.m., 10:30 a.m to 2:30 p.m. and 3:50 p.m. to 5:30 p.m. Per payroll, the agency failed to provide 15 hours of care. ii. On 2/10/18, skilled nursing provided 17 hours of services from 7:00 a.m. to 12:00 a.m. Per payroll, the agency failed to obtain an order for services to be provided beyond 15 hours. iii. On 2/11/18, skilled nursing was provided from 12:00 a.m. to 1:15 a.m. and at 3:00 p.m. to 4:45 p.m. Per payroll, the agency failed to provide 15 hours of care. iv. On 2/13/18, skilled nursing was provided by Employee F from 8:00 a.m. to 10:30 a.m.. The visit note failed to indicate what time the insulin was given and failed to indicate what the patient's blood sugar reading was. No other documentation of treatment or medication administration was indicated. The intervention and visit narrative included template documentation. Other skilled nursing visit per payroll included 4:50 p.m. to 6:05 p.m., and at 8:00 p.m. to 9:00 p.m. The agency failed to provide 15 hours of care. v. On 2/15/17, skilled nursing was provided from 9:45 a.m. to 11:00 a.m. per payroll documents. At 12:35 p.m. to 1:05 p.m., Employee B visited the patient but failed to complete the			

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	visit note. At 8:00 p.m to 9:45 p.m., the Employee E visited the patient and failed to evidence a blood sugar reading, indicated the patient needed periodic suctioning, lung sounds crackles / rales, but failed to include the amount, color, and consistency when the patient was suctioned. The intervention and visit narrative included template documenatation from the 2/10/18 OASIS recertification. The visit notes failed to evidence trach or gtube care and failed to indicate if any medications had been given. The agency failed to provide 15 hours of care and failed to be at the patient's home to provide the 3:00 p.m. insulin vi. On 2/16/17, skilled nursing was provided from 8:00 a.m. to 9:00 a.m. and at 9:00 p.m. to 10:00 p.m. The agency failed to provide 15 hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin. 2. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. The clinical record of patient #7 was reviewed on 12/20/18 at 10:33 a.m. B. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. C. Review of the home health aide visit notes dated 2/5 to 2/9/18 and 2/12 to 2/16/18, the home health aide provided services 3 hours each day. The home health aide failed to follow the plan of			

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	care. D. Review of a handwritten skilled nursing visit dated 2/9/18, failed to indicate if the medications were set up. The note only provided an vital signs and a physical assessment. E. On 2/20/18 at 11:54 a.m., Employee E was interviewed and indicated she would set up the patient's medications once a month. F. The clinical record was reviewed with the Administrator and the DOCS on 2/20/18 at 3:30 p.m. The DOCS indicated she had not contacted the physician for continuing orders. The agency failed to ensure the home health aide and the skilled nurse were not providing services until a physician's order could be obtained.			
G 0159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on record review and interview, the agency failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical	G 0159	Corrective Action: RN's will be educated on the purpose of the comprehensive assessment and the development of the Plan of Care. The Plan of Care will be developed in consultation with the physician and agency staff and	04/02/2018

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	agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, failed to include goals for the next certification period, and failed to include discipline frequencies and duration specific to the certification period in 4 out of 4 records reviewed. (#1, 2, 6, and 7) Findings included: 1. Review of clinical record #1 on 2/19/18, the clinical record evidenced an OASIS C2 Recertification visit note dated 2/10/18, which indicated the patient had a trach, a feeding tube, and a stage I pressure wound. The "Summary of Care" section indicated to change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD. VNS to control seizure, the magnet is to be place over left upper chest at onset of seizure. Document the time, severity and length of the seizure. Call 911 for any seizure lasting longer than 5 minutes. SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered. Patient gets up in wheel chair by hydraulic lift. Call orders to the physician if pulse >120 or < 60, respirations >31 or		based on the comprehensive assessment and will include all required data including pertinent diagnoses, mental status, types of services, equipment needed, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications, all treatments, interventions, care coordination with outside providers, services to be provided, discharge plan, and safety measures. The Plan of Care will be updated at every recertification and based on the comprehensive assessment. The Plan of Care will reflect patient's assessed needs and medical necessity for home health services. RN's will be instructed on the expectation of compliance with this regulation. Medications will include route, dosage, and frequency with any specific instructions for administration. Treatments will include specifics for implementation, including prefilling medication boxes. Medication Profile and Plan of Care will be reviewed after SOC and at the time of Recertification for compliance with this regulation. The deficiency report and 484.18 will be used for education of the RN's. Prevention: 100% of active charts will be audited for compliance.	

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	<12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80. The patient had 8 hours daily of waiver services through another agency [that is owned by the administrator-provides waiver both with personal service agency / home health aides and with FSSA / direct professionals] The equipment company was included and the services they provide, OT [occupational therapy] services in regards to the patient's wheelchair through a local hospital, nutritionist from local hospital for dietary concerns, name of medical company in regards to diabetic supplies, and name of a pharmacy who provided medications to the patient's home. A. Review of the Medication Administration Record from the pharmacy dated 2/28/18 (sic-future date), Florastor 250 mg twice a day was indicated of the form. The form also indicated the patient had an allergy to benzodiazepines, penicillin, red dyes, yellow dye - tartrazine. B. The medication profile record indicated a start date of 2/1/18, Florastor 500 mg cap per g-tube twice a day and also indicated 250 mg capsules twice a day per g-tube. The plan of care failed to include Florastor in the medication profile. C. Review of the plan of care for the certification period of 2/11/18 to 4/11/18, the durable medical equipment section failed to include all respiratory supplies, all diabetic supplies, kangaroo pump, hydraulic lift, and humidifier with tubing supplies. The plan of care failed to include the caregiver status, psychosocial status, directions for trach care, directions for PEG site care, directions to use humidifier including settings, directions for use of		Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	percussion vest, and goals. The medication section failed to include the type and amount of sliding scale insulin and the amount of normal saline used for suctioning. The plan of care also failed to evidenced all of the patient's allergies and goals for the next certification period. The recertification assessment summary was included in the plan of care locator 21 section, which included the 15 hour / day 7 days a week frequency but failed to accurately reflect the frequency and duration specific to the certification dates (ex. 7 hours a day, 7 days a week for 8 weeks, then 7 hours a day, 4 days a week for 1 week). D. The Director of Clinical Services (DOCS) was interviewed on 2/19/18 at 1:20 p.m. When queried the DOCS about contacting the physician to clarify medication discrepancy, the Director of Clinical Services indicated she did not get the orders clarified by the physician but took the information from the pharmacy medication administration profile. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The current call order of blood sugars had was different than what was in the most previous certification period of >600 without orders for change / clarification. The DOCS indicated the >600 was the correct call order. The DOCS had nothing further to provide in regards to the remainder of the findings. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. A. The clinical record evidenced a Non-OASIS recertification assessment dated 2/2/18.			

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B. The clinical record evidenced a home health aide careplan for the certification period of 2/7/18 to 4/7/18.

C. The plan of care for the certification period of 2/7/18 to 4/7/18, included orders for skilled nursing to provide home health aide supervisory "1M3" [1 time a month for 3 months] and home health aide services 2 hours a day 5 days a week for 9 weeks. The plan of care failed to evidence interventions and goals for the home health aide services, failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 4 days for 1 week, 2 hours a day 7 days a week for 8 weeks), and failed to accurately reflect the skilled nursing supervisory duration of 2 months.

3. The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. The electronic clinical record failed to evidenced a plan of care for the certification period of 2/13/17 to 4/14/18.

A. The DOCS was queried on 2/19/18 at 3:15 p.m. of the whereabouts of the plan of care and was unable to provide an explanation of why the recertification was not in the electronic medical record.

B. On 2/20/18 at 9:50 a.m., a typed document was provided which included a list of physicians (primary care physician, neurologist, podiatrist, otolaryngologist, dentist, optometrist, and urologist), pharmacy, and laboratory preference. An OASIS C2 recertification assessment was provided as well, but failed to evidenced a time, electronic signature and date of the assessment. During this time, the DOCS indicated Employee F had been working on changing the assessment to

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	the correct OASIS, the plan of care was developed once the OASIS was completed, and Employee F was not able to get this done in a timely manner due to her busy schedule. C. At 10:00 a.m. the electronic record was reviewed again and evidenced a plan of care for the certification of 2/13/17 to 4/14/18, with orders for skilled nursing 1 hour a day for 2 months to evaluate for complications and medication effectiveness, instruct neurological assessment each visit, assess and instruct on seizure disorder to include precautions, signs and symptoms and appropriate actions during seizure activity, instruct patient / caregiver to contact agency to report any fall with or without injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. The plan of care failed to evidenced goals for the certification period and the other physicians that were on the patient's case. D. At 11:00 a.m., the Employee X provided another OASIS C2 recertification assessment which included the time, electronic signature and date. The reassessment indicated Employee F pre-filled a pill box. The current plan of care failed to evidenced orders for skilled nursing to prefill medication boxes. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The DOCS confirmed that skill nursing was filling the medication box monthly and not every other week. 4. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care.			

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	A. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. The nursing frequency was inconsistent and failed to be clear and specific to the certification period (ex 1 hour per day, 1 day per month for 2 months) and failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 3 days for 1 week, 2 hours a day 7 days a week for 8 weeks). The plan of care failed to evidenced goals for the certification period. B. Review of the medication section of the plan of care indicated the following: i. The medication creams / ointments / lotions such as lac hydrin 5% lotion (medicated lotion used to treat dry skin), fluocinolone 0.025% topical cream (used to treat dermatitis, psoriasis, dermatitis and / or eczema), nystatin 100,000 units /topical cream (antifungal cream), mupirocin 2% topical cream (Antibacterial / antibiotic cream), and clotrimazole / betameth cr topical agent (antifungal cream) indicated to apply to affected area. The medicated creams and lotions failed to indicate the specific location to be applied. ii. Oral medications such as Milk of Magnesia (laxative), Loperamide (anti-diarrhea) capsule, and Sudogest (over the counter sinus medication) tablet indicated to take the medication as directed. The oral medications failed to indicate the dosage amount to ingest and it's frequency.			

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	C. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The Administrator and DOCS had nothing to provide in regards to the findings.			
G 0160 Bldg. 00	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. Based on record review and interview, the agency failed to ensure a physician was notified and orders obtained for the continuation of services upon recertification for additional 60 days in 1 out of 4 records reviewed. (#7) Findings included: 1. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The patient's OASIS C2 recertification assessment dated 1/26/18, failed to open for review. During this time, the DOCS was requested to print the assessment for review. The DOCS attempted to open the assessment without success and indicated a copy would be provided the next morning. A. Ongoing review of the patient's electronic clinical record, a communication note dated 2/7/18, indicated "2/5/18; 2/6/18 7:15 a.m. Writer has repeatedly tried to sign off after the med interactions were reviewed with no success. Unable to reach Axxess and no response to my inquiry on line ... This is also preventing the completion of the Recert. Writer will keep trying."	G 0160	Corrective Action: Recertification will be tracked to identify the last 5 days of the certification period. During this 5-day period the comprehensive assessment will be completed identifying the patient's need for continuation of care. The physician will be notified of the patient's assessed needs for continuation of care and an order to continue care will be accepted. The order will be put into writing and sent to the physician for signature. A tracking system is in place to insure compliance with this regulation. RN's will be educated regarding the recertification process. Recertification charts will be audited for compliance. Prevention: 100% of active recertification charts will be audited for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency.	04/02/2018

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	The note was signed by the DOCS on 2/6/18. The DOCS failed to provide a copy of the OASIS C2 recertification. B. The record was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:30 p.m. When queried about notifying the physician for ongoing orders, the DOCS indicated she had not notified the physician yet, she was out "all last week" (2/12 to 2/16/18) but would do so right away. The DOCS failed to obtain ongoing orders upon recertification.		Target date: April 2, 2018 Responsible Person: Director of Clinical Services	
G 0164 Bldg. 00	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on record review and interview, the agency failed to notify the physician when it was identified that there was a need to alter the plan of care in 1 out of 4 records reviewed. (#1) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week to "change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD	G 0164	Corrective Action: RN's will notify the physician promptly regarding any change in the patient's condition and status that would warrant modifying the Plan of Care. The specifics of the changes, and details of the patient's status and changes will be communicated to the physician and documented in the medical recorded. Communication from the physician regarding any patient changes will be documented in the medical record and sent to the physician for signature. Documentation will evidence compliance with this regulation. RN's will be educated on this regulation and the expectation of compliance. Prevention: 100% of active patient	04/02/2018

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	... SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80." Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin] 40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by		records will be audited for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	[name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. B. Review of the skilled nursing visits in the electronic medical record, the visits notes dated 2/13, and 2/15/18 did not equal to 15 hours. At 2:40 p.m., the Director of Clinical Services (DOCS) was asked to provide the skilled nursing documents from the EMR from 2/5 to 2/18/18. C. The DOCS was interviewed on 2/19/18 at 1:20 p.m. When queried on why the patient's visits were not per the plan of care, the DOCS indicated Employee B had a death in the family and was off all of 2/12 to 2/16, Employee A would not pick up extra visits, Employee F worked another full time job, Employee E had responsibilities with the adjoining agency and as for herself, she was not able to move a 200+ pound patient on top of her injury she acquired on 2/12/18. The DOCS indicated they have difficulty with interviewees showing up for scheduled interviews. The Administrator entered the office and indicated there were no missed visits, some staff has had problems with entering visit notes, there were scheduled visits 3 times a day to make sure the patient received his / her insulin in the morning, 3:00 p.m. and 10:00 p.m. The Administrator indicated that the Direct Care Professionals from the disability waiver through the FSSA program had been staying with the			

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	15K121	A. BUILDING 00 B. WING	02/20/2018

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patient when skilled nursing was not present.

D. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen through the payroll and could not provide the actual visit notes. The agency failed to ensure the skilled nurses followed the plan of care as evidenced by the following:

i. On 2/9/18, skilled nursing was provided at 7:55 a.m. to 8:55 a.m., 10:30 a.m to 2:30 p.m. and 3:50 p.m. to 5:30 p.m. Per payroll, the agency failed to provide 15 hours of care.

ii. On 2/10/18, skilled nursing provided 17 hours of services from 7:00 a.m. to 12:00 a.m. Per payroll, the agency failed to obtain an order for services to be provided beyond 15 hours.

iii. On 2/11/18, skilled nursing was provided from 12:00 a.m. to 1:15 a.m. and at 3:00 p.m. to 4:45 p.m. Per payroll, the agency failed to provide 15 hours of care.

iv. On 2/13/18, skilled nursing was provided by Employee F from 8:00 a.m. to 10:30 a.m. Other skilled nursing visit per payroll included 4:50 p.m. to 6:05 p.m., and at 8:00 p.m. to 9:00 p.m. The agency failed to provide 15 hours of care.

v. On 2/15/17, skilled nursing was provided from 9:45 a.m. to 11:00 a.m. per payroll documents. At 12:35 p.m. to 1:05 p.m., Employee B visited the patient but failed to complete the visit note. At 8:00 p.m to 9:45 p.m., the Employee

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	E visited the patient. The agency failed to provide 15 hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin. vi. On 2/16/17, skilled nursing was provided from 8:00 a.m. to 9:00 a.m. and at 9:00 p.m. to 10:00 p.m. The agency failed to provide 15 hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin. The agency failed to notify the physician when it was identified that there was a need to alter the plan of care on 2/10, 2/11, 2/13, 2/15, and 2/16/18.			
G 0166 Bldg. 00	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on record review and interview, the Registered Nurse failed to put orders into writing in 3 out of 4 records reviewed. (#1, 2, and 6) Findings include: 1. The clinical record of patient #1 was reviewed on 2/19/18 at 1:00 p.m. Review of an OASIS C2 Recertification visit note dated 2/10/18, indicated care coordination between Employee F and the physician in regards to recertification and the plan of care. The clinical record failed to evidence a physician order by Employee F. 2. The clinical record of patient #2 was reviewed on 2/20/18 at 12:00 p.m. Review of a Non OASIS	G 0166	Corrective Action: Documentation of physician's orders in the patient's file will evidence that verbal orders are put into writing with the date of receipt of the order and signed and dated by the RN. The written order is then sent to the physician for signature. Verbal orders are tracked for date returned and audited for the physicians' signature and date. If messages, as directed by the physician's protocol of taking messages, requires leaving a voicemail or electronic message, follow-up will be completed prior to implementing any changes in the	04/02/2018

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	Recertification visit note dated 2/2/18, indicated care coordination between Employee F and the physician in regards to recertification and the plan of care. The clinical record failed to evidence a physician order by Employee F. 3. The clinical record of patient #6 was reviewed on 2/19/18 and 2/20/18. Review of an OASIS C2 Recertification visit note dated 2/16/18, indicated care coordination between Employee F and the physician in regards to recertification and the plan of care. The clinical record failed to evidence a physician order by Employee F. 4. The Employee F was interviewed on 2/20/18 at 1:15 p.m. The Employee F indicated she would call all physicians to obtain continuing orders and would only documents it in her visit notes. The Employee F indicated she did not put patient's #1 continuing orders into writing and also indicated on occasion she would leave messages on voicemail's of what the plan of care would be and did not follow up with the messages. When queried about services being provided without a physician order when messages are left without follow up, the Employee F indicated she did not know that she needed to speak to someone for approval to continue services and didn't know she needed to write those orders when obtained.		patient's services assuring physician verbal orders are received. RN's will be instructed on this regulation and expectation of compliance. Prevention: Audit all (100%) of current charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	
G 0168 Bldg. 00	484.30 SKILLED NURSING SERVICES Based on record review and interview, the agency failed to ensure clinical staff follow the plan of care and the agency failed to ensure services were not provided until a physician's order could be obtained (See G 170); failed to ensure that a skin assessment addressed a skin impairment with	G 0168	Corrective Action: RN's and LPN's will be instructed on regulation 484.30 and the expectation of compliance, as well as, the findings cited in this deficiency report. RN's will insure the plan of care is followed and that services	04/02/2018

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	each visit and failed to ensure skilled nursing identified and addressed a patient's behavior (See G 172); failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, and failed to include discipline frequencies and duration specific to the certification period (See G 173); failed to document if trach care, g-tube care, medications, flushes, blood sugar checks, the time the insulin was given had been provided (See G 174); failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care (See G 176); LPNs failed to ensure to documentation was in real time in relation to specifing what medications were administered, when the patient was suctioned, the amount, color and viscosity, the specific treatments provided to the trach and g-tube, as well as skin appearance of treatment sites, patient tolerance, results and reassessment after cpt use, intake and each output, and failed to document occurences of bed bug festation and equipment issues (See G 180); failed to ensure to specifically document all procedures and treatment that had been provided through out the day / visit (See G 181); and failed to instruct the caregiver in all aspects of trach care and equipment, diabetic management, proper technique for tube feeding / apsiration precautions / care of feeding tube site, instruct on seizure disorder as per the plan of care (See G 183).		are provided by physician's orders accurately as ordered. RN's will assess and document all nursing assessment findings, including skin assessment and behavioral issues. All changes in the patient's condition and status will be promptly reported to the physician. The plan of care will reflect the patient's assessed needs as identified on the comprehensive assessment and include all the required items for completeness. All treatments will be implemented as ordered on the plan of care and the patient's response and outcome of such implementation will be assessed and documented. All medications will be administered as ordered and documentation will reflect the outcome and patient's response to medication administration. As appropriate, caregivers will be instructed on a continuous basis about the patient's care and services. Compliance with this regulation will insure safe and quality care for all patients. QAPI program will monitor this regulation for improvement. Prevention: 100% active charts will be audited for compliance with this regulation. Quarterly, 10% or at least 3 charts will be audited for compliance. Responsible Person: Director of Clinical Services	

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	The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.30 Skilled Nursing Services. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.		Target Date: April 2, 2018	
G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview, the agency failed to ensure clinical staff follow the plan of care in 2 out of 2 records reviewed (#1 and 7) of patient receiving skilled nursing services only and the agency failed to ensure services were not provided until a physician's order could be obtained. Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week to "change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD ... SN to maintain the PEG feedings via kangaroo	G 0170	Action Plan: Skilled nursing services will be compliant and provided in accordance with the established Plan of Care and physician's orders. Skilled nursing services will only be provided under the medical direction of a qualified physician and carried out as ordered. If the services cannot be provided as ordered, the physician will be notified and changes to the plan of care will be obtained and signed by the physician. Prevention: Implement the action plan immediately. Audit at least 10% or 3 charts quarterly for this deficiency to prevent recurrence. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	04/02/2018

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	pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80." Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin] 40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal			

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	service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. B. Review of the skilled nursing visits in the electronic medical record, visit dates 2/6, 2/8, 2/10, 211, 2/12, 2/14, 2/16 and 2/17/18 failed to evidenced documentation that skilled nursing visits had taken place. Review of the skilled nursing visits in the electronic medical record, the visits notes dated 2/9, 2/13, and 2/15/18 did not equal to 15 hours. i. The DOCS was interviewed on 2/19/18 at 1:20 p.m. When queried on why the patient's visits were not per the plan of care, the DOCS indicated Employee B had a death in the family and was off all of 2/12 to 2/16, Employee A would not pick up extra visits, Employee F worked another full time job, Employee E had responsibilities with the adjoining agency and as for herself, she was not able to move a 200+ pound patient on top of her injury she acquired on 2/12/18. The DOCS indicated they have difficulty with interviewees showing up for scheduled interviews. The Administrator entered the office and indicated there were no missed visits, some staff has had problems with entering visit notes, there were scheduled visits 3 times a day to make sure the patient received his / her insulin in the morning, 3:00 p.m. and 10:00 p.m. The Administrator indicated that the Direct Care Professionals from the disability waiver through			

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the FSSA program had been staying with the patient when skilled nursing was not present.

ii. On 2/19/18 at 2:40 p.m., the Director of Clinical Services (DOCS) was informed of the missing documentation between 2/5 and 2/17/18. The DOCS was requested to have all visit notes printed from the EMR during this time frame. The DOCS indicated that the staff was informed that all visit notes must be in the EMR. The Administrator had indicated she thought all the days had been covered. Also expressed problems with their computer program since the new updates.

iii. At 3:25 p.m., the Employee E provided hand written notes for 2/13 and 2/15/18, expressed problems with the computer as for not having the notes entered in the EMR. Employee E indicated she would have the notes in the EMR by 2/20/18.

iv. On 2/20/18 at 11:30 a.m., the Employee E provided two electronic visit notes that she had conducted on 2/13/18 from 8:00 a.m. to 10:30 a.m. and 2/15/18 from 8:00 p.m. to 9:45 p.m.

C. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen through the payroll and could not provide the actual visit notes. The agency failed to ensure the skilled nurses followed the plan of care as evidenced by the following:

i. On 2/9/18, skilled nursing was provided at 7:55 a.m. to 8:55 a.m., 10:30 a.m. to 2:30 p.m. and 3:50 p.m. to 5:30 p.m. Per payroll, the

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	agency failed to provide 15 hours of care. ii. On 2/11/18, skilled nursing was provided from 12:00 a.m. to 1:15 a.m. and at 3:00 p.m. to 4:45 p.m. Per payroll, the agency failed to provide 15 hours of care. iii. On 2/13/18, skilled nursing was provided by Employee F from 8:00 a.m. to 10:30 a.m.. The visit note failed to indicate what time the insulin was given and failed to indicate what the patient's blood sugar reading was. No other documentation of treatment or medication administration was indicated. The intervention and visit narrative included template documentation. Other skilled nursing visit per payroll included 4:50 p.m. to 6:05 p.m., and at 8:00 p.m. to 9:00 p.m. The agency failed to provide 15 hours of care. iv. On 2/15/17, skilled nursing was provided from 9:45 a.m. to 11:00 a.m. per payroll documents. At 12:35 p.m. to 1:05 p.m., Employee B visited the patient but failed to complete the visit note. At 8:00 p.m. to 9:45 p.m., the Employee E visited the patient and failed to evidence a blood sugar reading, indicated the patient needed periodic suctioning, lung sounds crackles / rales, but failed to include the amount, color, and consistency when the patient was suctioned. The intervention and visit narrative included template documentation. The visit notes failed to evidence trach or g-tube care and failed to indicate if any medication had been given. The agency failed to provide 15 hours of care and failed to be at the patient's home to provide the 3:00 p.m. insulin. v. On 2/16/17, skilled nursing was provided from 8:00 a.m. to 9:00 a.m. and at 9:00 p.m. to 10:00 p.m. The agency failed to provide 15			

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	hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin. 2. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. The clinical record of patient #7 was reviewed on 12/20/18 at 10:33 a.m. B. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. C. Review of the home health aide visit notes dated 2/5 to 2/9/18 and 2/12 to 2/16/18, the home health aide provided services 3 hours each day. D. Review of a handwritten skilled nursing visit dated 2/9/18, failed to indicate if the medications were set up. The note only provided an vital signs and a physical assessment. E. On 2/20/18 at 11:54 a.m., Employee E was interviewed and indicated she would set up the patient's medications once a month. F. The clinical record was reviewed with the Administrator and the DOCS on 2/20/18 at 3:30 p.m. The DOCS indicated she had not contacted the physician for continuing orders. The agency failed to ensure the home health aide and the skilled nurse were not providing services until a physician's order could be obtained.			

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G 0172 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on record review and interview, the agency failed to ensure that a skin assessment addressed a skin impairment with each visit and failed to ensure skilled nursing identified and addressed a patient's behavior in 2 out of 3 records reviewed of a patient with skilled nursing services. Findings include: 1. The clinical record for patient number 1 was reviewed on 2/19/18 at 1:00 p.m. An OASIS C2 Recertification assessment dated 2/10/18, indicated the patient had a stage 1 pressure ulcer on the coccyx that measured 5 cm [centimeters] x 4 cm. The narrative note indicated the patient was incontinent and prone to skin breakdown. A. Review of skilled nursing visit notes dated 2/13/18 at 8:00 a.m. to 10:30 p.m. and 2/15/18 at 8:00 p.m. to 9:45 p.m., Employee E failed to identify and indicate if the status of the patient's pressure area to the patient's coccyx. B. On 2/20/18 at 10:30 a.m., Employee E indicated she was helping out and this patient was not one of her patient's she case manages. 2. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. Review of a home health aide visit record, on 2/6/18, Employee J documented that patient #7 had a behavior while getting into the shower and described the incident in detail.	G 0172	Corrective Action: Skin assessments will be completed and documented by the RN or LPN every visit. Follow-up on any variance in the assessment will be documented and the physician notified for orders. Protocol for skin breakdown prevention will be ordered and implemented every visit and documented on the skilled nurse visit report. All significant changes in the patient's condition, including any behavior issues, will promptly be reported to the physician to determine if changes to the Plan of care are needed. Prevention: Audit 100% of current charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	04/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K121	A. BUILDING 00 B. WING	02/20/2018

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	B. Review of a handwritten skilled nursing visit dated 2/9/18, Employee E failed to identify behaviors the patient recently had. C. The clinical record was reviewed with the Administrator and the Director of Clinical Services on 2/20/18 at 3:30 p.m. The Administrator and the Director of Clinical Services had no further information or documentation to provide during this time.			
G 0173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on record review and interview, the Registered Nurse failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, failed to include goals for the next certification period, and failed to include discipline frequencies and duration specific to the certification period in 4 out of 4 records reviewed. (#1, 2, 6, and 7) Findings included: 1. Review of clinical record #1 on 2/19/18, the clinical record evidenced an OASIS C2 Recertification visit note dated 2/10/18, which indicated the patient had a trach, a feeding tube,	G 0173	Corrective Action: The is responsible for the initiation and revisions to the Plan of Care. The RN will ensure that the plan of care is developed in consultation with involved staff and the physician and reflects the findings the comprehensive assessment. The RN is responsible for insuring the plan of care is complete and accurate and includes the direction for all treatments provided, all medications prescribed including topical agents and all specific directions for use, equipment required, outside providers' responsibility, including other physicians involved in the patient's care, goals, outcomes, discharge plan, frequency and duration of disciplines, services to be provided and all other required data. The RN is responsible to insure a plan of is complete with	04/02/2018

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	and a stage I pressure wound. The "Summary of Care" section indicated to change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD. VNS to control seizure, the magnet is to be place over left upper chest at onset of seizure. Document the time, severity and length of the seizure. Call 911 for any seizure lasting longer than 5 minutes. SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered. Patient gets up in wheel chair by hydraulic lift. Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80. The patient had 8 hours daily of waiver services through another agency [that is owned by the administrator-provides waiver both with personal service agency / home health aides and with FSSA / direct professionals] The equipment company was included and the services they provide, OT services in regards to the patient's wheelchair through a local hospital, nutritionist from local hospital for dietary concerns, name of medical company in regards to diabetic supplies, and name of a pharmacy who provided medications to the patient's home.		all required data for any new certification period. It is acknowledged that this is the RN's responsibility and all RN's will be instructed on this duty as an RN and that compliance is expected. The RN will furnish services requiring substantial and specialized nursing skill. Documentation will evidence the skilled services provided and specific to the patient's needs. Prevention: Audit 100% of the current charts for compliance. Quarterly, 10% or at least 3 charts will be audited for compliance to insure this deficiency does not recur. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	A. Review of the Medication Administration Record from the pharmacy dated 2/28/18 (sic-future date), Florastor 250 mg twice a day was indicated of the form. The form also indicated the patient had an allergy to benzodiazepines, penicillin, red dyes, yellow dye - tartrazine. B. The medication profile record indicated a start date of 2/1/18, Florastor 500 mg cap per g-tube twice a day and also indicated 250 mg capsules twice a day per g-tube. The plan of care failed to include Florastor in the medication profile. C. Review of the plan of care for the certification period of 2/11/18 to 4/11/18, the durable medical equipment section failed to include all respiratory supplies, all diabetic supplies, kangaroo pump, hydraulic lift, and humidifier with tubing supplies. The plan of care failed to include the caregiver status, psychosocial status, directions for trach care, directions for PEG site care, directions to use humidifier including settings, directions for use of percussion vest, and goals. The medication section failed to include the type and amount of sliding scale insulin and the amount of normal saline used for suctioning. The plan of care also failed to evidenced all of the patient's allergies. The recertification assessment summary was included in the plan of care locator 21 section, which included the 15 hour / day 7 days a week frequency but failed to accurately reflect the frequency and duration specific to the certification dates (ex. 7 hours a day, 7 days a week for 8 weeks, then 7 hours a day, 4 days a week for 1 week). D. The Director of Clinical Services (DOCS) was interviewed on 2/19/18 at 1:20 p.m. When			

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	queried the DOCS about contacting the physician to clarify medication discrepancy, the Director of Clinical Services indicated she did not get the orders clarified by the physician but took the information from the pharmacy medication administration profile. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The current call order of blood sugars had was different than what was in the most previous certification period of >600 without orders for change / clarification. The DOCS indicated the >600 was the correct call order. The DOCS had nothing further to provide in regards to the remainder of the findings. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. A. The clinical record evidenced a Non-OASIS recertification assessment dated 2/2/18. B. The clinical record evidenced a home health aide careplan for the certification period of 2/7/18 to 4/7/18. C. The plan of care for the certification period of 2/7/18 to 4/7/18, included orders for skilled nursing to provide home health aide supervisory "1M3" [1 time a month for 3 months] and home health aide services 2 hours a day 5 days a week for 9 weeks. The plan of care failed to evidence interventions and goals for the home health aide services, failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 4 days for 1 week, 2 hours a day 7 days a week for 8 weeks), and failed to accurately reflect the skilled nursing			

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	supervisory duration of 2 months. 3. The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. The electronic clinical record failed to evidenced a plan of care for the certification period of 2/13/17 to 4/14/18. A. The DOCS was queried on 2/19/18 at 3:15 p.m. of the whereabouts of the plan of care and was unable to provide an explanation of why the recertification was not in the electronic medical record. B. On 2/20/18 at 9:50 a.m., a typed document was provided which included a list of physicians (primary care physician, neurologist, podiatrist, otolaryngologist, dentist, optometrist, and urologist), pharmacy, and laboratory preference. An OASIS C2 recertification assessment was provided as well, but failed to evidenced a time, electronic signature and date of the assessment. During this time, the DOCS indicated Employee F had been working on changing the assessment to the correct OASIS, the plan of care was developed once the OASIS was completed, and Employee F was not able to get this done in a timely manner due to her busy schedule. C. At 10:00 a.m. the electronic record was reviewed again and evidenced a plan of care for the certification of 2/13/17 to 4/14/18, with orders for skilled nursing 1 hour a day for 2 months to evaluate for complications and medication effectiveness, instruct neurological assessment each visit, assess and instruct on seizure disorder to include precautions, signs and symptoms and appropriate actions during seizure activity, instruct patient / caregiver to contact agency to report any fall with or without injury and to call 911 for fall resulting in serious injury or causing			

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	severe pain or immobility. The plan of care failed to evidenced goals for the certification period and the other physicians that were on the patient's case. D. At 11:00 a.m., the Employee X provided another OASIS C2 recertification assessment which included the time, electronic signature and date. The reassessment indicated Employee F pre-filled a pill box. The current plan of care failed to evidenced orders for skilled nursing to prefill medication boxes. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The DOCS confirmed that skill nursing was filling the medication box monthly and not every other week. 4. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. The nursing frequency was inconsistent and failed to be clear and specific to the certification period (ex 1 hour per day, 1 day per month for 2 months) and failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 3 days for 1 week, 2 hours a day 7 days a week for 8 weeks). The plan of care failed to evidenced goals for the certification period.			

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	B. Review of the medication section of the plan of care indicated the following: i. The medication creams / ointments / lotions such as lac hydrin 5% lotion (medicated lotion used to treat dry skin), fluocinolone 0.025% topical cream (used to treat dermatitis, psoriasis, dermatitis and / or eczema), nystatin 100,000 units /topical cream (antifungal cream), mupirocin 2% topical cream (Antibacterial / antibiotic cream), and clotrimazole / betameth cr topical agent (antifungal cream) indicated to apply to affected area. The medicated creams and lotions failed to indicate the specific location to be applied. ii. Oral medications such as Milk of Magnesia (laxative), Loperamide (anti-diarrhea) capsule, and Sudogest (over the counter sinus medication) tablet indicated to take the medication as directed. The oral medications failed to indicate the dosage amount to ingest and it's frequency. C. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The Administrator and DOCS had nothing to provide in regards to the findings.			
G 0174 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. Based on record review, the Registered Nurse failed to document if trach care, g-tube care, medications, flushes, blood sugar checks, the time the insulin was given had been provided in 1 out of 2 records reviewed of patient receiving skilled	G 0174	Corrective Action: The RN will be responsible for the initiation and any changes to the Plan of Care. The RN will ensure that the plan of care will be based on the comprehensive assessment and	04/02/2018

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	nursing services only in a sample of 4. (#1 and 7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week "to change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD ... SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80. Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin] 40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a		include direction for all treatments provided, medications prescribed with dosage, route, who will administer, and time, DME required, outside providers' responsibility, goals, discharge plan and any other required data. The RN will furnish services requiring substantial and specialized nursing skill. Documentation will evidence the skilled services provided and specific to the patient's needs. Prevention: Audit 100% of the current charts for compliance. Quarterly, 10% or at least 3 charts will be audited for compliance to insure this deficiency does not recur. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. B. On 2/13/18, skilled nursing was provided by Employee F from 8:00 a.m. to 10:30 a.m.. The visit note indicated the patient had facial grimacing under the pain profile. The intervention and visit narrative included template documentation. The visit note failed to evidence documentation if any trach or g-tube treatments had been provided, failed to evidence a blood sugar reading and what time the insulin had been given, and failed to indicated what medications			

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	with flushes had been provided, and if the patient's pain had been addressed. C. On 2/15/17, skilled nursing was provided from 8:00 p.m. to 9:45 p.m. The visit note indicated the patient needed periodic suctioning, lung sounds crackles / rales, but failed to include the amount, color, and consistency when the patient was suctioned. The intervention and visit narrative included template documentation that was documented from the 2/10/18 OASIS recertification. The visit note failed to evidence trach care, g-tube care, failed to evidence a blood sugar reading and time the insulin had been given, and failed to indicate what medications / flushes had been given. D. The record was reviewed with the Administrator and the Director of Clinical Services on 2/20/18 at 3:30 p.m. and no further documentation or information was provided in regards to the above findings during this time.			
G 0176 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on record review and interview, the Registered Nurse failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care in 3 out of 3 records reviewed of patients being seen by more than 1 discipline / clinician in a sample of 4. (#1, 2, and 7) Findings include:	G 0176	Corrective Action: The RN is responsible for insuring all staff involved in the patient's care participates in the exchange of patient information and case conferences. The RN is responsible for a coordinated and effective quality care delivery. All direct care staff, RN's, aides, LPN's, will be educated on care coordination and participation in	04/02/2018

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	1. The clinical record for patient #1 was reviewed on 2/19/18 at 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/18 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/10/17. The document only indicated the name of the case manager. B. Review of the skilled nursing visit notes, majority of the visit were made by 3 different licensed practical nurses. The case conference note failed to evidence participation of all clinicians involved in the patient's care. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. The clinical record included a plan of care for the certification period of 2/7/18 to 4/7/18, with orders for skilled nursing 1 time a month for supervisory visits and home health aide services 2 hours a day 5 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/4/17. The document only indicated the name of the case manager. The case conference note failed to evidenced participation of the home health aide involved in the patient's care. 3. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. A. The electronic record evidenced a document titled "Coordination of Care" for the certification period of 12/1/17 to 1/29/18. The document was incomplete and failed to evidenced functional limitations, patient condition, services		case conferences. The deficiency report will be used for education reviewing the findings and the correction plan. Minutes of the case conferences will evidence the effective interchange, reporting, and coordination of patient care. The minutes of the case conferences as well as the patient's record documentation will evidence that all involved staff participated in the case conferences and the coordination of patient care. The form "Coordination of Care" will be completed, all sections and required information be accurate and complete, by the RN Case Manager with input from all involved staff. Prevention: 100% active files will have a case conference completed by April 2, 2018. Case Conferences will be conducted at least every 60 days, unless the patient's condition warrants more frequently. Case Conferences will be tracked for completion by the Director of Clinical Services. 100% patient charts will be audited for compliance with this condition by April 2, 2018. 10% or at least 3 patient charts will be audited quarterly to insure no recurrence of the deficiency. Target Date: April 2, 2018	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEEWELL INC	6967 HILLSDALE COURT INDIANAPOLIS, IN 46250

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	provided, vital sign ranges, home bound status, and summary of care provided by the home health agency. B. On 2/20/18, at 9:30 a.m., provided another "Coordination of Care" document that included all the missing information with exception to summary of care provided by the agency and the author's signature and date of who completed the form and failed to evidenced participation of the home health aide involved in the patient's care. C. The clinical record was reviewed with the Administrator and the DOCS on 2/2/18 at 3:30 p.m. No further information was provided during this time.		Responsible Person: Director of Clinical Services	
G 0180 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares clinical and progress notes. Based on record review, the LPNs failed to ensure to documentation was in real time in relation to specifying what medications were administered, when the patient was suctioned, the amount, color and viscosity, the specific treatments provided to the trach and g-tube, as well as skin appearance of treatment sites, patient tolerance, results and reassessment after cpt use, intake and each output, and failed to document occurrences of bed bug festation and equipment issues in 1 out of 1 records reviewed (#1) of patients with LPN services in a sample of 4 Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical	G 0180	Corrective Action: The LPN is responsible for completing clinical and progress notes. The LPN's will be instructed on documenting all care provided at the time the care is provided. The expectation is that all documentation is completed by the LPN at the time of care furnished. Documentation reflects the real-time care is provided. The LPN will document for instance what medications are administered, when the patient is suctioned--the amount, color and viscosity, all treatments performed including trach care, g-tube care, skin assessment, patient's response to treatments, and the	04/02/2018

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	record included a plan of care for the certification period of 12/13/17 to 2/10/18, with orders for skilled nursing 15 hours a day 7 days a week to provide "direct hands on care of client requiring trach care, tube feedings, insulin administration ... SN [Skilled Nurse] has turn schedule that is implemented q2h [every 2 hours] ... SN to perform BG [blood glucose] checks every visit and prn [as needed]. SN to administer insulin ... SN to instruct on care of stoma, surrounding skin and use of skin barrier. SN to instruct on proper technique for tube feeding, aspiration precautions and care of feeding tube site. SN to perform a neurological assessment each visit. SN to assess / instruct on seizure disorder signs and symptoms and appropriate actions during seizure activity. SN to instruct the caregiver on seizure precautions. SN to ensure all staff are competent to use VNS [vagus nerve stimulation] and document time and length of seizure." The patient's medications included, but not limited to, miralax as needed, normal saline as needed for suctioning, Humulin N 40 units in the a.m. and 10:00 p.m., 45 units at 3:00 p.m., 350 cc flush four times a day, levocarnitine 7 ml three times daily, lactulose 30 ml three times daily, Florastor 500 mg capsule twice a day, depakene 15 mls three times a day, acetaminophen prn, albuterol inhalation four times a day prn, nystatin three times a day prn, erythromycin toping solution twice a day and prn, loperamide every 6 hours as needed, scopolamine 1.5 mg transdermal every 3 days, levetiracetam 20 mls three times a day and clorazepate at 2:00 a.m., 1 at noon, and 2 at bedtime. A. Review of a skilled nursing visit note by Employee A on 2/5/18 and 2/7/18 with hours of 7:00 a.m. to 10:00 p.m., indicated the patient was disoriented but also indicated the patient was oriented to person, place, and time. The narrative		results and outcome of assessments. The visit reports, assessments, clinical notes, progress notes will all be complete, accurate, and in real-time. Any changes in the patient's care, services, or status, such as the bed bug infestation, is documented and reported to the RN for follow-up. The LPN will be instructed on this deficiency and the correction plan and the expectation of prompt compliance. LPN notes are reviewed by the RN for compliance. Prevention: Audit 100% of the current charts for compliance. Quarterly, 10% or at least 3 charts will be audited for compliance to insure this deficiency does not recur. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	portion of both 2/5 and 2/7/18 notes indicated verbatim, "0700: patient awake in bed. vs [vital signs] wnl [within normal limits]. head to toe wnl. congestion noted, trach suctioned PRN..) 0800: blood sugar wnl, insulin as ordered. g-tube in place and patent, meds / flush tolerated well including PRN tussin d/t [due to] congestion. feeding bag changed and resumed at 40 cc / hr [hour]. incontinence care. partial bed bath d/t urine overflow. PROM. 0900: trach care, oral care, g-tube care. positioned on right side. 1100: cpt [chest physical therapy to loosen mucous] vest x 20 min. incontinence care. positioned on left side. 1200: meds / flush tolerated well. 1330: incontinence care. patient dressed and transferred to wheelchair with hoyer. positioned for comfort, suction machine within reach. 1430: reported to evening nurse. i. The hours of the 2/5 and 2/7/18 visit notes was inconsistent with the narrative note indicating Employee A reported to an evening nurse at 14:30 p.m. ii. Both 2/5 and 2/7/18 narrative notes failed to include documented of the name of the medications that was administered at 0800 and at 1200. The intervention section in both 2/5 and 2/7/18 notes indicated medication administration were 5 times. iii. The respiratory assessment in the 2/5 and 2/7/18 visit notes indicated the patient lung sounds were clear bilaterally, which was inconsistent with both narrative notes indicating the patient was congested, PRN tussin was provided. The intervention section to both 2/5 and 2/7/18 notes indicated trach care and g-tube was provided 2 times. The narrative note failed to include documentation of the specific treatment			

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	provided to the trach and g-tube, and how the patient tolerated the treatment / procedure and the skin appearance around the stoma sites as well as how the patient tolerated the cpt vest therapy, if any mucous removal, failed to include color, amount, and consistency of sputum that was suctioned, the specific times the patient was suctioned, and failed to indicated that both trach and g-tube care had been provided 2 times. iv. The diabetic care in the 2/5 and 2/7/18 visit notes indicated blood sugars in the "AM, PM, HS [bedtime]" which was inconsistent with the documentation indicated only 40 units of insulin was administered x 1. The intervention section indicated diabetic monitoring / care, insulin administration, and injection was three times. The note failed to include documentation of the 3:00 p.m. and 10:00 p.m. dosage. v. The intervention section in the 2/5 and 2/7/18 visit notes indicated the glucometer was calibrated. The narrative note failed to evidenced documentation of when the calibration had been completed and whether the calibration passed or failed. vi. The narrative notes for both 2/5 and 2/7/18 failed to include documentation of the patient being repositioned after 1:30 (13:30) p.m. B. A communication note dated 2/5/18 and signed by the Director of Clinical Services, indicated the patient's residence had a bed bug infestation. The 2/5/18 visit note by Employee A failed to include documentation of the bed bug infestation. C. A communication note dated 2/7/18 and signed by the Employee F, indicated she had			

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	received a call from Employee A in regards to the humidifier over the patient's trach was not working and when called the durable medical equipment company, Employee A was told it was not an emergency. Another communication note dated 2/7/18, indicated the Employee F had spoke to a respiratory therapist who would contact Employee A and talk Employee A through troubleshooting and / or if a part was needed that evening or the next day. The visit note by Employee A failed to evidenced documentation of the incident and communication with the Employee F, failed to evidence documentation and the communication with the durable medical equipment company and the end result of the troubleshooting. The 2/5 and 2/7/18 skilled nursing visit notes were inconsistent between the assessments, narrative, and interventions, documentation failed to be reflective of the entire 7:00 a.m. to 10:00 p.m. visits, failed to be specific in all medications, treatments, and services that were provided by Employee A, failed to include total intake and output, and failed to evidenced the bed bug infestation and equipment difficulties along with communication that had taken place. D. The findings was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:35 p.m. No further information or documentation regarding the above findings were provided.			
G 0181 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the physician and registered nurse in performing specialized procedures.			

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	Based on record review, the Licensed Practical Nurse (LPN) failed to ensure to specifically document all procedures and treatment that had been provided through out the day / visit in 1 out of 1 record reviewed of a patient with a trach, feeding tube, and insulin administration in a sample of 4 records. (#1) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18, with orders for skilled nursing 15 hours a day 7 days a week to provide "direct hands on care of client requiring trach care, tub feedings, insulin administration ... SN [Skilled Nurse] has turn schedule that is implemented q2h [every 2 hours] ... SN to perform BG [blood glucose] checks every visit and prn [as needed]. SN to administer insulin ... SN to instruct on care of stoma, surrounding skin and use of skin barrier. SN to instruct on proper technique for tube feeding, aspiration precautions and care of feeding tube site. SN to perform a neurological assessment each visit. SN to assess / instruct on seizure disorder signs and symptoms and appropriate actions during seizure activity. SN to instruct the Caregiver on seizure precautions. SN to ensure all staff are competent to use VNS and document time and length of seizure." The patient's medications included, but not limited to, miralax as needed, normal saline as needed for suctioning, Humulin N 40 units in the a.m. and 10:00 p.m., 45 units at 3:00 p.m., 350 cc flush four times a day, levocarnitine 7 ml three times daily, lactulose 30 ml three times daily, Florastor 500 mg capsule twice a day, depakene 15 mls three times a day, acetaminophen prn, albuterol inhalation four	G 0181	Corrective Action: The LPN'S will be educated on this deficiency, the findings of the deficiency, corrective action and the expectation of prompt compliance. The LPN will document all medications administered, name, dosage, route, date, time, patient's response. The specifics of all treatments provided such as trach care and g-tube care will be documented by the LPN with time, date, what was done, how the patient reacted, and the specifics of the outcome. The RN will review the LPN documentation to insure completeness and accuracy and to insure care is provided as ordered. Prevention: Audit 100% of the current charts for compliance. Quarterly, 10% or at least 3 charts will be audited for compliance to insure this deficiency does not recur. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	04/02/2018

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times a day prn, nystatin three times a day prn, erythromycin toping solution twice a day and prn, loperamide every 6 hours as needed, scopolamine 1.5 mg transdermal every 3 days, levetiracetam 20 mls three times a day and clorazepate at 2:00 a.m., 1 at noon, and 2 at bedtime.

A. Review of a skilled nursing visit note by Employee A on 2/5/18 and 2/7/18 with hours of 7:00 a.m. to 10:00 p.m., indicated the patient was disoriented but also indicated the patient was oriented to person, place, and time. The narrative portion of both 2/5 and 2/7/18 notes indicated verbatim, "0700: patient awake in bed. vs [vital signs] wnl [within normal limits]. head to toe wnl. congestion noted, trach suctioned PRN..) 0800: blood sugar wnl, insulin as ordered. g-tube in place and patent, meds / flush tolerated well including PRN tussin d/t [due to] congestion. feeding bag changed and resumed at 40 cc / hr [hour]. incontinence care. partial bed bath d/t urine overflow. PROM. 0900: trach care, oral care, g-tube care. positioned on right side. 1100: cpt vest x 20 min. incontinence care. positioned on left side. 1200: meds / flush tolerated well. 1330: incontinence care. patient dressed and transferred to wheelchair with hoyer. positioned for comfort, suction machine within reach. 1430: reported to evening nurse."

i. Both 2/5 and 2/7/18 narrative notes failed to include documented of the name of the medications that was administered at 0800 and at 1200. The intervention section in both 2/5 and 2/7/18 notes indicated medication administration were 5 times daily. The narrative note failed to evidenced documentation of medications administered after 2:30 p.m. and failed to evidence documentation if the g-tube residual had been checked (and amount if any) prior to each

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	medication administration. iii. The intervention section to both 2/5 and 2/7/18 visit notes indicated trach care and g-tube was provided 2 times. The narrative note failed to include documentation of the specific treatment provided to the trach and g-tube and how the patient tolerated the treatment / procedure and the skin appearance around the stoma sites, failed to include color, amount, and consistency of sputum that was suctioned, the specific times the patient was suctioned, and failed to indicated that both trach and g-tube care had been provided 2 times. iv. The diabetic care section in the 2/5 and 2/7/18 visit notes indicated blood sugars were obtained in the "AM, PM, HS [bedtime]" and indicated 40 units of insulin was administered x1. The intervention section indicated diabetic monitoring / care, insulin administration, and injection were three times daily. The note failed to include documentation if the insulin had been provided at 3:00 p.m. and 8:00 p.m. v. The intervention section in the 2/5 and 2/7/18 visit notes indicated the glucometer was calibrated. The narrative note failed to evidenced documentation of when the calibration had been completed and whether the calibration passed or failed. B. Employee A was not available for interview on 2/20/18, due to illness. C. The findings was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:35 p.m. No further information or documentation regarding the above findings were provided.			

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G 0183 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the patient in learning appropriate self-care techniques. Based on record review the LPNs failed to instruct the caregiver in all aspects of trach care and equipment, diabetic management, proper technique for tube feeding / aspiration precautions / care of feeding tube site, instruct on seizure disorder as per the plan of care in 1 out of 1 active records reviewed (#1) of patients with LPN services in a sample of 4. Findings include: 1. The clinical record for patient #1 was reviewed on 12/12/17 at approximately 2:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18, with orders for skilled nursing 15 hours a day 7 days a week to provide " ... SN to instruct on care of stoma, surrounding skin and use of skin barrier. SN to instruct on proper technique for tube feeding, aspiration precautions and care of feeding tube site ... SN to ... instruct on seizure disorder signs and symptoms and appropriate actions during seizure activity. SN to instruct the caregiver on seizure precautions. SN to ensure all staff are competent to use VNS and document time and length of seizure." A. Review of a skilled nursing visit note by Employee A on 2/5/18 and 2/7/18 with hours of 7:00 a.m. to 10:00 p.m., failed to evidence documentation of education / instruction to the caregiver.	G 0183	Corrective Action: Caregiver instruction will be given by the LPN as compiled, directed, and supervised by the RN. Documentation will evidence the content of the caregiver education, caregiver response, and ongoing assessment of compliance with the education. RN's and LPN's will be instructed on providing complete caregiver instruction regarding patient care. Compliance is expected promptly. LPN documentation will be reviewed by the RN for compliance. Prevention: Supervision of the LPN care monthly and documentation with oversight and education will insure that this deficiency does not recur. 100% of active charts will be audited for compliance, then quarterly 10% or at least 3 charts will be audited for compliance. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	04/02/2018

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	B. Employee A was not available for interview on 2/20/18, due to illness. C. The findings was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:35 p.m. No further information or documentation regarding the above findings were provided.			
G 0202 Bldg. 00	484.36 HOME HEALTH AIDE SERVICES Based on record review and interview, the agency failed to ensure home health aide skills competency evaluations were conducted by an outside non-employee / contracted registered nurse (See G 207); failed to ensure the home health aide followed the home health aide care plan (See G 224); failed to follow the plan of care in regards to duration of hours spent inside the home (See G 225); and failed to conduct supervisory visits with the home health aide every 14 days (See G 229). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.36 Home Health Aide Services. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.	G 0202	Corrective Action: The agency has an outside contract to provide aide competency and evaluation for new aide hires. The RN familiar with the patient's care will supervise the aide for a skilled case at least every 2 weeks on-site and for a non-skilled at least every 30 days on-site. The aide will be present and the provision of care will be observed by the RN at least every 60 days. The aide will provide care as directed by the RN on the aide care plan. Supervisory visits for all patient with aide services will be tracked for date due and completeness. Aide visit reports will be reviewed for completeness and accuracy. RN at supervisory visits will insure the aide is providing care as directed by the aide care plan. Hours ordered will be provided unless the patient's condition changes and modifications are needed. The physician will be notified of changes in the patient's condition	04/02/2018

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			and the need to modify the plan of care. The aides will be educated on this deficiency and the expectation for compliance. Prevention: 100% active charts with aide services will be audited for compliance, then quarterly 10% of cases with aide services will be audited for compliance. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	
G 0207 Bldg. 00	484.36(a)(2) HHA TRAINING - CONDUCT A home health aide training program may be offered by any organization except an HHA that, within the previous two years, has been found: - Out of compliance with requirements of this paragraph (a) or paragraph (b) of this section - To permit an individual that does not meet the definition of "home health aide" as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers) - Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State) - Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction - Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee			

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	the management of the HHA - Has had all or part of its Medicare payments suspended Further, under any Federal or State law within the 2-year period beginning on October 1, 1988: - Has had its participation in the Medicare program terminated - Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs - Was subject to a suspension of Medicare payments to which it otherwise would have been entitled; - Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients - Was closed or had its residents transferred by the State. Based on record review and interview, the agency failed to ensure home health aide skills competency evaluations were conducted by an outside non-employee / contracted registered nurse in 2 out of 3 home health aide personnel records reviewed. (#J and N) Findings include: 1. The personnel record for Employee J was reviewed on 2/20/18 at 2:10 p.m. The employee's skills competency evaluation indicated a date of check off of 12/28/18. At 2:25 p.m., Employee J was contacted and interviewed. Employee J confirmed that the Director of Clinical Services had been out to check him / her off and confirmed he / she signed the competency evaluation document.	G 0207	Corrective Action: The agency has not conducted any new hire aide competency or evaluations since December 19, 2017. There or none documented. A contractual agreement is in place with an outside non-employee RN to conduct new hire skills competency and evaluations. To ensure quality aide care, all current aides were observed in the home providing direct hands on care to their patients. This was not intended to be a new hire skills competency or evaluation, but to be a supervisory quality care experience. Prevention: The agency will	04/02/2018

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	2. The personnel record for Employee N was reviewed on 2/20/18 at 2:00 p.m. The employee's skills competency evaluation indicated a date of check off of 12/21/18. At 2:20 p.m., Employee J was contacted and interviewed. Employee J confirmed that the Director of Clinical Services had been out to check him / her off and confirmed he / she signed the competency evaluation document. 3. The Director of Clinical Services was interviewed on 2/20/18 at 4:10 p.m., and indicated the competency evaluation had been conducted prior to the survey from December (12/11 to 12/19/18). When queried about informing them of inability to conduct home health aide evaluation competencies at the exit conference on 12/19/18 and showed the dates on the competency evaluation documents, the Director of Clinical Services indicated "yes, I know." The agency failed to ensure home health aide skills competency evaluations were conducted by an outside non-employee / contracted registered nurse after 12/19/18.		comply with the sanction given regarding aide competency and evaluation by utilizing the contractual outside non-employee RN for new hires. Target Date: Immediately; Contract agreement February 16, 2018 Responsible Person: Administrator	
G 0224 Bldg. 00	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on record review and interview, the agency failed to ensure the home health aide followed the home health aide care plan in 2 out of 2 records	G 0224	Corrective Action: All home health aides were educated on compliance with the home health aide care plan and assigned	04/02/2018

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	reviewed (#2 and 7) in a sample of 4. Findings include: 1. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. A. The home health aide careplan for the certification period of 2/7/18 to 4/7/18, indicated duties included but not limited to for the home health aide to provide a shower with chair every visit and assist with chair bath weekly, shampoo hair weekly, nail care every visit, record bowel movements. The care plan did not indicate to assist with ambulation. i. Review of 2/7, 2/10, 2/11, 2/13, 2/14, and 2/16/18 visit notes, the home health aide documented assist with chair bath, assist with ambulation, and failed to evidenced a shampoo, shower with chair, and nail care. ii. Review of the 2/12/18 visit note, the home health aide documented tub / shower, assist with chair bath, shampoo, nail care, and assist with ambulation. The home health aide failed to specify if the patient received a tub or shower bath. The home health aide failed to follow the care plan. 2. The clinical record for patient #7 was initially reviewed on 2/19/18 at 4:00 a.m. A. The electronic record indicated a home health aide careplan dated 1/26/18. The home health aide careplan indicated a certification period of 12/1/17 to 1/29/18 and signed by the DOCS on 1/29/18. The duties included but not limited to tub bath and record bowel movement.		tasks. At least weekly, aide time sheets, documentation, aide care plan will be reconciled for compliance and accuracy of completion. Any discrepancies by the aide will initiate disciplinary actions. At supervisory visits the RN will insure that the aide is implementing the aide care plan as directed. An RN will supervise the aide for a skilled case at least every 2 weeks on-site and for a non-skilled at least every 30 days on-site. The aide will be present and the provision of care will be observed by the RN at least every 60 days. Prevention: Track supervisory visits scheduled versus performed visits to insure compliance with the regulations. RN's to insure supervisory visits are effective in determining the aide's performance and compliance with the care plan. These actions will prevent this deficiency from recurring. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	B. Review of the home health aide visit notes dated 2/5/18 to 2/9/18 and 2/12 to 2/16/18, failed to evidence a record of bowel movements and failed to indicate if the patient received a tub bath / shower. The home health aide evidenced documentation duties that were not included in the home health aide careplan such as foot care, checking pressure areas, and encouraging fluids. The home health aide failed to follow the plan of care. 3. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:30 p.m. The Administrator indicated that Employee X would be taking on the responsibility of ensuring the home health aides documented their visit sheets appropriately.			
G 0225 Bldg. 00	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on record review, the home health aide failed to follow the plan of care in regards to duration of hours spent inside the home in 1 out of 2 records reviewed of home health aide services in a sample of 4. (#7) Findings include: 1. The clinical record of patient #7 was reviewed on 12/20/18 at 10:33 a.m. A. The clinical record contained orders for home health aide services to be provided 2 hours a day, 5 days a week for 9 weeks. Review of the	G 0225	Corrective Action: The aides have been instructed on the physician orders the hours that are needed to meet the patient's needs. The aide reports to the RN if those hours are not met and the reason why. The aide documents this in the visit record. The physician is notified. Prevention: 100% of aide visit report are reviewed by the RN for hours provided, care provided, and compliance with the aide care plan.	04/02/2018

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	home health aide visit notes dated 2/5 to 2/9/18 and 2/12 to 2/16/18, the home health aide provided services 3 hours each day. The home health aide failed to follow the plan of care. B. The clinical record was reviewed with the Administrator and the DOCS on 2/20/18 at 3:30 p.m. The Administrator and the DOCS had no further information or documentation to provide during this time.		Responsible Person: Director of Clinical Services Target Date: April 2, 2018	
G 0229 Bldg. 00	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on record review and interview, the Registered Nurse failed to conduct supervisory visits with the home health aide every 14 days in 1 out of 1 record of a patient receiving skilled services with a home health aide in a sample of 4. (#7) Findings include: 1. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. During this time, the DOCS was informed and checked to computer and confirmed there was not a plan of care in the computer. A. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2 x" and home health aide services 2 hours a day, 5 days a	G 0229	Corrective Action: The RN will be educated on an RN will supervise the aide for a skilled case at least every 2 weeks on-site and for a non-skilled at least every 30 days on-site. The aide will be present and the provision of care will be observed by the RN at least every 60 days. Aide supervisory visits are tracked to insure compliance. Prevention: Track supervisory visits scheduled versus performed visits to insure compliance with the regulations. RN's to insure supervisory visits are effective in determining the aide's performance and compliance with the care plan. These actions will prevent this deficiency from recurring. Target Date: April 2, 2018	04/02/2018

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	week for 9 weeks. B. The clinical record evidenced the last completed home health aide supervisory visit note, dated 12/28/17. A home health aide supervisory visit note dated 1/26/18 was incomplete and did not include a signature. 2. The clinical record was reviewed with the Administrator and the Director of Clinical Services on 2/20/18 at 3:30 p.m. The Director of Clinical Services indicated she was not aware of providing services every 2 weeks when skilled nursing was only providing medication set ups.		Responsible Person: Director of Clinical Services	
G 0235 Bldg. 00	484.48 CLINICAL RECORDS Based on record review and interview, the agency failed to ensure orders were collaborated and co-signed by the collaborating / attending physician, failed to ensure communication notes were electronically signed by the visiting clinician, failed to ensure communication notes had accurate dates of visit, and failed to ensure clinical records contained visit notes, and notes were complete and contained consistent / accurate information in a timely manner (See G 236).	G 0235	Corrective Action: All patient charts will evidence the orders are signed by the collaborating or attending physician. All documentation is signed by the appropriate clinician, including visit/progress notes. All documentation will be completed at the time of the visit and incorporated into the EMR in real-time or scanned into the EMR within 7 days of the visit. All documentation will reflect accurate time, date of care provided and the appropriate staff signature. Clinical staff is educated on this deficiency and expectation of prompt compliance. This corrective action will be evidenced in all patient files. Prevention: 100% orders are	04/02/2018

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			tracked for signature and date returned. Documentation is reviewed weekly to insure completeness and signature. Visits ordered versus visits completed are tracked to insure completeness and compliance with physician's orders. Continuing this tracking will insure this deficiency does not recur. These deficiencies are included in the chart audit reviews. Responsible Person: Director of Clinical Services Target Date: April 2, 2018	
G 0236 Bldg. 00	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Based on record review and interview, the agency failed to ensure orders were collaborated and co-signed by the collaborating / attending physician, failed to ensure communication notes were electronically signed by the visiting clinician, failed to ensure communication notes had	G 0236	Corrective Action: Physician orders will be received and signed by a medical doctor, doctor of osteopathy, and doctor of podiatry. Orders communicated by a NP will be co-signed by the physician. All current charts have	04/02/2018

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	accurate dates of visit, and failed to ensure clinical records contained visit notes, and notes were complete and contained consistent / accurate information in a timely manner in 4 out of 4 records reviewed. (#1, 2, 6, and 7) Findings include: 1. The clinical record for patient #1 was reviewed on 12/12/17 at approximately 2:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18 and 2/11/18 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week and to provide insulin 40 Units at 8:00 a.m. and 8:00 p.m. and 45 Units at 3:00 p.m. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/10/17, that indicated the patient was receiving home health aide services. B. A communication note dated 2/5/17, failed to include an electronic signature and date of the author of who wrote the note. C. Review of the the 2/5 and 2/7/18 skilled nurse visit notes indicated the LPN was in the home from 7:00 a.m. to 10:00 p.m. 1. The diabetic care section indicated blood sugars were obtained in the "AM, PM, HS [bedtime]" and indicated 40 units of insulin was administered x1. 2. The intervention section indicated diabetic monitoring / care, insulin administration, and injection was three times daily. 3. The narrative section indicated the insulin was administered at 8:00 AM and the		been audited to verify compliance with this regulation. All entries, including physician's orders, in the clinical record will be signed, dated, timed by the appropriate clinician. Review of clinical documentation is implemented, including visit notes for nursing, and aide, physician's orders, plan of care for correctness and completeness. Prevention: Compliance with the correction plan will insure that this deficiency does not recur. This item is included in the chart audit process to insure ongoing compliance. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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nurse reported off at 2:30 PM. No further documentation was provided. The visit notes were inconsistent and failed to indicate if the insulin had been provided at 3:00 p.m. and 8:00 p.m. The clinical record failed to evidence other skilled nursing visit notes after 2:30 p.m.

D. A communication note dated 2/10/17, signed and dated by Employee F on 2/7/18 was reviewed with the Employee F on 2/20/18 at 1:15 p.m. Employee F indicated the correct date of the note should be 2/7/18, not 2/10/18. Employee F also indicated the patient was receiving home health aide services from BeeWell. When queried why didn't the plan of care include orders for home health aide services, Employee F indicated confusion with the sister company and the combined services the patient was being provided. When asked if she coordinated care with the sister companies, Employee F indicated she had not.

E. Review of the skilled nursing visits in the electronic medical record, visit dates 2/6, 2/8, 2/10, 211, 2/12, 2/14, 2/16 and 2/17/18 failed to evidenced documentation that skilled nursing visits had taken place.

i. On 2/19/18 at 2:40 p.m., the Director of Clinical Services (DOCS) was informed of the missing documentation between 2/5 and 2/17/18. The DOCS was requested to have all visit notes printed from the EMR during this time frame. The DOCS indicated that the staff was informed that all visit notes must be in the EMR. The Administrator had indicated she thought all the days had been covered. Also expressed problems with their computer program since the new updates. At 3:25 p.m., the Employee E provided hand written notes for 2/13 and 2/15/18, expressed

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	problems with the computer as for not having the notes entered in the EMR. Employee E indicated she would have the notes in the EMR by 2/20/18. ii. On 2/20/18 at 10:00 a.m., Employee E provided the 2/13 and 2/15/18 electronic visit notes. iii. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen. F. Review of a skilled nursing visit note dated 2/9/18 from 7:55 a.m. to 8:55 p.m., the note indicated in the Endocrine / Hematologic section: " ... 8 p.m. RBS [sic] - 135. SN administered 40 U N insulin per abdomen at 3 o'clock SQ ... " Care Coordinated with HHA [home health aide]. The narrative indicated " ... SN changed trach ties, trach dressing for second time this evening .... " The entries failed to be consistent with the time of the nursing visit. G. Review of a skilled nursing visit note dated 2/9/18 from 3:10 p.m. to 5:30 p.m., indicated " ... Hha, [name of aide] helped place supplies back into appropriate labeled drawers .... " The entry failed to correctly identify the caregiver. H. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by			

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	[name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. I. An order on a nurse practitioner's script, unsigned and dated 2/15/18, indicated for the patient to have amoxicillin every 8 hours for 10 days. i. The DOCS was interviewed on 2/19/18 at 1:20 p.m., indicated she did not obtain clarification orders from the physician as she was instructed by the consultant to wait until the script had been filled and obtain the order via script label. The DOCS expressed concerns with the nurse practitioner not wanting to cooperate with the need for co-signature from the collaborating physician. When queried about obtaining the patients medication administration record and orders in the patients home, the DOCS indicated the forms would be brought into the office monthly. When queried if the entire 2017 year and January 2018 had been obtained and put into the patient's record, the DOCS indicated the documents had not been obtained from the patient's home. J. Review of the physician address and phone number on the plan of care, the agency had the an address of a hospital that the physician worked from as a hospitalist and phone number was that of the hospital switchboard.			

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	i. On 2/20/18 at 2:20 p.m., the phone number on the nurse practitioner script was called. An interview with the receptionist during this time indicated that the address of phone number were incorrect. The receptionist indicated the physician was one of the collaborating physicians in the office and orders were to be faxed to their office, they review them to ensure that the patient was their patient and information was correct, then it would get uploaded for the physician to electronically sign, then the office would return the signed documents back to the agency. The agency failed to have the correct address, phone and fax number of the physician. 2. The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. A. The electronic clinical record evidenced a document titled "60-Day Summary / Case Conference" for the certification period of 12/15/17 to 2/12/18. The document was incomplete and failed to evidenced vital sign ranges, summary of care provided, patient's current condition, goals, and signature of author and date. B. On 2/20/18 at 9:30 a.m., another "60-Day Summary / Case Conference" for the certification period of 12/15/17 to 2/12/18 was provided. The summary indicated the patient's blood pressure had been under control with medication adjustments, blood sugars fairly well controlled with Metformin [oral diabetic medication] increased to 1 gm twice a day, and skilled nursing set's up patient medications every other week. The patient's current condition indicated the patient's blood pressures was controlled with amlodipine.			

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i. Review of the OASIS C2 Recertification assessment dated 2/16/18, indicated the patient's had a history of elevated blood pressure and was treated with carvedilol, spironolactone, and lisinopril.

ii. Review of the medication profile evidenced the patient's Metformin was increased to 1 gm on 9/26/18. The patient's blood pressure medications consist of spironolactone, carvedilol, amlodipine, and lisinopril. The last blood pressure medication change was Spironolactone on 7/24/17.

C. The clinical record was reviewed with the Administrator and the DOCS on 2/20/17 at 3:30 p.m. The DOCS confirmed skilled nursing visits were monthly for medication set up.

Employee F failed to complete the 60 day summary / case conference form within a timely manner and failed to be reflective of the patient's current status.

3. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m.

A. The electronic record evidenced a document titled "Coordination of Care" for the certification period of 12/1/17 to 1/29/18. The document was incomplete and failed to evidenced functional limitations, patient condition, services provided, vital sign ranges, home bound status, and summary of care provided by the home health agency.

B. On 2/20/18, at 9:30 a.m., provided another "Coordination of Care" document that included all the missing information with exception to

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	summary of care provided by the agency and the author's signature and date of who completed the form. C. The clinical record was reviewed with the Administrator and the DOCS on 2/2/18 at 3:30 p.m. No further information was provided during this time.			
G 0337 Bldg. 00	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure the medications listed on the medication profile was accurate, clarified by the physician, and authenticated by signature and date in 3 out of 4 records reviewed. (#1, 2 and 7) Findings include: 1. The clinical record for patient number 1 was reviewed on 2/19/18. A. Review of the Medication Administration Record from the pharmacy dated 2/28/18 (future date), Florastor 250 mg twice a day was indicated of the form. The form also indicated the patient had an allergy to benzodiazepines, penicillin, red dyes, yellow dye - tartrazine. B. The clinical record contained a medication profile, which indicated on 2/1/18, Florastor 500	G 0337	Corrective Action: The Medication Profile will include a complete list of all the medications that the patient is currently using with a review of those medications identifying any potential adverse effects and drug reactions. Significant findings of the drug review, will be reported to the physician for clarification and orders signed by the physician. The medication profile will reflect accurately the medications the patient is currently using and ordered by the physician. Accurate information regarding the patient's allergies, the pharmacy contact information, and physician to contact will be included in the patient's record. Reference to	04/02/2018

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	mg cap per g-tube twice a day and also indicated 250 mg capsules twice a day per g-tube. The medication profile indicated the patient was only allergic to Diastat (valium / type of benzodiazepine) and penicillin. The medication profile failed to evidenced a signature and date of medication reconciliation, failed to evidenced accurate allergy information, failed to evidenced the name and phone number of the pharmacy, primary and secondary diagnoses. C. The clinical record contained an OASIS C2 Recertification reassessment dated 2/10/18, indicating that the patient was to receive sliding scale insulin and normal saline for suctioning. The medication profile failed to evidenced the type and amount of sliding scale insulin and the amount of normal saline used for suctioning. D. The Director of Clinical Services was interviewed on 2/19/18 at 1:20 p.m. When queried the Director of Clinical Services about contacting the physician to clarify medication discrepancy, the Director of Clinical Services indicated she did not get the orders clarified by the physician but took the information from the pharmacy medication administration profile. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. A. Review of a medication profile, failed to evidenced a signature and date of medication reconciliation, failed to evidenced start dates of polyethylene glycol (stool softner), tiotropium inhalation (widens bronchi to alleviate shortness of breath), atorvastatin (antilipids), risperidone (antipsychotic), aspirin (blood thinner), vitamin B complex with B 12, lisinopril (antihypertensive), mirtazapine (antidepressant / sleep), donepezil		resources used for the drug regimen review will be documented in the patient's record. The responsible RN will sign and date the drug regimen review and document any contact with the physician or changes in the prescribed medications. The RN's are educated on this deficiency and corrective action to insure compliance. Prevention: 100% of active charts are audited for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	(anti alzheimer), failed to evidenced pharmacy name and phone number, as well as primary and secondary diagnoses. B. An interview with the Employee F on 2/20/18 at 1:15 p.m., indicated she did do medication reconciliation at recertification and was not able to explain why the medication profile was not authenticated with her name and date of reconciliation. 3. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. A. Review of the medication profile indicated the following: i. The medication creams / ointments / lotions such as lac hydrin 5% lotion (medicated lotion used to treat dry skin), fluocinolone 0.025% topical cream (used to treat dermatitis, psoriasis, dermatitis and / or eczema), nystatin 100,000 units /topical cream (antifungal cream), mupirocin 2% topical cream (Antibacterial / antibiotic cream), and clotrimazole / betameth cr topical agent (antifungals cream) indicated to apply to affected area. The medicated creams and lotions failed to indicate the specific location to be applied. ii. Oral medications such as Milk of Magnesia (stool softner), Loperamide (anti-diarrheal) capsule, and Sudogest (over the counter sinus medication) tablet indicated to take the medication as directed. The oral medications failed to indicate the dosage amount to ingest and it's frequency. iii. The medication profile failed to evidenced a primary and secondary diagnoses.			

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	iv. The medication profile failed to include a signature and date of the author. B. The DOCS was interviewed on 2/20/18 at 11:34 a.m., and indicated medications were taken from the pharmacy medication list and were not clarified by the physician. C. Employee E was interviewed on 2/20/18 at 11:54 a.m., and indicated she was also the Wellness Coordinator with the adjoining agency within the office (through FSSA developmental disabilities) and when she obtains written orders, she would send it to the pharmacy and provide the DOCS of BeeWell a copy of the medication sheets and not the scripts.			
G 0339 Bldg. 00	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on record review and interview, the Registered Nurse failed to ensure the correct OASIS recertification forms were completed within the last 5 days of a 60 day certification period and failed to ensure endocrine assessments included blood sugar ranges between certification periods in 1 out of 2 skilled certification reassessments in a sample of 4. (#6) Finding included:	G 0339	Corrective Action: The RN will complete the Comprehensive/OASIS Assessment between days 56-60 of the current certification period. The assessment will be complete and accurate based on the patient's status. All categories will be addressed. A 60-day episode tracking calendar is completed indicating days 56-60 for the RN.	04/02/2018

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	The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. The electronic clinical record failed to evidenced a plan of care for the certification period of 2/13/17 to 4/14/18. A. The DOCS was queried on 2/19/18 at 3:15 p.m. of the whereabouts of the plan of care and was unable to provide an explanation of why the recertification was not in the electronic medical record. B. On 2/20/18 at 9:50 a.m., an OASIS C2 recertification assessment dated 2/16/18 was provided but failed to evidenced a time, electronic signature and date of the assessment. During this time, the DOCS indicated Employee F had been working on changing the assessment to the correct OASIS, the plan of care was developed once the OASIS was completed, and Employee F was not able to get this done in a timely manner due to her busy schedule. C. At 10:00 a.m. the electronic record was reviewed again and evidenced a plan of care for the certification of 2/13/17 to 4/14/18, with orders for skilled nursing 1 hour a day for 2 months to evaluate for complications and medication effectiveness, instruct neurological assessment each visit, assess and instruct on seizure disorder to include precautions, signs and symptoms and appropriate actions during seizure activity, instruct patient / caregiver to contact agency to report any fall with or without injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. D. At 11:00 a.m., the Employee X provided another OASIS C2 recertification assessment dated 2/16/18, which included the time, electronic		Comprehensive tracking process is in place to insure compliance with this regulation. RN's are educated on this deficiency and corrective action to insure compliance. Prevention: audit 100% of active charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	signature and date of Employee F. The reassessment indicated the patient was a diabetic that was managed by oral hypoglycemic and insulin. The assessment failed to be completed within the last 5 days of the 60 day certification period and failed to evidenced the patient's blood sugars were reviewed and were within acceptable parameters and ensure no adjustments were needed. E. Employee F was interviewed on 2/20/18 at 1:15 p.m., and indicated she was having computer problems trying to access the correct OASIS.			
N 0000 Bldg. 00	This visit was a follow up State licensure survey. Dates of Survey: February 19 and 20, 2018 Facility ID #: 013425 Medicaid #: 201222410 Current Census: 13 (13 Skilled and 4 Home health aide only)	N 0000		
N 0449 Bldg. 00	410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure. Based on record review, the Administrator failed	N 0449	The administrator provides on-site agency supervision on most	04/02/2018

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	to ensure the home health agency met all the rules and regulations for continued state licensure in 1 of 1 agency. Findings include: 1. The agency failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care. 2. The agency failed to ensure clinical staff followed the plan of care and the agency failed to ensure services were not provided until a physician's order could be obtained. 3. The agency failed to ensure the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, failed to include goals for the next certification period, and failed to include discipline frequencies and duration specific to the certification period. 4. The agency failed to ensure a physician was notified and orders obtained for the continuation of services upon recertification for additional 60 days. 5. The agency failed to ensure the physician was notified when it was identified that there was a need to alter the plan of care.		business days and can be reached by phone, email, or texting nearly 24/7. Administrator shall ensure the agency meets all rules and regulations through onsite supervision, increased monitoring, enhanced management staff training, and consultation with experienced, knowledgeable professionals in the home healthcare industry. DCS has been instructed in numerous areas to insure complete, accurate, and timely documentation. The deficiency report has been used for education by reviewing the findings and the correction plan. A well experience, competent, and well reputed agency consultant will provide no less than monthly expertise, advice, and audit services until audits show consistent agency compliance with rules and expectations. Consultation will then continue at least quarterly for another year. Increased and enhanced agency systems tracking methods have been developed and implemented to provide agency-wide accountability. The administrator will review these results monthly; the QAPI committee will review these results no less than quarterly in attempt to identify problems and trends before they	

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	6. The agency failed to ensure orders were put into writing . 7. The agency failed to ensure clinical staff follow the plan of care and the agency failed to ensure services were not provided until a physician's order could be obtained. 8. The agency failed to ensure the skin assessment addressed a skin impairment with each visit and failed to ensure skilled nursing identified and addressed a patient's behavior. 9. The agency failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, and failed to include discipline frequencies and duration specific to the certification period. 10. The agency failed to ensure Registered Nurses documented if trach care, g-tube care, medications, flushes, blood sugar checks, the time the insulin was given had been provided. 11. The agency failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care. 12. The agency failed to ensure Licensed Practical Nurseto documentation was in real time in relation to specifing what medications were administered,		become systemic issues. Prevention: Agency tracking systems have been incorporated into the agency QAPI program to provide no less than quarterly compliance data. An outside consultant will provide monthly educational and audit visits until compliance has been achieved; quarterly visits for an additional year. Target date: April 2, 2018 Responsible party: Administrator	

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	when the patient was suctioned, the amount, color and viscosity, the specific treatments provided to the trach and g-tube, as well as skin appearance of treatment sites, patient tolerance, results and reassessment after cpt use, intake and each output, and failed to document occurences of bed bug festation and equipment issues 13. The agency failed to ensure Licensed Practical Nurses specifically documented all procedures and treatment that had been provided through out the day / visit. 14. The agency failed to ensure Licensed Practical Nurses instructed the caregiver in all aspects of trach care and equipment, diabetic management, proper technique for tube feeding / apsiration precautions / care of feeding tube site, instruct on seizure disorder as per the plan of care (See G 183). 15. The agency failed to ensure home health aide skills competency evaluations were conducted by an outside non-employee / contracted registered nurse (See G 207); 16. The agency failed to ensure the home health aide followed the home health aide care plan. 17. The agency failed to ensure a home health aides followed the plan of care in regards to duration of hours spent inside the home. 18. The agency failed to ensure orders were collaborated and co-signed by the collaborating / attending physician, failed to ensure communication notes were electronically signed by the visiting clinician, failed to ensure communication notes had accurate dates of visit, and failed to ensure clinical records contained			

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	complete and accurate information and failed to ensure visit notes were in the electronic medical record or in the office within a timely manner. 19. The agency failed to ensure the medications listed on the medication profile was accurate, clarified by the physician, and authenticated by signature. 20. The agency failed to ensure the correct recertification forms were completed within the last 5 days of a 60 day certification period and failed to ensure endocrine assessments included blood sugar ranges between certification periods.			
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview, the agency failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care in 3 out of 3 records reviewed of patients being seen by more than 1 discipline / clinician in a sample of 4. (#1, 2, and 7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/18 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week.	N 0484	Corrective Action: All direct care staff, RN's, aides, LPN's, will be educated on care coordination, participation in case conferences, and the importance of maintaining effective communications to assure that their efforts compliment one another and support the objectives of patient care. The deficiency report will be used for education reviewing the findings and the correction plan. Minutes of the case conferences will evidence the effective interchange, reporting,	03/30/2018

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	A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/10/17. The document only indicated the name of the case manager. B. Review of the skilled nursing visit notes, majority of the visit were made by 3 different licensed practical nurses. The case conference note failed to evidence participation of all clinicians involved in the patient's care. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. The clinical record included a plan of care for the certification period of 2/7/18 to 4/7/18, with orders for skilled nursing 1 time a month for supervisory visits and home health aide services 2 hours a day 5 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/4/17. The document only indicated the name of the case manager. The case conference note failed to evidenced participation of the home health aide involved in the patient's care. 3. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. A. The electronic record evidenced a document titled "Coordination of Care" for the certification period of 12/1/17 to 1/29/18. The document was incomplete and failed to evidenced functinal limitations, patient condition, services provided, vital sign ranges, home bound status, and summary of care provided by the home health agency. B. On 2/20/18, at 9:30 a.m., provided another		and coordination of patient. The minutes of the case conferences as well as the patient's record documentation will evidence that all involved staff communicated, participated in the case conferences, and in the coordination of patient care. If staff that are not familiar with the patient's case is utilized, the RN Case Manager will report on the patient's condition and treatments with the as needed staff and document in the patient's record. An updated copy of the Plan of Care will be maintained and given to the as needed staff as well as available in the patient's home. The form "Coordination of Care" will be completed, all sections and required information be accurate and complete, by the RN Case Manager with input from all involved staff. Prevention: 100% active files will have a case conference completed by April 2, 2018. Case Conferences will be conducted at least every 60 days, unless the patient's condition warrants more frequently. Case Conferences will be tracked for completion by the Director of Clinical Services. 100% patient charts will be audited for compliance with this condition by April 6, 2018. 10% or at least 3 patient charts will be audited quarterly to insure no recurrence of the deficiency.	

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	"Coordination of Care" document that included all the missing infomation with exception to summary of care provided by the agency and the author's signature and date of who completed the form and failed to evidenced participation of the home health aide involved in the patient's care. C. The clinical record was reviewed with the Administrator and the DOCS on 2/2/18 at 3:30 p.m. No further information was provided during this time.		Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to ensure clinical staff follow the plan of care in 2 out of 3 records reviewed (#1 and 7) of patient receiving skilled nursing services and 1 out of 2 records reviewed (#7) of patients receiving home health aide services in a sample of 4 and the agency failed to ensure services were not provided until a physician's order could be obtained in 1 out of 4 records reviewed. (#7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week to "change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage,	N 0522	Corrective Action: Patient #1 was transferred to Skilled LTC facility and was discharged from BeeWell services March 13, 2018 insuring the patient's needs and level of required care are met. The RN's and LPN's will be educated that every patient requires an updated, complete, and accurate Plan of Care and that care is only provided with physician's orders. Skilled nursing and HHAservices will be compliant and provided in accordance with the established Plan of Care and only as directed in the physician's orders. The physician will be notified if the clinical staff cannot implement the physician's orders as directed. All changes to the plan of care will be approved by and signed by the	04/02/2018

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	remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD ... SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80." Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin] 40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. Review of a skilled nursing visit note by		physician. As needed staff will be educated on this compliance issue as well and will be given report regarding the patient's orders and condition prior to providing care. The patient record will reflect this exchange of information. RN's will be educated on this deficiency and the correction plan. Compliance is expected promptly. Prevention: 100% of active charts will be audited for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	Employee A on 2/5/18 and 2/7/18 with hours of 7:00 a.m. to 10:00 p.m., indicated " ... 1100: cpt [chest physiotherapy] vest x 20 min ... " B. The diabetic care in the 2/5 and 2/7/18 visit notes indicated blood sugars in the "AM, PM, HS [bedtime]" which was inconsistent with the documentation indicated only 40 units of insulin was administered x1. The intervention section indicated diabetic monitoring / care, insulin administration, and injection was three times. The visit note failed to evidence documentation if the 3:00 p.m. and 10:00 p.m. blood sugars had been conducted and if insulin had been provided. C. The narrative notes for both 2/5 and 2/7/18 failed to include documentation of the patient being repositioned after 1:30 p.m. D. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. E. Review of the skilled nursing visits in the electronic medical record, visit dates 2/6, 2/8, 2/10,			

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	211, 2/12, 2/14, 2/16 and 2/17/18 failed to evidenced documentation that skilled nursing visits had taken place. Review of the skilled nursing visits in the electronic medical record, the visits notes dated 2/9, 2/13, and 2/15/18 did not equal to 15 hours. i. The DOCS was interviewed on 2/19/18 at 1:20 p.m. When queried on why the patient's visits were not per the plan of care, the DOCS indicated Employee B had a death in the family and was off all of 2/12 to 2/16, Employee A would not pick up extra visits, Employee F worked another full time job, Employee E had responsibilities with the adjoining agency and as for herself, she was not able to move a 200+ pound patient on top of her injury she acquired on 2/12/18. The DOCS indicated they have difficulty with interviewees showing up for scheduled interviews. The Administrator entered the office and indicated there were no missed visits, some staff has had problems with entering visit notes, there were scheduled visits 3 times a day to make sure the patient received his / her insulin in the morning, 3:00 p.m. and 10:00 p.m. The Administrator indicated that the Direct Care Professionals from the disability waiver through the FSSA program had been staying with the patient when skilled nursing was not present. ii. On 2/19/18 at 2:40 p.m., the Director of Clinical Services (DOCS) was informed of the missing documentation between 2/5 and 2/17/18. The DOCS was requested to have all visit notes printed from the EMR during this time frame. The DOCS indicated that the staff was informed that all visit notes must be in the EMR. The Administrator had indicated she thought all the days had been covered. Also expressed problems with their computer program since the new			

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updates.

iii. At 3:25 p.m., the Employee E provided hand written notes for 2/13 and 2/15/18, expressed problems with the computer as for not having the notes entered in the EMR. Employee E indicated she would have the notes in the EMR by 2/20/18.

iv. On 2/20/18 at 11:30 a.m., the Employee E provided two electronic visit notes that she had conducted on 2/13/18 from 8:00 a.m. to 10:30 a.m. and 2/15/18 from 8:00 p.m. to 9:45 p.m.

F. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen through the payroll and could not provide the actual visit notes. The agency failed to ensure the skilled nurses followed the plan of care as evidenced by the following:

i. On 2/9/18, skilled nursing was provided at 7:55 a.m. to 8:55 a.m., 10:30 a.m to 2:30 p.m. and 3:50 p.m. to 5:30 p.m. Per payroll, the agency failed to provide 15 hours of care.

ii. On 2/10/18, skilled nursing provided 17 hours of services from 7:00 a.m. to 12:00 a.m. Per payroll, the agency failed to obtain an order for services to be provided beyond 15 hours.

iii. On 2/11/18, skilled nursing was provided from 12:00 a.m. to 1:15 a.m. and at 3:00 p.m. to 4:45 p.m. Per payroll, the agency failed to provide 15 hours of care.

iv. On 2/13/18, skilled nursing was

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	provided by Employee F from 8:00 a.m. to 10:30 a.m.. The visit note failed to indicate what time the insulin was given and failed to indicate what the patient's blood sugar reading was. No other documentation of treatment or medication administration was indicated. The intervention and visit narrative included template documentation. Other skilled nursing visit per payroll included 4:50 p.m. to 6:05 p.m., and at 8:00 p.m. to 9:00 p.m. The agency failed to provide 15 hours of care. v. On 2/15/17, skilled nursing was provided from 9:45 a.m. to 11:00 a.m. per payroll documents. At 12:35 p.m. to 1:05 p.m., Employee B visited the patient but failed to complete the visit note. At 8:00 p.m to 9:45 p.m., the Employee E visited the patient and failed to evidence a blood sugar reading, indicated the patient needed periodic suctioning, lung sounds crackles / rales, but failed to include the amount, color, and consistency when the patient was suctioned. The intervention and visit narrative included template documenatation from the 2/10/18 OASIS recertification. The visit notes failed to evidence trach or gtube care and failed to indicate if any medications had been given. The agency failed to provide 15 hours of care and failed to be at the patient's home to provide the 3:00 p.m. insulin vi. On 2/16/17, skilled nursing was provided from 8:00 a.m. to 9:00 a.m. and at 9:00 p.m. to 10:00 p.m. The agency failed to provide 15 hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin. 2. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care.			

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	A. The clinical record of patient #7 was reviewed on 12/20/18 at 10:33 a.m. B. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. C. Review of the home health aide visit notes dated 2/5 to 2/9/18 and 2/12 to 2/16/18, the home health aide provided services 3 hours each day. The home health aide failed to follow the plan of care. D. Review of a handwritten skilled nursing visit dated 2/9/18, failed to indicate if the medications were set up. The note only provided an vital signs and a physical assessment. E. On 2/20/18 at 11:54 a.m., Employee E was interviewed and indicated she would set up the patient's medications once a month. F. The clinical record was reviewed with the Administrator and the DOCS on 2/20/18 at 3:30 p.m. The DOCS indicated she had not contacted the physician for continuing orders. The agency failed to ensure the home health aide and the skilled nurse were not providing services until a physician's order could be obtained.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:			

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	(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, failed to include goals for the next certification period, and failed to include discipline frequencies and duration specific to the certification period in 4 out of 4 records reviewed. (#1, 2, 6, and 7)	N 0524	Corrective Action: Patient #1 was transferred to Skilled LTC facility and was discharged from BeeWell services March 13, 2018 insuring the patient's needs and level of required care are met. RN's will be educated on the purpose of the comprehensive assessment and the development of the Plan of Care. The Plan of Care will be developed in consultation with the physician and agency staff and based on the comprehensive assessment and will include all required data including pertinent diagnoses,	04/02/2018

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	Findings included: 1. Review of clinical record #1 on 2/19/18, the clinical record evidenced an OASIS C2 Recertification visit note dated 2/10/18, which indicated the patient had a trach, a feeding tube, and a stage I pressure wound. The "Summary of Care" section indicated to change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD. VNS to control seizure, the magnet is to be place over left upper chest at onset of seizure. Document the time, severity and length of the seizure. Call 911 for any seizure lasting longer than 5 minutes. SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered. Patient gets up in wheel chair by hydraulic lift. Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80. The patient had 8 hours daily of waiver services through another agency [that is owned by the administrator-provides waiver both with personal service agency / home health aides and with FSSA / direct professionals] The equipment company was included and the services they provide, OT [occupational therapy] services in		mental status, types of services, equipment needed, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications, all treatments, interventions, care coordination with outside providers, services to be provided, discharge plan, and safety measures. The Plan of Care will be updated at every recertification and based on the comprehensive assessment. The Plan of Care will reflect patient's assessed needs and medical necessity for home health services. RN's will be instructed on the expectation of compliance with this regulation. Medications will include route, dosage, and frequency with any specific instructions for administration. Treatments will include specifics for implementation, including prefilling medication boxes. Medication Profile and Plan of Care will be reviewed after SOC and at the time of Recertification for compliance with this regulation. Recertification will be tracked to identify the last 5 days of the certification period. During this 5-day period the comprehensive assessment will be completed identifying the patient's need for continuation of care. The physician will be notified of the patient's assessed needs for	

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	regards to the patient's wheelchair through a local hospital, nutritionist from local hospital for dietary concerns, name of medical company in regards to diabetic supplies, and name of a pharmacy who provided medications to the patient's home. A. Review of the Medication Administration Record from the pharmacy dated 2/28/18 (sic-future date), Florastor 250 mg twice a day was indicated of the form. The form also indicated the patient had an allergy to benzodiazepines, penicillin, red dyes, yellow dye - tartrazine. B. The medication profile record indicated a start date of 2/1/18, Florastor 500 mg cap per g-tube twice a day and also indicated 250 mg capsules twice a day per g-tube. The plan of care failed to include Florastor in the medication profile. C. Review of the plan of care for the certification period of 2/11/18 to 4/11/18, the durable medical equipment section failed to include all respiratory supplies, all diabetic supplies, kangaroo pump, hydraulic lift, and humidifier with tubing supplies. The plan of care failed to include the caregiver status, psychosocial status, directions for trach care, directions for PEG site care, directions to use humidifier including settings, directions for use of percussion vest, and goals. The medication section failed to include the type and amount of sliding scale insulin and the amount of normal saline used for suctioning. The plan of care also failed to evidenced all of the patient's allergies and goals for the next certification period. The recertification assessment summary was included in the plan of care locator 21 section, which included the 15 hour / day 7 days a week frequency but failed to accurately reflect the		continuation of care and an order to continue care will be accepted. The order will be put into writing and sent to the physician for signature. A tracking system is in place to insure compliance with this regulation. RN's will be educated regarding the recertification process. Recertification charts will be audited for compliance. The RN's and LPN's will be educated that every patient requires an updated, complete, and accurate Plan of Care and that care is only provided with physician's orders. Clinical staff will provide services as directed by the physician on the Plan of Care and subsequent orders. The physician will be notified if the clinical staff cannot implement the physician's orders as directed. As needed staff will be educated on this compliance issue as well and will be given report regarding the patient's orders and condition prior to providing care. The patient record will reflect this exchange of information. RN's will notify the physician promptly regarding any change in the patient's condition and status that would warrant modifying the Plan of Care. The specifics of the changes, and details of the patient's status and changes will be communicated to the physician	

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	frequency and duration specific to the certification dates (ex. 7 hours a day, 7 days a week for 8 weeks, then 7 hours a day, 4 days a week for 1 week). D. The Director of Clinical Services (DOCS) was interviewed on 2/19/18 at 1:20 p.m. When queried the DOCS about contacting the physician to clarify medication discrepancy, the Director of Clinical Services indicated she did not get the orders clarified by the physician but took the information from the pharmacy medication administration profile. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The current call order of blood sugars had was different than what was in the most previous certification period of >600 without orders for change / clarification. The DOCS indicated the >600 was the correct call order. The DOCS had nothing further to provide in regards to the remainder of the findings. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. A. The clinical record evidenced a Non-OASIS recertification assessment dated 2/2/18. B. The clinical record evidenced a home health aide careplan for the certification period of 2/7/18 to 4/7/18. C. The plan of care for the certification period of 2/7/18 to 4/7/18, included orders for skilled nursing to provide home health aide supervisory "1M3" [1 time a month for 3 months] and home health aide services 2 hours a day 5 days a week		and documented in the medical recorded. Communication from the physician regarding any patient changes will be documented in the medical record and sent to the physician for signature. Documentation will evidence compliance with this regulation. RN's will be educated on this regulation and the expectation of compliance. Prevention: 100% of active patient records will be audited for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	for 9 weeks. The plan of care failed to evidence interventions and goals for the home health aide services, failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 4 days for 1 week, 2 hours a day 7 days a week for 8 weeks), and failed to accurately reflect the skilled nursing supervisory duration of 2 months. 3. The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. The electronic clinical record failed to evidenced a plan of care for the certification period of 2/13/17 to 4/14/18. A. The DOCS was queried on 2/19/18 at 3:15 p.m. of the whereabouts of the plan of care and was unable to provide an explanation of why the recertification was not in the electronic medical record. B. On 2/20/18 at 9:50 a.m., a typed document was provided which included a list of physicians (primary care physician, neurologist, podiatrist, otolaryngologist, dentist, optometrist, and urologist), pharmacy, and laboratory preference. An OASIS C2 recertification assessment was provided as well, but failed to evidenced a time, electronic signature and date of the assessment. During this time, the DOCS indicated Employee F had been working on changing the assessment to the correct OASIS, the plan of care was developed once the OASIS was completed, and Employee F was not able to get this done in a timely manner due to her busy schedule. C. At 10:00 a.m. the electronic record was reviewed again and evidenced a plan of care for the certification of 2/13/17 to 4/14/18, with orders for skilled nursing 1 hour a day for 2 months to evaluate for complications and medication			

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	effectiveness, instruct neurological assessment each visit, assess and instruct on seizure disorder to include precautions, signs and symptoms and appropriate actions during seizure activity, instruct patient / caregiver to contact agency to report any fall with or without injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. The plan of care failed to evidenced goals for the certification period and the other physicians that were on the patient's case. D. At 11:00 a.m., the Employee X provided another OASIS C2 recertification assessment which included the time, electronic signature and date. The reassessment indicated Employee F pre-filled a pill box. The current plan of care failed to evidenced orders for skilled nursing to prefill medication boxes. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The DOCS confirmed that skill nursing was filling the medication box monthly and not every other week. 4. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. The nursing frequency was inconsistent and failed to be clear and specific to the certification period (ex			

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	15K121	A. BUILDING 00 B. WING	02/20/2018

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	1 hour per day, 1 day per month for 2 months) and failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 3 days for 1 week, 2 hours a day 7 days a week for 8 weeks). The plan of care failed to evidenced goals for the certification period. B. Review of the medication section of the plan of care indicated the following: i. The medication creams / ointments / lotions such as lac hydrin 5% lotion (medicated lotion used to treat dry skin), fluocinolone 0.025% topical cream (used to treat dermatitis, psoriasis, dermatitis and / or eczema), nystatin 100,000 units /topical cream (antifungal cream), mupirocin 2% topical cream (Antibacterial / antibiotic cream), and clotrimazole / betameth cr topical agent (antifungal cream) indicated to apply to affected area. The medicated creams and lotions failed to indicate the specific location to be applied. ii. Oral medications such as Milk of Magnesia (laxative), Loperamide (anti-diarrhea) capsule, and Sudogest (over the counter sinus medication) tablet indicated to take the medication as directed. The oral medications failed to indicate the dosage amount to ingest and it's frequency. C. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The Administrator and DOCS had nothing to provide in regards to the findings.			
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency			

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	shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the agency failed to notify the physician when it was identified that there was a need to alter the plan of care in 1 out of 4 records reviewed (#1) and failed to ensure a physician was notified and orders obtained for the continuation of services upon recertification for additional 60 days in 1 out of 4 records reviewed. (#7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week to "change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD ... SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40,	N 0527	Corrective Action: RN's will notify the physician promptly regarding any change in the patient's condition and status that would warrant modifying the Plan of Care. The specifics of the changes, and details of the patient's status and changes will be communicated to the physician and documented in the medical recorded. Communication from the physician regarding any patient changes will be documented in the medical record and sent to the physician for signature. RN will ensure a physician is notified and orders are obtained for continuation of services upon recertification for an additional 60 days. Documentation will evidence compliance with this regulation. RN's will be educated on this regulation and the expectation of compliance. Compliance is expected promptly. Prevention: Audit 100% of the current charts for compliance. Quarterly, 10% or at least 3 charts will be audited for compliance to insure this deficiency does not recur. Target Date: April 2, 2018 Responsible Person: Director of	04/02/2018

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	systolic blood pressure >150 or <80." Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin] 40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the		Clinical Services	

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	waiver services were to be provided. B. Review of the skilled nursing visits in the electronic medical record, the visits notes dated 2/13, and 2/15/18 did not equal to 15 hours. At 2:40 p.m., the Director of Clinical Services (DOCS) was asked to provide the skilled nursing documents from the EMR from 2/5 to 2/18/18. C. The DOCS was interviewed on 2/19/18 at 1:20 p.m. When queried on why the patient's visits were not per the plan of care, the DOCS indicated Employee B had a death in the family and was off all of 2/12 to 2/16, Employee A would not pick up extra visits, Employee F worked another full time job, Employee E had responsibilities with the adjoining agency and as for herself, she was not able to move a 200+ pound patient on top of her injury she acquired on 2/12/18. The DOCS indicated they have difficulty with interviewees showing up for scheduled interviews. The Administrator entered the office and indicated there were no missed visits, some staff has had problems with entering visit notes, there were scheduled visits 3 times a day to make sure the patient received his / her insulin in the morning, 3:00 p.m. and 10:00 p.m. The Administrator indicated that the Direct Care Professionals from the disability waiver through the FSSA program had been staying with the patient when skilled nursing was not present. D. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen through the payroll and could not provide the actual visit notes. The agency			

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	failed to ensure the skilled nurses followed the plan of care as evidenced by the following: i. On 2/9/18, skilled nursing was provided at 7:55 a.m. to 8:55 a.m., 10:30 a.m to 2:30 p.m. and 3:50 p.m. to 5:30 p.m. Per payroll, the agency failed to provide 15 hours of care. ii. On 2/10/18, skilled nursing provided 17 hours of services from 7:00 a.m. to 12:00 a.m. Per payroll, the agency failed to obtain an order for services to be provided beyond 15 hours. iii. On 2/11/18, skilled nursing was provided from 12:00 a.m. to 1:15 a.m. and at 3:00 p.m. to 4:45 p.m. Per payroll, the agency failed to provide 15 hours of care. iv. On 2/13/18, skilled nursing was provided by Employee F from 8:00 a.m. to 10:30 a.m. Other skilled nursing visit per payroll included 4:50 p.m. to 6:05 p.m., and at 8:00 p.m. to 9:00 p.m. The agency failed to provide 15 hours of care. v. On 2/15/17, skilled nursing was provided from 9:45 a.m. to 11:00 a.m. per payroll documents. At 12:35 p.m. to 1:05 p.m., Employee B visited the patient but failed to complete the visit note. At 8:00 p.m to 9:45 p.m., the Employee E visited the patient. The agency failed to provide 15 hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin. vi. On 2/16/17, skilled nursing was provided from 8:00 a.m. to 9:00 a.m. and at 9:00 p.m. to 10:00 p.m. The agency failed to provide 15 hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin.			

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	The agency failed to notify the physician when it was identified that there was a need to alter the plan of care on 2/10, 2/11, 2/13, 2/15, and 2/16/18. 2. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The patient's OASIS C2 recertification assessment dated 1/26/18, failed to open for review. During this time, the DOCS was requested to print the assessment for review. The DOCS attempted to open the assessment without success and indicated a copy would be provided the next morning. A. Ongoing review of the patient's electronic clinical record, a communication note dated 2/7/18, indicated "2/5/18; 2/6/18 7:15 a.m. Writer has repeatedly tried to sign off after the med interactions were reviewed with no success. Unable to reach Axxess and no response to my inquiry on line ... This is also preventing the completion of the Recert. Writer will keep trying." The note was signed by the DOCS on 2/6/18. The DOCS failed to provide a copy of the OASIS C2 recertification. B. The record was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:30 p.m. When queried about notifying the physician for ongoing orders, the DOCS indicated she had not notified the physician yet, she was out "all last week" (2/12 to 2/16/18) but would do so right away. The DOCS failed to obtain ongoing orders upon recertification.			
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in			

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	accordance with the medical plan of care as follows: Based on record review and interview, the agency failed to ensure clinical staff follow the plan of care in 2 out of 2 records reviewed (#1 and 7) of patient receiving skilled nursing services only and the agency failed to ensure services were not provided until a physician's order could be obtained. Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week to "change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD ... SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80." Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin]	N 0537	Corrective Action: The RN is responsible for the initiation of and revisions to the Plan of Care. The RN will ensure that the plan of care is developed in consultation with involved staff and the physician and reflects the findings the comprehensive assessment. RN's will notify the physician promptly regarding any change in the patient's condition and status that would warrant modifying the Plan of Care. The RN is responsible to insure a plan of is complete with all required data for any new certification period. Communication from the physician regarding any patient changes will be documented in the medical record and sent to the physician for signature. Services will begin once the physician's order is obtained. Documentation will evidence compliance with this regulation. It is acknowledged that this is the RN's responsibility and all RN's will be instructed on this duty as an RN and that compliance is expected. RN's will be educated on this regulation and the expectation of compliance. The RN or LPN is responsible for furnishing substantial and specialized nursing care. In the case of the trach care, g-tube care, medication administration, blood glucose level	04/02/2018

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	40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. B. Review of the skilled nursing visits in the		measurements, insulin administration, the LPN was responsible for these treatments and care. The RN or LPN is responsible for the documentation of all care, treatment, and skilled services provided. The agency RNs and LPNs will be instructed on this deficiency and correction plan. In the cases receiving skilled nursing services, the RN or LPN will document all services, care, and treatment provided by the RN or LPN including the outcome and response by the patient. The LPN's will be instructed on documenting all care provided at the time the care is provided. The expectation is that all documentation is completed by the LPN at the time of care furnished. The visit reports, assessments, clinical notes, progress notes will all be complete, accurate, and in real-time. Any changes in the patient's care, services, or status (such as the bed bug infestation) is documented and reported to the RN for follow-up. The LPN will be instructed on this deficiency and the correction plan and the expectation of prompt compliance. LPN notes are reviewed by the RN for compliance. Compliance with this regulation is expected promptly. Compliance will be tracked by review of documentation.	

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	electronic medical record, visit dates 2/6, 2/8, 2/10, 211, 2/12, 2/14, 2/16 and 2/17/18 failed to evidenced documentation that skilled nursing visits had taken place. Review of the skilled nursing visits in the electronic medical record, the visits notes dated 2/9, 2/13, and 2/15/18 did not equal to 15 hours. i. The DOCS was interviewed on 2/19/18 at 1:20 p.m. When queried on why the patient's visits were not per the plan of care, the DOCS indicated Employee B had a death in the family and was off all of 2/12 to 2/16, Employee A would not pick up extra visits, Employee F worked another full time job, Employee E had responsibilities with the adjoining agency and as for herself, she was not able to move a 200+ pound patient on top of her injury she acquired on 2/12/18. The DOCS indicated they have difficulty with interviewees showing up for scheduled interviews. The Administrator entered the office and indicated there were no missed visits, some staff has had problems with entering visit notes, there were scheduled visits 3 times a day to make sure the patient received his / her insulin in the morning, 3:00 p.m. and 10:00 p.m. The Administrator indicated that the Direct Care Professionals from the disability waiver through the FSSA program had been staying with the patient when skilled nursing was not present. ii. On 2/19/18 at 2:40 p.m., the Director of Clinical Services (DOCS) was informed of the missing documentation between 2/5 and 2/17/18. The DOCS was requested to have all visit notes printed from the EMR during this time frame. The DOCS indicated that the staff was informed that all visit notes must be in the EMR. The Administrator had indicated she thought all the days had been covered. Also expressed problems		Prevention: Supervision of the LPN care monthly and documentation with oversight and education will insure that this deficiency does not recur. 100% of active charts will be audited for compliance, then quarterly 10% or at least 3 charts will be audited for compliance. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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with their computer program since the new updates.

iii. At 3:25 p.m., the Employee E provided hand written notes for 2/13 and 2/15/18, expressed problems with the computer as for not having the notes entered in the EMR. Employee E indicated she would have the notes in the EMR by 2/20/18.

iv. On 2/20/18 at 11:30 a.m., the Employee E provided two electronic visit notes that she had conducted on 2/13/18 from 8:00 a.m. to 10:30 a.m. and 2/15/18 from 8:00 p.m. to 9:45 p.m.

C. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen through the payroll and could not provide the actual visit notes. The agency failed to ensure the skilled nurses followed the plan of care as evidenced by the following:

i. On 2/9/18, skilled nursing was provided at 7:55 a.m. to 8:55 a.m., 10:30 a.m. to 2:30 p.m. and 3:50 p.m. to 5:30 p.m. Per payroll, the agency failed to provide 15 hours of care.

ii. On 2/11/18, skilled nursing was provided from 12:00 a.m. to 1:15 a.m. and at 3:00 p.m. to 4:45 p.m. Per payroll, the agency failed to provide 15 hours of care.

iii. On 2/13/18, skilled nursing was provided by Employee F from 8:00 a.m. to 10:30 a.m.. The visit note failed to indicate what time the insulin was given and failed to indicate what the patient's blood sugar reading was. No other

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	documentation of treatment or medication administration was indicated. The intervention and visit narrative included template documentation. Other skilled nursing visit per payroll included 4:50 p.m. to 6:05 p.m., and at 8:00 p.m. to 9:00 p.m. The agency failed to provide 15 hours of care. iv. On 2/15/17, skilled nursing was provided from 9:45 a.m. to 11:00 a.m. per payroll documents. At 12:35 p.m. to 1:05 p.m., Employee B visited the patient but failed to complete the visit note. At 8:00 p.m. to 9:45 p.m., the Employee E visited the patient and failed to evidence a blood sugar reading, indicated the patient needed periodic suctioning, lung sounds crackles / rales, but failed to include the amount, color, and consistency when the patient was suctioned. The intervention and visit narrative included template documentation. The visit notes failed to evidence trach or g-tube care and failed to indicate if any medication had been given. The agency failed to provide 15 hours of care and failed to be at the patient's home to provide the 3:00 p.m. insulin. v. On 2/16/17, skilled nursing was provided from 8:00 a.m. to 9:00 a.m. and at 9:00 p.m. to 10:00 p.m. The agency failed to provide 15 hours of care, failed to be at the patient's home to provide the 3:00 p.m. insulin. 2. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. The clinical record of patient #7 was reviewed on 12/20/18 at 10:33 a.m. B. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the			

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	certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. C. Review of the home health aide visit notes dated 2/5 to 2/9/18 and 2/12 to 2/16/18, the home health aide provided services 3 hours each day. D. Review of a handwritten skilled nursing visit dated 2/9/18, failed to indicate if the medications were set up. The note only provided an vital signs and a physical assessment. E. On 2/20/18 at 11:54 a.m., Employee E was interviewed and indicated she would set up the patient's medications once a month. F. The clinical record was reviewed with the Administrator and the DOCS on 2/20/18 at 3:30 p.m. The DOCS indicated she had not contacted the physician for continuing orders. The agency failed to ensure the home health aide and the skilled nurse were not providing services until a physician's order could be obtained.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the agency	N 0541	Corrective Action: Skin assessments will be completed	04/02/2018

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	failed to ensure that a skin assessment addressed a skin impairment with each visit and failed to ensure skilled nursing identified and addressed a patient's behavior in 2 out of 3 records reviewed of a patient with skilled nursing services. Findings include: 1. The clinical record for patient number 1 was reviewed on 2/19/18 at 1:00 p.m. An OASIS C2 Recertification assessment dated 2/10/18, indicated the patient had a stage 1 pressure ulcer on the coccyx that measured 5 cm [centimeters] x 4 cm. The narrative note indicated the patient was incontinent and prone to skin breakdown. A. Review of skilled nursing visit notes dated 2/13/18 at 8:00 a.m. to 10:30 p.m. and 2/15/18 at 8:00 p.m. to 9:45 p.m., Employee E failed to identify and indicate if the status of the patient's pressure area to the patient's coccyx. B. On 2/20/18 at 10:30 a.m., Employee E indicated she was helping out and this patient was not one of her patient's she case manages. 2. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. Review of a home health aide visit record, on 2/6/18, Employee J documented that patient #7 had a behavior while getting into the shower and described the incident in detail. B. Review of a handwritten skilled nursing visit dated 2/9/18, Employee E failed to identify behaviors the patient recently had. C. The clinical record was reviewed with the		and documented by the RN or LPN every visit. Follow-up on any variance in the assessment will be documented and the physician notified for orders. Protocol for skin breakdown prevention will be ordered and implemented every visit and documented on the skilled nurse visit report. All significant changes in the patient's condition, including any behavior issues, will promptly be reported to the physician to determine if changes to the Plan of care are needed. Prevention: Audit 100% of current charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	Administrator and the Director of Clinical Services on 2/20/18 at 3:30 p.m. The Administrator and the Director of Clinical Services had no further information or documentation to provide during this time.			
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the Registered Nurse failed to ensure that the plans of care were supported by the comprehensive assessment, failed to include direction for all treatments provided, failed to include all medications prescribed, failed to include where to apply topical agents, failed to include specific directions of use, failed to include all durable medical equipment and supplies, failed to include outside agencies and physicians providing services, failed to have an updated plan of care for a new certification period, failed to include goals for the next certification period, and failed to include discipline frequencies and duration specific to the certification period in 4 out of 4 records reviewed. (#1, 2, 6, and 7) Findings included: 1. Review of clinical record #1 on 2/19/18, the clinical record evidenced an OASIS C2 Recertification visit note dated 2/10/18, which indicated the patient had a trach, a feeding tube, and a stage I pressure wound. The "Summary of	N 0542	Corrective Action: RN's will be educated on the purpose of the comprehensive assessment and the development of the Plan of Care. The Plan of Care will be developed in consultation with the physician and agency staff and based on the comprehensive assessment and will include all required data including pertinent diagnoses, mental status, types of services, equipment needed, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications, all treatments, interventions, care coordination with outside providers, services to be provided (including discipline frequency and duration), discharge plan, and safety measures. Medications will include route, dosage, and frequency with any specific	04/02/2018

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	Care" section indicated to change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD. VNS to control seizure, the magnet is to be place over left upper chest at onset of seizure. Document the time, severity and length of the seizure. Call 911 for any seizure lasting longer than 5 minutes. SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered. Patient gets up in wheel chair by hydraulic lift. Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80. The patient had 8 hours daily of waiver services through another agency [that is owned by the administrator-provides waiver both with personal service agency / home health aides and with FSSA / direct professionals] The equipment company was included and the services they provide, OT services in regards to the patient's wheelchair through a local hospital, nutritionist from local hospital for dietary concerns, name of medical company in regards to diabetic supplies, and name of a pharmacy who provided medications to the patient's home. A. Review of the Medication Administration		instructions for administration. Treatments will include specifics for implementation, including prefilling medication boxes. The RN's will be educated that every patient requires an updated, complete, and accurate Plan of Care and that care is only provided with physician's orders. The Plan of Care will be updated at every recertification and based on the comprehensive assessment. The Plan of Care will reflect patient's assessed needs and medical necessity for home health services. Medication Profile and Plan of Care will be reviewed after SOC and at the time of Recertification for compliance with this regulation. The deficiency report and 484.18 will be used for education of the RN's. Prevention: Audit 100% of the current charts for compliance. Quarterly, 10% or at least 3 charts will be audited for compliance to insure this deficiency does not recur. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	Record from the pharmacy dated 2/28/18 (sic-future date), Florastor 250 mg twice a day was indicated of the form. The form also indicated the patient had an allergy to benzodiazepines, penicillin, red dyes, yellow dye - tartrazine. B. The medication profile record indicated a start date of 2/1/18, Florastor 500 mg cap per g-tube twice a day and also indicated 250 mg capsules twice a day per g-tube. The plan of care failed to include Florastor in the medication profile. C. Review of the plan of care for the certification period of 2/11/18 to 4/11/18, the durable medical equipment section failed to include all respiratory supplies, all diabetic supplies, kangaroo pump, hydraulic lift, and humidifier with tubing supplies. The plan of care failed to include the caregiver status, psychosocial status, directions for trach care, directions for PEG site care, directions to use humidifier including settings, directions for use of percussion vest, and goals. The medication section failed to include the type and amount of sliding scale insulin and the amount of normal saline used for suctioning. The plan of care also failed to evidenced all of the patient's allergies. The recertification assessment summary was included in the plan of care locator 21 section, which included the 15 hour / day 7 days a week frequency but failed to accurately reflect the frequency and duration specific to the certification dates (ex. 7 hours a day, 7 days a week for 8 weeks, then 7 hours a day, 4 days a week for 1 week). D. The Director of Clinical Services (DOCS) was interviewed on 2/19/18 at 1:20 p.m. When queried the DOCS about contacting the physician			

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	to clarify medication discrepancy, the Director of Clinical Services indicated she did not get the orders clarified by the physician but took the information from the pharmacy medication administration profile. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The current call order of blood sugars had was different than what was in the most previous certification period of >600 without orders for change / clarification. The DOCS indicated the >600 was the correct call order. The DOCS had nothing further to provide in regards to the remainder of the findings. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. A. The clinical record evidenced a Non-OASIS recertification assessment dated 2/2/18. B. The clinical record evidenced a home health aide careplan for the certification period of 2/7/18 to 4/7/18. C. The plan of care for the certification period of 2/7/18 to 4/7/18, included orders for skilled nursing to provide home health aide supervisory "1M3" [1 time a month for 3 months] and home health aide services 2 hours a day 5 days a week for 9 weeks. The plan of care failed to evidence interventions and goals for the home health aide services, failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 4 days for 1 week, 2 hours a day 7 days a week for 8 weeks), and failed to accurately reflect the skilled nursing supervisory duration of 2 months.			

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	3. The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. The electronic clinical record failed to evidenced a plan of care for the certification period of 2/13/17 to 4/14/18. A. The DOCS was queried on 2/19/18 at 3:15 p.m. of the whereabouts of the plan of care and was unable to provide an explanation of why the recertification was not in the electronic medical record. B. On 2/20/18 at 9:50 a.m., a typed document was provided which included a list of physicians (primary care physician, neurologist, podiatrist, otolaryngologist, dentist, optometrist, and urologist), pharmacy, and laboratory preference. An OASIS C2 recertification assessment was provided as well, but failed to evidenced a time, electronic signature and date of the assessment. During this time, the DOCS indicated Employee F had been working on changing the assessment to the correct OASIS, the plan of care was developed once the OASIS was completed, and Employee F was not able to get this done in a timely manner due to her busy schedule. C. At 10:00 a.m. the electronic record was reviewed again and evidenced a plan of care for the certification of 2/13/17 to 4/14/18, with orders for skilled nursing 1 hour a day for 2 months to evaluate for complications and medication effectiveness, instruct neurological assessment each visit, assess and instruct on seizure disorder to include precautions, signs and symptoms and appropriate actions during seizure activity, instruct patient / caregiver to contact agency to report any fall with or without injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. The plan of care failed			

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	to evidenced goals for the certification period and the other physicians that were on the patient's case. D. At 11:00 a.m., the Employee X provided another OASIS C2 recertification assessment which included the time, electronic signature and date. The reassessment indicated Employee F pre-filled a pill box. The current plan of care failed to evidenced orders for skilled nursing to prefill medication boxes. E. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The DOCS confirmed that skill nursing was filling the medication box monthly and not every other week. 4. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. The electronic record failed to evidenced a current plan of care. A. On 2/20/18 at 11:30 a.m., Employee X provided the patient's current plan of care for the certification period of 1/30/18 to 3/30/18, The "orders for discipline and treatment" section indicated skilled nursing "1 hr [hour] 2x" and home health aide services 2 hours a day, 5 days a week for 9 weeks. The summary indicated skilled nursing "1 x mo x 2 x 3 for medication set up. The nursing frequency was inconsistent and failed to be clear and specific to the certification period (ex 1 hour per day, 1 day per month for 2 months) and failed to accurately reflect home health aide frequency and duration specific to the certification date (ex. 2 hours a day, 3 days for 1 week, 2 hours a day 7 days a week for 8 weeks). The plan of care failed to evidenced goals for the certification period.			

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	B. Review of the medication section of the plan of care indicated the following: i. The medication creams / ointments / lotions such as lac hydrin 5% lotion (medicated lotion used to treat dry skin), fluocinolone 0.025% topical cream (used to treat dermatitis, psoriasis, dermatitis and / or eczema), nystatin 100,000 units /topical cream (antifungal cream), mupirocin 2% topical cream (Antibacterial / antibiotic cream), and clotrimazole / betameth cr topical agent (antifungal cream) indicated to apply to affected area. The medicated creams and lotions failed to indicate the specific location to be applied. ii. Oral medications such as Milk of Magnesia (laxative), Loperamide (anti-diarrhea) capsule, and Sudogest (over the counter sinus medication) tablet indicated to take the medication as directed. The oral medications failed to indicate the dosage amount to ingest and it's frequency. C. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:35 p.m. The Administrator and DOCS had nothing to provide in regards to the findings.			
N 0543 Bldg. 00	410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review, the Registered Nurse failed to document if trach care, g-tube care,	N 0543	Corrective Action: The RN is responsible for furnishing substantial and specialized	04/02/2018

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	medications, flushes, blood sugar checks, the time the insulin was given had been provided in 1 out of 2 records reviewed of patient receiving skilled nursing services only in a sample of 4. (#1 and 7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/17 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week "to change the patient trach with a #6 shiley every 30 days, suction the trach as needed to keep airway patent, change trach dressing as needed for soilage, remove inner cannula at bedtime and attach to humidity, soak inner cannula in saline and peroxide. After breathing treatments, check lung sounds for effectiveness. Use percussion vest to assist chest cleaning. Check 02 SATs every shift and prn for ventilation concerns and report to MD ... SN to maintain the PEG feedings via kangaroo pump. 350 cc flush of free water 4 times a day for hydration. Ensure the PEG site is clean and dry every day. Use gauze dressing as needed to site. SN to check blood glucose 4 times a day as ordered and administer insulin as ordered and also sliding scale as ordered ... Call orders to the physician if pulse >120 or < 60, respirations >31 or <12, random blood sugars >300 or <50, oxygen saturations <90%, diastolic b/p >90 or <40, systolic blood pressure >150 or <80. Scheduled medications include levocarnitine [treat carnitine deficiency] three times a day, Humulin N [insulin] 40 U at 8:00 a.m. and 8:00 p.m., Humulin N 45 U at 3:00 p.m., normal saline every shift for suctioning, erythromycin [antibiotic] topical solution twice a day, levetiracetam [anticonvulsant] three times a day, glycopyrrolate [reduces secretions and control excessive stomach acid production] three		nursing care. In the case of the trach care, g-tube care, medication administration, blood glucose level measurements, insulin administration, the RN was responsible for these treatments and care. The RN is responsible for the documentation of all care, treatment, and services provided by the RN. The agency RN's will be instructed on this deficiency and correction plan. In the cases receiving skilled nursing services, the RN will document all services, care, and treatment provided by the RN including the outcome and response by the patient. Compliance with this regulation is expected promptly. Compliance will be tracked by review of RN documentation. The RN will furnish services requiring substantial and specialized nursing skill. Documentation will evidence the skilled services provided and specific to the patient's needs. Prevention: Audit 100% of the current charts for compliance. Quarterly, 10% or at least 3 charts will be audited for compliance to insure this deficiency does not recur. Target Date: April 2, 2018	

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	times a day, miralax [stool softner] daily, lactulose [laxative plus plus binds amonia to be excreted] three times a day, 350 cc water flushes four times a day, Florastor [probiotic for digestive balance] 500 mg twice a day, Florastor 250 mg twice a day, depakene [anticonvulsant] three times a day, scopolamine [control excessive secretions] every 3 days, and clorazepate [control epilepsy] three times a day. As needed medications include loperamide [antidiarrheal], glucose gel [hypoglycemia], albuterol [for shortness of breath], nystatin [antifungal], and acetaminophen [treat pain / fever]. A. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. B. On 2/13/18, skilled nursing was provided by Employee F from 8:00 a.m. to 10:30 a.m.. The visit note indicated the patient had facial grimacing under the pain profile. The intervention and visit narrative included template documentation. The visit note failed to evidence documentation if any trach or g-tube treatments		Responsible Person: Director of Clinical Services	

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BEEWELL INC	6967 HILLSDALE COURT INDIANAPOLIS, IN 46250

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	had been provided, failed to evidence a blood sugar reading and what time the insulin had been given, and failed to indicated what medications with flushes had been provided, and if the patient's pain had been addressed. C. On 2/15/17, skilled nursing was provided from 8:00 p.m. to 9:45 p.m. The visit note indicated the patient needed periodic suctioning, lung sounds crackles / rales, but failed to include the amount, color, and consistency when the patient was suctioned. The intervention and visit narrative included template documentation that was documented from the 2/10/18 OASIS recertification. The visit note failed to evidence trach care, g-tube care, failed to evidence a blood sugar reading and time the insulin had been given, and failed to indicate what medications / flushes had been given. D. The record was reviewed with the Administrator and the Director of Clinical Services on 2/20/18 at 3:30 p.m. and no further documentation or information was provided in regards to the above findings during this time.			
N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the Registered Nurse failed to ensure effective interchange / staff participation in case conferences between all staff involved in the patients care in 3 out of 3 records reviewed of	N 0545	Corrective Action: The RN is responsible for insuring all staff involved in the patient's care participates in the exchange of patient information and case conferences. The RN is	04/02/2018

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	patients being seen by more than 1 discipline / clinician in a sample of 4. (#1, 2, and 7) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at 1:00 p.m. The clinical record included a plan of care for the certification period of 2/11/18 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/10/17. The document only indicated the name of the case manager. B. Review of the skilled nursing visit notes, majority of the visit were made by 3 different licensed practical nurses. The case conference note failed to evidence participation of all clinicians involved in the patient's care. 2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. The clinical record included a plan of care for the certification period of 2/7/18 to 4/7/18, with orders for skilled nursing 1 time a month for supervisory visits and home health aide services 2 hours a day 5 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/4/17. The document only indicated the name of the case manager. The case conference note failed to evidenced participation of the home health aide involved in the patient's care. 3. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m.		responsible for a coordinated and effective quality care delivery. All direct care staff, RN's, aides, LPN's, will be educated on care coordination and participation in case conferences. The deficiency report will be used for education reviewing the findings and the correction plan. Minutes of the case conferences will evidence the effective interchange, reporting, and coordination of patient care. The minutes of the case conferences as well as the patient's record documentation will evidence that all involved staff participated in the case conferences and the coordination of patient care. The form "Coordination of Care" will be completed, all sections and required information be accurate and complete, by the RN Case Manager with input from all involved staff. Prevention: 100% active files will have a case conference completed by April 2, 2018. Case Conferences will be conducted at least every 60 days, unless the patient's condition warrants more frequently. Case Conferences will be tracked for completion by the Director of Clinical Services. 100% patient charts will be audited for compliance with this condition by April 6, 2018. 10% or at least 3 patient charts will be audited	

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	A. The electronic record evidenced a document titled "Coordination of Care" for the certification period of 12/1/17 to 1/29/18. The document was incomplete and failed to evidenced functional limitations, patient condition, services provided, vital sign ranges, home bound status, and summary of care provided by the home health agency. B. On 2/20/18, at 9:30 a.m., provided another "Coordination of Care" document that included all the missing information with exception to summary of care provided by the agency and the author's signature and date of who completed the form and failed to evidenced participation of the home health aide involved in the patient's care. C. The clinical record was reviewed with the Administrator and the DOCS on 2/2/18 at 3:30 p.m. No further information was provided during this time.		quarterly to insure no recurrence of the deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	
N 0547 Bldg. 00	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview, the Registered Nurse failed to put orders into writing in 3 out of 4 records reviewed. (#1, 2, and 6) Findings include: 1. The clinical record of patient #1 was reviewed	N 0547	Corrective Action: Documentation of physician's orders in the patient's file will evidence that verbal orders are put into writing with the date of receipt of the order and signed and dated by the RN. The written order is then sent to the physician for signature. Verbal	04/02/2018

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	on 2/19/18 at 1:00 p.m. Review of an OASIS C2 Recertification visit note dated 2/10/18, indicated care coordination between Employee F and the physician in regards to recertification and the plan of care. The clinical record failed to evidence a physician order by Employee F. 2. The clinical record of patient #2 was reviewed on 2/20/18 at 12:00 p.m. Review of a Non OASIS Recertification visit note dated 2/2/18, indicated care coordination between Employee F and the physician in regards to recertification and the plan of care. The clinical record failed to evidence a physician order by Employee F. 3. The clinical record of patient #6 was reviewed on 2/19/18 and 2/20/18. Review of an OASIS C2 Recertification visit note dated 2/16/18, indicated care coordination between Employee F and the physician in regards to recertification and the plan of care. The clinical record failed to evidence a physician order by Employee F. 4. The Employee F was interviewed on 2/20/18 at 1:15 p.m. The Employee F indicated she would call all physicians to obtain continuing orders and would only documents it in her visit notes. The Employee F indicated she did not put patient's #1 continuing orders into writing and also indicated on occasion she would leave messages on voicemail's of what the plan of care would be and did not follow up with the messages. When queried about services being provided without a physician order when messages are left without follow up, the Employee F indicated she did not know that she needed to speak to someone for approval to continue services and didn't know she needed to write those orders when obtained.		orders are tracked for date returned and audited for the physicians' signature and date. If messages, as directed by the physician's protocol of taking messages, requires leaving a voicemail or electronic message, follow-up will be completed prior to implementing any changes in the patient's services assuring physician verbal orders are received. RN's will be instructed on this regulation and expectation of compliance. Prevention: Audit all (100%) of current charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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N 0550 Bldg. 00	410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on record review and interview, the agency failed to ensure the home health aide followed the home health aide care plan in 2 out of 2 records reviewed (#2 and 7) in a sample of 4. Findings include: 1. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. A. The home health aide careplan for the certification period of 2/7/18 to 4/7/18, indicated duties included but not limited to for the home health aide to provide a shower with chair every visit and assist with chair bath weekly, shampoo hair weekly, nail care every visit, record bowel movements. The care plan did not indicate to assist with ambulation. i. Review of 2/7, 2/10, 2/11, 2/13, 2/14, and 2/16/18 visit notes, the home health aide documented assist with chair bath, assist with ambulation, and failed to evidenced a shampoo, shower with chair, and nail care. ii. Review of the 2/12/18 visit note, the home health aide documented tub / shower, assist with chair bath, shampoo, nail care, and assist with ambulation. The home health aide failed to	N 0550	Corrective Action: All home health aides were educated on compliance with the home health aide care plan and assigned tasks. At least weekly, aide time sheets, documentation, aide care plan will be reconciled for compliance and accuracy of completion. Any discrepancies by the aide will initiate disciplinary actions. At supervisory visits the RN will insure that the aide is implementing the aide care plan as directed. An RN will supervise the aide for a skilled case at least every 2 weeks on-site and for a non-skilled at least every 30 days on-site. The aide will be present and the provision of care will be observed by the RN at least every 60 days. The aides have been instructed on following the physician orders for the hours that are needed to meet the patient's needs. The aide reports to the RN if those hours are not met and the reason why. The aide documents this in the visit record. The physician is	04/02/2018

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	specify if the patient received a tub or shower bath. The home health aide failed to follow the care plan. 2. The clinical record for patient #7 was initially reviewed on 2/19/18 at 4:00 a.m. A. The electronic record indicated a home health aide careplan dated 1/26/18. The home health aide careplan indicated a certification period of 12/1/17 to 1/29/18 and signed by the DOCS on 1/29/18. The duties included but not limited to tub bath and record bowel movement. B. Review of the home health aide visit notes dated 2/5/18 to 2/9/18 and 2/12 to 2/16/18, failed to evidence a record of bowel movements and failed to indicate if the patient received a tub bath / shower. The home health aide evidenced documentation duties that were not included in the home health aide careplan such as foot care, checking pressure areas, and encouraging fluids. The home health aide failed to follow the plan of care. 3. The record was reviewed with the Administrator and DOCS on 2/20/18 at 3:30 p.m. The Administrator indicated that Employee X would be taking on the responsibility of ensuring the home health aides documented their visit sheets appropriately.		notified. Prevention: 100% of aide visit report are reviewed by the RN for hours provided, care provided, and compliance with the aide care plan. RN's to insure supervisory visits are effective in determining the aide's performance and compliance with the care plan. These actions will prevent this deficiency from recurring. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	
N 0554 Bldg. 00	410 IAC 17-14-1(a)(2)(B) Scope of Services Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes.	N 0554	Corrective Action: The LPN is	04/02/2018

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	Based on record review, the LPNs failed to ensure to documentation was in real time in relation to specifying what medications were administered, when the patient was suctioned, the amount, color and viscosity, the specific treatments provided to the trach and g-tube, as well as skin appearance of treatment sites, patient tolerance, results and reassessment after cpt use, intake and each output, and failed to document occurrences of bed bug festation and equipment issues in 1 out of 1 records reviewed (#1) of patients with LPN services in a sample of 4 Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18, with orders for skilled nursing 15 hours a day 7 days a week to provide "direct hands on care of client requiring trach care, tube feedings, insulin administration ... SN [Skilled Nurse] has turn schedule that is implemented q2h [every 2 hours] ... SN to perform BG [blood glucose] checks every visit and prn [as needed]. SN to administer insulin ... SN to instruct on care of stoma, surrounding skin and use of skin barrier. SN to instruct on proper technique for tube feeding, aspiration precautions and care of feeding tube site. SN to perform a neurological assessment each visit. SN to assess / instruct on seizure disorder signs and symptoms and appropriate actions during seizure activity. SN to instruct the caregiver on seizure precautions. SN to ensure all staff are competent to use VNS [vagus nerve stimulation] and document time and length of seizure." The patient's medications included, but not limited to, miralax as needed, normal saline as needed for suctioning, Humulin N 40 units in the a.m. and 10:00 p.m., 45 units at 3:00		responsible for completing clinical and progress notes. The LPN's will be instructed on documenting all care provided at the time the care is provided. The expectation is that all documentation is completed by the LPN at the time of care furnished. Documentation reflects the real-time care is provided. The LPN will document for instance what medications are administered, when the patient is suctioned--the amount, color and viscosity, all treatments performed including trach care, g-tube care, skin assessment, patient's response to treatments, and the results and outcome of assessments. The visit reports, assessments, clinical notes, progress notes will all be complete, accurate, and in real-time. Any changes in the patient's care, services, or status, such as the bed bug infestation, is documented and reported to the RN for follow-up. The LPN will be instructed on this deficiency and the correction plan and the expectation of prompt compliance. LPN notes are reviewed by the RN for compliance. If included in the plan of care, Caregiver instruction will be given by the LPN as compiled, directed, and supervised by the RN. Documentation will evidence the content of the caregiver education, caregiver response, and ongoing	

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	p.m., 350 cc flush four times a day, levocarnitine 7 ml three times daily, lactulose 30 ml three times daily, Florastor 500 mg capsule twice a day, depakene 15 mls three times a day, acetaminophen prn, albuterol inhalation four times a day prn, nystatin three times a day prn, erythromycin toping solution twice a day and prn, loperamide every 6 hours as needed, scopolamine 1.5 mg transdermal every 3 days, levetiracetam 20 mls three times a day and clorazepate at 2:00 a.m., 1 at noon, and 2 at bedtime. A. Review of a skilled nursing visit note by Employee A on 2/5/18 and 2/7/18 with hours of 7:00 a.m. to 10:00 p.m., indicated the patient was disoriented but also indicated the patient was oriented to person, place, and time. The narrative portion of both 2/5 and 2/7/18 notes indicated verbatim, "0700: patient awake in bed. vs [vital signs] wnl [within normal limits]. head to toe wnl. congestion noted, trach suctioned PRN..) 0800: blood sugar wnl, insulin as ordered. g-tube in place and patent, meds / flush tolerated well including PRN tussin d/t [due to] congestion. feeding bag changed and resumed at 40 cc / hr [hour]. incontinence care. partial bed bath d/t urine overflow. PROM. 0900: trach care, oral care, g-tube care. positioned on right side. 1100: cpt [chest physical therapy to loosen mucous] vest x 20 min. incontinence care. positioned on left side. 1200: meds / flush tolerated well. 1330: incontinence care. patient dressed and transferred to wheelchair with hoyer. positioned for comfort, suction machine within reach. 1430: reported to evening nurse. i. The hours of the 2/5 and 2/7/18 visit notes was inconsistent with the narrative note indicating Employee A reported to an evening nurse at 14:30 p.m.		assessment of compliance with the education. RN's and LPN's will be instructed on providing complete caregiver instruction regarding patient care. Compliance is expected promptly. LPN documentation will be reviewed by the RN for compliance. Prevention: Supervision of the LPN care monthly and documentation with oversight and education will insure that this deficiency does not recur. 100% of active charts will be audited for compliance, then quarterly 10% or at least 3 charts will be audited for compliance. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	ii. Both 2/5 and 2/7/18 narrative notes failed to include documented of the name of the medications that was administered at 0800 and at 1200. The intervention section in both 2/5 and 2/7/18 notes indicated medication administration were 5 times. iii. The respiratory assessment in the 2/5 and 2/7/18 visit notes indicated the patient lung sounds were clear bilaterally, which was inconsistent with both narrative notes indicating the patient was congested, PRN tussin was provided. The intervention section to both 2/5 and 2/7/18 notes indicated trach care and g-tube was provided 2 times. The narrative note failed to include documentation of the specific treatment provided to the trach and g-tube, and how the patient tolerated the treatment / procedure and the skin appearance around the stoma sites as well as how the patient tolerated the cpt vest therapy, if any mucous removal, failed to include color, amount, and consistency of sputum that was suctioned, the specific times the patient was suctioned, and failed to indicated that both trach and g-tube care had been provided 2 times. iv. The diabetic care in the 2/5 and 2/7/18 visit notes indicated blood sugars in the "AM, PM, HS [bedtime]" which was inconsistent with the documentation indicated only 40 units of insulin was administered x 1. The intervention section indicated diabetic monitoring / care, insulin administration, and injection was three times. The note failed to include documentation of the 3:00 p.m. and 10:00 p.m. dosage. v. The intervention section in the 2/5 and 2/7/18 visit notes indicated the glucometer was calibrated. The narrative note failed to			

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	evidenced documentation of when the calibration had been completed and whether the calibration passed or failed. vi. The narrative notes for both 2/5 and 2/7/18 failed to include documentation of the patient being repositioned after 1:30 (13:30) p.m. B. A communication note dated 2/5/18 and signed by the Director of Clinical Services, indicated the patient's residence had a bed bug infestation. The 2/5/18 visit note by Employee A failed to include documentation of the bed bug infestation. C. A communication note dated 2/7/18 and signed by the Employee F, indicated she had received a call from Employee A in regards to the humidifier over the patient's trach was not working and when called the durable medical equipment company, Employee A was told it was not an emergency. Another communication note dated 2/7/18, indicated the Employee F had spoke to a respiratory therapist who would contact Employee A and talk Employee A through troubleshooting and / or if a part was needed that evening or the next day. The visit note by Employee A failed to evidenced documentation of the incident and communication with the Employee F, failed to evidence documentation and the communication with the durable medical equipment company and the end result of the troubleshooting. The 2/5 and 2/7/18 skilled nursing visit notes were inconsistent between the assessments, narrative, and interventions, documentation failed to be reflective of the entire 7:00 a.m. to 10:00 p.m. visits, failed to be specific in all medications, treatments, and services that were provided by Employee A,			

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	failed to include total intake and output, and failed to evidenced the bed bug infestation and equipment difficulties along with communication that had taken place. D. The findings was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:35 p.m. No further information or documentation regarding the above findings were provided.			
N 0555 Bldg. 00	410 IAC 17-14-1(a)(2)(C) Scope of Services Rule 14 Sec. 1(a) (2)(C) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (C) Assist the physician and/or registered nurse in performing specialized procedures. Based on record review, the Licensed Practical Nurse (LPN) failed to ensure to specifically document all procedures and treatment that had been provided through out the day / visit in 1 out of 1 record reviewed of a patient with a trach, feeding tube, and insulin administration in a sample of 4 records. (#1) Findings include: 1. The clinical record for patient #1 was reviewed on 2/19/18 at approximately 1:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18, with orders for skilled nursing 15 hours a day 7 days a week to provide "direct hands on care of client requiring trach care, tub feedings, insulin administration ... SN [Skilled Nurse] has turn schedule that is implemented q2h [every 2 hours] ... SN to perform BG [blood glucose] checks every visit and prn [as	N 0555	Corrective Action: The LPN'S will be educated on this deficiency, the findings of the deficiency, corrective action and the expectation of prompt compliance. The LPN will document all medications administered, name, dosage, route, date, time, patient's response. The specifics of all treatments provided such as trach care and g-tube care will be documented by the LPN with time, date, what was done, how the patient reacted, and the specifics of the outcome. The RN will review the LPN documentation to insure completeness and accuracy and to insure care is provided as ordered.	04/02/2018

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	needed]. SN to administer insulin ... SN to instruct on care of stoma, surrounding skin and use of skin barrier. SN to instruct on proper technique for tube feeding, aspiration precautions and care of feeding tube site. SN to perform a neurological assessment each visit. SN to assess / instruct on seizure disorder signs and symptoms and appropriate actions during seizure activity. SN to instruct the Caregiver on seizure precautions. SN to ensure all staff are competent to use VNS and document time and length of seizure." The patient's medications included, but not limited to, miralax as needed, normal saline as needed for suctioning, Humulin N 40 units in the a.m. and 10:00 p.m., 45 units at 3:00 p.m., 350 cc flush four times a day, levocarnitine 7 ml three times daily, lactulose 30 ml three times daily, Florastor 500 mg capsule twice a day, depakene 15 mls three times a day, acetaminophen prn, albuterol inhalation four times a day prn, nystatin three times a day prn, erythromycin toping solution twice a day and prn, loperamide every 6 hours as needed, scopolamine 1.5 mg transdermal every 3 days, levetiracetam 20 mls three times a day and clorazepate at 2:00 a.m., 1 at noon, and 2 at bedtime. A. Review of a skilled nursing visit note by Employee A on 2/5/18 and 2/7/18 with hours of 7:00 a.m. to 10:00 p.m., indicated the patient was disoriented but also indicated the patient was oriented to person, place, and time. The narrative portion of both 2/5 and 2/7/18 notes indicated verbatim, "0700: patient awake in bed. vs [vital signs] wnl [within normal limits]. head to toe wnl. congestion noted, trach suctioned PRN..) 0800: blood sugar wnl, insulin as ordered. g-tube in place and patent, meds / flush tolerated well including PRN tussin d/t [due to] congestion. feeding bag changed and resumed at 40 cc / hr [hour]. incontinence care. partial bed bath d/t		Prevention: Supervision of the LPN care monthly and documentation with oversight and education will insure that this deficiency does not recur. 100% of active charts will be audited for compliance, then quarterly 10% or at least 3 charts will be audited for compliance. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	15K121	A. BUILDING 00 B. WING	02/20/2018

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	urine overflow. PROM. 0900: trach care, oral care, g-tube care. positioned on right side. 1100: cpt vest x 20 min. incontinence care. positioned on left side. 1200: meds / flush tolerated well. 1330: incontinence care. patient dressed and transferred to wheelchair with hoyer. positioned for comfort, suction machine within reach. 1430: reported to evening nurse." i. Both 2/5 and 2/7/18 narrative notes failed to include documented of the name of the medications that was administered at 0800 and at 1200. The intervention section in both 2/5 and 2/7/18 notes indicated medication administration were 5 times. The narrative note failed to evidenced documentation of medications administered after 2:30 p.m. and failed to evidence documentation if the g-tube residual had been checked (and amount if any) prior to each medication administration. iii. The intervention section to both 2/5 and 2/7/18 visit notes indicated trach care and g-tube was provided 2 times. The narrative note failed to include documentation of the specific treatment provided to the trach and g-tube and how the patient tolerated the treatment / procedure and the skin appearance around the stoma sites, failed to include color, amount, and consistency of sputum that was suctioned, the specific times the patient was suctioned, and failed to indicated that both trach and g-tube care had been provided 2 times. iv. The diabetic care section in the 2/5 and 2/7/18 visit notes indicated blood sugars in the "AM, PM, HS [bedtime]" which was inconsistent with the documentation indicated only 40 units of insulin was administered x1. The intervention section indicated diabetic monitoring			

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	/ care, insulin administration, and injection was three times. The note failed to include documentation of the 3:00 p.m. and 10:00 p.m. dosage. v. The intervention section in the 2/5 and 2/7/18 visit notes indicated the glucometer was calibrated. The narrative note failed to evidenced documentation of when the calibration had been completed and whether the calibration passed or failed. B. Employee A was not available for interview on 2/20/18, due to illness. C. The findings was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:35 p.m. No further information or documentation regarding the above findings were provided.			
N 0557 Bldg. 00	410 IAC 17-14-1(a)(2)(E) Scope of Services Rule 14 Sec. 1(a) (2)(E) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (E) Assist the patient in learning appropriate self-care techniques. Based on record review the LPNs failed to instruct the caregiver in all aspects of trach care and equipment, diabetic management, proper technique for tube feeding / aspiration precautions / care of feeding tube site, instruct on seizure disorder as per the plan of care in 1 out of 1 active records reviewed (#1) of patients with LPN services in a sample of 4. Findings include:	N 0557	Corrective Action: As of March 13, 2018, BeeWell does have or has not employed any LPNs. If employed, LPN will be instructed on performing services only as ordered by the physician and as outlined in the Plan of Care and directed by the RN. LPN will document promptly and accurately all care provided in accordance with physician's orders. The LPN	04/02/2018

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	1. The clinical record for patient #1 was reviewed on 12/12/17 at approximately 2:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18, with orders for skilled nursing 15 hours a day 7 days a week to provide " ... SN to instruct on care of stoma, surrounding skin and use of skin barrier. SN to instruct on proper technique for tube feeding, aspiration precautions and care of feeding tube site ... SN to ... instruct on seizure disorder signs and symptoms and appropriate actions during seizure activity. SN to instruct the caregiver on seizure precautions. SN to ensure all staff are competent to use VNS and document time and length of seizure." A. Review of a skilled nursing visit note by Employee A on 2/5/18 and 2/7/18 with hours of 7:00 a.m. to 10:00 p.m., failed to evidence documentation of education / instruction to the caregiver. B. Employee A was not available for interview on 2/20/18, due to illness. C. The findings was reviewed with the Administrator and Director of Nursing on 2/20/18 at 3:35 p.m. No further information or documentation regarding the above findings were provided.		will consult with the RN prior to any implementation of new orders. The LPN will be supervised at least monthly in the home while providing care. 100% of LPN documentation will be reviewed by the RN for completeness and accuracy. Caregiver instruction will be given by the LPN as compiled, directed, and supervised by the RN. Documentation will evidence the content of the caregiver education, caregiver response, and ongoing assessment of compliance with the education. Prevention: Compliance with the Correction Action. Supervision of the LPN care and documentation with oversight and education will insure that this deficiency does not recur. Target Date: April 2, 2018 Responsible Person: Director of Clinical Services	
N 0563 Bldg. 00	410 IAC 17-14-1(c)(2) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months;	N 0563	Corrective Action: The RN will	04/02/2018

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	Based on record review and interview, the Registered Nurse failed to ensure the correct OASIS recertification forms were completed within the last 5 days of a 60 day certification period and failed to ensure endocrine assessments included blood sugar ranges between certification periods in 1 out of 2 skilled certification reassessments in a sample of 4. (#6) Finding included: The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. The electronic clinical record failed to evidenced a plan of care for the certification period of 2/13/17 to 4/14/18. A. The Director of Clinical Services (DOCS) was queried on 2/19/18 at 3:15 p.m. of the whereabouts of the plan of care and was unable to provide an explanation of why the recertification was not in the electronic medical record. B. On 2/20/18 at 9:50 a.m., a recertification assessment dated 2/16/18 was provided but failed to evidenced a time, electronic signature and date of the assessment. During this time, the DOCS indicated Employee F had been working on changing the reassessment and Employee F was not able to get this done in a timely manner due to her busy schedule. C. At 11:00 a.m., the Employee X provided another recertification assessment dated 2/16/18, which included the time, electronic signature and date of Employee F. The reassessment indicated the patient was a diabetic that was managed by oral hypoglycemic and insulin. The assessment failed to be completed within the last 5 days of the 60 day certification period and failed to evidenced the patient's blood sugars were reviewed and were		complete the Comprehensive/OASIS Assessment between days 56-60 of the current certification period. The assessment will be complete and accurate based on the patient's status. All categories will be addressed. A 60-day episode tracking calendar is completed indicating days 56-60 for the RN. Comprehensive tracking process is in place to insure compliance with this regulation. RN's are educated on this deficiency and corrective action to insure compliance. Prevention: audit 100% of active charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	within acceptable parameters and ensure no adjustments were needed. E. Employee F was interviewed on 2/20/18 at 1:15 p.m., and indicated she was having computer problems trying to access the correct OASIS.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency failed to ensure failed to ensure clinical records contained visit notes, and notes were complete and contained consistent / accurate information in a timely manner in 3 out of 4 records reviewed. (#1, 6, and 7) Findings include: 1. The clinical record for patient #1 was reviewed	N 0608	Corrective Action: Visit notes will be completed at the time of the visit and submitted for review and filing within 24 hours of the visit. Clinicians will accurately record the events of the visit, sign, date, and time the visit note and submit. Every employee is encouraged to use electronic documentation. Electronic documentation and	04/02/2018

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	on 12/12/17 at approximately 2:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18 and 2/11/18 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week. A. The clinical record evidenced an agency document titled "60-Day Summary / Case Conference" dated 2/10/17, that indicated the patient was receiving home health aide services. B. A communication note dated 2/5/17, failed to include an electronic signature and date of the author of who wrote the note. C. A communication note dated 2/10/17, signed and dated by Employee F on 2/7/18 was reviewed with the Employee F on 2/20/18 at 1:15 p.m. Employee F indicated the correct date of the note should be 2/7/18, not 2/10/18. Employee F also indicated the patient was receiving home health aide services from BeeWell. When queried why didn't the plan of care include orders for home health aide services, Employee F indicated confusion with the sister company and the combined services the patient was being provided. When asked if she coordinated care with the sister companies, Employee F indicated she had not. D. Review of the skilled nursing visits in the electronic medical record, visit dates 2/6, 2/8, 2/10, 211, 2/12, 2/14, 2/16 and 2/17/18 failed to evidenced documentation that skilled nursing visits had taken place. i. On 2/19/18 at 2:40 p.m., the Director of Clinical Services (DOCS) was informed of the missing documentation between 2/5 and 2/17/18. The DOCS was requested to have all visit notes		signatures are preferred, encouraged, and expected. When electronic documentation is not possible, paper documentation will be accepted and attached to the electronic record within 72 hours of submission. Clinical records will be complete and accurate and signed and dated by the appropriate clinician. Prevention: Audit all (100%) of current charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	

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	printed from the EMR during this time frame. The DOCS indicated that the staff was informed that all visit notes must be in the EMR. The Administrator had indicated she thought all the days had been covered. Also expressed problems with their computer program since the new updates. At 3:25 p.m., the Employee E provided hand written notes for 2/13 and 2/15/18, expressed problems with the computer as for not having the notes entered in the EMR. Employee E indicated she would have the notes in the EMR by 2/20/18. ii. On 2/20/18 at 10:00 a.m., Employee E provided the 2/13 and 2/15/18 electronic visit notes. iii. On 2/20/18 at 3:35 p.m., the record was reviewed with the Administrator and the DOCS. The Administrator indicated she knew the visits were made and asked to look for the visits. The Administrator could only provide time records provided indicating times and dates of when the patient was seen. E. Review of a skilled nursing visit note dated 2/9/18 from 7:55 a.m. to 8:55 p.m., the note indicated in the Endocrine / Hematologic section: " ... 8 p.m. RBS [sic] - 135. SN administered 40 U N insulin per abdomen at 3 o'clock SQ ... " Care Coordinated with HHA [home health aide]. The narrative indicated " ... SN changed trach ties, trach dressing for second time this evening .... " The entries failed to be consistent with the time of the nursing visit. F. Review of a skilled nursing visit note dated 2/9/18 from 3:10 p.m. to 5:30 p.m., indicated " ... Hha, [name of aide] helped place supplies back into appropriate labeled drawers .... " The entry failed to correctly identify the caregiver.			

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	G. A communication note dated 2/9/18, indicated " Spoke with [name of physician representative] regarding the inability to provide 15 hours of skilled nursing care for client today. She was told the RN case manager will be going in to do the meds and treatments during the day but the remainder of the care will be provided by [name of agency that provides both personal service / attendant care waiver with home health aides and FSSA [Family and Social Services Administration / Bureau of Developmental Disability waiver services with direct care professionals]. who provide waiver services. They will be doing the hands on personal care and are educated through their waiver training on how to do the trach care for the Client .... " The note failed to be specific to the which part of the waiver services were to be provided. H. Review of the physician address and phone number on the plan of care, the agency had the an address of a hospital that the physician worked from as a hospitalist and phone number was that of the hospital switchboard. i. On 2/20/18 at 2:20 p.m., the phone number on the nurse practitioner script was called. An interview with the receptionist during this time indicated that the address of phone number were incorrect. The receptionist indicated the physician was one of the collaborating physicians in the office and orders were to be faxed to their office, they review them to ensure that the patient was their patient and information was correct, then it would get uploaded for the physician to electronically sign, then the office would return the signed documents back to the agency. The agency failed to have the correct address, phone and fax number of the physician.			

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	2. The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m. A. The electronic clinical record evidenced a document titled "60-Day Summary / Case Conference" for the certification period of 12/15/17 to 2/12/18. The document was incomplete and failed to evidenced vital sign ranges, summary of care provided, patient's current condition, and goals. B. On 2/20/18 at 9:30 a.m., another "60-Day Summary / Case Conference" for the certification period of 12/15/17 to 2/12/18 was provided. The summary indicated the patient's blood pressure had been under control with medication adjustments, blood sugars fairly well controlled with Metformin [oral diabetic medication] increased to 1 gm twice a day, and skilled nursing set's up patient medications every other week. The patient's current condition indicated the patient's blood pressures was controlled with amlodipine. i. Review of the OASIS C2 Recertification assessment dated 2/16/18, indicated the patient's had a history of elevated blood pressure and was treated with carvedilol, spironolactone, and lisinopril. ii. Review of the medication profile evidenced the patient's Metformin was increased to 1 gm on 9/26/18. The patient's blood pressure medications consist of spironolactone, carvedilol, amlodipine, and lisinopril. The last blood pressure medication change was Spironolactone on 7/24/17. C. The clinical record was reviewed with the			

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	Administrator and the DOCS on 2/20/17 at 3:30 p.m. The DOCS confirmed skilled nursing visits were monthly for medication set up. Employee F failed to complete the 60 day summary / case conference form within a timely manner and failed to be reflective of the patient's current status. 3. The clinical record of patient #7 was initially reviewed on 2/19/18 at 4:00 p.m. A. The electronic record evidenced a document titled "Coordination of Care" for the certification period of 12/1/17 to 1/29/18. The document was incomplete and failed to evidenced functional limitations, patient condition, services provided, vital sign ranges, home bound status, and summary of care provided by the home health agency. B. On 2/20/18, at 9:30 a.m., provided another "Coordination of Care" document that included all the missing information with exception to summary of care provided by the agency and the author's signature and date of who completed the form. C. The clinical record was reviewed with the Administrator and the DOCS on 2/2/18 at 3:30 p.m. No further information was provided during this time.			
N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.			

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	Based on record review and interview, the agency failed to ensure orders were collaborated and co-signed by the collaborating / attending physician, failed to ensure communication notes were electronically signed by the visiting clinician, and failed to ensure medication profile were signed and dated when medications were reconciled in 4 out of 4 records reviewed. Findings include: 1. The clinical record for patient #1 was reviewed on 12/12/17 at approximately 2:00 p.m. The clinical record included a plan of care for the certification period of 12/13/17 to 2/10/18 and 2/11/18 to 4/11/18, with orders for skilled nursing 15 hours a day 7 days a week. A. A communication note dated 2/5/17, failed to include an electronic signature and date of the author of who wrote the note. B. Review of a medication profile, failed to evidenced a signature and date of medication reconciliation. C. An order on a nurse practitioner's script, unsigned and dated 2/15/18, indicated for the patient to have amoxicillin every 8 hours for 10 days. i. The DOCS was interviewed on 2/19/18 at 1:20 p.m., indicated she did not obtain clarification orders from the physician as she was instructed by the consultant to wait until the script had been filled and obtain the order via script label. The DOCS expressed concerns with the nurse practitioner not wanting to cooperate with the need for co-signature from the	N 0610	Corrective Action: Visit notes will be completed at the time of the visit and submitted for review and filing within 24 hours of the visit. Clinicians will accurately record the events of the visit, sign, date, and time the visit note and submit. Every employee is encouraged to use electronic documentation. Electronic documentation and signatures are preferred, encouraged, and expected. When electronic documentation is not possible, paper documentation will be accepted and attached to the electronic record within 72 hours of submission. Clinical records will be complete and accurate and signed and dated by the appropriate clinician. Prevention: Audit all (100%) of current charts for compliance. Quarterly, 10% or at least 3 of the patient charts will be audited to prevent the recurrence of this deficiency. Target date: April 2, 2018 Responsible Person: Director of Clinical Services	04/02/2018

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BEEWELL INC	6967 HILLSDALE COURT INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

collaborating physician. When queried about obtaining the patients medication administration record and orders in the patients home, the DOCS indicated the forms would be brought into the office monthly. When queried if the entire 2017 year and January 2018 had been obtained and put into the patient's record, the DOCS indicated the documents had not been obtained from the patient's home.

D. On 2/20/18 at 10:00 a.m., Employee E provided the 2/13 and 2/15/18 electronic visit notes but failed to include an electronic signature and date of the author of who wrote the note.

2. The clinical record for patient #2 was reviewed on 2/20/18 at 12:00 p.m. Review of a medication profile, failed to evidenced a signature and date of medication reconciliation.

3. The clinical record of patient number 6, was reviewed on 2/19/18 at 3:00 p.m.

A. Review of a medication profile, failed to evidenced a signature and date of medication reconciliation.

B. The electronic clinical record evidenced a document titled "60-Day Summary / Case Conference" for the certification period of 12/15/17 to 2/12/18. The document was incomplete and failed to evidenced signature of author and date.

4. The clinical record for patient #7 was reviewed on 2/20/18 at 10:30 a.m. Review of a medication profile, failed to evidenced a signature and date of medication reconciliation.