STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157653	A. BUILDING 00 B. WING	08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RN2U INC	9731 NORTH KITCHEN ROAD MOORESVILLE, IN 46158

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This was a federal home health recertification and complaint investigation survey. The survey was extended. Complaint # IN00164290 - Substantiated with unrelated deficiencies cited Complaint # IN00164255 - Substantiated with unrelated deficiencies cited Survey dates: July 29 through August 5, 2015 Facility Number: 012905 Medicaid Provider ID 201075310 Census: 63 Home visits 5 Clinical records reviewed 12 RN2U, Inc. is precluded from providing its own training and competency evaluation program for a period of 2 years beginning August 5, 2015, to August 5, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30 Skilled Nursing	G 0000		

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

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	Services. QR; K.H., RN			
G 0114 Bldg. 00	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. Based on clinical record review and interview, the agency failed to inform the patient, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 12 of 12 records reviewed, potentially affecting all 63 patients receiving services within the agency. (#1 - 12) Findings include: 1. Clinical record number 1, SOC (start of care) 06/26/15. The Admission Service Agreement dated 06/26/15 failed to evidence the charges that may occur for services not covered by the insurance benefit. 2. Clinical record number 2, SOC	G 0114	All current patient's charts will be reviewed Patient will be informed of possible charges on admission. Admission paperwork has been rewritten to include charges DON/designee will in-service all admission staff on requirement to inform patient of possible charges at time of admission and to document this in the patient's chart Form has been revised The admitting discipline (SN/PT) will be responsible for informing the patient on admission DON/designee will monitor admissions weekly	08/29/2015

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	04/28/15. The Admission Service Agreement dated 04/28/15 failed to evidence the charges that may occur for services not covered by the insurance benefit. 3. Clinical record number 3, SOC 06/26/15. The Admission Service Agreement dated 06/26/15 failed to evidence the charges that may occur for services not covered by the insurance benefit. 4. Clinical record number 4, SOC 07/16/15. The Admission Service Agreement dated 07/16/15 failed to evidence the charges that may occur for services not covered by the insurance benefit. 5. Clinical record number 5, SOC 06/02/15. The Admission Service Agreement dated 06/02/15, failed to evidence the charges that may occur for services not covered by the insurance benefit. 6. Clinical record number 6, SOC 10/28/14. The Admission Service Agreement dated 10/28/14, failed to evidence the charges that may occur for services not covered by the insurance benefit.			

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	7. Clinical record number 7, SOC 02/04/15. The Admission Service Agreement dated 02/04/15 failed to evidence the charges that may occur for services not covered by the insurance benefit. 8. Clinical record number 8, SOC 10/30/14. The Admission Service Agreement dated 10/30/14 failed to evidence the charges that may occur for services not covered by the insurance benefit. 9. Clinical record number 9, SOC 04/03/14. The Admission Service Agreement dated 04/03/14 failed to evidence the charges that may occur for services not covered by the insurance benefit. 10. Clinical record number 10, 10/29/14. The Admission Service Agreement dated 10/29/14 failed to evidence the charges that may occur for services not covered by the insurance benefit. 11. Clinical record number 11, SOC 10/30/14. The Admission Service Agreement dated 10/30/14 failed to evidence the charges that may occur for services not covered by the insurance benefit.			

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	12. Clinical record number 12, SOC 10/30/14. The Admission Service Agreement dated 10/30/14 failed to evidence the charges that may occur for services not covered by the insurance benefit. 13. Employee A, Administrator / Registered Nurse, was interviewed on 08/05/15. Employee A indicated he / she was not aware the service plan needed to include charges that may not be paid by insurances. 14. An undated policy titled Service Agreement indicated "A Service Agreement shall be developed with all clients upon admission, before care is provided. The service agreement will identify the services to be provided, disciplines providing care, charges and expected sources of reimbursement for services. The patient will be informed of their liability for payment ... The charges the individual may have to pay ... A copy shall be provided to the client and / or financially responsible person."			
G 0143 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.			

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	Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with other home health agencies that were furnishing services for 3 of 3 records reviewed of patients receiving services from another provider creating the potential to affect all of the agency's patients that receive more than one service. (#1, 3, 4) Findings include: 1. Clinical record number 1, SOC (start of care) 6/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During clinical record review on 07/30/15, a typed piece of paper signed and dated by Employee A, Administrator / Registered Nurse, on 06/25/15 indicated "SN [skilled nurse] was informed that pt [patient] has a MCD [Medicaid] company in home as well. SN called [Name of Agency] and informed of Medicare admit for skilled needs. Receptionist will call back if any needs noted after communicated to RN." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 2. Clinical record number 3, SOC 06/26/15, included a plan of care	G 0143	All patients currently being seen by other agencies will be reviewed, agency will be contacted and documented (This includes wound care centers, dialysis, personal service agencies) DON/designee will in-service all admit staff on requirement to contact other agencies involved in care of patient at admission, resumption, recertification, any change in status and discharge In the future agencies will be contacted and documented on admission, resumption, change of status and discharge DON/designee to audit all charts for compliance Once 100% compliance is achieved, DON/designee will audit 10% of admissions, resumptions, recertifications and discharges weekly	08/29/2015

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	established by the physician for the certification period 06/26/15 to 08/24/15. During a home visit on 07/30/15 at 3:55 PM, the patient was observed to have an aide from another home health company in the home. Employee A, Administrator / RN, stated that the patient has 24 hour care in their home. The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 3. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15. During clinical record review on 08/03/15, a typed piece of paper signed and dated by Employee A on 07/16/15, indicated "Communication with MCD (Medicaid) HHC (Home Health Company) in home as well. SN (skilled nurse) called [Name of Agency] and left a message for [Name of personnel] and informed of Medicare admit for skilled needs. [Name of personnel] to call back if any questions." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 4. Employee A, Administrator / Registered Nurse, was interviewed during the Entrance Conference on 07/29/15,			

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	from 12:30 PM to 12:50 PM. Employee A stated he / she would notify the outside agencies that were also providing services upon admission and as needed. 5. An undated policy titled Coordination of Client Services indicated, "After initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure ... Coordination with other agencies and institutions ... "			
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 patient care does occur. Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated and documented effectively with other home health agencies that were furnishing services for 3 of 3 records reviewed of patients receiving services from another provider creating the potential to affect all of the agency's patients that receive more than one service. (#1, 3, 4) Findings include:	G 0144	All patients currently being seen by other agencies will be reviewed, agency will be contacted and documented (This includes wound care centers, dialysis, personal care agencies) DON/designee will in-service all professional staff on requirement to contact other agencies involved in care of the patient on admission,resumption, recertification, change of status and discharge in the future agencies will be contacted and documented on admission, resumption, recertification, change of status	08/29/2015

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	1. Clinical record number 1, SOC (start of care) 6/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During clinical record review on 07/30/15, a typed piece of paper signed and dated by Employee A, Administrator / Registered Nurse, on 06/25/15 indicated "SN [skilled nurse] was informed that pt [patient] has a MCD [Medicaid] company in home as well. SN called [Name of Agency] and informed of Medicare admit for skilled needs. Receptionist will call back if any needs noted after communicated to RN." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During a home visit on 07/30/15 at 3:55 PM, the patient was observed to have an aide from another home health company in the home. Employee A, Administrator / RN, stated that the patient has 24 hour care in their home. The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 3. Clinical record number 4, SOC		and discharge DON/designee will audit all charts for compliance Once 100% compliance is achieved DON/designee will audit 10% of admissions, resumptions, recertifications and discharges weekly (on-going)	

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	07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15. During clinical record review on 08/03/15, a typed piece of paper signed and dated by Employee A on 07/16/15, indicated "Communication with MCD (Medicaid) HHC (Home Health Company) in home as well. SN (skilled nurse) called [Name of Agency] and left a message for [Name of personnel] and informed of Medicare admit for skilled needs. [Name of personnel] to call back if any questions." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 4. Employee A, Administrator / Registered Nurse, was interviewed during the Entrance Conference on 07/29/15, from 12:30 PM to 12:50 PM. Employee A stated he / she would notify the outside agencies that were also providing services upon admission and as needed. 5. An undated policy titled Coordination of Client Services indicated, "After initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure ... Coordination with other agencies and institutions ... "			

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G 0153 Bldg. 00	484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. Based on interview, the agency failed to conduct the annual program evaluation of the agency for 1 of 1 agency. Finding include: On 07/29/15 at 1:40 PM, the annual program evaluation was requested. Employee A, Administrator, indicated she had not conducted an annual program evaluation since the previous survey in 2012.	G 0153	Agency has conducted an annual program evaluation on 8/27/15 Agency will continue this process annually at the end of the fiscal year Administrator will monitor annually	08/29/2015
G 0156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on observation, clinical record review, agency policy review, and interview, it was determined the agency failed to ensure visits had been provided only as ordered by the physician in 4 of	G 0156	An all staff meeting will be held on 9/9/15 to go over findings with staff All current patient charts will be reviewed to ensure plans of care are revised to include all	08/29/2015

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	12 records reviewed (See G 158); failed to ensure plans of care were revised that included all medications, all durable medical equipment / supplies, pertinent diagnoses, correct date of verbal orders at recertification for 11 of 12 records reviewed (See G 159); failed to ensure that the physical and occupational therapist notified the physician in relation to a delay in the physical therapy assessment for 4 of 12 records reviewed (See G 164); and failed to ensure that the Skilled Nursing and Medical Social Worker put verbal orders in writing, signed, and dated with the receipt for ordered services for 3 of 12 records reviewed. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision.		medications, durable medical equipment/supplies, pertinent diagnosis and correct orders DON/designee will continue to review charts for compliance 15 charts per week Physician notification of delayed start of care and verbal orders will also be reviewed on an on-going basis DON/designee to monitor 15 charts per week on-going DON/designee will in-service all professional staff on requirement to update (as applicable) medication profile, home health aide care plan, diagnosis, DME at least every sixty (60) days or whenever there are changes	
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 clinical record and policy review and interview, the agency failed to	G 0158	Staff meeting was held with staff on 8/24/15 and frequencies were	09/09/2015

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	ensure visits had been provided only as ordered by the physician in 4 of 12 records reviewed. (# 1, 2, 3, and 8) Findings include: 1. Clinical record number 1, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, that identified skilled nursing visits were to be provided one time a week for one week, two times a week for six weeks, one time a week for two weeks and physical therapy visits were to be provided two times a week for six weeks starting 07/05/15. a. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nurse visit during week two and four. The skilled nurse failed to follow the physician ordered plan of care. b. Upon review of the physical therapy visit notes, the clinical record failed to evidenced two physical therapy visits during week four and a second visit during week five. The physical therapist failed to follow the physician ordered plan of care. 2A. Clinical record number 2, SOC 4/28/15, included a plan of care		discussed. Frequencies were discussed with Home Health Aides at the 8/17/15 meeting. Frequencies will be discussed again at All staff meeting 9/9/15. DON/designee will review frequencies with chart review by monitoring 15 per week ongoing 15 charts per week was selected for review due to this is more than 10% and would guarantee that each chart would get reviewed at least every 30 days This tag involves multiple disciplines that are not exclusively our staff, it will take until 9/9/15 to fully implement this tag correction The system would not take 9/9/15 as a completion date	

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	established by the physician for the certification period 04/28/15 to 06/26/15, with orders for skilled nursing at least every 30 days and home health aide visits three times a week for eight weeks for one hour per day. On 05/26/15, HHA (home health aide) frequency and days was increased to five days a week up to three hours per visit. a. The skilled nurse made a visit on 5/13/15 and on 06/25/15. Upon review of the skilled nursing visit notes, the clinical record failed to evidence that skilled nursing visits were made within 30 days per the plan of care. b. Upon review of the home health aide visit notes, the home health aide made 2 visits to the patient's home on 06/25/15. The home health aide failed to follow the physician ordered plan of care. 2B. Clinical record number 2 evidenced another plan of care established by the physician for the certification period of 06/27/15 to 08/26/15, with orders for home health aide services four days a week up to three hours per day. Upon review of the home health aide visit notes, the home health aide made visits five days during week two and week three. The home health aide failed to			

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	follow the physician ordered plan of care. 3. Clinical record number 8, included a plan of care established by the physician for the certification period 02/27/15 to 04/27/15, that evidenced a clarification order on 03/20/15, that identified skill nursing visits were to be provided one time a week for one week, two times a week for six weeks, then one time a week for two weeks and home health aide visits were to be provided one time a week for one week then two times a week for seven weeks. a. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nursing visit during week five and week nine. The skilled nurse failed to follow the physician ordered plan of care. b. Upon review of the home health aide visit notes, the clinical record failed to evidenced a second home health aide visit during week four and evidenced two home health aide visits during week nine that was not ordered. The home health aide failed to follow the physician ordered plan of care. 4. Employee A, Administrator / Registered Nurse, was interviewed on 08/04/15 at 3:30 PM. Employee A			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	acknowledged clinicians were not following the plan of care in regards to frequencies as ordered. 5. An undated policy titled Care Plans indicated, "Purpose: To assure continuity and consistency between the disciplines providing care under the current plan, To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals, and To provide updated, coordinated document that reflects the current home care services ... "			
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 observation, clinical record and policy review and interview, the agency failed to ensure plans of care were revised that included all medications, all durable medical equipment / supplies,	G 0159	An All Staff meeting will be held 9/9/15 All Care Plans will be reviewed and updated. A new form will be utilized for home health aide care plans DON/designee will rein-service	08/29/2015

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	157653	A. BUILDING 00 B. WING	08/05/2015

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	pertinent diagnoses, correct date of verbal orders at recertification for 11 of 12 records reviewed. (# 1 - 8, 10 - 12) Findings include: 1. Clinical record number 1, SOC (start of care) 6/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, with a primary diagnosis of Pressure Ulcer to the buttock and other pertinent diagnoses of Pressure Ulcer Stage II, Muscle weakness, dependent on supplemental oxygen and long term use of aspirin. Hospital discharge paperwork dated 06/25/15, indicated the patient had a diagnoses of Acute on Chronic diastolic CHF (Congestive Heart Failure), Exacerbation of COPD (Chronic Obstructive Pulmonary Disease), history of atrial fibrillation, pulmonary embolism, pulmonary nodules, aortic stenosis, coronary artery disease, angina, cellulitis of female breast, chronic hypertension, chronic respiratory failure, chronic kidney disease, and neuropathy. The plan of care failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services. 2. Clinical record number 2, SOC		professional staff on requirement to follow MD ordered Plan Of Care When something is outside the Plan of Care staff will notify the MD of the situation and document in the patients chart DON/designee will monitor 15 charts weekly	

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	04/28/15, included a plan of care established by the physician for the certification period of 04/28/15 to 06/25/15, for skilled nursing every 30 days to evaluate Cardiopulmonary status, evaluate nutrition / hydration, evaluate for signs and symptoms of infection, teach disease process, teach diet, medication teaching, pulse oximetry as needed, teach patient pressure relief, and teach patient pain relief. The plan of care also included home health aide services three times a week for eight weeks up to one hour to check vitals, shower, personal care, assist with dressing, hair care, skin care, check for pressure areas, use device for gait, assist with feeding as needed, wash clothes as needed and housekeeping. A signed physician's order dated 05/26/15, indicated the home health aide hours had been increased to three hours per day. a. On 7/30/15 at 11:50 AM, the patient's home was observed. The patient resides in a Medicaid Assisted Living home where meals and medication administration is provided. The patient's home was observed to be small, one room, with just a bed, plastic chair, closet and bathroom. There was no microwave or stove. b. On 7/30/15 at 11:55 AM, the			

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	significant other was interviewed. The significant other stated the home health aide assisted the patient with showers, cleans up the bathroom after the showers, sets out clothes for the patient to wear, and sometimes did a little bit of walking and exercise with the patient. The significant other stated the home health aide comes daily for three hours. c. Upon departure of the patient's home on 7/30/15, Employee A, RN-Administrator was interviewed. Employee A stated the home health aide duties included bathing and assist with the patient's laundry but there was only one washer and dryer for the entire facility. Employee A stated she was not aware that the patient was receiving a home health aide up to three hours for each visit and stated that she would need to look into why the patient is there for three hours a day. d. Patient's number 2 record was reviewed on 08/03/15. A skilled nursing visit note dated 05/13/15, indicated the patient vital signs were within the call order parameters, no pain, lungs clear, skin intact, denial of nausea and vomiting, and no urine frequency or dysuria. Skilled nursing interventions provided were education on diabetes such as disease process, importance of			

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	checking feet, skin care, recognition of breakdown and impaired circulation. There were no changes to the home health aide care plan. The clinical record failed to evidence an assessment of decline in the patient's functional status to warrant an increase in hours with Medicaid. 3. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, with a primary diagnosis of aftercare joint replace and other pertinent diagnoses of joint replaced hip and lack of coordination. The DME (durable medical equipment) section was left blank. The medication section only indicated the patient was taking Miralax by mouth twice a day. a. During a home visit on 7/30/15 at 3:45 PM, the patient was observed to be utilizing a walker. The spouse had indicated the patient had a motor vehicle accident last fall and obtained a hip fracture at that time. Spouse indicated that he / she had been in a facility and the patient had functionally declined during his / her departure. b. A form called "Face to Face			

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	Attestation Form" indicated the primary reason for home health care was fractured right hip, labile hypertension, edema, and weakness. The form also indicated the patient had weakness, fatigue, shortness of breath, and / or activity intolerance, confusion and / or impaired decision making processes, history and / or risk of falls. c. A physician visit note dated 05 /13/15, indicated the patient had diagnoses of non-insulin dependent diabetes, hypertension, hyperlipidemia, cerebral vascular accident, malignant tumor in his job bone, depression, hypothyroidism, and dementia. The visit note also indicated the patient was taking amlodipine 5 MG (milligrams) by mouth daily, aspirin 81 MG by mouth daily, atorvastatin 10 MG by mouth daily, clopidogrel 75 MG by mouth daily, levothyroxine 50 MCG (micrograms) by mouth daily, oxybutin 5 MG by mouth daily, Polyethylene Glycol 1000 powder, 17 grams mix with 8 ounces of liquid every morning, sertraline 50 MG by mouth daily, terazosin 2 MG by mouth at bedtime, torsemide 10 MG by mouth daily, and losartan 50 MG by mouth daily. The plan of care failed to evidence DME used in the home, all pertinent diagnoses			

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	and medications relevant to the patient's care while on home health services. 4. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15, with a primary diagnosis of Counseling and other pertinent diagnoses of long term use meds NEC (not elsewhere classified), chronic airway obstruction NEC, osteoporosis NOS (not otherwise specified), hypertension NOS. The DME (durable medical equipment) section was left blank. a. During a home visit on 7/31/15 at 2:15 PM, Employee A stated that the patient had been very ill and had came a long way since being on their services. The patient had indicated she had been vomiting since January 2015 and had his / her gallbladder removed on 07/07/15. The patient also stated that he / she had been in the hospital two other times since then for infection and pneumonia. A shower chair, grab bars, walker / rollator, and a hospital bed was observed to be in the patient's home. b. Patient number 4's record was reviewed on 08/03/15. A referral form dated 07/14/15, indicated the patient had neuropathy, hypertension,			

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	hyperlipidemia, edema, chronic kidney disease stage three, carotid stenosis, hyperkalemia, renal arterial stenosis with status post stent placement and coronary artery disease with status post coronary artery bypass graft. A hospital discharge summary dated 07/15/15, indicated the patient has a past medical history of, but not limited to congestive heart failure, hypertension, osteoporosis, gastroesophageal reflux disease, chronic obstructive pulmonary disease, chronic kidney disease, nephrolithiasis, dementia, hyperglycemia, muscle spasms, and status post laparoscopic choleecystectomy. The plan of care failed to evidence DME used in the home and all pertinent diagnoses relevant to the patient's care while on home health services. 5. Clinical record number 5, SOC 06/02/15, included a plan of care established by the physician for the certification period 06/02/15 to 07/31/15, with a primary diagnosis of an open wound of hip/thigh and other diagnoses of Muscle weakness, other lymphadema, and cellulitis of leg. The plan of care medication list included atarax, torsemide, and cymbalta. a. During a home visit on 7/30/15			

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	at 3:45 PM, the patient was observed to have a wound to the posterior left lower leg that was receiving treatment. The patient stated that he use to take a lot of medication. b. Patient number 5's clinical record was reviewed on 08/04/25. A form called Face to Face Attestation and a podiatry visit note dated 06/12/15, indicated that patient's diagnoses were ulcer of the lower leg related to ischemia and venous stasis ulcer. The podiatry visit note also indicated the patient has a history of cellulitis and the medications included ascorbic acid, atarax, colace, cymbalta, florastor, gabapentin, norco, potassium chloride, and torsemide. The plan of care failed to evidence all pertinent diagnoses and medications relevant to the patient's care while on home health services. 6. Clinical record number 6, SOC 10/28/14, included a plan of care established by the physician for the certification period of 12/27/14 to 02/24/15, with a primary diagnosis of digestive system symptom, diabetes mellitus type 2, myalgia / myositis, and anxiety. Patient number 6's clinical record was			

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	reviewed on 08/04/15. A skilled nursing note dated 12/24/14, indicated the patient was having pain and having difficulty lifting her arms without pain and weakness. The patient suffered from visual and auditory impairment. The plan of care failed to be updated and reflect the patient's current status upon recertification. 7. Clinical record number 7, SOC 02/04/15, included a plan of care established by the physician for the certification period of 02/04/15 to 04/04/15, with a primary diagnosis of lack of coordination and other pertinent diagnosis of muscle weakness. Patient number 7's clinical record was reviewed on 08/04/15. A referral form dated 02/03/15, indicated the patient had diagnoses of "breast cancer, blood pressure [sic], hearing implants, arthritis, low back [sic], trouble up from chair, general weakness, hip trouble pain." The plan of care failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services. 8. Clinical record number 8, SOC 10/30/14, included a plan of care			

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	established by the physician for the certification period of 02/27/15 to 04/27/15, with a diagnosis of counseling and other pertinent diagnoses of muscle weakness, debility, chronic airway obstruction, arthropathy, scoliosis, and cirrhosis of the liver. a. Patient number 8's clinical record was reviewed on 08/04/15. A referral form dated 10/20/14, indicated the patient has a history of falls, hepatitis C, cirrhosis of the liver, arthritis, scoliosis, chronic obstructive pulmonary disease, sleep apnea, hypertension, and low platelets. b. Plan of cares established by the physician for certification periods of 10/30/14 to 12/28/14, 12/29/14 to 02/26/15, 2/27/15 to 4/28/15 to 6/26/15, continued to have the same primary and other pertinent diagnosis. Line 23 of all of the plan of cares indicated that the verbal order was obtained on 10/30/14. The interventions indicated that the skilled nurse would "evaluate cardiopulmonary status, evaluate nutrition/hydration, evaluate for signs and symptoms of infection, teach disease process teach diet, medication teaching, medication setup, pulse oximetry as needed, teach patient pain control mechanisms, enforce fall precautions,			

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	and perform medication set up." Goals included "demonstrates compliance with medication (s) by end of cert, stabilize cardiovascular pulmonary condition by end of cert, demonstrates competence with medical regime by end of cert ... Pt will be able to participate more effectively with activities of daily living once [illegible word / abbreviation] is controlled; debilitating effects of hypertension, anemia [sic] is corrected with med regimen." c. The clinical record evidence a social service initial assessment visit was made on 02/20/15, with documentation indicating that 1-2 more visits would be made with the patient. Social service visits was made on 03/12/15 and 04/27/15. The plan of cares failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services, failed to update the date of the verbal order at each recertification period, failed to include social services, and failed to update skilled nursing interventions and goals. 9. Clinical record number 10 SOC 10/29/14, included a plan of care established by the physician for certification period of 10/29/14 to			

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	12/27/14, with a primary diagnosis of diabetes type 2 and other pertinent diagnoses of chronic pain. a. Patient number 10's clinical record was reviewed on 08/03/15. A comprehensive assessment dated 10/29/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease, history of falls, obesity, anxiety, gastroesophageal reflux, chronic pain related to sciatica pain, and depression. b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/28/14 to 02/25/15, 2/26/15 to 4/27/15, indicated that the verbal order was obtained by Employee A on 10/29/14. The plan of cares failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 10. Clinical record number 11 SOC 10/30/14, included a plan of care established by the physician for certification period of 10/30/14 to 12/28/14, with a primary diagnosis of muscle weakness and other pertinent			

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	diagnoses of abnormality of gait and joint pain. a. Patient number 11's clinical record was reviewed on 08/03/15. A comprehensive assessment dated 10/30/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease, history of falls, anxiety, and depression. b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/29/14 to 02/26/15, 2/27/15 to 4/27/15, indicated that the verbal order was obtained on 10/30/14. The plans of care failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 11. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for certification periods of 12/29/14 to 02/26/15 and 02/27/15 to 04/27/15. Line 23 of the plans of care indicated that the verbal order was obtained on 10/30/14. The verbal order date failed to be updated			

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	upon each recertification period on the plans of care. 12. Employee A, Administrator / Registered Nurse, was interviewed on 8/04/15 at 3:30 PM. Employee A stated she was aware that goals and interventions should be updated at every certification period and was not aware that all pertinent diagnoses should be included in the plan of care. 13. An undated policy titled Care Plans indicated "The Care Plan shall be reviewed, evaluated, and revised (minimally every sixty (60) days and as needed) based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. The Care Plan shall include, but not limited to: Nursing diagnosis(es) / problems and needs identified; Reasonable, measurable, and realistic goals as determined by the assessment and client expectations; A list of specific interventions with plans of implementation; and Indicators for measuring goal achievement and identified time frames ... " 14. An undated policy titled Plan of Care indicated "The Plan of Care shall be			

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	completed in full to include: All pertinent diagnosis(es), principle and secondary ... Type, frequency, and duration of all visits / services ... Medications, treatments ... Medical supplies and equipment required ... Treatment goals ... "			
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 clinical record and policy review and interview, the agency failed to ensure that the physical and occupational therapist followed company policy and notified the physician of the delay in the therapy assessments for 4 of 12 records reviewed. (# 1, 3, 7, 12) Findings include: 1. Clinical record number 1, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 06/25/15 indicated for the patient to have a physical therapy evaluation. Upon reviewing the physical therapy visit	G 0164	All current charts will be reviewed for delays in start of care DON/designee will review 15 charts weekly DON/designee to in-service professional staff on requirement to complete admission or evaluation within forty eight (48) hours of obtaining physicians order If not able to complete the admission or evaluation within forty eight hours, MD will be notified and reason documented DON/designee will monitor 15 charts per week for compliance	08/29/2015

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	notes, the clinical record evidence the physical therapist did not see the patient until 07/02/15. The physical therapist failed to notify the physician of the delay of assessment / services. 2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 05/13/15 indicated for the patient to have a physical therapy evaluation. Upon reviewing the physical therapy visit notes, the clinical record evidence the physical therapist did not see the patient until 07/06/15. The physical therapist failed to notify the physician of the delay of assessment / services. 3. Clinical record number 7, SOC 02/04/15, included a plan of care established by the physician for the certification period of 02/04/15 to 04/04/15. A Face to Face Attestation dated 02/12/15 indicated for the patient to have an occupational therapy evaluation. Upon reviewing the physical therapy visit notes, the clinical record evidence the occupational therapist did not see the patient until 02/10/15. The occupational therapist failed to notify the physician for the delay of assessment / services.			

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	157653	A. BUILDING 00 B. WING	08/05/2015

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	4. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for the certification period of 10/30/14 to 12/27/14 with orders for skilled nursing and physical therapy. An agency referral form dated 10/29/14, indicated for the patient to have a physical therapy evaluation. Upon reviewing the physical therapy visit notes, the clinical record evidence the physical therapist did not see the patient until 11/03/14. The physical therapist failed to notify the physician for the delay of assessment / services. 5. Employee A, Administrator / Registered Nurse was interviewed on 08/03/15 at 10:43 AM. Employee A stated therapy had 48 hours to perform an initial assessment after the start of care. Employee A stated she was aware of the delay of services but was not aware of the physicians not being notified by the clinicians. 6. An undated policy titled Plan of Care indicated, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ... " 7. An undated policy titled Physical			

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	Therapist indicated "Completes initial assessments within forty eight (48) hours of referral unless other arrangements are made ... communicates plans and changes to the physician and to the client Case Manager and other caregivers through the care plan, progress notes ... Communicates changes in schedule and physician orders to the office on the day the changes are made ... "			
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 clinical record review, policy review and interview, the agency failed to ensure that the Skilled Nursing and Medical Social Worker put verbal orders in writing, signed, and dated with the receipt for ordered services for 3 of 12 records reviewed. (#3, 8, 12)	G 0166	All current charts are being reviewed for SN/MSW missed verbal orders by DON/designee. Routine charts are being reviewed by DON/designee DON/designee will in-service SN/MSW on requirement to write verbal orders on MD order sheet to be sent to MD for signature	08/29/2015

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	Findings include: 1. Clinical record number 3, SOC (start of care) 06/25/15, included a plan of care established by the physician for certification period 06/25/15 to 08/23/15. Upon review of the established plan of care, line 23 indicated "Nurse's signature and date of verbal SOC." The plan of care failed to evidence the date of the verbal start of care by Employee B, Director of Clinical Services. 2. Clinical record number 8, SOC 10/30/14 included a plan of care established by the physician for certification period 02/27/15 to 04/27/15. The clinical record evidence a Medical Social Worker assessment dated 02/20/15. The assessment indicated the social worker planned to see the patient for one to two more visits within the certification period and that the physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing services. 3. Clinical record number 12, SOC 10/30/14 included a plan of care established by the physician for certification period of 12/29/14 to		and date, DON/designee will monitor with 15 random charts per month	

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	02/26/15. The clinical record evidence a Medical Social Worker assessment dated 12/30/14. The assessment indicated the social worker planned to see the patient for three more visits within the certification period and that physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing services. 4. Employee A, Administrator / Registered Nurse was interviewed on 08/04/15 at 3:45 PM. Employee A stated she was not aware the medical social worker had not wrote the orders for ongoing services. 5. An undated policy titled Physician Orders indicated "When the nurse or therapist receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature ... "			
G 0168 Bldg. 00	484.30 SKILLED NURSING SERVICES			

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	Based on clinical record, agency policy review and interview, the Registered Nurse failed to ensure visits had been provided only as ordered by the physician in 3 of 10 records reviewed for skilled nursing (See G 170); failed to ensure plans of care were revised that included all medications, all durable medical equipment / supplies, pertinent diagnoses, correct date of verbal orders at recertification for 11 of 12 records reviewed (See G 173); and failed to ensure their efforts were coordinated and documented effectively with other home health agencies that were furnishing services for 3 of 3 records reviewed. 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.	G 0168	All current charts are being reviewed for compliance to frequency, plan of care revision and correct date of recertification DON/designee will in-service professional staff on requirement to follow visit frequency as ordered by the physician on Plan of Care by 9/9/15 DON/designee to in-service professional staff on requirement to update Plan of Care as MD orders change based on patients status by 9/9/15 DON/designee will in-service professional staff on importance of making sure recertification dates on Plan of Care are correct by 9/9/15 one in-service was completed on 8/17/15 DON/designee will monitor 15 charts per week on-going 15 charts per week was selected for review due to this is more than 10% and would guarantee that each chart would get reviewed at least every 30 days	08/29/2015
G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record agency policy review and interview, the Registered Nurse failed to ensure visits had been provided only as ordered by the physician in 3 of 10 records reviewed for skilled nursing. (# 1, 2, 8)	G 0170	All current charts are being reviewed for compliance to frequency, plan of care revision and correct date of recertification Issues found will be addressed with staff DON/designee will in-service professional staff on requirement	08/29/2015

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	Findings include: 1. Clinical record number 1, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, that identified skilled nursing visits were to be provided one time a week for one week, two times a week for six weeks, one time a week for two weeks. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nurse visit during week two and four. 2. Clinical record number 2, SOC 4/28/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/25/15, with orders for skilled nursing at least every 30 days. The skilled nurse made a visit on 5/13/15 and on 06/25/15. Upon review of the skilled nursing visit notes, the clinical record failed to evidence that skilled nursing visits was made within 30 days per the plan of care. 3. Clinical record number 8, included a plan of care established by the physician for the certification period 02/27/15 to 04/27/15, that evidenced a clarification order on 03/20/15, that identified skill nursing visits were to be provided one time a week for one week, two times a		to follow visit frequency as ordered by MD on Plan of Care DON/designee will monitor 15 charts per week	

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	week for six weeks, then one time a week for two weeks. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nursing visit during week five and week nine. 4. Employee A, Administrator / Registered Nurse, was interviewed on 08/04/15 at 3:30 PM. Employee A acknowledged clinicians were not following the plan of care in regards to frequencies as ordered. 5. An undated policy titled Care Plans indicated, "Purpose: To assure continuity and consistency between the disciplines providing care under the current plan, To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals, and To provide updated, coordinated document that reflects the current home care services ... "			
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 observation, clinical record and policy review, and interview, the Registered Nurse failed to ensure plans of	G 0173	All current charts are being reviewed to ensure plans of care were reviewed to include meds, equipment/supplies, pertinent	08/29/2015

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	care were revised that included all medications, all durable medical equipment / supplies, pertinent diagnoses, correct date of verbal orders at recertification for 11 of 12 records reviewed. (# 1 - 8, 10 - 12) Findings include: 1. Clinical record number 3, SOC 06/26/15 included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, with a primary diagnosis of aftercare joint replace and other pertinent diagnoses of joint replaced hip and lack of coordination. The DME (durable medical equipment) section was left blank. The medication section only indicated the patient was taking Miralax by mouth twice a day. a. During a home visit on 7/30/15 at 3:45 PM, the patient was observed to be utilizing a walker. The spouse had indicated the patient had a motor vehicle accident last fall and obtained a hip fracture at that time. The spouse indicated that he / she had been in a facility and the patient had functionally declined during his / her departure. b. A form called "Face to Face Attestation Form" indicated the primary		diagnosis, correct date of verbal orders DON/designee will in-service all professional staff to update (as applicable) medication profile, home health aide care plan, diagnosis, DME/supplies at least every 60 days or whenever there are changes (on-going) Don/designee will monitor 15 charts per week	

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	reason for home health care was a fractured right hip, labile hypertension, edema, and weakness. The form also indicated the patient had weakness, fatigue, shortness of breath, and / or activity intolerance, confusion and / or impaired decision making processes, history and / or risk of falls. c. A physician visit note dated 05 /13/15, indicated the patient had diagnoses of non-insulin dependent diabetes, hypertension, hyperlipidemia, cerebral vascular accident, malignant tumor in his job bone, depression, hypothyroidism, and dementia. The visit note also indicated the patient was taking amlodipine 5 MG (milligrams) by mouth daily, aspirin 81 MG by mouth daily, atorvastatin 10 MG by mouth daily, clopidogrel 75 MG by mouth daily, levothyroxine 50 MCG (micrograms) by mouth daily, oxybutin 5 MG by mouth daily, Polyethylene Glycol 1000 powder, 17 grams mix with 8 ounces of liquid every morning, sertraline 50 MG by mouth daily, terazosin 2 MG by mouth at bedtime, torsemide 10 MG by mouth daily, and losartan 50 MG by mouth daily. The Registered Nurse failed to evidence DME used in the home, all pertinent diagnoses and medications relevant to the			

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	patient's care while on home health services. 2. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15, with a primary diagnosis of Counseling and other pertinent diagnoses of long term use meds NEC (not elsewhere classified), chronic airway obstruction NEC, osteoporosis NOS (not otherwise specified), hypertension NOS. The DME (durable medical equipment) section was left blank. a. During a home visit on 7/31/15 at 2:15 PM, Employee A stated that the patient had been very ill and had came a long way since being on their services. The patient had indicated she had been vomiting since January 2015 and had his / her gallbladder removed on 07/07/15. The patient also stated that he / she had been in the hospital 2 other times since then for infection and pneumonia. A shower chair, grab bars, walker / rollator, and a hospital bed was observed to be in the patient's home. b. Clinical record number 4 was reviewed on 08/03/15. A referral form dated 07/14/15, indicated the patient had neuropathy, hypertension,			

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	hyperlipidemia, edema, chronic kidney disease stage 3, carotid stenosis, hyperkalemia, renal arterial stenosis with status post stent placement and coronary artery disease with status post coronary artery bypass graft. A hospital discharge summary dated 07/15/15, indicated the patient has a past medical history of, but not limited to congestive heart failure, hypertension, osteoporosis, gastroesophageal reflux disease, chronic obstructive pulmonary disease, chronic kidney disease, nephrolithiasis, dementia, hyperglycemia, muscle spasms, and status post laparoscopic choleecystectomy. The Registered Nurse failed to evidence DME used in the home and all pertinent diagnoses relevant to the patient's care while on home health services. 3. Clinical record number 5, SOC 06/02/15, included a plan of care established by the physician for the certification period 06/02/15 to 07/31/15, with a primary diagnosis of an open wound of hip/thigh and other diagnoses of Muscle weakness, other lymphadema, and cellulitis of leg. The plan of care medication list included atarax, torsemide, and cymbalta. a. During a home visit on 7/30/15			

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	at 3:45 PM, the patient was observed to have a wound to the posterior left lower leg that was receiving treatment. The patient stated that he use to take a lot of medication. b. Clinical record number 5 was reviewed on 08/04/25. A form called Face to Face Attestation and a podiatry visit note dated 06/12/15, indicated that patient's diagnoses were ulcer of the lower leg related to ischemia and venous stasis ulcer. The podiatry visit note also indicated the patient has a history of cellulitis and the medications included ascorbic acid, atarax, colace, cymbalta, florastor, gabapentin, norco, potassium chloride, and torsemide. The Registered Nurse failed to evidence all pertinent diagnoses and medications relevant to the patient's care while on home health services. 4. Clinical record number 6, SOC 10/28/14, included a plan of care established by the physician for the certification period of 12/27/14 to 02/24/15, with a primary diagnosis of digestive system symptom, diabetes mellitus type 2, myalgia / myositis, and anxiety. Clinical record number 6 was reviewed			

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	on 08/04/15. A skilled nursing note dated 12/24/14, indicated the patient was having pain and having difficulty lifting her arms without pain and weakness. The patient suffered from visual and auditory impairment. The Registered Nurse failed to update the plan of care and reflect the patient's current status upon recertification. 5. Clinical record number 7, SOC 02/04/15, included a plan of care established by the physician for the certification period of 02/04/15 to 04/04/15, with a primary diagnosis of lack of coordination and other pertinent diagnosis of muscle weakness. Clinical record number 7 was reviewed on 08/04/15. A referral form dated 02/03/15, indicated the patient had diagnoses of "breast cancer, blood pressure [sic], hearing implants, arthritis, low back [sic], trouble up from chair, general weakness, hip trouble pain." The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services. 6. Clinical record number 8, SOC 10/30/14, included a plan of care			

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	established by the physician for the certification period of 02/27/15 to 04/27/15, with a diagnosis of counseling and other pertinent diagnoses of muscle weakness, debility, chronic airway obstruction, arthropathy, scoliosis, and cirrhosis of the liver. a. Clinical record number 8 was reviewed on 08/04/15. A referral form dated 10/20/14, indicated the patient has a history of falls, hepatitis C, cirrhosis of the liver, arthritis, scoliosis, chronic obstructive pulmonary disease, sleep apnea, hypertension, and low platelets. b. Plan of cares established by the physician for certification periods of 10/30/14 to 12/28/14, 12/29/14 to 02/26/15, 2/27/15 to 4/28/15 to 6/26/15, continued to have the same primary and other pertinent diagnosis. Line 23 of all of the plan of cares indicated that the verbal order was obtained on 10/30/14. The interventions indicated that the skilled nurse would "evaluate cardiopulmonary status, evaluate nutrition/hydration, evaluate for signs and symptoms of infection, teach disease process teach diet, medication teaching, medication setup, pulse oximetry as needed, teach patient pain control mechanisms, enforce fall precautions, and perform medication set up." Goals			

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	included "demonstrates compliance with medication (s) by end of cert, stabilize cardiovascular pulmonary condition by end of cert, demonstrates competence with medical regime by end of cert ... Pt will be able to participate more effectively with activities of daily living once [illegible word / abbreviation] is controlled; debilitating effects of hypertension, anemia [sic] is corrected with med regimen." c. The clinical record evidence a social service initial assessment visit was made on 02/20/15, with documentation indicating that 1-2 more visits would be made with the patient. Social service visits was made on 03/12/15 and 04/27/15. The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services, failed to update the date of the verbal order at each recertification period, failed to include social services, and failed to update skilled nursing interventions and goals. 7. Clinical record number 10 SOC 10/29/14, included a plan of care established by the physician for certification period of 10/29/14 to 12/27/14, with a primary diagnosis of			

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	157653	A. BUILDING 00 B. WING	08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RN2U INC	9731 NORTH KITCHEN ROAD MOORESVILLE, IN 46158

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	diabetes type 2 and other pertinent diagnoses of chronic pain. a. Clinical record number 10 was reviewed on 08/03/15. A comprehensive assessment dated 10/29/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease, history of falls, obesity, anxiety, gastroesophageal reflux, chronic pain related to sciatica pain, and depression. b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/28/14 to 02/25/15, 2/26/15 to 4/27/15, indicated that the verbal order was obtained by Employee A on 10/29/14. The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 8. Clinical record number 11 SOC 10/30/14, included a plan of care established by the physician for certification period of 10/30/14 to 12/28/14, with a primary diagnosis of muscle weakness and other pertinent diagnoses of abnormality of gait and joint			

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	pain. a. Clinical record number 11 was reviewed on 08/03/15. A comprehensive assessment dated 10/30/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease, history of falls, anxiety, and depression. b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/29/14 to 02/26/15, 2/27/15 to 4/27/15, indicated that the verbal order was obtained on 10/30/14. The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 9. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for certification periods of 12/29/14 to 02/26/15 and 02/27/15 to 04/27/15. Line 23 of the plan of care indicated that the verbal order was obtained on 10/30/14. The Registered Nurse failed to update the verbal order upon each recertification			

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	period on the plans of care. 12. Employee A, Administrator / Registered Nurse, was interviewed on 7/31/15. Employee A stated she was aware that goals and interventions should be updated at every certification period and was not aware that all pertinent diagnoses should be included in the plan of care. 13. An undated policy titled Care Plans indicated "The Care Plan shall be reviewed, evaluated, and revised (minimally every sixty (60) days and as needed) based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. The Care Plan shall include, but not limited to: Nursing diagnosis(es) / problems and needs identified; Reasonable, measurable, and realistic goals as determined by the assessment and client expectations; A list of specific interventions with plans of implementation; and Indicators for measuring goal achievement and identified time frames ... " 14. An undated policy titled Plan of Care indicated "The Plan of Care shall be completed in full to include: All			

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	pertinent diagnosis(es), principle and secondary ... Type, frequency, and duration of all visits / services ... Medications, treatments ... Medical supplies and equipment required ... Treatment goals ... "			
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 observation, clinical record and policy review and interview, the Registered Nurse failed to ensure their efforts were coordinated and documented effectively with other home health agencies that were furnishing services for 3 of 3 records reviewed. (#1, 3, 4) Findings include: 1. Clinical record number 1, SOC (start of care) 6/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During clinical record review on 07/30/15, a typed piece of paper signed and dated by Employee A, Administrator / Registered Nurse, on 06/25/15 indicated "SN [skilled nurse] was informed that pt	G 0176	All patients currently being seen by other agencies will be reviewed, agency will be contacted and documented In the future agencies will be contacted and documented on admission, resumption, recertification, changes and discharge DON/designee will in-service all admit staff on requirement to contact other agencies involved in care of the patient at admission, resumption, recertification, change or discharge DON/designee to monitor 15 charts weekly	08/29/2015

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	[patient] has a MCD [Medicaid] company in home as well. SN called [Name of Agency] and informed of Medicare admit for skilled needs. Receptionist will call back if any needs noted after communicated to RN." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During a home visit on 07/30/15 at 3:55 PM, the patient was observed to have an aide from another home health company in the home. Employee A, Administrator / RN, stated that the patient has 24 hour care in their home. The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 3. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15. During clinical record review on 08/03/15, a typed piece of paper signed and dated by Employee A on 07/16/15, indicated "Communication with MCD (Medicaid) HHC (Home Health Company) in home as well. SN (skilled			

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	nurse) called [Name of Agency] and left a message for [Name of personnel] and informed of Medicare admit for skilled needs. [Name of personnel] to call back if any questions." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 4. Employee A, Administrator / Registered Nurse, was interviewed during the Entrance Conference on 07/29/15, from 12:30 PM to 12:50 PM. Employee A stated he / she would notify the outside agencies that were also providing services upon admission and as needed. 5. An undated policy titled Coordination of Client Services indicated, "After initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure ... Coordination with other agencies and institutions ... "			
G 0186 Bldg. 00	484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on clinical record review and interview, the physical therapist failed to	G 0186	All current Physical Therapy charts are being reviewed by	08/29/2015

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	follow the plan of care for 1 of 12 records reviewed; failed to follow company policy on assessing patients within 48 hours after the start of care for 4 of 12 records reviewed; and failed to notify the physician of the delay in assessments for 4 of 12 records reviewed. (# 1, 3, 7, 12) Findings include: 1. Clinical record number 1, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 06/25/15 indicated for the patient to have a physical therapy evaluation. a. Upon review of the physical therapy visit notes, the clinical record evidenced the physical therapist did not see the patient until 07/02/15. The physical therapist failed to assess the patient within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services. b. Upon review of the physical therapy careplan, the physical therapist were to be provided two times a week for six weeks starting 07/05/15. The clinical record failed to evidenced two physical therapy visits during week four and a second visit during week five.		DON/designee for following of POC-48 hour assessment and delay of assessment to be called to MD DON/designee will in-service professional staff on requirement to follow visit frequency as ordered by MD on Plan of Care DON/designee to in-service professional staff on requirement to complete admission or evaluation within forty eight (48) hours of receiving order If not able to complete within forty eight (48) hours, MD must be notified and reason/MD conversation documented DON/designee to monitor all admits each week	

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2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 05/13/15 indicated for the patient to have a physical therapy evaluation.

a. Upon review of the physical therapy visit notes, the clinical record evidence the physical therapist did not see the patient until 07/06/15. The physical therapist failed to assess the patient within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services.

b. Upon review of the physical therapy visit notes, the physical therapy visits were to be provided two times a week for six weeks starting 07/13/15. The clinical record failed to evidenced two physical therapy visits during week four.

3. Clinical record number 7, SOC 02/04/15 included a plan of care established by the physician for the certification period of 02/04/15 to 04/04/15. A Face to Face Attestation dated 02/12/15 indicated for the patient to have an occupational therapy evaluation. Upon review of the

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	occupational therapy notes, the clinical record evidenced the occupational therapist did not see the patient until 02/10/15. The occupational therapist failed to assess the patient within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services. 4. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for the certification period of 10/30/14 to 12/27/14. An agency referral form dated 10/29/14, indicated for the patient to have a physical therapy evaluation. Upon review of the physical therapy notes, the clinical record evidenced the physical therapist did not see the patient until 11/03/14. The physical therapist failed to assess the patient within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services. 5. Employee A, Administrator / Registered Nurse was interviewed on 08/03/15 at 10:43 AM. Employee A stated therapy had 48 hours to an initial assessment after the start of care. Employee A stated she was aware of the delay of services but was not aware of the physicians not being notified by the clinicians.			

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	6. An undated policy titled Plan of Care indicated, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ... " 7. An undated policy titled Physical Therapist indicated "Completes initial assessments within forty eight (48) hours of referral unless other arrangements are made ... communicates plans and changes to the physician and to the client Case Manager and other caregivers through the care plan, progress notes ... Communicates changes in schedule and physician orders to the office on the day the changes are made ... "			
G 0196 Bldg. 00	484.34 MEDICAL SOCIAL SERVICES The social worker participates in the development of the plan of care. Based on clinical record review, policy review and interview, the agency failed to ensure that the Skilled Nursing and Medical Social Worker put verbal orders in writing, signed, and dated with the date of receipt for ordered services for 2 of 2 records reviewed. (# 8, 12)	G 0196	All current charts are being reviewed by DON/designee for SN/MSW verbal orders- written, signed and dated, an with a date of receipt from the physician DON/designee will in-service SN/MSW on requirement to write verbal orders on MD order sheet to be sent to MD for signature	08/29/2015

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	Findings include: 1. Clinical record number 8, SOC 10/30/14 included a plan of care established by the physician for certification period 02/27/15 to 04/27/15. The clinical record evidence a Medical Social Worker assessment dated 02/20/15. The assessment indicated the social worker planned to see the patient for one to two more visits within the certification period and that the physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing services. 2. Clinical record number 12, SOC 10/30/14 included a plan of care established by the physician for certification period of 12/29/14 to 02/26/15. The clinical record evidence a Medical Social Worker assessment dated 12/30/14. The assessment indicated the social worker planned to see the patient for three more visits within the certification period and that physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing social		and date. Future charts will be reviewed upon admission by DON/designee	

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	worker services. 3. Employee A, Administrator / Registered Nurse was interviewed on 08/04/15 at 3:45 PM. Employee A stated she was not aware the medical social worker had not wrote the orders for ongoing social worker services. 4. An undated policy titled Physician Orders indicated "When the nurse or therapist receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature ... "			
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 clinical record review and interview, the Registered Nurse failed to establish two written patient care instructions for the home health aides who provided care in the morning and evening for 1 of 4 records reviewed. (#	G 0224	All patients charts that could be effected have been reviewed by DON/designee. Patients with more than one visit per day will have separate care plans for each visit Case Manager will be responsible for initiating the Plans of Care DON/designee will	08/29/2015

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	2) Finding include: 1. Clinical record number 2, SOC 4/28/15, included a plan of care established by the physician for the certification period 04/28/15 to 06/25/15, with orders for home health aide three times a week for eight weeks one hour a day. A physician's order dated 5/26/15, indicated the HHA (home health aide) days and hours was increased to five days a week up to three hours per day. Upon review of the home health aide visit notes, the clinical record evidenced on 06/25/15, the home health aide made two visits to the patient's home from 8:00 AM to 10:00 AM and again at 3:40 PM to 5:40 PM. Upon review of the home health aide written plan of care, only one written plan of care was established for the home health aide. The clinical record failed to evidence two written patient care instructions, one for the morning and one for the evening. 2B. Clinical record number 2 evidenced another plan of care established by the physician for the certification period of 06/26/15 to 8/25/15, with orders for home health aide services four days a week up to three hours per day.		monitor weekly	

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	On 6/30/15, the home health aide made two visits to the patient's home from 8:11 AM to 9:11 AM and 1:35 PM to 2:35 PM. On 07/02/15, the home health aide made two visits to the patient's home from 2:20 PM to 4:20 PM and 6:35 PM to 7:05 PM. Upon review of the home health aide written plan of care, only one written plan of care was established for the home health aide. The clinical record failed to evidence a two written patient care instructions, one for the morning and one for the evening. 3. Employee A, Administrator / Registered Nurse, was interviewed on 08/04/15 at 3:30 PM. Employee A acknowledged clinicians not following the plan of care in regards to frequencies as ordered. Employee A stated she was not aware that the there needed to be patient written instructions for each home health aide visit if they are going into the home more than once a day. 4. An undated policy titled Care Plans indicated "The Care Plan shall include, but not limited to: Nursing diagnosis(es) / problems and needs identified; reasonable, measurable, and realistic goals as determined by the assessment and client expectations; a list of specific interventions with plans of			

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	implementation ... "			
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 clinical record review and interview, the Home Health Aide failed to follow the written plan of care established in relation to frequency of visits for 1 of 4 records reviewed receiving home health aide services under Medicaid creating the potential to affect all patients receiving home health aide services. (#2) Findings include: 1 A. Clinical record number 2, SOC 4/28/15, included a plan of care established by the physician for the certification period 04/28/15 to 06/26/15, with orders for home health aide three times a week for eight weeks one hour a day. A physician's order dated 5/26/15, indicated the HHA (home health aide) days and hours was increased to five days a week up to three hours per day. Upon review of the home health aide visit notes, the clinical record evidenced on	G 0225	Staffing person was hired to assist with management She is being trained by Office manager and DONDON/designee will monitor compliance weekly-compliance to Medicaid hours, staff availability , 15 charts reviewed for accuracy Non-compliance will result in counseling	08/29/2015

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	157653	A. BUILDING 00 B. WING	08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RN2U INC	9731 NORTH KITCHEN ROAD MOORESVILLE, IN 46158

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	06/25/15, the home health aide made two visits to the patient's home. 1 B. Clinical record number 2 evidence another plan of care established by the physician for the certification period of 06/27/15 to 8/26/15, had orders for home health aide services four days a week up to three hours per day. a. Upon review of the home health aide visit notes, the clinical record evidenced on 6/30/15 and on 07/02/15, the home health aide made two visits to the patient's home. b. The clinical record evidence the home health aide made one visit during week one and made five visits during week two and week week. The home health aid failed to follow the physician ordered plan of care. 2. Clinical record number 8, included a plan of care established by the physician for the certification period 02/27/15 to 04/27/15, that evidenced a physician clarification order on 03/20/15, with orders for home health aide visits to be provided one time a week for one week then two times a week for seven weeks. Upon review of the home health aide visit notes, the clinical record failed to evidenced a second home health aide			

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	visit during week four and evidenced two home health aide visits during week nine that was not ordered. The home health aide failed to follow the physician ordered plan of care. 3. Employee A, Administrator / Registered Nurse, was interviewed on 08/04/15. Employee A acknowledged clinicians not following the plan of care in regards to frequencies as ordered. 4. An undated policy titled Care Plans indicated, "Purpose: To assure continuity and consistency between the disciplines providing care under the current plan, To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals, and To provide updated, coordinated document that reflects the current home care services ... "			
G 0336 Bldg. 00	484.55(b)(3) COMPLETION OF THE COMPREHENSIVE ASSESSMENT When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The			

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	occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility. Based on clinical record review and interview, the agency failed to ensure that a qualifying service was provided at the start of care for 1 of 4 records reviewed that was receiving occupational therapy. (#7) Findings include: 1. Clinical record number 7, included a plan of care established by the physician for the certification period 02/04/15 to 04/04/15 with orders for skilled nursing, occupational and physical therapy services. Clinical record number 7 was reviewed on 8/4/15. The clinical record evidence skilled nursing completing the start of care comprehensive assessment only. No further skilled nursing services was provided. An order dated 02/10/15, indicated that the patient had refused physical therapy services, but accepted occupational services. Occupational therapy provided therapy services under Medicare on 02/10/15, 02/16/15, 02/24/15, 03/03/15, and 03/10/15. The agency failed to evidence a qualified service while the patient was receiving occupational therapy services.	G 0336	All current charts are being reviewed by DON/designee for non-qualifying services Patients will be monitored weekly for non-qualifying services DON/designee will in-service professional staff on what services are considered qualifying based on payer source DON/designee will monitor weekly	08/29/2015

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	2. Employee A, Administrator / Owner / Registered Nurse, was interviewed on 08/05/15. The Employee A indicated that she was not aware that occupational therapy was not a qualifying service.			
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 observation, clinical record and policy review and interview, the agency failed to ensure the medication profiles were revised and accurate for 7 of 12 records reviewed. (# 1, 2, 3, 6, 7, 10, and 12) Findings include: 1. Clinical record number 1, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. The medication profile was incomplete and failed to evidence diagnoses, drug classifications, collaboration with physician, and medication follow up.	G 0337	All current medication profiles are being reviewed by DON/designee for diagnosis, drug classification, collaboration with MD and follow up DON/designee will in-service staff on requirement to review all patients medications at the time of admission, resumption of care, and recertification: to complete medication profile including classification and need to contact MD with any medication concerns Future medication profiles will be reviewed at 15 charts per week DON/designee to review 15 charts per week	08/29/2015

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	2. Clinical record number 2, SOC 04/28/15, included a plan of care established by the physician for the certification period 04/28/15 to 06/26/15. The medication profile was incomplete and failed to evidence height, weight, allergies, diagnoses, drug classifications, drug regimen review, collaboration with physician, medication follow up, and if the patient / caregiver was provided education for high risk drug education. 3. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. The medication profile was incomplete and failed to evidence diagnoses, drug classifications, collaboration with physician, and medication follow up. 4. Clinical record number 6, included a plan of care established by the physician for the certification period 12/27/14 to 02/24/15. The medication profile was incomplete and failed to evidence allergies, diagnoses, height, dates reviewed upon recert since 10/30/14, start date of medications, classification of medications, collaboration with the physician, and date of follow up with Employee K. 5. Clinical record number 7, included a			

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	plan of care established by the physician for the certification period 02/04/15 to 04/04/15. The medication profile was incomplete and failed to evidence diagnoses, dates reviewed, classification of medications, collaboration with physician, and medication follow up. 6. Clinical record number 10, included a plan of care established by the physician for the certification period 10/29/14 to 12/27/14. The medication profile was incomplete and failed to evidence diagnoses, start date of medications, classification of medications, collaboration with physician, and medication follow up. 7. Clinical record number 12, included a plan of care established by the physician for the certification period 10/30/14 to 12/27/14. The medication profile was incomplete and failed to evidence diagnoses, classification of medications, collaborating with physician, and medication follow up. 8. Employee A, Administrator / Registered Nurse, was interviewed during the Entrance Conference on 07/29/15 from 12:30 to 12:50 PM. Employee A stated she performs all the admissions and the case managers will do the recertification's. Employee A stated the			

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	physician was to be notified for any medication discrepancies upon admission and at recertification. 9. An undated policy titled Medication Profile indicated "The Medication Profile shall document: Allergies, Date of medication ordered or care initiated ... contraindications or special precautions, medication actions and side effects ... The medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation and , at minimum, every sixty (60) days thereafter ... " 10. An undated policy titled Medication Reconciliation indicated "Agency will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, before and after inpatient facility stays, and at the time of discharge ... "			
N 0000 Bldg. 00	This was a state home health relicensure and complaint investigation survey. The	N 0000		

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	survey was extended. Complaint # IN00164290 - Substantiated without deficiencies Complaint # IN00164255 - Substantiated without deficiencies Survey dates: July 29 through August 5, 2015 Facility Number: 012905 Medicaid Provider ID 201075310 Census: 63 Home visits 5 Clinical records reviewed 12			
N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with other home health agencies that were furnishing services for 3 of 3 records reviewed of patients receiving services from another provider creating the potential to affect all of the agency's patients that receive	N 0486	All patients currently being seen by other agencies will be reviewed, agency will be contacted and documented (This includes wound care centers, dialysis, personal service agencies) DON/designee will in-service all professional staff on requirement to contact other agencies involved in care of patient at	08/29/2015

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	more than one service. (#1, 3, 4) Findings include: 1. Clinical record number 1, SOC (start of care) 6/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During clinical record review on 07/30/15, a typed piece of paper signed and dated by Employee A, Administrator / Registered Nurse, on 06/25/15 indicated "SN [skilled nurse] was informed that pt [patient] has a MCD [Medicaid] company in home as well. SN called [Name of Agency] and informed of Medicare admit for skilled needs. Receptionist will call back if any needs noted after communicated to RN." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During a home visit on 07/30/15 at 3:55 PM, the patient was observed to have an aide from another home health company in the home. Employee A, Administrator / RN, stated that the patient has 24 hour care in their home. The clinical record failed to evidence care coordination with		admission, resumption, recertification and discharge In the future agencies will be contacted and documented on admission, resumption, recertification, and discharge and with any status changes DON/designee to audit all charts for compliance Once 100% compliance is achieved DON/designee will audit 10% of admissions, resumptions, recertifications and discharges weekly(on-going)	

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	outside services that was also providing care to the patient. 3. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15. During clinical record review on 08/03/15, a typed piece of paper signed and dated by Employee A on 07/16/15, indicated "Communication with MCD (Medicaid) HHC (Home Health Company) in home as well. SN (skilled nurse) called [Name of Agency] and left a message for [Name of personnel] and informed of Medicare admit for skilled needs. [Name of personnel] to call back if any questions." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 4. Employee A, Administrator / Registered Nurse, was interviewed during the Entrance Conference on 07/29/15, from 12:30 PM to 12:50 PM. Employee A stated he / she would notify the outside agencies that were also providing services upon admission and as needed. 5. An undated policy titled Coordination of Client Services indicated, "After initial assessment, the admitting Registered Nurse / Therapist shall discuss the			

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	findings of the initial visit with the Clinical manager to ensure ... Coordination with other agencies and institutions ... "			
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 clinical record and policy review and interview, the agency failed to ensure visits had been provided only as ordered by the physician in 4 of 12 records reviewed. (# 1, 2, 3, and 8) Findings include: 1. Clinical record number 1, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, that identified skilled nursing visits were to be provided one time a week for one week, two times a week for six weeks, one time a week for two weeks and physical therapy visits were to be provided two times a week for six weeks starting 07/05/15. a. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nurse	N 0522	All staff meeting was held8/17/15 Frequencies were part of the meeting with staff for care planning DON/designee will rein-service professional staff on requirement to follow visit frequency as ordered by MD on plan of care DON/designee to review frequency with chart review by monitoring 15 per week	08/29/2015

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	visit during week two and four. The skilled nurse failed to follow the physician ordered plan of care. b. Upon review of the physical therapy visit notes, the clinical record failed to evidenced two physical therapy visits during week four and a second visit during week five. The physical therapist failed for follow the physician ordered plan of care. 2A. Clinical record number 2, SOC 4/28/15, included a plan of care established by the physician for the certification period 04/28/15 to 06/26/15, with orders for skilled nursing at least every 30 days and home health aide visits three times a week for eight weeks for one hour per day. On 05/26/15, HHA (home health aide) frequency and days was increased to five days a week up to three hours per visit. a. The skilled nurse made a visit on 5/13/15 and on 06/25/15. Upon review of the skilled nursing visit notes, the clinical record failed to evidence that skilled nursing visits was made within 30 days per the plan of care. b. Upon review of the home health aide visit notes, the home health aide made 2 visits to the patient's home			

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	on 06/25/15. The home health aide failed to follow the physician ordered plan of care. 2B. Clinical record number 2 evidenced another plan of care established by the physician for the certification period of 06/27/15 to 08/26/15, with orders for home health aide services four days a week up to three hours per day. Upon review of the home health aide visit notes, the home health aide made visits five days during week two and week three. The home health aide failed to follow the physician ordered plan of care. 3. Clinical record number 8, included a plan of care established by the physician for the certification period 02/27/15 to 04/27/15, that evidenced a clarification order on 03/20/15, that identified skill nursing visits were to be provided one time a week for one week, two times a week for six weeks, then one time a week for two weeks and home health aide visits were to be provided one time a week for one week then two times a week for seven weeks. a. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nursing visit during week five and week nine. The skilled nurse failed to follow			

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	the physician ordered plan of care. b. Upon review of the home health aide visit notes, the clinical record failed to evidenced a second home health aide visit during week four and evidenced two home health aide visits during week nine that was not ordered. The home health aide failed to follow the physician ordered plan of care. 4. Employee A, Administrator / Registered Nurse, was interviewed on 08/04/15 at 3:30 PM. Employee A acknowledged clinicians were not following the plan of care in regards to frequencies as ordered. 5. An undated policy titled Care Plans indicated, "Purpose: To assure continuity and consistency between the disciplines providing care under the current plan, To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals, and To provide updated, coordinated document that reflects the current home care services ... "			
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 observation, clinical record and policy review and interview, the agency failed to ensure plans of care were revised that included all medications, all durable medical equipment / supplies, pertinent diagnoses, correct date of verbal orders at recertification for 11 of 12 records reviewed. (# 1 - 8, 10 - 12) Findings include: 1. Clinical record number 1, SOC (start of care) 6/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15,	N 0524	An all staff meeting will be held 9/9/15 to go over findings with the staff lead by DON/designee All current patient charts will be reviewed to ensure plans of care are revised to include all medications, durable medical equipment/supplies, pertinent diagnosis and correct orders Physician notification of delayed start of care and verbal orders will also be reviewed on an on-going basis DON/designee will in-service all professional staff on requirement to update (as applicable) medication profile, home health aide care plan, diagnoses, DME at least every 60 days or	08/29/2015

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RN2U INC	9731 NORTH KITCHEN ROAD MOORESVILLE, IN 46158

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	with a primary diagnosis of Pressure Ulcer to the buttock and other pertinent diagnoses of Pressure Ulcer Stage II, Muscle weakness, dependent on supplemental oxygen and long term use of aspirin. Hospital discharge paperwork dated 06/25/15, indicated the patient had a diagnoses of Acute on Chronic diastolic CHF (Congestive Heart Failure), Exacerbation of COPD (Chronic Obstructive Pulmonary Disease), history of atrial fibrillation, pulmonary embolism, pulmonary nodules, aortic stenosis, coronary artery disease, angina, cellulitis of female breast, chronic hypertension, chronic respiratory failure, chronic kidney disease, and neuropathy. The plan of care failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services. 2. Clinical record number 2, SOC 04/28/15, included a plan of care established by the physician for the certification period of 04/28/15 to 06/25/15, for skilled nursing every 30 days to evaluate Cardiopulmonary status, evaluate nutrition / hydration, evaluate for signs and symptoms of infection, teach disease process, teach diet, medication teaching, pulse oximetry as needed, teach patient pressure relief, and		whenever there are changes DON/designee to monitor 15 charts per week on-going	

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	teach patient pain relief. The plan of care also included home health aide services three times a week for eight weeks up to one hour to check vitals, shower, personal care, assist with dressing, hair care, skin care, check for pressure areas, use device for gait, assist with feeding as needed, wash clothes as needed and housekeeping. A signed physician's order dated 05/26/15, indicated the home health aide hours had been increased to three hours per day. a. On 7/30/15 at 11:50 AM, the patient's home was observed. The patient resides in a Medicaid Assisted Living home where meals and medication administration is provided. The patient's home was observed to be small, one room, with just a bed, plastic chair, closet and bathroom. There was no microwave or stove. b. On 7/30/15 at 11:55 AM, the significant other was interviewed. The significant other stated the home health aide assisted the patient with showers, cleans up the bathroom after the showers, sets out clothes for the patient to wear, and sometimes did a little bit of walking and exercise with the patient. The significant other stated the home health aide comes daily for three hours.			

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	c. Upon departure of the patient's home on 7/30/15, Employee A, RN-Administrator was interviewed. Employee A stated the home health aide duties included bathing and assist with the patient's laundry but there was only one washer and dryer for the entire facility. Employee A stated she was not aware that the patient was receiving a home health aide up to three hours for each visit and stated that she would need to look into why the patient is there for three hours a day. d. Patient's number 2 record was reviewed on 08/03/15. A skilled nursing visit note dated 05/13/15, indicated the patient vital signs were within the call order parameters, no pain, lungs clear, skin intact, denial of nausea and vomiting, and no urine frequency or dysuria. Skilled nursing interventions provided were education on diabetes such as disease process, importance of checking feet, skin care, recognition of breakdown and impaired circulation. There were no changes to the home health aide care plan. The clinical record failed to evidence an assessment of decline in the patient's functional status to warrant an increase in hours with Medicaid.			

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	3. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, with a primary diagnosis of aftercare joint replace and other pertinent diagnoses of joint replaced hip and lack of coordination. The DME (durable medical equipment) section was left blank. The medication section only indicated the patient was taking Miralax by mouth twice a day. a. During a home visit on 7/30/15 at 3:45 PM, the patient was observed to be utilizing a walker. The spouse had indicated the patient had a motor vehicle accident last fall and obtained a hip fracture at that time. Spouse indicated that he / she had been in a facility and the patient had functionally declined during his / her departure. b. A form called "Face to Face Attestation Form" indicated the primary reason for home health care was fractured right hip, labile hypertension, edema, and weakness. The form also indicated the patient had weakness, fatigue, shortness of breath, and / or activity intolerance, confusion and / or impaired decision making processes, history and / or risk of falls.			

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	c. A physician visit note dated 05 /13/15, indicated the patient had diagnoses of non-insulin dependent diabetes, hypertension, hyperlipidemia, cerebral vascular accident, malignant tumor in his job bone, depression, hypothyroidism, and dementia. The visit note also indicated the patient was taking amlodipine 5 MG (milligrams) by mouth daily, aspirin 81 MG by mouth daily, atorvastatin 10 MG by mouth daily, clopidogrel 75 MG by mouth daily, levothyroxine 50 MCG (micrograms) by mouth daily, oxybutin 5 MG by mouth daily, Polyethylene Glycol 1000 powder, 17 grams mix with 8 ounces of liquid every morning, sertraline 50 MG by mouth daily, terazosin 2 MG by mouth at bedtime, torsemide 10 MG by mouth daily, and losartan 50 MG by mouth daily. The plan of care failed to evidence DME used in the home, all pertinent diagnoses and medications relevant to the patient's care while on home health services. 4. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15, with a primary diagnosis of Counseling and other pertinent diagnoses of long term use meds NEC (not elsewhere			

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	classified), chronic airway obstruction NEC, osteoporosis NOS (not otherwise specified), hypertension NOS. The DME (durable medical equipment) section was left blank. a. During a home visit on 7/31/15 at 2:15 PM, Employee A stated that the patient had been very ill and had came a long way since being on their services. The patient had indicated she had been vomiting since January 2015 and had his / her gallbladder removed on 07/07/15. The patient also stated that he / she had been in the hospital two other times since then for infection and pneumonia. A shower chair, grab bars, walker / rollator, and a hospital bed was observed to be in the patient's home. b. Patient number 4's record was reviewed on 08/03/15. A referral form dated 07/14/15, indicated the patient had neuropathy, hypertension, hyperlipidemia, edema, chronic kidney disease stage three, carotid stenosis, hyperkalemia, renal arterial stenosis with status post stent placement and coronary artery disease with status post coronary artery bypass graft. A hospital discharge summary dated 07/15/15, indicated the patient has a past medical history of, but not limited to congestive heart failure, hypertension, osteoporosis,			

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	gastroesophageal reflux disease, chronic obstructive pulmonary disease, chronic kidney disease, nephrolithiasis, dementia, hyperglycemia, muscle spasms, and status post laparoscopic choleecystectomy. The plan of care failed to evidence DME used in the home and all pertinent diagnoses relevant to the patient's care while on home health services. 5. Clinical record number 5, SOC 06/02/15, included a plan of care established by the physician for the certification period 06/02/15 to 07/31/15, with a primary diagnosis of an open wound of hip/thigh and other diagnoses of Muscle weakness, other lymphadema, and cellulitis of leg. The plan of care medication list included atarax, torsemide, and cymbalta. a. During a home visit on 7/30/15 at 3:45 PM, the patient was observed to have a wound to the posterior left lower leg that was receiving treatment. The patient stated that he use to take a lot of medication. b. Patient number 5's clinical record was reviewed on 08/04/25. A form called Face to Face Attestation and a podiatry visit note dated 06/12/15,			

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	indicated that patient's diagnoses were ulcer of the lower leg related to ischemia and venous stasis ulcer. The podiatry visit note also indicated the patient has a history of cellulitis and the medications included ascorbic acid, atarax, colace, cymbalta, florastor, gabapentin, norco, potassium chloride, and torsemide. The plan of care failed to evidence all pertinent diagnoses and medications relevant to the patient's care while on home health services. 6. Clinical record number 6, SOC 10/28/14, included a plan of care established by the physician for the certification period of 12/27/14 to 02/24/15, with a primary diagnosis of digestive system symptom, diabetes mellitus type 2, myalgia / myositis, and anxiety. Patient number 6's clinical record was reviewed on 08/04/15. A skilled nursing note dated 12/24/14, indicated the patient was having pain and having difficulty lifting her arms without pain and weakness. The patient suffered from visual and auditory impairment. The plan of care failed to be updated and reflect the patient's current status upon recertification.			

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	7. Clinical record number 7, SOC 02/04/15, included a plan of care established by the physician for the certification period of 02/04/15 to 04/04/15, with a primary diagnosis of lack of coordination and other pertinent diagnosis of muscle weakness. Patient number 7's clinical record was reviewed on 08/04/15. A referral form dated 02/03/15, indicated the patient had diagnoses of "breast cancer, blood pressure [sic], hearing implants, arthritis, low back [sic], trouble up from chair, general weakness, hip trouble pain." The plan of care failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services. 8. Clinical record number 8, SOC 10/30/14, included a plan of care established by the physician for the certification period of 02/27/15 to 04/27/15, with a diagnosis of counseling and other pertinent diagnoses of muscle weakness, debility, chronic airway obstruction, arthropathy, scoliosis, and cirrhosis of the liver. a. Patient number 8's clinical record was reviewed on 08/04/15. A			

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	referral form dated 10/20/14, indicated the patient has a history of falls, hepatitis C, cirrhosis of the liver, arthritis, scoliosis, chronic obstructive pulmonary disease, sleep apnea, hypertension, and low platelets. b. Plan of cares established by the physician for certification periods of 10/30/14 to 12/28/14, 12/29/14 to 02/26/15, 2/27/15 to 4/28/15 to 6/26/15, continued to have the same primary and other pertinent diagnosis. Line 23 of all of the plan of cares indicated that the verbal order was obtained on 10/30/14. The interventions indicated that the skilled nurse would "evaluate cardiopulmonary status, evaluate nutrition/hydration, evaluate for signs and symptoms of infection, teach disease process teach diet, medication teaching, medication setup, pulse oximetry as needed, teach patient pain control mechanisms, enforce fall precautions, and perform medication set up." Goals included "demonstrates compliance with medication (s) by end of cert, stabilize cardiovascular pulmonary condition by end of cert, demonstrates competence with medical regime by end of cert ... Pt will be able to participate more effectively with activities of daily living once [illegible word / abbreviation] is controlled; debilitating effects of			

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	hypertension, anemia [sic] is corrected with med regimen." c. The clinical record evidence a social service initial assessment visit was made on 02/20/15, with documentation indicating that 1-2 more visits would be made with the patient. Social service visits was made on 03/12/15 and 04/27/15. The plan of cares failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services, failed to update the date of the verbal order at each recertification period, failed to include social services, and failed to update skilled nursing interventions and goals. 9. Clinical record number 10 SOC 10/29/14, included a plan of care established by the physician for certification period of 10/29/14 to 12/27/14, with a primary diagnosis of diabetes type 2 and other pertinent diagnoses of chronic pain. a. Patient number 10's clinical record was reviewed on 08/03/15. A comprehensive assessment dated 10/29/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease,			

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	history of falls, obesity, anxiety, gastroesophageal reflux, chronic pain related to sciatica pain, and depression. b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/28/14 to 02/25/15, 2/26/15 to 4/27/15, indicated that the verbal order was obtained by Employee A on 10/29/14. The plan of cares failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 10. Clinical record number 11 SOC 10/30/14, included a plan of care established by the physician for certification period of 10/30/14 to 12/28/14, with a primary diagnosis of muscle weakness and other pertinent diagnoses of abnormality of gait and joint pain. a. Patient number 11's clinical record was reviewed on 08/03/15. A comprehensive assessment dated 10/30/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease, history of falls, anxiety, and depression.			

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	b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/29/14 to 02/26/15, 2/27/15 to 4/27/15, indicated that the verbal order was obtained on 10/30/14. The plans of care failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 11. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for certification periods of 12/29/14 to 02/26/15 and 02/27/15 to 04/27/15. Line 23 of the plans of care indicated that the verbal order was obtained on 10/30/14. The verbal order date failed to be updated upon each recertification period on the plans of care. 12. Employee A, Administrator / Registered Nurse, was interviewed on 8/04/15 at 3:30 PM. Employee A stated she was aware that goals and interventions should be updated at every certification period and was not aware that all pertinent diagnoses should be			

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	included in the plan of care. 13. An undated policy titled Care Plans indicated "The Care Plan shall be reviewed, evaluated, and revised (minimally every sixty (60) days and as needed) based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. The Care Plan shall include, but not limited to: Nursing diagnosis(es) / problems and needs identified; Reasonable, measurable, and realistic goals as determined by the assessment and client expectations; A list of specific interventions with plans of implementation; and Indicators for measuring goal achievement and identified time frames ... " 14. An undated policy titled Plan of Care indicated "The Plan of Care shall be completed in full to include: All pertinent diagnosis(es), principle and secondary ... Type, frequency, and duration of all visits / services ... Medications, treatments ... Medical supplies and equipment required ... Treatment goals ... "			

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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 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 clinical record and policy review and interview, the agency failed to ensure that the physical and occupational therapist followed company policy and notified the physician of the delay in the therapy assessments for 4 of 12 records reviewed. (# 1, 3, 7, 12) Findings include: 1. Clinical record number 1, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 06/25/15 indicated for the patient to have a physical therapy evaluation. Upon reviewing the physical therapy visit notes, the clinical record evidence the physical therapist did not see the patient until 07/02/15. The physical therapist failed to notify the physician of the delay of assessment / services. 2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the	N 0527	All current Physical Therapy charts are being reviewed by DON/designee for following of POC or 48 hour assessment and delay of assessment to be called to the MD DON/designee will in-service professional staff on requirement to follow visit frequency as ordered by MD on plan of care DON/designee to in-service professional staff on requirement to complete admission or evaluation within forty eight (48) hours, MD must be notified and reason/MD conversation documented in patient chart DON/designee will monitor all admits each week	08/29/2015

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	certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 05/13/15 indicated for the patient to have a physical therapy evaluation. Upon reviewing the physical therapy visit notes, the clinical record evidence the physical therapist did not see the patient until 07/06/15. The physical therapist failed to notify the physician of the delay of assessment / services. 3. Clinical record number 7, SOC 02/04/15, included a plan of care established by the physician for the certification period of 02/04/15 to 04/04/15. A Face to Face Attestation dated 02/12/15 indicated for the patient to have an occupational therapy evaluation. Upon reviewing the physical therapy visit notes, the clinical record evidence the occupational therapist did not see the patient until 02/10/15. The occupational therapist failed to notify the physician for the delay of assessment / services. 4. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for the certification period of 10/30/14 to 12/27/14 with orders for skilled nursing and physical therapy. An agency referral form dated 10/29/14, indicated for the patient to have a physical therapy			

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RN2U INC	9731 NORTH KITCHEN ROAD MOORESVILLE, IN 46158

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	evaluation. Upon reviewing the physical therapy visit notes, the clinical record evidence the physical therapist did not see the patient until 11/03/14. The physical therapist failed to notify the physician for the delay of assessment / services. 5. Employee A, Administrator / Registered Nurse was interviewed on 08/03/15 at 10:43 AM. Employee A stated therapy had 48 hours to perform an initial assessment after the start of care. Employee A stated she was aware of the delay of services but was not aware of the physicians not being notified by the clinicians. 6. An undated policy titled Plan of Care indicated, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ... " 7. An undated policy titled Physical Therapist indicated "Completes initial assessments within forty eight (48) hours of referral unless other arrangements are made ... communicates plans and changes to the physician and to the client Case Manager and other caregivers through the care plan, progress notes ... Communicates changes in schedule and physician orders to the office on the day			

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	the changes are made ... "			
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record agency policy review and interview, the Registered Nurse failed to ensure visits had been provided only as ordered by the physician in 3 of 10 records reviewed for skilled nursing. (# 1, 2, 8) Findings include: 1. Clinical record number 1, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15, that identified skilled nursing visits were to be provided one time a week for one week, two times a week for six weeks, one time a week for two weeks. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nurse visit during week two and four.	N 0537	Frequencies were discussed during care planning meeting on 8/17/15 All staff meeting will be held on 9/9/15 DON/designee will in-service professional staff on requirement to follow visit frequency as ordered by MD on Plan of Care DON/designee to review frequency with chart review by monitoring 15 charts per week 15 charts per week was selected for review due to this is more than 10% and would guarantee that each chart would get reviewed at least every 30 days	08/29/2015

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	2. Clinical record number 2, SOC 4/28/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/25/15, with orders for skilled nursing at least every 30 days. The skilled nurse made a visit on 5/13/15 and on 06/25/15. Upon review of the skilled nursing visit notes, the clinical record failed to evidence that skilled nursing visits was made within 30 days per the plan of care. 3. Clinical record number 8, included a plan of care established by the physician for the certification period 02/27/15 to 04/27/15, that evidenced a clarification order on 03/20/15, that identified skill nursing visits were to be provided one time a week for one week, two times a week for six weeks, then one time a week for two weeks. Upon review of the skilled nursing visit notes, the clinical record failed to evidence a second skilled nursing visit during week five and week nine. 4. Employee A, Administrator / Registered Nurse, was interviewed on 08/04/15 at 3:30 PM. Employee A acknowledged clinicians were not following the plan of care in regards to frequencies as ordered. 5. An undated policy titled Care Plans			

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	indicated, "Purpose: To assure continuity and consistency between the disciplines providing care under the current plan, To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals, and To provide updated, coordinated document that reflects the current home care services ... "			
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 observation, clinical record and policy review and interview, the Registered Nurse failed to ensure plans of care were revised that included all medications, all durable medical equipment / supplies, pertinent diagnoses, correct date of verbal orders at recertification for 11 of 12 records reviewed. (# 1 - 8, 10 - 12) Findings include: 1. Clinical record number 3, SOC 06/26/15 included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15,	N 0542	An all staff meeting will be held on 9/9 15 to go over findings with staff All current charts will be reviewed by DON/designee to ensure plans of care are revised to include all medications, DME/supplies, pertinent diagnosis and correct orders Physician notification of delayed start of care and verbal orders will also be reviewed on an on-going basis DON/designee to monitor 15 charts per week on-going DON/designee will in-service all professional staff on requirement to update (as applicable) medication profile, home health aide care plan, diagnosis, DME at	08/29/2015

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	with a primary diagnosis of aftercare joint replace and other pertinent diagnoses of joint replaced hip and lack of coordination. The DME (durable medical equipment) section was left blank. The medication section only indicated the patient was taking Miralax by mouth twice a day. a. During a home visit on 7/30/15 at 3:45 PM, the patient was observed to be utilizing a walker. The spouse had indicated the patient had a motor vehicle accident last fall and obtained a hip fracture at that time. The spouse indicated that he / she had been in a facility and the patient had functionally declined during his / her departure. b. A form called "Face to Face Attestation Form" indicated the primary reason for home health care was a fractured right hip, labile hypertension, edema, and weakness. The form also indicated the patient had weakness, fatigue, shortness of breath, and / or activity intolerance, confusion and / or impaired decision making processes, history and / or risk of falls. c. A physician visit note dated 05 /13/15, indicated the patient had diagnoses of non-insulin dependent diabetes, hypertension, hyperlipidemia,		least every 60 days or whenever changes are made	

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	cerebral vascular accident, malignant tumor in his job bone, depression, hypothyroidism, and dementia. The visit note also indicated the patient was taking amlodipine 5 MG (milligrams) by mouth daily, aspirin 81 MG by mouth daily, atorvastatin 10 MG by mouth daily, clopidogrel 75 MG by mouth daily, levothyroxine 50 MCG (micrograms) by mouth daily, oxybutin 5 MG by mouth daily, Polyethylene Glycol 1000 powder, 17 grams mix with 8 ounces of liquid every morning, sertraline 50 MG by mouth daily, terazosin 2 MG by mouth at bedtime, torsemide 10 MG by mouth daily, and losartan 50 MG by mouth daily. The Registered Nurse failed to evidence DME used in the home, all pertinent diagnoses and medications relevant to the patient's care while on home health services. 2. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15, with a primary diagnosis of Counseling and other pertinent diagnoses of long term use meds NEC (not elsewhere classified), chronic airway obstruction NEC, osteoporosis NOS (not otherwise specified), hypertension NOS. The DME			

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	(durable medical equipment) section was left blank. a. During a home visit on 7/31/15 at 2:15 PM, Employee A stated that the patient had been very ill and had came a long way since being on their services. The patient had indicated she had been vomiting since January 2015 and had his / her gallbladder removed on 07/07/15. The patient also stated that he / she had been in the hospital 2 other times since then for infection and pneumonia. A shower chair, grab bars, walker / rollator, and a hospital bed was observed to be in the patient's home. b. Clinical record number 4 was reviewed on 08/03/15. A referral form dated 07/14/15, indicated the patient had neuropathy, hypertension, hyperlipidemia, edema, chronic kidney disease stage 3, carotid stenosis, hyperkalemia, renal arterial stenosis with status post stent placement and coronary artery disease with status post coronary artery bypass graft. A hospital discharge summary dated 07/15/15, indicated the patient has a past medical history of, but not limited to congestive heart failure, hypertension, osteoporosis, gastroesophageal reflux disease, chronic obstructive pulmonary disease, chronic kidney disease, nephrolithiasis, dementia,			

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	hyperglycemia, muscle spasms, and status post laparoscopic choleecystectomy. The Registered Nurse failed to evidence DME used in the home and all pertinent diagnoses relevant to the patient's care while on home health services. 3. Clinical record number 5, SOC 06/02/15, included a plan of care established by the physician for the certification period 06/02/15 to 07/31/15, with a primary diagnosis of an open wound of hip/thigh and other diagnoses of Muscle weakness, other lymphadema, and cellulitis of leg. The plan of care medication list included atarax, torsemide, and cymbalta. a. During a home visit on 7/30/15 at 3:45 PM, the patient was observed to have a wound to the posterior left lower leg that was receiving treatment. The patient stated that he use to take a lot of medication. b. Clinical record number 5 was reviewed on 08/04/25. A form called Face to Face Attestation and a podiatry visit note dated 06/12/15, indicated that patient's diagnoses were ulcer of the lower leg related to ischemia and venous stasis ulcer. The podiatry visit note also			

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	indicated the patient has a history of cellulitis and the medications included ascorbic acid, atarax, colace, cymbalta, florastor, gabapentin, norco, potassium chloride, and torsemide. The Registered Nurse failed to evidence all pertinent diagnoses and medications relevant to the patient's care while on home health services. 4. Clinical record number 6, SOC 10/28/14, included a plan of care established by the physician for the certification period of 12/27/14 to 02/24/15, with a primary diagnosis of digestive system symptom, diabetes mellitus type 2, myalgia / myositis, and anxiety. Clinical record number 6 was reviewed on 08/04/15. A skilled nursing note dated 12/24/14, indicated the patient was having pain and having difficulty lifting her arms without pain and weakness. The patient suffered from visual and auditory impairment. The Registered Nurse failed to update the plan of care and reflect the patient's current status upon recertification. 5. Clinical record number 7, SOC 02/04/15, included a plan of care			

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	established by the physician for the certification period of 02/04/15 to 04/04/15, with a primary diagnosis of lack of coordination and other pertinent diagnosis of muscle weakness. Clinical record number 7 was reviewed on 08/04/15. A referral form dated 02/03/15, indicated the patient had diagnoses of "breast cancer, blood pressure [sic], hearing implants, arthritis, low back [sic], trouble up from chair, general weakness, hip trouble pain." The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services. 6. Clinical record number 8, SOC 10/30/14, included a plan of care established by the physician for the certification period of 02/27/15 to 04/27/15, with a diagnosis of counseling and other pertinent diagnoses of muscle weakness, debility, chronic airway obstruction, arthropathy, scoliosis, and cirrhosis of the liver. a. Clinical record number 8 was reviewed on 08/04/15. A referral form dated 10/20/14, indicated the patient has a history of falls, hepatitis C, cirrhosis of the liver, arthritis, scoliosis, chronic			

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	obstructive pulmonary disease, sleep apnea, hypertension, and low platelets. b. Plan of cares established by the physician for certification periods of 10/30/14 to 12/28/14, 12/29/14 to 02/26/15, 2/27/15 to 4/28/15 to 6/26/15, continued to have the same primary and other pertinent diagnosis. Line 23 of all of the plan of cares indicated that the verbal order was obtained on 10/30/14. The interventions indicated that the skilled nurse would "evaluate cardiopulmonary status, evaluate nutrition/hydration, evaluate for signs and symptoms of infection, teach disease process teach diet, medication teaching, medication setup, pulse oximetry as needed, teach patient pain control mechanisms, enforce fall precautions, and perform medication set up." Goals included "demonstrates compliance with medication (s) by end of cert, stabilize cardiovascular pulmonary condition by end of cert, demonstrates competence with medical regime by end of cert ... Pt will be able to participate more effectively with activities of daily living once [illegible word / abbreviation] is controlled; debilitating effects of hypertension, anemia [sic] is corrected with med regimen." c. The clinical record evidence a			

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	social service initial assessment visit was made on 02/20/15, with documentation indicating that 1-2 more visits would be made with the patient. Social service visits was made on 03/12/15 and 04/27/15. The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services, failed to update the date of the verbal order at each recertification period, failed to include social services, and failed to update skilled nursing interventions and goals. 7. Clinical record number 10 SOC 10/29/14, included a plan of care established by the physician for certification period of 10/29/14 to 12/27/14, with a primary diagnosis of diabetes type 2 and other pertinent diagnoses of chronic pain. a. Clinical record number 10 was reviewed on 08/03/15. A comprehensive assessment dated 10/29/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease, history of falls, obesity, anxiety, gastroesophageal reflux, chronic pain related to sciatica pain, and depression.			

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	b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/28/14 to 02/25/15, 2/26/15 to 4/27/15, indicated that the verbal order was obtained by Employee A on 10/29/14. The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 8. Clinical record number 11 SOC 10/30/14, included a plan of care established by the physician for certification period of 10/30/14 to 12/28/14, with a primary diagnosis of muscle weakness and other pertinent diagnoses of abnormality of gait and joint pain. a. Clinical record number 11 was reviewed on 08/03/15. A comprehensive assessment dated 10/30/14, indicated the patient had a past medical history of hypertension, diabetes, chronic obstructive pulmonary disease, history of falls, anxiety, and depression. b. Line 23 of the plan of cares that had been established by the physician for certification periods of 12/29/14 to			

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	02/26/15, 2/27/15 to 4/27/15, indicated that the verbal order was obtained on 10/30/14. The Registered Nurse failed to evidence all pertinent diagnoses relevant to the patient's care while on home health services and the verbal order date failed to be updated upon each recertification period. 9. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for certification periods of 12/29/14 to 02/26/15 and 02/27/15 to 04/27/15. Line 23 of the plan of care indicated that the verbal order was obtained on 10/30/14. The Registered Nurse failed to update the verbal order upon each recertification period on the plans of care. 12. Employee A, Administrator / Registered Nurse, was interviewed on 7/31/15. Employee A stated she was aware that goals and interventions should be updated at every certification period and was not aware that all pertinent diagnoses should be included in the plan of care. 13. An undated policy titled Care Plans indicated "The Care Plan shall be			

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	reviewed, evaluated, and revised (minimally every sixty (60) days and as needed) based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. The Care Plan shall include, but not limited to: Nursing diagnosis(es) / problems and needs identified; Reasonable, measurable, and realistic goals as determined by the assessment and client expectations; A list of specific interventions with plans of implementation; and Indicators for measuring goal achievement and identified time frames ... " 14. An undated policy titled Plan of Care indicated "The Plan of Care shall be completed in full to include: All pertinent diagnosis(es), principle and secondary ... Type, frequency, and duration of all visits / services ... Medications, treatments ... Medical supplies and equipment required ... Treatment goals ... "			
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			

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	following: (F) Coordinate services. Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated and documented effectively with other home health agencies that were furnishing services for 3 of 3 records reviewed of patients receiving services from another provider creating the potential to affect all of the agency's patients that receive more than one service. (#1, 3, 4) Findings include: 1. Clinical record number 1, SOC (start of care) 6/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During clinical record review on 07/30/15, a typed piece of paper signed and dated by Employee A, Administrator / Registered Nurse, on 06/25/15 indicated "SN [skilled nurse] was informed that pt [patient] has a MCD [Medicaid] company in home as well. SN called [Name of Agency] and informed of Medicare admit for skilled needs. Receptionist will call back if any needs noted after communicated to RN." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient.	N 0545	All patients currently being seen by other agencies will be reviewed, agency will be contacted and documented (This includes wound care centers, dialysis, personal service agencies) DON/designee will in-service all admit staff on requirement to contact other agencies involved in care of patient at admission resumption, recertification, discharge and with any change in status. In the future agencies will be contacted and documented on admission, resumption, recertification and discharge and with any change in status DON/designee to audit all charts for compliance Once 100% compliance is achieved, DON/designee will audit 10 % of admissions, resumptions, recertifications and discharges weekly (on-going)	08/29/2015

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	157653	A. BUILDING 00 B. WING	08/05/2015

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	2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. During a home visit on 07/30/15 at 3:55 PM, the patient was observed to have an aide from another home health company in the home. Employee A, Administrator / RN, stated that the patient has 24 hour care in their home. The clinical record failed to evidence care coordination with outside services that was also providing care to the patient. 3. Clinical record number 4, SOC 07/16/15, included a plan of care established by the physician for the certification period 07/16/15 to 09/13/15. During clinical record review on 08/03/15, a typed piece of paper signed and dated by Employee A on 07/16/15, indicated "Communication with MCD (Medicaid) HHC (Home Health Company) in home as well. SN (skilled nurse) called [Name of Agency] and left a message for [Name of personnel] and informed of Medicare admit for skilled needs. [Name of personnel] to call back if any questions." The clinical record failed to evidence care coordination with outside services that was also providing care to the patient.			

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	4. Employee A, Administrator / Registered Nurse, was interviewed during the Entrance Conference on 07/29/15, from 12:30 PM to 12:50 PM. Employee A stated he / she would notify the outside agencies that were also providing services upon admission and as needed. 5. An undated policy titled Coordination of Client Services indicated, "After initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure ... Coordination with other agencies and institutions ... "			
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 clinical record review, policy review and interview, the agency failed to ensure that Skilled Nursing dated the dated start of care orders on the plan of care for 1 of 12 records reviewed. (#3) Findings include:	N 0547	All staff meeting to be held 9/9/15 All current patient charts are being reviewed for SN start of care order dates. In the future all admissions will be reviewed within 1 week of admission for appropriate orders> DON/designee will review all admissions for appropriate SOC dates wweekly	08/29/2015

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	1. Clinical record number 3, SOC (start of care) 06/25/15, included a plan of care established by the physician for certification period 06/25/15 to 08/23/15. Upon review of the established plan of care, line 23 indicated "Nurse's signature and date of verbal SOC." The plan of care failed to evidence the date of the verbal start of care by Employee B, Director of Clinical Services. 2. Employee A, Administrator / Registered Nurse was interviewed on 08/04/15 at 3:45 PM. Employee A stated she was not aware the medical social worker had not wrote the orders for ongoing services. 3. An undated policy titled Physician Orders indicated "When the nurse or therapist receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature ... "			
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			

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	following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on clinical record review and interview, the Registered Nurse failed to establish two written patient care instructions for the home health aides who provided care in the morning and evening for 1 of 4 records reviewed. (# 2) Finding include: 1. Clinical record number 2, SOC 4/28/15, included a plan of care established by the physician for the certification period 04/28/15 to 06/25/15, with orders for home health aide three times a week for eight weeks one hour a day. A physician's order dated 5/26/15, indicated the HHA (home health aide) days and hours was increased to five days a week up to three hours per day. Upon review of the home health aide visit notes, the clinical record evidenced on 06/25/15, the home health aide made two visits to the patient's home from 8:00 AM to 10:00 AM and again at 3:40 PM to 5:40 PM. Upon review of the home health aide written plan of care, only one written plan of care was established for the home health aide. The clinical record failed to evidence a two	N 0550	All patients charts that could be effected have been reviewed Patients with more than one visit per day will have separate care plans for each visit DON/designee will in-service professional on requirement to have separate care plans for each visit Home health aides were in-serviced on 8/17/15 DON/designee will monitor weekly	08/29/2015

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	written patient care instructions, one for the morning and one for the evening. 2B. Clinical record number 2 evidenced another plan of care established by the physician for the certification period of 06/26/15 to 8/25/15, with orders for home health aide services four days a week up to three hours per day. On 6/30/15, the home health aide made two visits to the patient's home from 8:11 AM to 9:11 AM and 1:35 PM to 2:35 PM. On 07/02/15, the home health aide made two visits to the patient's home from 2:20 PM to 4:20 PM and 6:35 PM to 7:05 PM. Upon review of the home health aide written plan of care, only one written plan of care was established for the home health aide. The clinical record failed to evidence a two written patient care instructions, one for the morning and one for the evening. 3. Employee A, Administrator / Registered Nurse, was interviewed on 08/04/15 at 3:30 PM. Employee A acknowledged clinicians not following the plan of care in regards to frequencies as ordered. Employee A stated she was not aware that the there needed to be patient written instructions for each home health aide visit if they are going into the home more than once a day.			

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	4. An undated policy titled Care Plans indicated "The Care Plan shall include, but not limited to: Nursing diagnosis(es) / problems and needs identified; reasonable, measurable, and realistic goals as determined by the assessment and client expectations; a list of specific interventions with plans of implementation ... "			
N 0562 Bldg. 00	410 IAC 17-14-1(c) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (1) make an initial evaluation visit to the patient for whom only therapy services are required; Based on clinical record review and interview, the agency failed to ensure that a qualifying service was provided at the start of care for 1 of 4 records reviewed that was receiving occupational therapy. (#7) Findings include: 1. Clinical record number 7, included a plan of care established by the physician for the certification period 02/04/15 to 04/04/15 with orders for skilled nursing, occupational and physical therapy services.	N 0562	All current charts are being reviewed for non-qualifying services Patients will be monitored weekly for non0qualifying services DON/designee will in-service staff on what services are considered qualifying based on payer source DON/designee will monitor weekly	08/29/2015

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	Clinical record number 7 was reviewed on 8/4/15. The clinical record evidence skilled nursing completing the start of care comprehensive assessment only. No further skilled nursing services was provided. An order dated 02/10/15, indicated that the patient had refused physical therapy services, but accepted occupational services. Occupational therapy provided therapy services under Medicare on 02/10/15, 02/16/15, 02/24/15, 03/03/15, and 03/10/15. The agency failed to evidence a qualified service while the patient was receiving occupational therapy services. 2. Employee A, Administrator / Owner / Registered Nurse, was interviewed on 08/05/15. The Employee A indicated that she was not aware that occupational therapy was not a qualifying service.			
N 0564 Bldg. 00	410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function; Based on clinical record review and interview, the physical therapist failed to follow the plan of care for 1 of 12 records reviewed; failed to follow company policy on assessing patients within 48 hours after the start of care for 4 of 12	N 0564	All current Physical Therapy charts are being reviewed for following the POC and forty eight (48) hour assessment and delay of assessment to be called to MD DON/designee will in-service	08/29/2015

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	records reviewed; and failed to notify the physician of the delay in assessments for 4 of 12 records reviewed. (# 1, 3, 7, 12) Findings include: 1. Clinical record number 1, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 06/25/15 indicated for the patient to have physical therapy. a. Upon review of the physical therapy visit notes, the clinical record evidenced the physical therapist did not see the patient until 07/02/15. The physical therapist failed to assess the patient within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services. b. Upon review of the physical therapy careplan, the physical therapist were to be provided two times a week for six weeks starting 07/05/15. The clinical record failed to evidenced two physical therapy visits during week four and a second visit during week five. 2. Clinical record number 3, SOC 06/26/15, included a plan of care established by the physician for the		professional staff on requirement to follow visit frequency as ordered on the POC DON/designee will in-service professional staff on requirement to complete admission or evaluation within forty eight hours of receiving order If not able to complete within 48 hours MD must be notified and reason/MD conversation documented in patient's chart DON/designee will monitor all admits each week	

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	certification period 06/26/15 to 08/24/15. A Face to Face Attestation dated 05/13/15 indicated for the patient to have physical therapy. a. Upon review of the physical therapy visit notes, the clinical record evidence the physical therapist did not see the patient until 07/06/15. The physical therapist failed to assess the patient within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services. b. Upon review of the physical therapy visit notes, the physical therapy visits were to be provided two times a week for six weeks starting 07/13/15. The clinical record failed to evidenced two physical therapy visits during week four. 3. Clinical record number 7, SOC 02/04/15 included a plan of care established by the physician for the certification period of 02/04/15 to 04/04/15. A Face to Face Attestation dated 02/12/15 indicated for the patient to have occupational therapy. Upon review of the occupational therapy notes, the clinical record evidenced the occupational therapist did not see the patient until 02/10/15. The occupational therapist failed to assess the patient			

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	within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services. 4. Clinical record number 12, SOC 10/30/14, included a plan of care established by the physician for the certification period of 10/30/14 to 12/27/14. An agency referral form dated 10/29/14, indicated for the patient to have a physical therapy evaluation. Upon review of the physical therapy notes, the clinical record evidenced the physical therapist did not see the patient until 11/03/14. The physical therapist failed to assess the patient within 48 hours after the start of care and failed to notify the physician of the delay of assessment / services. 5. Employee A, Administrator / Registered Nurse was interviewed on 08/03/15 at 10:43 AM. Employee A stated therapy had 48 hours to an initial assessment after the start of care. Employee A stated she was aware of the delay of services but was not aware of the physicians not being notified by the clinicians. 6. An undated policy titled Plan of Care indicated, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the			

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	Plan of Care ... " 7. An undated policy titled Physical Therapist indicated "Completes initial assessments within forty eight (48) hours of referral unless other arrangements are made ... communicates plans and changes to the physician and to the client Case Manager and other caregivers through the care plan, progress notes ... Communicates changes in schedule and physician orders to the office on the day the changes are made ... "			
N 0574 Bldg. 00	410 IAC 17-14-1(e)(2) Scope of Services Rule 14 Sec. 1(e) The social worker shall do the following: (2) Participate in the development of the plan of care. Based on clinical record review, policy review and interview, the agency failed to ensure that the Skilled Nursing and Medical Social Worker put verbal orders in writing, signed, and dated with the date of receipt for ordered services for 2 of 2 records reviewed. (# 8, 12) Findings include: 1. Clinical record number 8, SOC 10/30/14 included a plan of care established by the physician for certification period 02/27/15 to 04/27/15.	N 0574	All current charts are being reviewed for SN/MSW missed verbal orders Routine charts ware being reviewed by DON/designee DON/designee will in-service SN/MSN on requirement to write verbal orders on MD order sheet to be sent to MD for signature and date DON/designee will monitor with 15 random charts per month	08/29/2015

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	The clinical record evidence a Medical Social Worker assessment dated 02/20/15. The assessment indicated the social worker planned to see the patient for one to two more visits within the certification period and that the physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing services. 2. Clinical record number 12, SOC 10/30/14 included a plan of care established by the physician for certification period of 12/29/14 to 02/26/15. The clinical record evidence a Medical Social Worker assessment dated 12/30/14. The assessment indicated the social worker planned to see the patient for three more visits within the certification period and that physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing social worker services. 3. Employee A, Administrator / Registered Nurse was interviewed on 08/04/15 at 3:45 PM. Employee A stated she was not aware the medical social worker had not wrote the orders for			

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	ongoing social worker services. 4. An undated policy titled Physician Orders indicated "When the nurse or therapist receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature ... "			
N 0580 Bldg. 00	410 IAC 17-14-1(e)(8) Scope of Services Rule 14 Sec. 1(e) The social worker shall do the following: (8) Accept and carry out physician orders for social work services. Based on clinical record review, policy review and interview, the agency failed to ensure that the Medical Social Worker put verbal orders in writing, signed, and dated with the receipt for ordered services for 2 of 2 records reviewed. (# 8, 12) Findings include: 1. Clinical record number 8, SOC 10/30/14 included a plan of care established by the physician for certification period 02/27/15 to 04/27/15. The clinical record evidence a Medical Social Worker assessment dated	N 0580	All current MSW charts are being reviewed by DON/designee for missed verbal orders DON/designee will in-service MSW on requirement to write verbal orders on MD order sheet to be sent to MD for signature and date DON/designee will monitor with 15 random charts per month	08/29/2015

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	02/20/15. The assessment indicated the social worker planned to see the patient for one to two more visits within the certification period and that the physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing services. 2. Clinical record number 12, SOC 10/30/14 included a plan of care established by the physician for certification period of 12/29/14 to 02/26/15. The clinical record evidence a Medical Social Worker assessment dated 12/30/14. The assessment indicated the social worker planned to see the patient for three more visits within the certification period and that physician had been informed. Upon review of physician orders and the social worker's care plan, the clinical record failed to evidence that the social service order was put into writing for ongoing services. 3. Employee A, Administrator / Registered Nurse was interviewed on 08/04/15 at 3:45 PM. Employee A stated she was not aware the medical social worker had not wrote the orders for ongoing services. 4. An undated policy titled Physician			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RN2U INC	9731 NORTH KITCHEN ROAD MOORESVILLE, IN 46158

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Orders indicated "When the nurse or therapist receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature ... "			