STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157538	A. BUILDING 00 B. WING	01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROCARE HOME HEALTH SERVICES	8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410

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G 0000 Bldg. 00	This survey was a recertification, post-condition revisit of a federal/state licensed home health agency. Federal and State deficiencies were cited. Survey Date: 1/16/18 - 1/19/18 Facility #: 003042 Provider #: 157538 Active Patient #: 49 Discharge Patient #: 167	G 0000		
G 0121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on record review and observation the home health agency failed to ensure infection control procedures were followed in 1 of 1 home health agency. The findings include: 1. The agency policy dated 11/05/01 titled "8.4 Infection Control/Maintenance Of Environment Equipment" stated "... Policy ProCare Home Health care staff members implement infection control and maintenance procedures for environment and equipment as appropriate. Purpose To control spread of infection To	G 0121	G121. The Director of Nursing (DON) reviewed the policies titled “8.4 Infection Control/Maintenance of Environment and Equipment” for reeducation and clarification of procedures. The DON took a video training (01-22-18) on Infection Control/Maintenance of Environment and Equipment	02/14/2018

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

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	protect individuals from transmission of communicable/infectious diseases To protect individual from malfunctioning or non-functioning equipment Procedure ProCare Home Health agency staff members implement infection control and maintenance procedures with regard to patients, staff, and their environment and equipment. Patient infection control procedures include, but are not limited to the following: Frequent hand washing by home health care staff members before and after provision of direct patient care according to ProCare Home Health agency policy and procedure. Appropriate patient wound and skin dressing techniques according to ProCare's agency policy and procedure. Appropriate patient skin care according to ProCare Home Health agency policy and procedure. Appropriate handling and disposal of waste products Maintenance of Foley catheter according to ProCare Home Health agency policy and procedure ProCare Home Health staff members infection control procedures include, but are not limited to the following frequent hand washing by home health care staff members: Before and after provision of direct patient care Before working in kitchen After handling soiled or contaminated materials After going to bathroom Other actions for infection control include; covering nose and mouth with tissue or appropriate item when coughing or sneezing and washing hands afterwards; covering open sores and/or cuts on hands with clean bandages; use personal leave days when ill. Environmental and equipment infection control procedures include but not limited to the following: Maintaining a clean work environment for example, by maintaining clean counters, tables and shelves where food is stored Covering food by closing cartons and replacing covers. Refrigerating food promptly as appropriate		and in-serviced the field staff on following the procedures on Infection Control. The field staff also took a Video training on 1/23/18. The use of unexpired medications and maintaining a clean and sterile environment were reiterated and emphasized. A random home visit was made (02-14-18) on a nursing field staff and compliance was assured. The DON or her clinical designee will review all nursing progress notes weekly to assure compliance with Infection Control measures. The DON will be responsible for ensuring that this deficiency does not recur.	

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	Rinsing cans and bottles before disposal in garbage Washing garbage cans, dirty pails and trashcans with hot soapy water Disposing of garbage properly by: draining off liquid before putting garbage in paper or plastic-lined pails wrapping garbage in paper and placing outside in large covered cans or down apartment incinerator chutes each day putting hard or stringy foods in plastic bags rather than in garbage disposal Cleaning all areas of the bathroom, especially around the toilet base Keeping clean and dirty items separate Using sterile items that are not outdated Keeping the patient environment clean, neat and orderly Regularly cleaning patient supplies such as commodes, bedpans, urinals, suction machines and measuring containers. Equipment maintenance procedures include but are not limited to the following: Inspecting equipment every two weeks to ensure it is appropriately maintained. Keeping equipment repaired and in optima functioning capacity. Instructing patient; patient's family; and home health staff members regarding appropriate use of equipment. Use equipment only for its intended purpose without subjecting it to abusive use. ProCare Home Health staff members provide information to patients regarding infection control and maintenance of environment and equipment policies and procedures as appropriate. ProCare Home Health Registered Nurses: Monitor infection control and maintenance of environment an equipment when conducting patient home health visits. Document monitored infection control and maintenance of environment an equipment on an observation...." 2. Observation of a home visit on 1/17/18 at 11:00 a.m. for patient #3, start of care 12/28/17, certification period 12/28/17 - 2/25/18 evidenced employee C providing wound care. Employee C			

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	placed all wound care supplies on a table adjacent to patient #2. Employee C was observed cleansing patient #2's wounds with a pre-opened bottle of normal saline. On 1/17/18 at 11:20 a.m. a label was observed on the pre-opened saline bottle employee C used that indicated it was from a pharmacy, date ordered of 10/12/16 with a use by date of 01/2017. There was no other handwritten time or date on the normal saline bottle that indicated when the bottle was opened. This practice failed to follow infection control guidelines and the agency's policy and procedures on infection control.			
G 0133 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Based on record review and interview the administrator failed to organize and direct the agency's ongoing functions in 1 of 1 agency. The findings include: 1. The agency job description titled "Administrator" stated "Position Summary: Administers, directs, and coordinates activities of the Home Health Agency and its staff. Reports To: The President and the Board of Directors. Qualifications: Registered Nurse, Physician, or experienced health care Administrator Demonstrated ability to supervise and direct personnel Ability to interface with providers, professionals, employees, and members of the community Knowledge of organization and	G 0133	G133. The Administrator reviewed the Home Health Agency's policies on Policy 2.4 Administrative Control and the Job Description Titled "Administrator" for reeducation and clarification (01-22-18). The importance of knowing the scope of Agency services was noted, so also was ensuring the Physicians' signatures are obtained on all plans of care documents and orders.	01/22/2018

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	business management Minimum of two (2) years supervisory or administrative experience Effective written and oral communication and interpersonal skills Essential Functions/Areas of Accountability: Plans overall development and administration of the Agency as set forth in the Conditions of participation and/or applicable state regulations under the direction of the Board of Directors and the advisory board Develops administrative policies and procedures relating to the Home Health Agency Directs installation of improved work methods and procedures to ensure achievement of objectives of the program Coordinates and integrates the total Agency activities through regular conferences with department supervisors Maintain a Quality Assurance and Performance Improvement (QAPI) Program Interprets and transmits policy to the Board of Director, Advisory Committee and supervisory staff to ensure compliance with policies Develops standards and methods of measurement of Agency activity and coordinates the annual program evaluation Prepares a yearly budget in cooperation with the Budget Committee and Board of Directors Approves monthly expenditures, co-signs checks as needed, and monitors the financial position of the Agency Prepares reports on the Agency activity for the Board of Directors and Advisory Committee Determines organization lines of authority and fixes areas of responsibility Approves hiring and termination of all employees Approves salary increases and staff promotions Authorizes purchase of supplies and equipment Contacts local, state, and national associations and participates in meetings, conventions, etc. Cooperates with health and health-related agencies to increase and improve services to the community Promotes education awareness to Agency Staff Ensures continuous compliance		This will be monitored with the review of this Policy for the next two quarters and then yearly during our Professional Advisory Committee meetings in October/November annually. The Board of Directors, the Administrator is responsible for monitoring this corrective action to ensure that this deficiency does not recur.	

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	with all applicable federal and state regulations and Agency policy Handles patients complaints not resolved Handles unresolved problems between staff and supervisors If not appointed by the Board of Directors, appoints a qualified individual to act in the administrator's absence Ensures the development and implementation of a continuing education program to meet identified staff needs Develops an open, positive rapport with community resources affiliated with home health care services Maintains high visibility and availability while in the office via telephone to physicians, referral sources, community resources, patients, and staff ..." 2. Clinical record review on 1/18/18 evidenced patient #7 to have only home health aide services. During the entrance interview on 1/16/18 at 11:05 a.m. the administrator indicated that they did not provide any home health only aide services. The administrator failed to ensure he/she was aware of all the services the agency currently provided. 3. Record review on 1/19/18 evidenced patient #4 and patient #5 failed to have the physician sign the plan of care. The administrator failed to ensure he/she obtained physician orders/signatures on all patients serviced by the home health agency.			
G 0134 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on record review and interview the administrator failed to ensure all staff had adequate education for all population of patients	G 0134	G134. The Administrator and Director of Nursing (DON) reviewed the policies titled	01/23/2018

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	the agency serviced in 1 of 1 agency. The findings include: 1. The agency policy dated 10/15/05 titled "3.1 Referral And Acceptance Of Patients" stated "... The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection. Persons residing outside of the service area or in need of services not provided by the Agency will be assisted in contacting the appropriate resources. Upon receipt of a referral, an evaluation by a Registered Nurse or Physical Therapist (Therapy only cases) will be made to determine that the care can be adequately and safely performed at home, to assess the patient care needs, and to ensure that the patient meets the admission criteria. Patients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility whenever possible. Patients will be assigned to the appropriate staff members by a registered nurse or under the supervision of the registered nurse according to geographical location, clinical needs of the patient, and the qualifications and availability of staff...." 2. The undated agency policy titled "5.1 Inservice Education Programs" stated "... Policy The home health care agency provides in-service education programs for home health care staff members. Purpose 1. To increase home health care staff member competency in a specific area of practice 2. To provide home health care staff members with current health care information. Procedure 1. The Director of Nursing of Home Health Care		"3.1 Referral and Acceptance of Patients" and "5.1. Inservice Education Programs" for reeducation and clarification of procedures. The Administrator and the DON in-serviced all Field on caring for the Pediatric patient. The staff were issued handouts and tested on the in-service given. All staff were expected to have a passing grade of 80% before starting or continuing to care for pediatric patients and this was accomplished (01-23-18). This will be monitored with the review of Agency policies and procedures yearly during our Professional Advisory Committee meetings in October/November annually. The Administrator and DON are responsible for monitoring this corrective action to ensure that this deficiency does not recur.	

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	plans an [sic] in-service education program calendar which could include: 1) Needs and assessment 2) Organizational/Program objectives 2. Posts in-service education program calendar in designated areas one month in advance of the program offerings 3. Home Health Aides are required to attend a minimum of 12 in-service education hours per year. 4. The Director of Nursing or the Administrator of Home Health Care completes and files an In-service Education Program Summary form. 5. Home health care staff members document their participation in in-service education programs on an In-service Education program Attendance form and an Individual In-service/ Continuing Education Record form...." 3. Record Review on 1/17/18 evidenced patient #8 as a current, active patient with ProCare home health. Patient #8 is a pediatric patient that receives skilled nursing care and home health aide care. ProCare has failed to ensure that pediatric in-services were provided to their employees that care for pediatric patients. 4. On 1/19/18 at 12:50 p.m. the administrator and clinical supervisor were interviewed and indicated they were in the process of providing in-service pediatric training to their staff.			
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. Based on record review, observation and interview the home health agency failed to coordinate services with all health care providers serving their patients in 5 of 7 clinical records reviewed. (#1, #2, #4, #5, #6)	G 0143	G143. The Administrator and Director of Nursing (DON) reviewed the policy titled "3.16 Case Conferences" for	02/08/2018

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	The findings include: 1. The undated agency policy titled "3.16 Case Conferences" stated "The purpose of case conferences is to: Determine the adequacy of the plan of treatment and appropriateness of continuation of care Assure coordination of services in patient-goal directed activity on the part of each home care staff member Evaluate patient progress and plans for future care Provide assistance to team members having difficulty planning care for specific problem cases Refer cases that require further study to the clinical record review committee Case conferences shall be held regularly to review problem cases and to review the plan of treatment for appropriateness and feasibility of continued services. Such conferences shall be documented separately or in the clinical record and should be held on each patient at the time of admission; prior to the date the plan of treatment is due for the review at least every 60 days and prior to discharge. However, if a problem arises, a case-specific conference would be indicated. All professional disciplines participating in the patient's care should have input at his [sic] conference. For personnel participating in the patient's care but unable to attend the conference, a telephone conference could be established. Documentation of the conference shall be the responsibility of the primary nurse or supervisor, or other professional as instructed by the supervisor. The documentation shall include a summary of progress, assessment of the need for continued care, plans and discharge goals. ... All staff delivering patient care services is encouraged to have at least weekly contact with their Case manager and as needed. Any conference related to an individual patient may be documented as a		reeducation on coordinating services provided by all Healthcare Providers in the patients Home. All field staff was in-serviced by the DON on 02-08-18 on the importance of identifying all Healthcare providers; types, disciplines with frequencies and documenting and coordinating services with them. The DON or her clinical designee will review all progress notes weekly to assure compliance with Care Coordination. Also, during the monthly case conference meetings, Coordination of Care will be emphasized. The DON will be responsible for ensuring that this deficiency does not recur.	

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	case conference...." 2. Clinical record review on 1/19/18 for patient #1 evidenced an agency document titled "OASIS-C2 START OF CARE" that was dated 12/19/17 and electronically signed by employee C. This document had an area subtitled "Coordination of Care" that stated "... Name: [agency #26] Regarding: Homemaker Services 9 Hours/Week". The home health agency failed to provide any documentation that evidenced coordination of care with agency #26. During an interview on 1/19/18 at 1:35 p. m. the administrator indicated that they are not documenting coordination of care. The administrator also indicated that if everything is going ok they don't write anything down. 3. Clinical record review on 1/18/18 for patient #2 evidenced an agency document titled "OASIS-C2 START OF CARE" dated 11/25/17 and electronically signed by employee C. This document had an area subtitled "Coordination of Care" that stated "... Regarding: HHA [home health aide] services 5 days/week. This document failed to indicate what agency was providing home health aide services and failed to evidence any coordination of care with other agency. 4. Clinical record review on 1/19/18 for patient #4 failed to evidence any coordination of care with the patient's primary care physician. The agency document titled "Home Health Certification And Plan Of Care" dated 11/30/17 and electronically signed by employee L indicated the patient's physician is physician #BB, which was a hospitalist affiliated with agency #29. This physician only practices inside the facility with admitted patients. The home health agency failed to identify the patient's primary physician.			

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	5. Clinical record review on 1/17/18 for patient #5, start of care 7/23/17, certification period 11/20/17 - 1/18/18, evidenced a document titled "Home Health Care Certification And Plan Of Care", electronically signed by employee C and undated, with no physician signature. This document had an area subtitled "21. Orders for Discipline and Treatment (Specify Amount/Frequency/Duration)" that stated "... Coordination of Care with agency #26 (HHA [Home Health Aide] services) and agency #27 (SN [Skilled Nursing] for wound care)". The agency failed to provide any clinical documentation to show coordination of care with the other health care agencies that provided care to their patient. During an interview on 1/19/18 at 2:16 p.m., employee C indicated that "the patient likes agency #26 because there is a home health aide at that agency that the patient really likes. We speak with both agencies and there have been no problems but I'm not sure if that has been documented." During the same interview employee G stated "agency #28 does that, they assign different companies for different reasons" in reference to the multiple health care agencies that cared for one patient. 6. Clinical record review on 1/19/18 for patient #6 evidenced an agency document titled "NON-OASIS START OF CARE" dated 1/9/18 and electronically signed by employee C. This document had an area subtitled "Dialysis" that indicated the patient was on dialysis, that the dialysis type is "Home dialysis Permacath and a statement that read "Patient receives home dialysis daily with Dialysis nurse". During a home visit on 1/19/18 observation was made of a home dialysis machine in the patient's bedroom. During an interview with patient #6 on 1/19/18 at 10:50			

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	a.m. the patient indicated he/she received dialysis Monday - Friday from a home dialysis nurse. Patient #6 was unaware of the company that provided the in-home dialysis. During an interview with the family member on 1/19/18, he/she indicated he/she was not aware of the company name. Observation was made of a folder on patient #6 dining room table with agency #30 on the label; upon asking the family member what services they provided for patient #6 he/she indicated they offered the patient free home health aide hours and that they were considering employing agency #30. During an interview with the clinical supervisor and administrator on 1/19/18 at 1:42 p.m. the clinical supervisor indicated that their should probably be coordination because he/she gets home dialysis every day. During the interview the clinical supervisor indicated he/she did not remember the name of the company that provided the patient home hemodialysis. The agency failed to coordinate care with the home hemodialysis company for patient #6.			
G 0157 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Based on record review the home health agency failed to meet the patient's therapy needs in 1 of 7 clinical charts reviewed. (#1) The findings include: 1. The agency policy dated 10/15/05 titled "3.1 Referral and Acceptance Of Patients" stated "...	G 0157	G157. The Administrator and Director of Nursing (DON) reviewed the policies titled "3.1 Referral and Acceptance of Patients" and "9.4 Therapy Services" for reeducation and clarification	01/22/2018

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	The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection. Persons residing outside of the service area or in need of services not provided by the Agency will be assisted in contacting the appropriate resources. Upon receipt of a referral, an evaluation by a Registered Nurse of Physical Therapist (Therapy only cases) will be made to determine that the care can adequately and safely performed [sic] at home, to assess the patient care needs, and to ensure that the patient meets the admission criteria. Patients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility whenever possible. Patients will be assigned to the appropriate staff members by a registered nurse or under the supervision of the registered nurse according to geographical location, clinical needs of the patient, and the qualifications and availability of staff...." 2. The agency policy dated 10/19/06 titled "9.4 Therapy Services" stated "... A copy of the verbal order and the Therapy Referral Form will be faxed to the Agency/Therapist providing therapy services. A copy of the Therapy Referral Form will be submitted along with the M.D. [medical director] order. The Nursing Supervisor will contact the agency Therapist providing therapy services and verbally inform them of the referral. The Nursing Supervisor will fax a copy of the verbal order and referral. The Therapist will visit the patient within 48-72 hours. The Director of Nursing will be notified if the family requested an evaluation other than the above stated time frame. After the assessment, the Therapist will Contact		of the procedures. The need to meet the medical, nursing, rehabilitation and social needs of the patient was emphasized. The DON will review all new referrals to ensure that the agency can provide the requested services directly or by contract. The DON will contact the patient's physician when the agency cannot meet the patient's needs and arrange for the patient to be transferred to another agency. To assure that this deficiency is corrected, the DON or Assistant Director of Nursing (ADON) will review all new referrals to ensure that the agency can provide the requested services directly or by contract. The Administrator and DON will be responsible for ensuring that this deficiency does not recur.	

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	the Case Manager/DON [director of nursing] to communicate the findings and plan. The Therapist will submit initial assessment to ProCare Home Health within 24-48 hrs [hours]. ProCare Home Health Services will submit the submitted initial assessment to the physician for signature. The agency will receive a copy of the patient therapy schedule each Monday. If there are problems, contact the Director of Nurses/Clinical Supervisor immediately. A case conference for each patient receiving PT [physical therapy], OT [occupational therapy], and ST [speech therapy] services will be conducted at least every thirty (60) [sic] days. The assigned Case Manager and HHA [home health aide] (if applicable) will be in attendance. A case conference will be scheduled prior to discharge of each patient. The Physical Therapist will report directly to the Director of Nursing...." 2. Clinical record review on 1/19/18 for patient #1, start of care 12/19/17, certification period 12/19//17 - 2/16/18, evidenced an agency document titled "Patient Profile" that indicated the services required for patient #1 was PT [physical therapy], OT [occupational therapy] and ST [speech therapy]. Only PT was evidenced as being provided to patient #1 by the home health agency. 3. Clinical record review on 1/19/18 for patient #1 evidenced faxed hospital paperwork dated 1/16/18 this paperwork had an area subtitled "Referrals/Response Letter" that stated "Per Dr. #AA, have PT/OT/ST. Dx [diagnosis]: dysarthria...." This area was addressed to Procare HHC [home health care]. There was no evidence of OT or ST ever being provided. Record review failed to evidence any documentation or physician order cancelling the occupational and speech therapy.			

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	4. Clinical record review on 1/19/18 for patient #1 evidenced an agency document titled "OASIS-C2 START OF CARE" dated 12/19/17 and electronically signed by employee C. This document had an area subtitled "Functional Limitations" that had an "x" noted by endurance, speech, contracture, incontinence and ambulation. The same document listed multiple areas that supported the need for OT and ST services as follows: a. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled Oasis M1230 (M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language) that had the code "03" placed in a box. Code "03" stated "3 - Has severe difficulty expressing basic ideas; requires maximal assistance or guessing by listener. Limited to single words/short phrases." b. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)" with a "x" marked by "2 - Impaired decision-making: failure to perform usual (I)ADLs [activities of daily living], inability to appropriately stop activities, jeopardized safety through actions". c. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1810) Current ability to dress upper body including undergarments, pullovers, front-opening shirts and blouses, managing zippers/buttons/snaps." that had a code of "02" placed in box. Code "02" stated "2 - Someone			

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	must help the patient put on upper body clothing." An area subtitled "(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes." that had a code of "03" placed in box. Code "03" stated "3 - Patient depends entirely upon another person to dress lower body." An area subtitled "(M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair)." that had a code of "05" placed in box. Code "05" stated "5 - Unable to use the shower/tub, able to participate in bathing self in bed/sink/bedside chair/commode with assistance or supervision." d. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten." that had a code of "01" placed in box. Code "01" stated "1 - Able to feed self but requires meal set-up, or intermittent assistance/supervision, or a liquid/pureed/ground meat diet." e. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:" that had a code of "02" placed in box. Code "02" stated "2 - Unable to prepare any light meals or reheat any delivered meals." f. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including			

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	dialing numbers, and effectively using the telephone to communicate." that had a code of "04" placed in box. Code "04" stated "4 - Unable to answer the telephone at all but can listen if assisted with equipment." 5. Clinical record review on 1/19/18 evidenced the skilled nurse initial/comprehensive assessment titled "OASIS-C2 START OF CARE" dated 12/19/17 and electronically signed by employee C. This document assessment provided by employee C evidenced the need for the patient to have occupational therapy and speech therapy as ordered by the physician. The home health agency failed to provide these services to patient #1 and failed to meet patient #1's needs in their place of residence.			
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on record review the home health agency failed to follow the plan of care established and periodically reviewed by the physician in 6 of 7 clinical charts reviewed. (#1, #2, #3, #4, #5, #6, #7) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To	G 0158	G158. The Administrator and Director of Nursing (DON) reviewed the policies titled “3.1 Referral and Acceptance of Patients” and “3.9 Medical Supervision” for reeducation and clarification of procedures. The DON in-serviced the skilled staff on following the Physicians’ orders (including disciplines requested, with frequencies), performing only ordered	02/08/2018

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	ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members. Includes the following: ... Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to		tasks, providing instructions (for example; caregiver/patient instructions on employing non-pharmaceutical pain relief modalities, filling the medication box, patient positioning and repositioning etc.) in accordance with the plan of care. Also, staff is to notify the patient's physicians of missed visits when they cannot be made up. To assure the physician orders and plan of care are being followed, the DON or her clinical designee will review all progress notes weekly as part of the weekly quality assurance process to ensure compliance. The DON will be responsible for ensuring that this deficiency does not recur.	

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	approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. Record review on 1/19/18 of patient #1, start of care 12/19/17, certification period 12/19/17 - 2/16/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN [skilled nurse] Frequency: 1W9 [once a week for 9 weeks]. PT [physical therapy] Frequency: 2W4 [2 times weekly for 4 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN to assess if the Caregiver can verbalize an understanding of the indication for each mediation. Physical therapist to evaluate and submit plan of treatment. SN to instruct the Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The physician signed plan of care failed to be followed by the skilled nurse as follows: a. Record review on 1/19/18 evidenced an			

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	agency document titled "LVN [licensed vocational nurse]/LPN [licensed practical nurse] Visit" dated 12/27/17 and electronically signed by employee E. This document had an area subtitled "Diabetic Care" that indicated patient #1's a.m. blood sugar was 109 mg/dl [milligram/deciliter] that the check was performed by the skilled nurse on the patient's left finger. The physician signed plan of care did not order for the skilled nurse to perform blood sugar checks on patient #1. The skilled nurse failed to follow the plan of care. b. Record review on 1/19/18 failed to evidence the skilled nurse instructed the patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs, failed to assess if the Caregiver can verbalize an understanding of the indication for each medication, and failed to instruct the caregiver to contact the agency to report any fall with or without minor injury and to call 911 for fall resulting is serious injury or causing severe pain or immobility as directed on the physician signed plan of care. 3. Record review on 1/18/18 of patient #2, start of care 11/25/17, certification period 11/25/17 - 1/23/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 12/11/17 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W10 [once weekly for 10 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); SN to instruct Patient/Caregiver on turning/repositioning every 2			

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	hours. SN to assess skin for breakdown every visit. SN to assess/instruct on seizure disorder signs & symptoms and appropriate actions during seizure activity. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing sever pain or immobility. SN to assess caregiver filling mediation box to determine if caregiver is preparing correctly. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. Patient refused Physical Therapy services at this time." The physician signed plan of care failed to be followed by the skilled nurse as follows: a. Record review on 1/18/18 for patient #2 evidenced a missed visit the week of 12/31/17 - 1/6/18. During an interview on 1/18/18 at 3:23 p.m. employee C indicated the skilled nurse couldn't see the patient at a certain time the family requested. There was no evidence that another visit time was arranged or that the physician was notified for the missed visit. The skilled nurse failed to follow the physician signed plan of care. b. Record review on 1/18/18 for patient #2 failed to evidence the nurse assess/instructed on seizure disorder signs and symptoms and appropriate actions during seizure activity, assessed the caregiver filling the medication box to determine if the caregiver is preparing correctly, and determine if the caregiver is able to identify the correct dose route, and frequency of each medication on skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/22/17, 12/28/17 and 1/10/18. The skilled nurse failed to follow the physician signed plan of care. c. Record review on 1/18/18 for patient #2			

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	failed to evidence the nurse instructed the caregiver on turning/repositioning every 2 hours on the skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/28/17 and 1/10/18 as ordered on the physician signed plan of care. 4. Record review on 1/19/18 of patient #3, start of care 12/28/17, certification period 12/28/17 - 2/25/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W1 [once a week for 1 week], 2W4 [2 times a week for 4 weeks], 1W5 [once a week for 5 weeks]. HHA [home health aide] Frequency: 1W1, 2W4. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to assess pain eve and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to instruct the Patient on methods to reduce friction and shear. SN to perform/instruct on wound care as follows: clean with NaCl [sodium chloride] apply Medihoney cover with Allevyn. SN to assess skin for breakdown every visit. May discontinue wound care when wound(s) have healed. SN to assess patient for diet compliance. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to use prescribed assistive device when ambulating. SN to instruct patient to change positions slowly. HHA to assist with ADL's [activities of daily living] & IADL's [instrumental			

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	activities of daily living] per HHA care plan. SN to assess patient filling medication box to determine if patient is preparing correctly. SN to determine if the Patient is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient can verbalize an understanding of the indication for each medication. Physical therapist to evaluate and submit plan of treatment." The physician signed plan of care failed to be followed as evidenced by: a. Record review on 1/19/18 for patient #3 evidenced the skilled nurse had an extra visit during the week of 1/7/18 - 1/13/18. No extra visit order was evidenced in the clinical record and no prn [as needed] visits were ordered on the plan of care. During an interview on 1/19/18 at 1:55 p.m. employee C indicated he/she would have to write an order for the extra visit made to patient #3. The skilled nurse failed to follow the physician signed plan of care and failed to obtain a physician order for the extra visit. b. Record review on 1/19/18 for patient #3 failed to evidence the skilled nurse to instruct the patient on nonpharmacologic pain relief measures on the skilled nurse visits dated 1/2/18 and 1/5/18 as ordered on the physician signed plan of care. c. Record review on 1/19/18 for patient #3 failed to evidence the skilled nurse instructed the patient to wear proper footwear when ambulating, instructed the patient to use prescribed assistive device when ambulating, assessed the patient filling medication box to determine if the patient was preparing correctly, determined if the patient is able to identify the correct dose, route, and frequency of each medication and assessed if the patient can verbalize an understanding of the			

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	indication for each medication on the skilled nurse visits dated 1/2/18, 1/5/18, 1/8/18, 1/10/18 and 1/12/18 as ordered on the physician signed plan of care. 5. Record review on 1/19/18 for patient #4 failed to evidence a physician signed plan of care. During an interview on 1/19/18 at 2:10 p.m. the clinical supervisor indicated that the agency never received a signed plan of care from the physician. Record review failed to evidence any physician signed order for ProCare Home Health services. The only order evidenced was titled "Coram ... Prescriber Order" signed by a pharmacist on 12/6/17 with no prescriber signature evidenced. 6. Record review on 1/19/18 for patient #5 failed to evidence a physician signed plan of care for certification period 11/20/17 - 1/18/18. Record review failed to evidence any physician signed order for ProCare Home Health services for this certification period. Skilled nursing care was provided for this certification period on 11/24/17 by employee J, 11/27/17 by employee E, 11/29/17 by employee J, 12/1/17 by employee J, 12/4/17 by employee E, 12/6/17 by employee J, 12/8/17 by employee J, 12/11/17 by employee E, 12/12/17 by employee J and 12/13/17 by employee J. 7. Record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced a document titled "Home Health Certification And Plan Of Care". This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 24visits. PT Frequency: 6 visits. OT [occupational therapy]: 3 visits. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to			

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	get up and move safely; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); Other: Bilateral BKA [below knee amputation]; SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient to take pain mediation before pain becomes severe to achieve better pain control. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain mediations, pain affecting ability to perform patient's normal activities. SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to instruct the Patient/Caregiver on methods to reduce friction and shear. SN to instruct the Patient/Caregiver to pad all bony prominences. SN to perform/instruct on wound care as follows: SN to cleanse wound to sacral area with wound cleanser and apply Silver Alginate to wound bed and packed with gauze and tape 3XW [3 times weekly]. SN to assess skin for breakdown every visit. SN to instruct the Patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes. May discontinue wound care when wound(s) have healed. SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications. SN to prefill syringes with Levemir insulin as follows: 10units to be taken Q [every] HS [at bedtime]. Patient to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2GM [gram] Na+ [sodium] ADA [American			

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	157538	A. BUILDING 00 B. WING	01/19/2018

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	diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver can verbalize an understanding of the indication for each medication. SN to assess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics. Physical therapist to evaluate and submit plan of treatment. Occupational therapist to evaluate and submit plan of treatment. Physical therapy to evaluate. Occupational therapy to evaluate. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The skilled nurse and occupational therapist failed to follow the plan of care this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/caregiver to pad all bony prominences, instruct the patient/caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes, instruct the patient/caregiver on 2GM Na+ ADA diet, determine if the caregiver is able to identify the correct dose, route, and frequency of each medication, assess if the caregiver can verbalize an understanding of the indication for each medication, assess the caregiver administering injectable medications to determine if proper technique was utilized, instruct the caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics and to			

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	instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility as ordered on the plan of care for the skilled nurse visits dated 1/11/18 and 1/12/18. b. Record review on 1/19/18 failed to evidence the occupational therapist evaluated or submitted a plan of treatment as ordered on the plan of care for patient #6. 8. Clinical record review on 1/19/18 for patient #7, start of care 2/22/2016, certification period 12/13/17 - 2/10/18, evidenced a document titled "Home Health Care Certification And Plan Of Care", electronically signed and dated by physician on 12/27/18. This document had an area subtitled "Section 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "HHA Frequency: 2W1 [2 times a week for 1 week], 3W8 [3 times a week for 8 weeks]. Mondays and Wednesdays 4hrs [hours]/visit; Fridays 2 hrs/visit Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; HHA to assist with ADL's & IADL's per HHA care plan. HHA to report significant changes to SN....". The physician signed plan of care failed to be followed as evidenced by: a) Record review on 1/19/18 evidenced an agency document dated 12/13/17, titled "ProCare Home Health Services HHA Visit", electronically signed and dated by employee B on 12/13/2017, evidenced the following: "Time In 10:00 a.m. Time Out: 01:00 p.m." The agency failed to present documentation showing that the home health aide			

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	completed the 4 hour visit as ordered. b) Record review on 1/19/18 evidenced an agency document dated 12/26/17, titled "ProCare Home Health Services ...HHA Visit", electronically signed and dated by employee B on 12/26/2017, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered. The agency also failed to present documentation indicating physician orders for home health aide to complete the visit on a Tuesday. c) Record review on 1/19/18 evidenced an agency document dated 12/27/17, titled "ProCare Home Health Services HHA Visit", electronically signed and dated by employee B on 12/27/2017, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered. d) Record review on 1/19/18 evidenced an agency documented dated 1/2/2018, titled "ProCare Home Health Services HHA Visit", electronically signed and dated by employee B on 1/2/2018. The agency failed to present documentation indicating physician orders for home health aide to complete the visit on a Tuesday. e) Record review on 1/19/18 evidenced an agency document dated 1/10/2018, titled "ProCare Home Health Services HHA Visit", electronically signed and dated by employee B on 1/10/2018, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered.			

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	f) Record review on 1/19/18 evidenced an agency document dated 1/15/2018, titled "ProCare Home Health Services HHA Visit", electronically signed and dated by employee B on 1/15/2018, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered.			
G 0159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on record review the home health agency failed to ensure all plans of care contained pertinent patient diagnosis and all equipment patient required to maintain health in 1 of 7 clinical charts reviewed. (#6) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To	G 0159	G159. Director of Nursing (DON) reviewed the policy titled “3.9 Medical Supervision/Patient Plan of Care” for reeducation and clarification of procedures. The DON in-serviced the skilled staff on the importance of ensuring that all pertinent patient information including diagnosis, all equipment are captured in the plan of care as a standard of	02/08/2018

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	ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members. Includes the following: Date the patient plan of care is written Type of ProCare Home Health services and equipment required Patient diagnosis Patient mental status Patient functional limitations Patient rehabilitation potential Type of nursing services needed Frequency of needed nursing services Patient medication Patient special diet Patient activities permitted Patient treatment Rehabilitation and therapy services Home health aide services Medical supplies/appliances necessary Any safety measures to protect against patient injury Instructions for timely patient discharge or referral Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed		professional practice. The DON or her clinical designee will review each Plan of Care for completeness before mailing to the physician for signature. The DON will be responsible for ensuring that this deficiency does not recur.	

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	plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. Clinical record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced an agency document titled "Physician Face To Face Encounter" dated 1/12/18 and signed by the physician. This document stated "... The primary medical reason, diagnosis, or condition related to the reason for home healthcare for the encounter was: Renal failure on Dialysis B [bilateral] BKA [below knee amputation] Due to PAD [peripheral arterial disease] And Ischemia Sacral Wound gait [illegible writing] Other Conditions/Diagnoses related to the needed home care: Wound Care help c [with] Home Dialysis Med mgt [medication management] PT/OT ..." 3. Clinical record review on 1/19/18 for patient #6, primary diagnosis of osteomyelitis, unspecified, evidenced an agency document titled "Home Health Certification And Plan Of Care" with no date and electronically signed by employee C.			

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	This document had an area subtitled "13. ICD-10-CM Other Pertinent Diagnoses" that stated "...Complete traum [traumatic] amp [amputation] at lev [level] betw [between] kn [knee] and ankl [ankle], r [right] low [lower] leg, subs ... Complete traum amp at lev betw kn and ankl, l [left] low leg, subs ... Dysphagia, oropharyngeal phase ... Anemia, unspecified ... Pressure ulcer of sacral region, stage 4 ... Type 2 diabetes mellitus without complications ..." This plan of care document failed to list patient #6's renal failure in which the patient receives dialysis at home 5 days a week. The agency failed to ensure identification of all the patient's pertinent health conditions. 4. Clinical record review on 1/19/18 for patient #6 evidenced an agency document titled "Home Health Certification And Plan Of Care" undated and electronically signed by employee C. This document had an area subtitled "14. DME [durable medical equipment and Supplies" that stated "Hospital Bed, Wheelchair, hoyer lift, Overhead trapeze, alcohol pads, Chux/Underpads, Diabetic Supplies, Dressing Supplies, Gauze Pads, Needles, Probe Covers, Sharps Container, Syringe, Tape, non sterile gloves, Silver Alginate pads, wound cleanser". The home health agency failed to list the type of home hemodialysis machine and dialysate fluids the patient had in the home. The plan of care failed to contain all the DME's and supplies the patient utilized.			
G 0165 Bldg. 00	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on record review and interview the home health agency failed to ensure physician orders	G 0165	G165. Director of Nursing (DON) reviewed the policy	02/08/2018

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	were obtained before administering medications and/or treatments in 2 of 7 clinical records reviewed. (#4, #5) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff and interdisciplinary team members. ... 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if the changes are requested orally, are reduced to writing, signed by a ProCare Home Health		titled “3.9 Medical Supervision/Patient Plan of Care” for reeducation and clarification of procedures. The DON in-serviced the skilled staff on adhering to the Physicians’ orders and Plan of Care. Also all orders must be signed before being carried out and no intervention should be carried without the Physicians’ orders. The DON or her clinical designee will review the clinical notes weekly to ensure the orders and treatment plans are being followed. Also 10% of clinical records will be selected and reviewed quarterly for evidence that physician’s orders are being followed. The DON will be responsible to ensure that this deficiency does not recur.	

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	Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ..." 2. Record review on 1/19/18 for patient #4 start of care 11/30/17, certification period 11/30/17 - 1/28/18, failed to evidence a physician signed order for the intravenous administration of Vancomycin [antibiotic] or Daptomycin [antibiotic]. Record review did evidence a document titled "Coram ... Prescriber Order" dated 12/6/17 and signed only by a pharmacist. There was no evidence of a physician signature on the document or any another documented signed physician order for the intravenous administration of the antibiotics evidenced in clinical record #4. During an interview on 1/19/19 at 2:04 p.m. the clinical supervisor indicated that Daptomycin was not listed on the agency medication reconciliation. a. Clinical record review on 1/19/18 evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 11/30/17 and electronically signed by employee L. This document had an area subtitled "10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged" that listed "Vancomycin 750mg [milligrams]/250ml [milliliters] q [every] day intravenous (IV) N". This agency document failed to be signed by a physician. During an interview on 1/19/18 at 1:57 p.m. the clinical supervisor indicated he/she would have to look for the orders. The home health agency failed to obtain a physician order before the administration of the medication. 3. Record review on 1/19/18 for patient #5, start of care 11/23/16, certification period 11/20/17 -			

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	1/18/18 evidenced the skilled nurse performed enemas on the patient. No physician signed order for the skilled nurse to perform enemas was evidenced in the clinical record. The skilled nurse performed enemas on the following visits dated: 11/24/17, 11/27/17, 11/29/17, 12/4/17, 12/6/17, 12/8/17, 12/11/17 and 12/13/17. The skilled nurse failed to obtain a physician order before performing treatments on patient #5.			
G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review the skilled nurse failed to follow the plan of care established by the physician in 4 of 7 clinical charts reviewed. (#1, #2, #3, #6) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members.	G 0170	G170. Director of Nursing (DON) reviewed the policy titled “3.9 Medical Supervision/Patient Plan of Care” for reeducation and clarification of procedures. The DON in-serviced the skilled staff on adhering to the Plan of Care; no intervention should be carried without the Physicians’ orders. Orders must be obtained for missed visits that are not made up and all instructions to patients/caregivers must be given in accordance to the treatment plan. The DON or her clinical designee will review the clinical notes weekly to ensure the orders and	02/08/2018

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	Includes the following: ... Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. Clinical record review on 1/19/18 of patient #1, start of care 12/19/17, certification period 12/19/17 - 2/16/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This		treatment plans are being followed. Also 10% of clinical records will be selected and reviewed quarterly for evidence that physician's orders are being followed. The DON will be responsible to ensure that this deficiency does not recur.	

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	document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN [skilled nurse] Frequency: 1W9 [once a week for 9 weeks]. PT [physical therapy] Frequency: 2W4 [2 times weekly for 4 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN to assess if the Caregiver can verbalize an understanding of the indication for each mediation. Physical therapist to evaluate and submit plan of treatment. SN to instruct the Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by: a. Clinical record review on 1/19/18 evidenced an agency document titled "LVN [licensed vocational nurse]/LPN [licensed practical nurse] Visit" dated 12/27/17 and electronically signed by employee E. This document had an area subtitled "Diabetic Care" that indicated patient #1's a.m. blood sugar was 109 mg/dl [milligram/deciliter] that the check was performed by the skilled nurse on the patient's left finger. The physician signed plan of care did not order for the skilled nurse to perform blood sugar checks on patient #1. The skilled nurse failed to			

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	follow the plan of care. b. Record review on 1/19/18 failed to evidence the skilled nurse instructed the patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs, failed to assess if the Caregiver can verbalize an understanding of the indication for each medication, and failed to instruct the caregiver to contact the agency to report any fall with or without minor injury and to call 911 for fall resulting is serious injury or causing severe pain or immobility as directed on the physician signed plan of care. 3. Clinical record review on 1/18/18 of patient #2, start of care 11/25/17, certification period 11/25/17 - 1/23/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 12/11/17 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W10 [once weekly for 10 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to assess skin for breakdown every visit. SN to assess/instruct on seizure disorder signs & symptoms and appropriate actions during seizure activity. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing sever pain or immobility. SN to assess caregiver filling mediation box to determine if caregiver is preparing correctly. SN to determine if the			

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	Caregiver is able to identify the correct dose, route, and frequency of each medication. Patient refused Physical Therapy services at this time." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by: a. Clinical record review on 1/18/18 for patient #2 evidenced a missed visit the week of 12/31/17 - 1/6/18. During an interview on 1/18/18 at 3:23 p.m. employee C indicated the skilled nurse couldn't see the patient at a certain time the family requested. There was no evidence that another visit time was arranged or that the physician was notified for the missed visit. The skilled nurse failed to follow the physician signed plan of care. b. Record review on 1/18/18 for patient #2 failed to evidence the nurse assess/instructed on seizure disorder signs and symptoms and appropriate actions during seizure activity, assessed the caregiver filling the medication box to determine if the caregiver is preparing correctly, and determine if the caregiver is able to identify the correct dose route, and frequency of each medication on skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/22/17, 12/28/17 and 1/10/18. The skilled nurse failed to follow the physician signed plan of care. c. Record review on 1/18/18 for patient #2 failed to evidence the nurse instructed the caregiver on turning/repositioning every 2 hours on the skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/28/17 and 1/10/18 as ordered on the physician signed plan of care. 4. Clinical record review on 1/19/18 of patient #3, start of care 12/28/17, certification period 12/28/17 - 2/25/18, evidenced an agency document titled "Home Health Certification And Plan Of Care"			

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	dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W1 [once a week for 1 week], 2W4 [2 times a week for 4 weeks], 1W5 [once a week for 5 weeks]. HHA [home health aide] Frequency: 1W1, 2W4. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to assess pain eve and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to instruct the Patient on methods to reduce friction and shear. SN to perform/instruct on wound care as follows: clean with NaCl [sodium chloride] apply Medihoney cover with Allevyn. SN to assess skin for breakdown every visit. May discontinue wound care when wound(s) have healed. SN to assess patient for diet compliance. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to use prescribed assistive device when ambulating. SN to instruct patient to change positions slowly. HHA to assist with ADL's [activities of daily living] & IADL's [instrumental activities of daily living] per HHA care plan. SN to assess patient filling medication box to determine if patient is preparing correctly. SN to determine if the Patient is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient can verbalize an understanding of the indication for each medication. Physical therapist to evaluate and submit plan of treatment." The physician signed plan of care failed to be followed as			

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	evidenced by: a. Clinical record review on 1/19/18 for patient #3 evidenced the skilled nurse had an extra visit during the week of 1/7/18 - 1/13/18. No extra visit order was evidenced in the clinical record and no prn [as needed] visits were ordered on the plan of care. During an interview on 1/19/18 at 1:55 p.m. employee C indicated he/she would have to write an order for the extra visit made to patient #3. The skilled nurse failed to follow the physician signed plan of care and failed to obtain a physician order for the extra visit. b. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse to instruct the patient on nonpharmacologic pain relief measures on the skilled nurse visits dated 1/2/18 and 1/5/18 as ordered on the physician signed plan of care. c. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse instructed the patient to wear proper footwear when ambulating, instructed the patient to use prescribed assistive device when ambulating, assessed the patient filling medication box to determine if the patient was preparing correctly, determined if the patient is able to identify the correct dose, route, and frequency of each medication and assessed if the patient can verbalize an understanding of the indication for each medication on the skilled nurse visits dated 1/2/18, 1/5/18, 1/8/18, 1/10/18 and 1/12/18 as ordered on the physician signed plan of care. 5. Clinical record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced a document titled "Home Health			

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	Certification And Plan Of Care". This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 24visits. PT Frequency: 6 visits. OT [occupational therapy]: 3 visits. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); Other: Bilateral BKA [below knee amputation]; SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient to take pain mediation before pain becomes severe to achieve better pain control. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain mediations, pain affecting ability to perform patient's normal activities. SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to instruct the Patient/Caregiver on methods to reduce friction and shear. SN to instruct the Patient/Caregiver to pad all bony prominences. SN to perform/instruct on wound care as follows: SN to cleanse wound to sacral area with wound cleanser and apply Silver Alginate to wound bed and packed with gauze and tape 3XW [3 times weekly]. SN to assess skin for breakdown every visit. SN to instruct the Patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes. May discontinue wound care when wound(s) have healed. SN to assess			

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	wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications. SN to prefill syringes with Levemir insulin as follows: 10units to be taken Q [every] HS [at bedtime]. Patient to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2GM [gram] Na+ [sodium] ADA [American diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver can verbalize an understanding of the indication for each medication. SN to assess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics. Physical therapist to evaluate and submit plan of treatment. Occupational therapist to evaluate and submit plan of treatment. Physical therapy to evaluate. Occupational therapy to evaluate. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The skilled nurse failed to follow the plan of care, this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/caregiver to pad all bony prominences, instruct the patient/caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes, instruct the patient/caregiver on 2GM Na+ ADA diet, determine if the caregiver is able to identify the correct dose, route, and			

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	frequency of each medication, assess if the caregiver can verbalize an understanding of the indication for each medication, assess the caregiver administering injectable medications to determine if proper technique was utilized, instruct the caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics and to instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility as ordered on the plan of care for the skilled nurse visits dated 1/11/18 and 1/12/18.			
G 0173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on record review the skilled nurse failed to list all patients pertinent diagnoses on the initial plan of care in 1 of 7 clinical charts reviewed. (#6) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application	G 0173	G173. The Director of Nursing (DON) reviewed the policy titled “3.9 Medical Supervision/Patient Plan of Care” for reeducation and clarification of procedures. The DON in-serviced the skilled staff on the importance of ensuring that all pertinent patient information including diagnosis, all equipment are captured in the plan of care as a standard of professional practice. The DON or her clinical designee will review each Plan of Care for	02/08/2018

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	of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members. Includes the following: Date the patient plan of care is written Type of ProCare Home Health services and equipment required Patient diagnosis Patient mental status Patient functional limitations Patient rehabilitation potential Type of nursing services needed Frequency of needed nursing services Patient medication Patient special diet Patient activities permitted Patient treatment Rehabilitation and therapy services Home health aide services Medical supplies/appliances necessary Any safety measures to protect against patient injury Instructions for timely patient discharge or referral Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant		completeness before mailing to the physician for signature. The DON will be responsible for ensuring that this deficiency does not recur.	

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	out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. Clinical record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced an agency document titled "Physician Face To Face Encounter" signed 1/12/18 and signed by the physician. This document stated "... The primary medical reason, diagnosis, or condition related to the reason for home healthcare for the encounter was: Renal failure on Dialysis B [bilateral] BKA [below knee amputation] Due to PAD [peripheral arterial disease] And Ischemia Sacral Wound gait [illegible writing] Other Conditions/Diagnoses related to the needed home care: Wound Care help c [with] Home Dialysis Med mgt [medication management] PT/OT ..." 3. Clinical record review on 1/19/18 for patient #6, primary diagnosis of osteomyelitis, unspecified, evidenced an agency document titled "Home Health Certification And Plan Of Care" with no dated and electronically signed by employee C. This document had an area subtitled "13. ICD-10-CM Other Pertinent Diagnoses" that stated "...Complete traum [traumatic] amp [amputation] at lev [level] betw [between] kn [knee] and ankl [ankle], r [right] low [lower] leg, subs ... Complete traum amp at lev betw kn and ankl, l [left] low leg, subs ... Dysphagia, oropharyngeal phase ...			

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	Anemia, unspecified ... Pressure ulcer of sacral region, stage 4 ... Type 2 diabetes mellitus without complications ..." This plan of care document failed to list patient #6's renal failure in which the patient receives dialysis at home 5 days a week. The agency failed to ensure identification of all the patient's pertinent health conditions.			
G 0180 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares clinical and progress notes. Based on record review the licensed practical nurse failed to ensure the clinical notes were complete upon each visit to the patient in 1 of 7 clinical records reviewed. (#5) The findings include: 1. The undated agency policy titled "4.4 Charting" stated "... Policy Home health services given during each home visit shall be documented on the appropriate disciplines visit note. Documentation is made on the day the service is rendered. Purpose To document the home health care services given to patients. To provide permanent and continuous records of home health care observations, interventions, and outcomes. Procedure Home health care staff and interdisciplinary team members document all patient home health care on the day the service is rendered. Such documentation includes, but is not limited to, the following: A. Month, day, and year of home health care visit B. Time of home health visits ... F. Patient assessment G. Additional patient assessments H. Patient interventions I. Patient outcomes J. Patient health care education K. Contacts and visits by physician ... O. Pertinent current and past	G 0180	G180. Director of Nursing (DON) reviewed the policy titled “4.4 Charting” for reeducation and clarification of procedures. The DON in-serviced the Nursing staff on the importance of complete documentation of clinical notes as a standard of professional practice. All aspects of the documentation form must be completed. Assessments of patient’s pain, respiratory, cardiovascular, nutritional and neurological statuses etc. must be performed and recorded. The DON or her clinical designee will review the clinical notes weekly to ensure that all aspects of the clinical notes are complete	02/08/2018

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	findings ... Home health care staff and interdisciplinary team members: A. Document patient home health care information on patient flow sheets, as appropriate B. Dictate patient home health care information whenever possible D. Dictate clearly D. Document ... K. charting entries following last charting entry without leaving blank lines or spaces in progress notes ..." 2. Clinical record review on 1/19/18 for patient #5, start of care 7/23/17 certification period 11/20/17 - 1/18/18, evidenced multiple agency documents titled "LVN [licensed vocational nurse]/LPN [licensed practical nurse] Visit" that failed to be completed in their entirety. This was evidenced as follows: a. The agency document titled "LVN/LPN Visit" dated 11/24/17 and electronically signed by employee J failed to provide evidence that the respiratory, cardiovascular or nutrition was assessed during the nursing visit. The clinical notes failed to be complete. b. The agency document titled "LVN/LPN Visit" dated 11/27/17 and electronically signed by employee E failed to provide evidence that pain or respiratory was assessed during the nursing visit. The clinical notes failed to be complete. c. The agency document titled "LVN/LPN Visit" dated 11/29/17 and electronically signed by employee J failed to provide evidence that the respiratory, cardiovascular or nutrition was assessed during the nursing visit. The clinical notes failed to be complete. d. The agency document titled "LVN/LPN Visit" dated 12/1/17 and electronically signed by		and all the needed assessments are being done and recorded. The DON will be responsible to ensure that this deficiency does not recur.	

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	employee J failed to provide evidence that the respiratory, cardiovascular or nutrition was assessed during the nursing visit. The clinical notes failed to be complete. e. The agency document titled "LVN/LPN Visit" dated 12/4/17 and electronically signed by employee E failed to provide evidence that the respiratory system was assessed during the nursing visit. The clinical notes failed to be complete. f. The agency document titled "LVN/LPN Visit" dated 12/6/17 and electronically signed by employee J failed to provide evidence that the respiratory, cardiovascular or nutrition was assessed during the nursing visit. The clinical notes failed to be complete. g. The agency document titled "LVN/LPN Visit" dated 12/8/17 and electronically signed by employee J failed to provide evidence that the respiratory, cardiovascular or nutrition was assessed during the nursing visit. The clinical notes failed to be complete. h. The agency document titled "LVN/LPN Visit" dated 12/11/17 and electronically signed by employee E failed to provide evidence that the pain and respiratory system was assessed during the nursing visit. The clinical notes failed to be complete. i. The agency document titled "LVN/LPN Visit" dated 12/12/17 and electronically signed by employee J failed to provide evidence that the respiratory, cardiovascular, gastrointestinal or nutrition was assessed during the nursing visit. The clinical notes failed to be complete.			

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	j. The agency document titled "LVN/LPN Visit" dated 12/13/17 and electronically signed by employee J failed to provide evidence that the respiratory, cardiovascular and nutrition was assessed during the nursing visit. The clinical notes failed to be complete.			
G 0225 Bldg. 00	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on record review the home health aide failed to follow the nursing plan of care in 2 of 7 clinical records reviewed. (#3, #7) The findings include: 1. The agency policy dated 10/15/05 titled "3.18 Visit Protocol For Home Health Aides" stated "... Policy ProCare Home Health Aides implement correct agency visit protocol when making a home health care visit to a patient. Purpose To ensure correct ProCare Home Health Aide implementation of home health care patient visit protocol. Procedure The ProCare Home Health Aide make scheduled home health care visits to patients. The Aide: Receives verbal and written instructions for patient care from the Registered Nurse - case manager. Clarifies the patient assignment with Registered Nurse case manager, as necessary. Identifies self as a ProCare Home Health Aide to the patient and patient family upon arrival at the patient's home. Explains tasks performed during Home Health Aide visits. Implements assigned ProCare Home Health Aide tasks Informs the Registered Nurse case manager of any pertinent observations/information	G 0225	G225. The Director of Nursing (DON) in-serviced the home health aides on the importance of complying fully with the patients' care plans; only tasks assigned in the care plan should be carried out. No task should be performed that is not in the care plan. Also the set frequency for each task must be followed. The DON will designate an office staff to review the home health aides' notes weekly to ensure that the care plans are being followed. Also 10% of clinical records will be selected and reviewed quarterly for evidence that the care plans are being followed.	02/13/2018

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	regarding the patient Refers appropriate patient and patient family questions and concerns to the ProCare Home Health Registered Nurse case manager." 2. The agency policy dated 11/05/01 titled "9.2 Home Health Aide Services" stated "... The Agency shall provide home health aide services by appropriately qualified home health aides in accordance with a physician's order and under the direction and supervision of a registered nurse or therapist. The home health aide shall be supervised every 14 days by the nurse or appropriate therapist. Aides shall meet all requirements for competency and training required by federal and state regulations. Home health aide services shall include but not limited to: Assisting the patient to maintain personal hygiene Assisting the patient with ambulation as appropriate Planning and preparing meals Maintaining a health, safe environment Performing certain treatments when ordered by the physician and approved, instructed and supervised by the nurse or therapist Reporting any change in the mental or physical condition or in pt's [patients] home situation to the supervisor Documenting clinical notes Participation in case conferences, staff meetings, and in-service programs as indicated ..." 3. Clinical record review on 1/19/18 for patient #3, start of care 12/28/17, certification period 12/28/17 - 2/5/18, evidenced an agency document titled "HHA [home health aide] Care Plan" this document was dated 12/28/17 and electronically signed by employee C. This document had an area subtitled "Plan Details" which indicated the home health aide was to perform the following duties as ordered by the plan of care and registered nurse every visit; vitals signs which		The DON will be responsible to ensure that this deficiency does not recur.	

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	included temperature, blood pressure, heart rate and respirations; shower with chair, shampoo hair, hair care/comb hair, oral care, skin care, shave, assist with dressing, medication reminder, assist with bed pan/urinal, incontinence care, record bowel movement, range of motion, assist with ambulation, make bed, change linen, light housekeeping and meal set-up. The home health aide/s failed to follow the nursing plan of care as follows: a. Clinical record review on 1/19/18 for patient #3 evidenced agency documents titled "HHA Visit" electronically signed by employee F and dated 1/3/18, 1/5/18, 1/10/18 and 1/12/18. Employee F failed to shampoo patient's hair as ordered on the nursing plan of care and performed a bed bath on the patient instead of a shower with chair as ordered on the nursing plan of care. b. Clinical record review on 1/19/18 for patient #3 evidenced agency documents titled "HHA Visit" dated 1/5/18, 1/10/18, 1/12/18 and electronically signed by employee F. These documents evidenced the home health aide performed pericare that was not ordered on the nursing plan of care. The home health aide failed to follow the nursing plan of care. c. Clinical record review on 1/19/18 for patient #3 evidenced an agency document titled "HHA Visit" dated 1/12/18 and electronically signed by employee F. This document evidenced the home health aide performed nail care, failed to shave the patient, failed to make the bed, failed to assist patient with bed pan/urinal and assisted the patient with the bedside commode that was not ordered. The home health aide failed to follow the nursing plan of care as ordered.			

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	4. Clinical record review on 1/19/18 for patient #7, start of care 2/22/16, certification period 12/13/17 - 2/10/18, evidenced an agency document titled "HHA Care Plan" dated 12/12/17 and electronically signed by employee C. This document had an area subtitled "Plan Details" which indicated the home health aide was to perform the following duties as ordered by the plan of care and registered nurse either every visit or weekly. The home health aide weekly duties are shampoo hair and change linen. The home health aide duties to be performed every visit were vital signs which included temperature, blood pressure, heart rate, respirations; shower with chair, hair care/comb hair, oral care, skin care, pericare, nail care, assist with dressing, medication reminder, incontinence care, record bowel movement, assist with transfer, range of motion, assist with ambulation, equipment care, make bed, light housekeeping and meal set-up. The home health aide/s failed to follow the nursing plan of care as follows: a. Clinical record review on 1/19/18 for patient #7 evidenced an agency document titled "HHA Visit" dated 12/13/17 and electronically signed by employee B. This agency document failed to evidence the home health aide provided oral care, skin care, nail care, incontinence care or meal set-up as ordered on the nursing plan of care. b. Clinical record review on 1/19/18 for patient #7 evidenced agency documents titled "HHA Visit" dated 12/15/17, 12/18/17, 12/18/17, 12/20/17, 12/22/17 and electronically signed by employee B. These agency documents failed to evidence the home health aide provided oral care, nail care, incontinence care and meal set-up as ordered on the nursing plan of care.			

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c. Clinical record review on 1/19/18 for patient #7 evidenced agency documents titled "HHA Visit" that were electronically signed by employee B. The nursing plan of care dated 12/12/17 indicated the patient was to have his/her hair shampooed weekly. Record review indicated the patient had their hair shampooed on 12/18/17 and then did not have their hair shampooed again until 12/29/17. This was 11 days between shampoos. The home health aide failed to follow the nursing plan of care as ordered.

d. Clinical record review on 1/19/18 for patient #7 evidenced agency documents titled "HHA Visit" dated 1/2/18 and 1/3/18 that were electronically signed by employee B. These agency documents failed to evidence the home health aide provided the meal set-up as ordered on the nursing plan of care.

e. Clinical record review on 1/19/18 for patient #7 evidenced an agency document titled "HHA Visit" dated 1/6/18 and electronically signed by employee B. This agency document failed to evidence the home health aide provided incontinence care as ordered on the nursing plan of care.

f. Clinical record review on 1/19/18 for patient #7 evidenced agency documents titled "HHA Visit" all electronically signed by employee B. The last evidenced home health aide note was 1/15/18 and there was no documentation of the patients hair being shampooed or the linen changed as was ordered weekly by the nursing plan of care. The last evidenced time the patients hair was shampooed was a home health aide visit note dated 1/2/18; this evidenced there have been 13 days with the patient's hair not being

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	shampooed. This fails to follow the nursing plan of care as ordered. The last evidenced time the patient had their linen changed was 1/6/18; this evidenced there have been 9 days since the patient's linen has been changed. This fails to follow the nursing plan of care as ordered.			
G 0236 Bldg. 00	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Based on record review and interview the home health agency failed to maintain clinical records in accordance with professional standards in 2 of 7 clinical charts reviewed. (#4, #5) The findings include: 1. The agency policy dated 10/15/05 titled "4.13 Patient Record Contents" stated "... The agency shall maintain a clinical record for each patient, which is initiated at the time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patient's chart shall contain data including but not limited to: Identifying date: name, address, date of birth, sex, patient number (Agency record number), health insurance claim number, the attending physicians name, address, telephone number, the status of the patient upon	G 0236	G236. The Director of Nursing (DON) reviewed the policy titled “4.13 Patient Record Contents” for reeducation and clarification of procedures. A check-off log has been created to monitor physicians’ orders and signatures on the patient’s plan of care. The DON or designee will be monitor the Clinical records weekly and 10% will be selected and reviewed quarterly for evidence that the physicians’ orders are	02/13/2018

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	discharge for the hospital or institution (discharge report), and the patient's payment source such as Medicare, Medicaid, Private Insurance, or Private Pay A complete physical assessment including: vital signs, height, weight, systems review, and other relevant information. Primary diagnosis and secondary diagnosis Homebound status, activity permitted, and functional limitations Specific written orders as prescribed and signed by the attending physician Prognosis and length of time the services are projected to be needed An assessment of the home environment including safety factors the ability of the patient to perform activities of daily living Persons available in the home, if any, to assist with care Medication profile including action, allergies, effects, and side effect or prescribed and over-the-counter drugs An individualized plan of care for all disciplines providing services Clinical and progress notes (clinical notes are written the day of service delivery, and incorporated into the chart at least weekly [sic] A discharge summary shall be sent to the physician within 30 days of discharge and shall contain the patient's physical, mental and emotional status on admission and at discharge, date of discharge, extent to which the goals were met, and plans for follow-up or referral. A copy of the discharge summary sent to the physician is also retained in the clinical record...." 2. Clinical record review on 1/19/18 for patient #4, start of care 11/30/17, certification period 11/30/17 - 1/28/18, principal diagnosis bacterial infection, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 11/20/17 and electronically signed by employee L. This document failed to be signed by the physician. The home health agency failed to obtain a physician signature for the plan of care. During an interview on 1/19/18 at 2:10 p.m. the		obtained and their signatures are on the patient's plan of care. The DON will be responsible to ensure that this deficiency does not recur.	

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	clinical supervisor indicated that they never got one. 3. Clinical record review on 1/17/18 for patient #5, start of care 7/23/17, certification period 11/20/17 - 1/18/18, evidenced a document titled "Home Health Care Certification and Plan of Care", electronically signed by employee C. The electronic signature of employee C did not include a date. On this same document, the agency failed to ensure a physician signature and date. During an interview on 1/19/18 at 2:17 p.m., employee C stated "okay". 4. Clinical record review on 1/17/18 for patient #5, evidenced a document titled "Home Health Care Certification and Plan of Care". This document evidenced a start of care date of 07/23/2017 and was not signed or dated by a physician. On a separate agency document titled "Physician Face to Face Encounter" signed and dated on 3/30/17, evidenced a Start of Care of 11/23/2016. A third agency document titled "Patient Profile" stated "Cert. [certification] Period: 11/23/2016 - 1/21/2017 ... SOC [Start of Care]: 11/23/2016 ... Referral Date 11/21/2016 ...". During an interview on 1/19/18 at 2:20 p.m., employee C stated "there must be a documentation error because the start of care for [patient #5] was 7/23/17".			
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.			

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	Based on record review,observation and interview the skilled nurse failed to ensure all the patient's medications were on the medication reconciliation during the comprehensive assessment in 2 of 6 clinical charts reviewed. (#4, #6) The findings include: 1. The agency policy dated 10/15/05 titled "4.13 Patient Record Contents" stated "... The agency shall maintain a clinical record for each patient, which is initiated at the time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patient's chart shall contain data including but not limited to: ... A complete physical assessment including: vital signs, height, weight, systems review, and other relevant information. ... Specific written orders as prescribed and signed by the attending physician ... Medication profile including action, allergies, effects, and side effects or prescribed and over-the-counter drugs ..." 2. Record review on 1/19/18 of clinical record #4 evidenced a pharmacy order for Daptomycin [antibiotic] 650 mg [milligrams] IV [intravenous] Q24 [every 24 hours]. This medication failed to be listed on the agency's plan of care or medication reconciliation. 3. Observation at a home visit on 1/19/18 at 10:30 a.m. for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced patient's home medications on his/her kitchen table. Comparison of patient's home medications against ProCare's medication reconciliation evidenced the following medication discrepancies: a. Patient #6 home prescription bottle	G 0337	G337. The Director of Nursing (DON) reviewed the policy titled “4.13 Patient Record Contents” for reeducation and clarification of procedures. Medication reconciliation, review and profile update was completed for Clinical Record #4, on 01-23-18. Medication reconciliation, review and profile update was completed for Patient #6 on 01-23-18. The DON has provided education to all staff involved in providing skilled care to the patient referred to in Record #4 and patient #6. The DON in-serviced the skilled staff on performing a comprehensive review of all medications the patient is currently using to identify adverse effects, drug reactions, ineffective drug therapy and non-compliance with drug therapy. Recording the patient’s medications from discharge paperwork from another medical facility as an alternative is unacceptable. The DON or her clinical	01/23/2018

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	indicated: Clonidine [for blood pressure] 0.1 mg [milligram] by mouth three times a day. ProCare medication reconciliation indicated: Clonidine 0.1 mg oral tablet 1 tab daily by mouth (PO). The frequency on the agency's medication reconciliation was not congruent with patient's home prescription. b. Vitamin D2 [supplement] 50,000 IU [international unit] 1 capsule by mouth every week for 12 weeks. This prescription was ordered on 1/17/18 and had not been updated on the agency medication reconciliation. c. Potassium Cl [Chloride] [supplement] micro 10 MEQ [milliequivalents] ER [extended release] tabs take 1 tablet by mouth daily. This medication failed to be on the agency's medication reconciliation. d. Niferex [iron supplement] take 1 tablet by mouth daily. This prescription was ordered 1/17/18 and had not been updated on the agency medication reconciliation. e. Patient #6 over-the-counter medication: Acetaminophen 500 mg as needed for pain. ProCare medication reconciliation indicated: Acetaminophen 160 mg oral tablet 1 tab q 6 hours by mouth (PO). The dosage of the medication in the patient's home was not congruent with the dosage on the agency's medication reconciliation. f. Levemir [insulin] 10 units subcutaneously at bedtime, caregiver indicated he/she administers at 9:00 p.m. every night. This medication failed to be on the agency's medication reconciliation. g. The following medication was on the agency's medication reconciliation but was not a		designee will review all start of cares and recertifications documentation weekly to ensure compliance. Also 10% of clinical records will be selected and reviewed quarterly for evidence that Medication reconciliation, review and profile update is being done. The DON will be responsible to ensure that this deficiency does not recur.	

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	medication in the patient's home medications: Calcium Acetate, Benadryl and Hydrocodone. 3. During an interview on 1/19/18 at 1:18 p.m. the clinical supervisor indicated he/she recorded the patient's medications from discharge paperwork received from another medical facility.			
N 0000 Bldg. 00	This survey was a recertification, post-condition revisit of a federal/state licensed home health agency. Federal and State deficiencies were cited. Survey Date: 1/16/18 - 1/19/18 Facility #: 003042 Provider #: 157538 Active Patient #: 49 Discharge Patient #: 167	N 0000		
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.			

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	Based on record review and interview the administrator failed to organize and direct the agency's ongoing functions in 1 of 1 agency. The findings include: 1. The agency job description titled "Administrator" stated "Position Summary: Administers, directs, and coordinates activities of the Home Health Agency and its staff. Reports To: The President and the Board of Directors. Qualifications: Registered Nurse, Physician, or experienced health care Administrator Demonstrated ability to supervise and direct personnel Ability to interface with providers, professionals, employees, and members of the community Knowledge of organization and business management Minimum of two (2) years supervisory or administrative experience Effective written and oral communication and interpersonal skills Essential Functions/Areas of Accountability: Plans overall development and administration of the Agency as set forth in the Conditions of participation and/or applicable state regulations under the direction of the Board of Directors and the advisory board Develops administrative policies and procedures relating to the Home Health Agency Directs installation of improved work methods and procedures to ensure achievement of objectives of the program Coordinates and integrates the total Agency activities through regular conferences with department supervisors Maintain a Quality Assurance and Performance Improvement (QAPI) Program Interprets and transmits policy to the Board of Director, Advisory Committee and supervisory staff to ensure compliance with policies Develops standards and methods of measurement of Agency activity and coordinates the annual program evaluation Prepares a yearly	N 0444	N444. The Administrator reviewed the Home Health Agency's policies on Policy 2.4 Administrative Control and the Job Description Titled "Administrator" for reeducation and clarification (01-22-18). The importance of knowing the scope of Agency services was noted, so also was ensuring the Physicians' signatures are obtained on all plans of care documents and orders. This will be monitored with the review of this Policy for the next two quarters and then yearly during our Professional Advisory Committee meetings in October/November annually. The Board of Directors, the Administrator is responsible for monitoring this corrective action to ensure that this deficiency does not recur.	01/22/2018

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	budget in cooperation with the Budget Committee and Board of Directors Approves monthly expenditures, co-signs checks as needed, and monitors the financial position of the Agency Prepares reports on the Agency activity for the Board of Directors and Advisory Committee Determines organization lines of authority and fixes areas of responsibility Approves hiring and termination of all employees Approves salary increases and staff promotions Authorizes purchase of supplies and equipment Contacts local, state, and national associations and participates in meetings, conventions, etc. Cooperates with health and health-related agencies to increase and improve services to the community Promotes education awareness to Agency Staff Ensures continuous compliance with all applicable federal and state regulations and Agency policy Handles patients complaints not resolved Handles unresolved problems between staff and supervisors If not appointed by the Board of Directors, appoints a qualified individual to act in the administrator's absence Ensures the development and implementation of a continuing education program to meet identified staff needs Develops an open, positive rapport with community resources affiliated with home health care services Maintains high visibility and availability while in the office via telephone to physicians, referral sources, community resources, patients, and staff ..." 2. Clinical record review on 1/18/18 evidenced patient #7 to have only home health aide services. During the entrance interview on 1/16/18 at 11:05 a.m. the administrator indicated that they did not provide any home health only aide services. The administrator failed to ensure he/she was aware of all the services the agency currently provided.			

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	3. Record review on 1/19/18 evidenced patient #4 and Patient #5 failed to have the physician sign the plan of care. The administrator failed to ensure he/she obtained physician orders/signatures on all patients serviced by the home health agency.			
N 0446 Bldg. 00	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on record review and interview the administrator failed to ensure all staff had adequate education for all population of patients the agency serviced in 1 of 1 agency. The findings include: 1. The agency policy dated 10/15/05 titled "3.1 Referral And Acceptance Of Patients" stated "... The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection. Persons residing outside of the service area or in need of services not provided by the Agency will be assisted in contacting the appropriate resources. Upon receipt of a referral, an evaluation by a Registered Nurse or Physical Therapist (Therapy only cases) will be made to determine that the care can be adequately and	N 0446	N446. The Administrator and Director of Nursing (DON) reviewed the policies titled “3.1 Referral and Acceptance of Patients” and “5.1. Inservice Education Programs” for reeducation and clarification of procedures. The Administrator and the DON in-serviced all Field on caring for the Pediatric patient. The staff were issued handouts and tested on the in-service given. All staff were expected to have a passing grade of 80% before starting or continuing to care for pediatric patients	01/23/2018

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	safely performed at home, to assess the patient care needs, and to ensure that the patient meets the admission criteria. Patients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility whenever possible. Patients will be assigned to the appropriate staff members by a registered nurse or under the supervision of the registered nurse according to geographical location, clinical needs of the patient, and the qualifications and availability of staff...." 2. The undated agency policy titled "5.1 Inservice Education Programs" stated "... Policy The home health care agency provides in-service education programs for home health care staff members. Purpose 1. To increase home health care staff member competency in a specific area of practice 2. To provide home health care staff members with current health care information. Procedure 1. The Director of Nursing of Home Health Care plans an [sic] in-service education program calendar which could include: 1) Needs and assessment 2) Organizational/Program objectives 2. Posts in-service education program calendar in designated areas one month in advance of the program offerings 3. Home Health Aides are required to attend a minimum of 12 in-service education hours per year. 4. The Director of Nursing or the Administrator of Home Health Care completes and files an In-service Education Program Summary form. 5. Home health care staff members document their participation in in-service education programs on an In-service Education program Attendance form and an Individual In-service/ Continuing Education Record form...." 3. Record Review on 1/17/18 evidenced patient #8 as a current, active patient with ProCare home health. Patient #8 is a pediatric patient that		and this was accomplished (01-23-18). This will be monitored with the review of Agency policies and procedures yearly during our Professional Advisory Committee meetings in October/November annually. The Administrator and DON are responsible for monitoring this corrective action to ensure that this deficiency does not recur.	

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	receives skilled nursing care and home health aide care. ProCare has failed to ensure that pediatric in-services were provided to their employees that care for pediatric patients. During an interview on 1/19/18 at 12:50 p.m. the administrator and clinical supervisor indicated they are still in the process of providing in-service pediatric training to their staff.			
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on personnel record review the home health agency failed to ensure a signed job description was in each employee's personnel file. (employee G) The findings include: 1. Personnel record review on 1/18/18 evidenced a signed job description by employee G titled "Assistant Administrator" signed and dated by employee G on 2/22/02, no other signed job	N 0458	N458. The Administrator has signed the signed job description and it is now in the Administrator's personnel file records. Personnel files are monitored monthly by the personnel officer using a tool created for that purpose to	01/19/2018

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	description was evidenced in the employee file. Employee G is the current administrator at the home health agency and the review of the personnel record failed to evidence an administrator signed job description.		ensure that all personnel requirements are complete and up to date. The Administrator will be responsible for ensuring that this deficiency does not recur.	
N 0466 Bldg. 00	410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review the home health agency failed to ensure confidential medical records were filed in a separate folder in 1 of 7 employee records reviewed. (employee N) The findings include: 1. The agency policy dated 10/19/06 titled "6.5 Employment Health Requirements" stated "... Policy Home health care staff members are expected to comply with home health care agency employment requirements. Purpose To identify pertinent health problems of home health care staff members. ... 3. Documented employee health information is held in strictest confidence. 4. Completed employee health records are filed in the appropriate employee's personnel files...." 2. Personnel record review on 1/18/18 evidenced	N 0466	N466. The Administrator and Personnel Staff reviewed Policy titled “6.5 Employment Health requirements” for reeducation and clarification of the procedures. The importance of holding the employee medical information in the strictest confidence was acknowledged. The employee health information are now separated from the other employee personnel records. This separation was completed on 1/19/18.	01/19/2018

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	employee N's personnel record with a start date of 11/16/17. Employee N's personnel record contained his/her certification, criminal background check, physical exam, TB test, job description, orientation, test and skills competency all in the same folder. The home health agency failed to separate the employee's confidential records in a different folder.		Personnel Officer now monitors the personnel files monthly to ensure that the employee medical information is held in the strictest confidence and separate from the other employee personnel records. The Administrator and Personnel Staff will review and monitor the Agency's Policy and Procedure yearly for ensuring that this deficiency does not recur.	
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview the home health agency failed to maintain effective documentation and communications in the clinical record to ensure that their efforts appropriately complement one another and support the objectives of the patient's care in 1 of 7 clinical records reviewed. (#5) The findings include: 1. Clinical record review on 1/17/18 for patient #5,	N 0484	N484. The Administrator and Director of Nursing (DON) developed a tool to log patients' hospitalization (Hospitalization Log) in order to document patients' hospitalizations and discharges to facilitate and maintain effective	01/22/2018

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	start of care 7/23/17, certification period 11/20/17 to 1/18/18, evidenced an agency document titled "OASIS-C2 Transfer Not Discharged" with an Assessment Date of 12/13/17 and a Visit Date of 12/13/17, electronically signed by employee C on 12/14/17. Under the section "OASIS M2430" it stated "Reason for Hospitalization ..." a box is checked next to "19 - Scheduled treatment or procedure". During an interview with employee C on 1/19/18 at 2:14 p.m., he/she stated that patient #5 did have a physician appointment and was admitted to the hospital. Upon further interview, employee C indicated that she "was not sure if the hospital was going to discharge patient #5 and that he/she had heard from others seeing patient #5 that he/she was possibly going to a SNF [skilled nursing facility]". Employee C continued on to state "as far as he/she knows patient #5 is still in the hospital because no one has notified them otherwise". The agency failed to provide documentation that communicated the discharge of the patient to the hospital, what hospital the patient was admitted to, and agency objectives for the care of patient #5. 2. Clinical record review on 1/17/18 for patient #5, start of care 7/23/17, certification period 11/20/17 - 1/18/18, evidenced document titled "Home Health Care Certification and Plan of Care", electronically signed by employee C and undated, with no physician signature. Section "21. Orders for Discipline and Treatments ..." stated " ...SN to instruct Patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > [greater than] 100.5 ...". A second agency document titled "Vital Signs, ProCare Home Health Services, Patient: #5, Effective Date: 1/17/2018, Date Range: 11/18/2017 - 01/17/2018" indicated a table with patient vital signs. The following dates on the table were		communications to all disciplines. The DON or the designee will review the hospitalization log daily to ensure that all the disciplines are aware of the patient's hospitalization status. The DON will be responsible to ensure this deficiency does not recur.	

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	missing blood pressure, pulse, O2 [oxygen] saturation, and temperature assessments: 11/19/2017 signed by employee C, 11/20/2017 signed by employee E, 11/22/17 signed by employee J, 11/24/2017 signed by employee J, 11/27/2017 signed by employee E, 11/29/2017 signed by employee J, 12/01/2017 signed by employee J, 12/04/2017 signed by employee E, 12/06/17 signed by employee J, 12/08/2017 signed by employee J, 12/11/2017 signed by employee E, 12/12/17 signed by employee J, and 12/13/2017 signed by employee J. During an interview on 1/19/2018 at 2:16 p.m. with employee C, she indicated that patient #5 refuses to have his/her vitals taken. The agency failed to provide documentation that the patient refused vital sign assessments and that it is is communicated in the clinical record.			
N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review, observation and interview the home health agency failed to coordinate services with all health care providers serving their patients in 5 of 7 clinical records reviewed. (#1, #2, #4, #5, #6) The findings include: 1. The undated agency policy titled "3.16 Case Conferences" stated "The purpose of case conferences is to: Determine the adequacy of the plan of treatment and appropriateness of continuation of care Assure coordination of services in patient-goal directed activity on the part of each home care staff member Evaluate patient progress and plans for future care Provide	N 0486	N486. The Administrator and Director of Nursing (DON) reviewed the policy titled "3.16 Case Conferences" for clarification and reeducation on coordinating services provided by all Healthcare Providers in the patient's home. All field staff were in-serviced by the DON on 1/23/18 on the importance of identifying all Healthcare providers; types, disciplines, with frequencies and	01/23/2018

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	assistance to team members having difficulty planning care for specific problem cases Refer cases that require further study to the clinical record review committee Case conferences shall be held regularly to review problem cases and to review the plan of treatment for appropriateness and feasibility of continued services. Such conferences shall be documented separately or in the clinical record and should be held on each patient at the time of admission; prior to the date the plan of treatment is due for the review at least every 60 days and prior to discharge. However, if a problem arises, a case-specific conference would be indicated. All professional disciplines participating in the patient's care should have input at his [sic] conference. For personnel participating in the patient's care but unable to attend the conference, a telephone conference could be established. Documentation of the conference shall be the responsibility of the primary nurse or supervisor, or other professional as instructed by the supervisor. The documentation shall include a summary of progress, assessment of the need for continued care, plans and discharge goals. ... All staff delivering patient care services is encouraged to have at least weekly contact with their Case manager and as needed. Any conference related to an individual patient may be documented as a case conference...." 2. Clinical record review on 1/19/18 for patient #1 evidenced an agency document titled "OASIS-C2 START OF CARE" that was dated 12/19/17 and electronically signed by employee C. This document had an area subtitled "Coordination of Care" that stated "... Name: [agency #26] Regarding: Homemaker Services 9 Hours/Week". The home health agency failed to provide any documentation that evidenced coordination of		documenting and coordinating services with them. The DON or clinical designee will review all progress notes weekly to ensure compliance with Care Coordination. Also, during the monthly case conference meetings, Coordination of Care will be emphasized. The DON will be responsible for ensuring that this deficiency does not recur.	

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	care with agency #26. During an interview on 1/19/18 at 1:35 p.m. the administrator indicated that they are not documenting coordination of care. The administrator also indicated that if everything was going ok they don't write anything down. 3. Clinical record review on 1/18/18 for patient #2 evidenced an agency document titled "OASIS-C2 START OF CARE" dated 11/25/17 and electronically signed by employee C. This document had an area subtitled "Coordination of Care" that stated "... Regarding: HHA [home health aide] services 5 days/week. This document failed to indicate what agency was providing home health aide services and failed to evidence any coordination of care with other agency. 4. Clinical record review on 1/19/18 for patient #4 failed to evidence any coordination of care with the patient's primary care physician. The agency document titled "Home Health Certification And Plan Of Care" dated 11/30/17 and electronically signed by employee L indicated the patient's physician is physician #BB, which was a hospitalist affiliated with agency #29. This physician only practices inside the facility with admitted patients. The home health agency failed to identify the patient's primary physician. 5. Clinical record review on 1/17/18 for patient #5, start of care 7/23/17, certification period 11/20/17 - 1/18/18, evidenced a document titled "Home Health Care Certification And Plan Of Care", electronically signed by employee C and undated, with no physician signature. This document had an area subtitled "21. Orders for Discipline and Treatment (Specify Amount/Frequency/Duration)" that stated "... Coordination of Care with agency #26 (HHA			

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	[Home Health Aide] services) and agency #27 (SN [Skilled Nursing] for wound care)". The agency failed to provide any clinical documentation to show coordination of care with the other health care agencies that provided care to their patient. During an interview on 1/19/18 at 2:16 p.m., employee C indicated that "the patient likes agency #26 because there is a home health aide at that agency that the patient really likes. We speak with both agencies and there have been no problems but I'm not sure if that has been documented." During the same interview employee G stated "agency #28 does that, they assign different companies for different reasons" in reference to the multiple health care agencies that cared for one patient. 6. Clinical record review on 1/19/18 for patient #6 evidenced an agency document titled "NON-OASIS START OF CARE" dated 1/9/18 and electronically signed by employee C. This document had an area subtitled "Dialysis" that indicated the patient was on dialysis, that the dialysis type is "Home dialysis Permacath and a statement that read "Patient receives home dialysis daily with Dialysis nurse". During a home visit on 1/19/18 observation was made of a home dialysis machine in the patient's bedroom. During an interview with patient #6 on 1/19/18 at 10:50 a.m. the patient indicated he/she received dialysis Monday - Friday from a home dialysis nurse. Patient #6 was unaware of the company that provided the in-home dialysis. During an interview with the family member on 1/19/18, he/she indicated he/she was not aware of the company name. Observation was made of a folder on patient #6 dining room table with agency #30 on the label; upon asking the family member what services they provided for patient #6 he/she indicated they offered the patient free home health			

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	aide hours and that they were considering employing agency #30. During an interview with the clinical supervisor and administrator on 1/19/18 at 1:42 p.m. the clinical supervisor indicated that their should probably be coordination because he/she gets home dialysis every day. During the interview the clinical supervisor indicated he/she did not remember the name of the company that provided the patient home hemodialysis. The agency failed to coordinate care with the home hemodialysis company for patient #6.			
N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on record review the home health agency failed to meet the patient's therapy needs in 1 of 7 clinical charts reviewed. (#1) The findings include: 1. The agency policy dated 10/15/05 titled "3.1 Referral and Acceptance Of Patients" stated "... The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection. Persons residing outside of the service area or in need of services not provided by the Agency will be assisted in contacting the appropriate resources. Upon receipt of a referral, an evaluation by a Registered Nurse of Physical Therapist (Therapy only cases) will be made to	N 0520	N520. The Administrator and Director of Nursing (DON) reviewed the policies “3.1 Referral and Acceptance of Patients” and “9.4 Therapy Services” for reeducation and clarification of the procedures. The need to meet the medical, nursing, rehabilitation and social needs of the patient was emphasized. The DON will now review all new referrals to ensure that the agency can provide the requested services directly or by contract. The DON will	01/22/2018

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	determine that the care can adequately and safely performed [sic] at home, to assess the patient care needs, and to ensure that the patient meets the admission criteria. Patients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility whenever possible. Patients will be assigned to the appropriate staff members by a registered nurse or under the supervision of the registered nurse according to geographical location, clinical needs of the patient, and the qualifications and availability of staff...." 2. The agency policy dated 10/19/06 titled "9.4 Therapy Services" stated "... A copy of the verbal order and the Therapy Referral Form will be faxed to the Agency/Therapist providing therapy services. A copy of the Therapy Referral Form will be submitted along with the M.D. [medical director] order. The Nursing Supervisor will contact the agency Therapist providing therapy services and verbally inform them of the referral. The Nursing Supervisor will fax a copy of the verbal order and referral. The Therapist will visit the patient within 48-72 hours. The Director of Nursing will be notified if the family requested an evaluation other than the above stated time frame. After the assessment, the Therapist will Contact the Case Manager/DON [director of nursing] to communicate the findings and plan. The Therapist will submit initial assessment to ProCare Home Health within 24-48 hrs [hours]. ProCare Home Health Services will submit the submitted initial assessment to the physician for signature. The agency will receive a copy of the patient therapy schedule each Monday. If there are problems, contact the Director of Nurses/Clinical Supervisor immediately. A case conference for each patient receiving PT [physical therapy], OT [occupational therapy], and ST [speech therapy]		contact the patient's physician when the agency cannot meet the patient's needs directly or by contract and arrange for the patient to be transferred to another agency. To assure that this deficiency is corrected, the DON or Assistant Director of Nursing (ADON) will review all new referrals to ensure that the agency can provide the requested services or by contract. The Administrator and DON will be responsible to ensure that this deficiency does not recur.	

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	services will be conducted at least every thirty (60) [sic] days. The assigned Case Manager and HHA [home health aide] (if applicable) will be in attendance. A case conference will be scheduled prior to discharge of each patient. The Physical Therapist will report directly to the Director of Nursing...." 2. Clinical record review on 1/19/18 for patient #1, start of care 12/19/17, certification period 12/19//17 - 2/16/18, evidenced an agency document titled "Patient Profile" that indicated the services required for patient #1 was PT [physical therapy], OT [occupational therapy] and ST [speech therapy]. Only PT was evidenced as being provided to patient #1 by the home health agency. 3. Clinical record review on 1/19/18 for patient #1 evidenced faxed hospital paperwork dated 1/16/18 this paperwork had an area subtitled "Referrals/Response Letter" that stated "Per Dr. #AA, have PT/OT/ST. Dx [diagnosis]: dysarthria...." This area was addressed to Procare HHC [home health care]. There was no evidence of OT or ST ever being provided. 4. Clinical record review on 1/19/18 for patient #1 evidenced an agency document titled "OASIS-C2 START OF CARE" dated 12/19/17 and electronically signed by employee C. This document had an area subtitled "Functional Limitations" that had an "x" noted by endurance, speech, contracture, incontinence and ambulation. The same document listed multiple areas that supported the need for OT and ST services as follows: a. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled Oasis M1230 (M1230) Speech and Oral (Verbal) Expression of Language (in patient's own			

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	language) that had the code "03" placed in a box. Code "03" stated "3 - Has severe difficulty expressing basic ideas; requires maximal assistance or guessing by listener. Limited to single words/short phrases." b. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)" with a "x" marked by "2 - Impaired decision-making: failure to perform usual (I)ADLs [activities of daily living], inability to appropriately stop activities, jeopardized safety through actions". c. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1810) Current ability to dress upper body including undergarments, pullovers, front-opening shirts and blouses, managing zippers/buttons/snaps." that had a code of "02" placed in box. Code "02" stated "2 - Someone must help the patient put on upper body clothing." An area subtitled "(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes." that had a code of "03" placed in box. Code "03" stated "3 - Patient depends entirely upon another person to dress lower body." An area subtitled "(M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair)." that had a code of "05" placed in box. Code "05" stated "5 - Unable to use the shower/tub, able to participate in bathing self in bed/sink/bedside chair/commode with assistance or supervision."			

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	d. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten." that had a code of "01" placed in box. Code "01" stated "1 - Able to feed self but requires meal set-up, or intermittent assistance/supervision, or a liquid/pureed/ground meat diet." e. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:" that had a code of "02" placed in box. Code "02" stated "2 - Unable to prepare any light meals or reheat any delivered meals." f. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate." that had a code of "04" placed in box. Code "04" stated "4 - Unable to answer the telephone at all but can listen if assisted with equipment." 5. Clinical record review on 1/19/18 evidenced the skilled nurse initial/comprehensive assessment titled "OASIS-C2 START OF CARE" dated 12/19/17 and electronically signed by employee C. This document assessment provided by employee C evidenced the need for the patient to have occupational therapy and speech therapy as ordered by the physician. The home health agency failed to provide these services to patient #1 and failed to meet patient #1's needs in their			

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	place of residence.			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review the skilled nurse failed to follow the plan of care establish by the physician in 5 of 7 clinical charts reviewed. (#1, #2, #3, #6, #7) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members. Includes the following: ... Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the	N 0522	N522. The Administrator and Director of Nursing (DON) reviewed the Policy "3.9 Medical Supervision/Patient Plan of Care" for reeducation and clarification of procedures. The DON in-serviced the skilled staff on following the Physician's orders (including disciplines requested with frequencies), performing only ordered tasks, providing instructions i.e. caregiver/patient instructions on employing non-pharmacological pain relief modalities, filling the medication box, patient positioning and repositioning, etc. in accordance with the plan of cares. Staff must notify the patient's physician of missed visits when they cannot be made up. To assure the physician	02/08/2018

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	ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. Clinical record review on 1/19/18 of patient #1, start of care 12/19/17, certification period 12/19/17 - 2/16/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN [skilled nurse] Frequency: 1W9 [once a week for 9 weeks]. PT [physical therapy] Frequency: 2W4 [2		orders and plan of cares are being followed, the DON or clinical designee will review all progress notes weekly as part of the weekly quality assurance process to ensure compliance. The DON will be responsible for ensuring that this deficiency does not recur.	

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	times weekly for 4 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN to assess if the Caregiver can verbalize an understanding of the indication for each mediation. Physical therapist to evaluate and submit plan of treatment. SN to instruct the Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by: a. Clinical record review on 1/19/18 evidenced an agency document titled "LVN [licensed vocational nurse]/LPN [licensed practical nurse] Visit" dated 12/27/17 and electronically signed by employee E. This document had an area subtitled "Diabetic Care" that indicated patient #1's a.m. blood sugar was 109 mg/dl [milligram/deciliter] that the check was performed by the skilled nurse on the patient's left finger. The physician signed plan of care did not order for the skilled nurse to perform blood sugar checks on patient #1. The skilled nurse failed to follow the plan of care. b. Record review on 1/19/18 failed to evidence the skilled nurse instructed the patient on nonpharmacologic pain relief measures,			

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	including relaxation techniques, massage, stretching, positioning, and hot/cold packs, failed to assess if the Caregiver can verbalize an understanding of the indication for each medication, and failed to instruct the caregiver to contact the agency to report any fall with or without minor injury and to call 911 for fall resulting is serious injury or causing severe pain or immobility as directed on the physician signed plan of care. 3. Clinical record review on 1/18/18 of patient #2, start of care 11/25/17, certification period 11/25/17 - 1/23/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 12/11/17 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W10 [once weekly for 10 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to assess skin for breakdown every visit. SN to assess/instruct on seizure disorder signs & symptoms and appropriate actions during seizure activity. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing sever pain or immobility. SN to assess caregiver filling mediation box to determine if caregiver is preparing correctly. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. Patient refused Physical Therapy services at this time." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by:			

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	a. Clinical record review on 1/18/18 for patient #2 evidenced a missed visit the week of 12/31/17 - 1/6/18. During an interview on 1/18/18 at 3:23 p.m. employee C indicated the skilled nurse couldn't see the patient at a certain time the family requested. There was no evidence that another visit time was arranged or that the physician was notified for the missed visit. The skilled nurse failed to follow the physician signed plan of care. b. Record review on 1/18/18 for patient #2 failed to evidence the nurse assess/instructed on seizure disorder signs and symptoms and appropriate actions during seizure activity, assessed the caregiver filling the medication box to determine if the caregiver is preparing correctly, and determine if the caregiver is able to identify the correct dose route, and frequency of each medication on skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/22/17, 12/28/17 and 1/10/18. The skilled nurse failed to follow the physician signed plan of care. c. Record review on 1/18/18 for patient #2 failed to evidence the nurse instructed the caregiver on turning/repositioning every 2 hours on the skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/28/17 and 1/10/18 as ordered on the physician signed plan of care. 4. Clinical record review on 1/19/18 of patient #3, start of care 12/28/17, certification period 12/28/17 - 2/25/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W1 [once a week for 1 week], 2W4 [2			

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	times a week for 4 weeks], 1W5 [once a week for 5 weeks]. HHA [home health aide] Frequency: 1W1, 2W4. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to assess pain eve and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to instruct the Patient on methods to reduce friction and shear. SN to perform/instruct on wound care as follows: clean with NaCl [sodium chloride] apply Medihoney cover with Allevyn. SN to assess skin for breakdown every visit. May discontinue wound care when wound(s) have healed. SN to assess patient for diet compliance. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to use prescribed assistive device when ambulating. SN to instruct patient to change positions slowly. HHA to assist with ADL's [activities of daily living] & IADL's [instrumental activities of daily living] per HHA care plan. SN to assess patient filling medication box to determine if patient is preparing correctly. SN to determine if the Patient is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient can verbalize an understanding of the indication for each medication. Physical therapist to evaluate and submit plan of treatment." The physician signed plan of care failed to be followed as evidenced by: a. Clinical record review on 1/19/18 for patient #3 evidenced the skilled nurse had an extra visit during the week of 1/7/18 - 1/13/18. No extra			

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	visit order was evidenced in the clinical record and no prn [as needed] visits were ordered on the plan of care. During an interview on 1/19/18 at 1:55 p.m. employee C indicated he/she would have to write an order for the extra visit made to patient #3. The skilled nurse failed to follow the physician signed plan of care and failed to obtain a physician order for the extra visit. b. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse to instruct the patient on nonpharmacologic pain relief measures on the skilled nurse visits dated 1/2/18 and 1/5/18 as ordered on the physician signed plan of care. c. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse instructed the patient to wear proper footwear when ambulating, instructed the patient to use prescribed assistive device when ambulating, assessed the patient filling medication box to determine if the patient was preparing correctly, determined if the patient is able to identify the correct dose, route, and frequency of each medication and assessed if the patient can verbalize an understanding of the indication for each medication on the skilled nurse visits dated 1/2/18, 1/5/18, 1/8/18, 1/10/18 and 1/12/18 as ordered on the physician signed plan of care. 5. Clinical record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced a document titled "Home Health Certification And Plan Of Care". This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 24visits. PT Frequency: 6 visits. OT			

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	[occupational therapy]: 3 visits. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); Other: Bilateral BKA [below knee amputation]; SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient to take pain mediation before pain becomes severe to achieve better pain control. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain mediations, pain affecting ability to perform patient's normal activities. SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to instruct the Patient/Caregiver on methods to reduce friction and shear. SN to instruct the Patient/Caregiver to pad all bony prominences. SN to perform/instruct on wound care as follows: SN to cleanse wound to sacral area with wound cleanser and apply Silver Alginate to wound bed and packed with gauze and tape 3XW [3 times weekly]. SN to assess skin for breakdown every visit. SN to instruct the Patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes. May discontinue wound care when wound(s) have healed. SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications. SN to prefill syringes with Levemir insulin as follows: 10units to be taken Q [every] HS [at bedtime]. Patient to have incontinence			

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	157538	A. BUILDING 00 B. WING	01/19/2018

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	cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2GM [gram] Na+ [sodium] ADA [American diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver can verbalize an understanding of the indication for each medication. SN to assess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics. Physical therapist to evaluate and submit plan of treatment. Occupational therapist to evaluate and submit plan of treatment. Physical therapy to evaluate. Occupational therapy to evaluate. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The skilled nurse failed to follow the plan of care, this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/caregiver to pad all bony prominences, instruct the patient/caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes, instruct the patient/caregiver on 2GM Na+ ADA diet, determine if the caregiver is able to identify the correct dose, route, and frequency of each medication, assess if the caregiver can verbalize an understanding of the indication for each medication, assess the caregiver administering injectable medications to determine if proper technique was utilized, instruct			

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	the caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics and to instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility as ordered on the plan of care for the skilled nurse visits dated 1/11/18 and 1/12/18. 6. Clinical record review on 1/19/18 for patient #7, start of care 2/22/2016, certification period 12/13/17 - 2/10/18, evidenced a document titled "Home Health Care Certification and Plan of Care", electronically signed and dated by physician AA on 12/27/18. This document had a section titled "Section 21. Orders for Discipline and Treatments ..." that stated "HHA [Home Health Aide] Frequency: 2W1 [twice a week for one week], 3W8 [three times a week for 8 weeks]. Mondays and Wednesdays 4hrs [hours]/visit; Fridays 2 hrs/visit ...". a. An agency document dated 12/13/17, titled "ProCare Home Health Services ...HHA Visit", electronically signed and dated by employee B on 12/13/2017, evidenced the following: "Time In 10:00 a.m. Time Out: 01:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered. b. An agency document dated 12/26/17, titled "ProCare Home Health Services ...HHA Visit", electronically signed and dated by employee B on 12/26/2017, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered. The agency also failed to present documentation indicating physician orders for home health aide			

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	to complete the visit on a Tuesday. c. An agency document dated 12/27/17, titled "ProCare Home Health Services ...HHA Visit", electronically signed and dated by employee B on 12/27/2017, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered. d. An agency documented dated 1/2/2018, titled "ProCare Home Health Services ... HHA Visit", electronically signed and dated by employee B on 1/2/2018. The agency failed to present documentation indicating physician orders for home health aide to complete the visit on a Tuesday. e. An agency document dated 1/10/2018, titled "ProCare Home Health Services ...HHA Visit", electronically signed and dated by employee B on 1/10/2018, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered. f. An agency document dated 1/15/2018, titled "ProCare Home Health Services ...HHA Visit", electronically signed and dated by employee B on 1/15/2018, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered.			
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: (A) Be developed in consultation with the			

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	home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review the home health agency failed to ensure the medical plan of care contained all pertinent diagnoses, durable medical equipment and complete and accurate medication reconciliation in 2 of 7 clinical charts reviewed. (#4, #6) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally	N 0524	N524. The Administrator and Director of Nursing (DON) reviewed the Policy “3.9 Medical Supervision/Patient Plan of Care” for reeducation and clarification of procedures. The DON in-serviced the skilled staff on following the Physician’s orders (including disciplines requested with frequencies), performing only ordered tasks, providing instructions i.e. caregiver/patient instructions on employing	02/08/2018

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	approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members. Includes the following: Date the patient plan of care is written Type of ProCare Home Health services and equipment required Patient diagnosis Patient mental status Patient functional limitations Patient rehabilitation potential Type of needed nursing services Patient medication Patient special diet Patient activities permitted Patient treatment Rehabilitation and therapy services Home health aide services Medical supplies/appliances necessary Any safety measures to protect against patient injury Instructions for timely patient discharge or referral Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare		non-pharmacological pain relief modalities, filling the medication box, patient positioning and repositioning, etc. in accordance with the plan of care. Staff to notify the patient's physician of missed visits when they cannot be made up. To assure the physician orders and plan of cares are being followed, the DON or clinical designee will review all progress notes weekly as part of the weekly quality assurance process to ensure compliance. The DON will be responsible for ensuring that this deficiency does not recur.	

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	Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. The agency policy dated 10/15/05 titled "4.13 Patient Record Contents" stated "... The agency shall maintain a clinical record for each patient, which is initiated at the time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patient's chart shall contain data including but not limited to: ... A complete physical assessment including: vital signs, height, weight, systems review, and other relevant information. ... Specific written orders as prescribed and signed by the attending physician ... Medication profile including action, allergies, effects, and side effects or prescribed and over-the-counter drugs ..." 3. Record review on 1/19/18 of clinical record #4 evidenced a pharmacy order for Daptomycin [antibiotic] 650 mg [milligrams] IV [intravenous] Q24 [every 24 hours]. This medication failed to be listed on the agency's plan of care or medication reconciliation.			

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	4. Clinical record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced an agency document titled "Physician Face To Face Encounter" signed 1/12/18 and signed by the physician. This document stated "... The primary medical reason, diagnosis, or condition related to the reason for home healthcare for the encounter was: Renal failure on Dialysis B [bilateral] BKA [below knee amputation] Due to PAD [peripheral arterial disease] And Ischemia Sacral Wound gait [illegible writing] Other Conditions/Diagnoses related to the needed home care: Wound Care help c [with] Home Dialysis Med mgt [medication management] PT/OT ..." 5. Clinical record review on 1/19/18 for patient #6, primary diagnosis of osteomyelitis, unspecified, evidenced an agency document titled "Home Health Certification And Plan Of Care" with no date and electronically signed by employee C. This document had an area subtitled "13. ICD-10-CM Other Pertinent Diagnoses" that stated "...Complete traum [traumatic] amp [amputation] at lev [level] betw [between] kn [knee] and ankl [ankle], r [right] low [lower] leg, subs ... Complete traum amp at lev betw kn and ankl, l [left] low leg, subs ... Dysphagia, oropharyngeal phase ... Anemia, unspecified ... Pressure ulcer of sacral region, stage 4 ... Type 2 diabetes mellitus without complications ..." This plan of care document failed to list patient #6's renal failure in which the patient receives dialysis at home 5 days a week. The agency failed to ensure identification of all the patient's pertinent health conditions. 6. Clinical record review on 1/19/18 for patient #6 evidenced an agency document titled "Home Health Certification And Plan Of Care" undated and electronically signed by employee C. This			

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	document had an area subtitled "14. DME [durable medical equipment and Supplies" that stated "Hospital Bed, Wheelchair, hoyer lift, Overhead trapeze, alcohol pads, Chux/Underpads, Diabetic Supplies, Dressing Supplies, Gauze Pads, Needles, Probe Covers, Sharps Container, Syringe, Tape, non sterile gloves, Silver Alginate pads, wound cleanser". The home health agency failed to list the type of home hemodialysis machine and dialysate fluids the patient had in the home. The plan of care failed to contain all the DME's and supplies the patient utilized. 7. Observation at a home visit on 1/19/18 at 10:30 a.m. for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced patient's home medications on his/her kitchen table. Comparison of patient's home medications against ProCare's medication reconciliation evidenced the following medication discrepancies: a. Patient #6 home prescription bottle indicated: Clonidine [for blood pressure] 0.1 mg [milligram] by mouth three times a day. ProCare medication reconciliation indicated: Clonidine 0.1 mg oral tablet 1 tab daily by mouth (PO). The frequency on the agency's medication reconciliation was not congruent with patient's home prescription. b. Vitamin D2 [supplement] 50,000 IU [international unit] 1 capsule by mouth every week for 12 weeks. This prescription was ordered on 1/17/18 and had not been updated on the agency medication reconciliation. c. Potassium Cl [Chloride] [supplement] micro 10 MEQ [milliequivalents] ER [extended release] tabs take 1 tablet by mouth daily. This medication failed to be on the agency's medication			

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	reconciliation. d. Niferex [iron supplement] take 1 tablet by mouth daily. This prescription was ordered 1/17/18 and had not been updated on the agency medication reconciliation. e. Patient #6 over-the-counter medication: Acetaminophen 500 mg as needed for pain. ProCare medication reconciliation indicated: Acetaminophen 160 mg oral tablet 1 tab q 6 hours by mouth (PO). The dosage of the medication in the patient's home was not congruent with the dosage on the agency's medication reconciliation. f. Levemir [insulin] 10 units subcutaneously at bedtime, caregiver indicated he/she administers at 9:00 p.m. every night. This medication failed to be on the agency's medication reconciliation. g. The following medication was on the agency's medication reconciliation but was not a medication in the patient's home medications: Calcium Acetate, Benadryl and Hydrocodone. 8. During an interview on 1/19/18 at 1:18 p.m. the clinical supervisor indicated he/she recorded the patient's medications from discharge paperwork received from another medical facility.			
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on record review the skilled nurse failed to follow the plan of care establish by the physician in 4 of 7 clinical charts reviewed. (#1, #2, #3, #6)	N 0537	N537. The Administrator and Director of Nursing (DON) reviewed the Policy “3.9	02/08/2018

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	The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members. Includes the following: ... Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare		Medical Supervision/Patient Plan of Care" for reeducation and clarification of procedures. The DON in-serviced the skilled staff on following the Physician's orders (including disciplines requested with frequencies), performing only ordered tasks, providing instructions i.e. caregiver/patient instructions on employing non-pharmacological pain relief modalities, filling the medication box, patient positioning and repositioning, etc. in accordance with the plan of care. Staff to notify the patient's physician of missed visits when they cannot be made up. To assure the physician orders and plan of cares are being followed, the DON or clinical designee will review all progress notes weekly as part of the weekly quality assurance process to ensure compliance. The DON will be responsible to ensure that this deficiency does not recur.	

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	Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. Clinical record review on 1/19/18 of patient #1, start of care 12/19/17, certification period 12/19/17 - 2/16/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN [skilled nurse] Frequency: 1W9 [once a week for 9 weeks]. PT [physical therapy] Frequency: 2W4 [2 times weekly for 4 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN to assess if the Caregiver can verbalize an			

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	understanding of the indication for each mediation. Physical therapist to evaluate and submit plan of treatment. SN to instruct the Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by: a. Clinical record review on 1/19/18 evidenced an agency document titled "LVN [licensed vocational nurse]/LPN [licensed practical nurse] Visit" dated 12/27/17 and electronically signed by employee E. This document had an area subtitled "Diabetic Care" that indicated patient #1's a.m. blood sugar was 109 mg/dl [milligram/deciliter] that the check was performed by the skilled nurse on the patient's left finger. The physician signed plan of care did not order for the skilled nurse to perform blood sugar checks on patient #1. The skilled nurse failed to follow the plan of care. b. Record review on 1/19/18 failed to evidence the skilled nurse instructed the patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs, failed to assess if the Caregiver can verbalize an understanding of the indication for each medication, and failed to instruct the caregiver to contact the agency to report any fall with or without minor injury and to call 911 for fall resulting is serious injury or causing severe pain or immobility as directed on the physician signed plan of care. 3. Clinical record review on 1/18/18 of patient #2, start of care 11/25/17, certification period 11/25/17			

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	157538	A. BUILDING 00 B. WING	01/19/2018

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	- 1/23/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 12/11/17 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W10 [once weekly for 10 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to assess skin for breakdown every visit. SN to assess/instruct on seizure disorder signs & symptoms and appropriate actions during seizure activity. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing sever pain or immobility. SN to assess caregiver filling mediation box to determine if caregiver is preparing correctly. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. Patient refused Physical Therapy services at this time." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by: a. Clinical record review on 1/18/18 for patient #2 evidenced a missed visit the week of 12/31/17 - 1/6/18. During an interview on 1/18/18 at 3:23 p.m. employee C indicated the skilled nurse couldn't see the patient at a certain time the family requested. There was no evidence that another visit time was arranged or that the physician was notified for the missed visit. The skilled nurse failed to follow the physician signed plan of care. b. Record review on 1/18/18 for patient #2 failed to evidence the nurse assess/instructed on			

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	seizure disorder signs and symptoms and appropriate actions during seizure activity, assessed the caregiver filling the medication box to determine if the caregiver is preparing correctly, and determine if the caregiver is able to identify the correct dose route, and frequency of each medication on skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/22/17, 12/28/17 and 1/10/18. The skilled nurse failed to follow the physician signed plan of care. c. Record review on 1/18/18 for patient #2 failed to evidence the nurse instructed the caregiver on turning/repositioning every 2 hours on the skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/28/17 and 1/10/18 as ordered on the physician signed plan of care. 4. Clinical record review on 1/19/18 of patient #3, start of care 12/28/17, certification period 12/28/17 - 2/25/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W1 [once a week for 1 week], 2W4 [2 times a week for 4 weeks], 1W5 [once a week for 5 weeks]. HHA [home health aide] Frequency: 1W1, 2W4. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to assess pain eve and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to instruct the Patient on methods to			

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	reduce friction and shear. SN to perform/instruct on wound care as follows: clean with NaCl [sodium chloride] apply Medihoney cover with Allevyn. SN to assess skin for breakdown every visit. May discontinue wound care when wound(s) have healed. SN to assess patient for diet compliance. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to use prescribed assistive device when ambulating. SN to instruct patient to change positions slowly. HHA to assist with ADL's [activities of daily living] & IADL's [instrumental activities of daily living] per HHA care plan. SN to assess patient filling medication box to determine if patient is preparing correctly. SN to determine if the Patient is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient can verbalize an understanding of the indication for each medication. Physical therapist to evaluate and submit plan of treatment." The physician signed plan of care failed to be followed as evidenced by: a. Clinical record review on 1/19/18 for patient #3 evidenced the skilled nurse had an extra visit during the week of 1/7/18 - 1/13/18. No extra visit order was evidenced in the clinical record and no prn [as needed] visits were ordered on the plan of care. During an interview on 1/19/18 at 1:55 p.m. employee C indicated he/she would have to write an order for the extra visit made to patient #3. The skilled nurse failed to follow the physician signed plan of care and failed to obtain a physician order for the extra visit. b. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse to instruct the patient on nonpharmacologic pain relief measures on the skilled nurse visits dated			

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	1/2/18 and 1/5/18 as ordered on the physician signed plan of care. c. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse instructed the patient to wear proper footwear when ambulating, instructed the patient to use prescribed assistive device when ambulating, assessed the patient filling medication box to determine if the patient was preparing correctly, determined if the patient is able to identify the correct dose, route, and frequency of each medication and assessed if the patient can verbalize an understanding of the indication for each medication on the skilled nurse visits dated 1/2/18, 1/5/18, 1/8/18, 1/10/18 and 1/12/18 as ordered on the physician signed plan of care. 5. Clinical record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced a document titled "Home Health Certification And Plan Of Care". This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 24visits. PT Frequency: 6 visits. OT [occupational therapy]: 3 visits. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); Other: Bilateral BKA [below knee amputation]; SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient to take pain mediation before pain becomes severe to achieve better pain control. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques,			

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	massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain mediations, pain affecting ability to perform patient's normal activities. SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to instruct the Patient/Caregiver on methods to reduce friction and shear. SN to instruct the Patient/Caregiver to pad all bony prominences. SN to perform/instruct on wound care as follows: SN to cleanse wound to sacral area with wound cleanser and apply Silver Alginate to wound bed and packed with gauze and tape 3XW [3 times weekly]. SN to assess skin for breakdown every visit. SN to instruct the Patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes. May discontinue wound care when wound(s) have healed. SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications. SN to prefill syringes with Levemir insulin as follows: 10units to be taken Q [every] HS [at bedtime]. Patient to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2GM [gram] Na+ [sodium] ADA [American diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver can verbalize an understanding of the indication for each medication. SN to assess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on precautions for high risk medications, such as, hypoglycemics,			

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	anticoagulants/antiplatelets, narcotics. Physical therapist to evaluate and submit plan of treatment. Occupational therapist to evaluate and submit plan of treatment. Physical therapy to evaluate. Occupational therapy to evaluate. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The skilled nurse failed to follow the plan of care, this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/caregiver to pad all bony prominences, instruct the patient/caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes, instruct the patient/caregiver on 2GM Na+ ADA diet, determine if the caregiver is able to identify the correct dose, route, and frequency of each medication, assess if the caregiver can verbalize an understanding of the indication for each medication, assess the caregiver administering injectable medications to determine if proper technique was utilized, instruct the caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics and to instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility as ordered on the plan of care for the skilled nurse visits dated 1/11/18 and 1/12/18.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where			

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	services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review the home health agency failed to meet the patient's therapy needs in 1 of 7 clinical charts reviewed. (#1) The findings include: 1. The agency policy dated 10/15/05 titled "3.1 Referral and Acceptance Of Patients" stated "... The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection. Persons residing outside of the service area or in need of services not provided by the Agency will be assisted in contacting the appropriate resources. Upon receipt of a referral, an evaluation by a Registered Nurse of Physical Therapist (Therapy only cases) will be made to determine that the care can adequately and safely performed [sic] at home, to assess the patient care needs, and to ensure that the patient meets the admission criteria. Patients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility whenever possible. Patients will be assigned to the appropriate staff members by a registered nurse or under the supervision of the registered nurse according to geographical location, clinical needs of the patient, and the qualifications and availability of staff...." 2. The agency policy dated 10/19/06 titled "9.4	N 0541	N541. The Administrator and Director of Nursing (DON) reviewed the policies “3.1 Referral and Acceptance of Patients” for reeducation and clarification of the procedures. The need to meet the medical, nursing, rehabilitation and social needs of the patient was emphasized. The DON will review all new referrals to ensure that the agency can provide the requested services directly or by contract. The DON will contact the patient’s physician when the agency cannot meet the patient’s needs and arrange for the patient to be transferred to another agency. To assure that this deficiency is corrected, the DON or Assistant Director of Nursing (ADON) will review all new referrals to ensure that the agency can provide the requested services directly	01/22/2018

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	Therapy Services" stated "... A copy of the verbal order and the Therapy Referral Form will be faxed to the Agency/Therapist providing therapy services. A copy of the Therapy Referral Form will be submitted along with the M.D. [medical director] order. The Nursing Supervisor will contact the agency Therapist providing therapy services and verbally inform them of the referral. The Nursing Supervisor will fax a copy of the verbal order and referral. The Therapist will visit the patient within 48-72 hours. The Director of Nursing will be notified if the family requested an evaluation other than the above stated time frame. After the assessment, the Therapist will Contact the Case Manager/DON [director of nursing] to communicate the findings and plan. The Therapist will submit initial assessment to ProCare Home Health within 24-48 hrs [hours]. ProCare Home Health Services will submit the submitted initial assessment to the physician for signature. The agency will receive a copy of the patient therapy schedule each Monday. If there are problems, contact the Director of Nurses/Clinical Supervisor immediately. A case conference for each patient receiving PT [physical therapy], OT [occupational therapy], and ST [speech therapy] services will be conducted at least every thirty (60) [sic] days. The assigned Case Manager and HHA [home health aide] (if applicable) will be in attendance. A case conference will be scheduled prior to discharge of each patient. The Physical Therapist will report directly to the Director of Nursing...." 2. Clinical record review on 1/19/18 for patient #1, start of care 12/19/17, certification period 12/19//17 - 2/16/18, evidenced an agency document titled "Patient Profile" that indicated the services required for patient #1 was PT [physical therapy], OT [occupational therapy] and ST [speech		or by contract. The Administrator and DON will be responsible to ensure that this deficiency does not recur.	

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	therapy]. Only PT was evidenced as being provided to patient #1 by the home health agency. 3. Clinical record review on 1/19/18 for patient #1 evidenced faxed hospital paperwork dated 1/16/18 this paperwork had an area subtitled "Referrals/Response Letter" that stated "Per Dr. #AA, have PT/OT/ST. Dx [diagnosis]: dysarthria...." This area was addressed to Procare HHC [home health care]. There was no evidence of OT or ST ever being provided. 4. Clinical record review on 1/19/18 for patient #1 evidenced an agency document titled "OASIS-C2 START OF CARE" dated 12/19/17 and electronically signed by employee C. This document had an area subtitled "Functional Limitations" that had an "x" noted by endurance, speech, contracture, incontinence and ambulation. The same document listed multiple areas that supported the need for OT and ST services as follows: a. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled Oasis M1230 (M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language) that had the code "03" placed in a box. Code "03" stated "3 - Has severe difficulty expressing basic ideas; requires maximal assistance or guessing by listener. Limited to single words/short phrases." b. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)" with a "x" marked by "2 - Impaired decision-making: failure to perform usual (I)ADLs [activities of daily living], inability to			

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	appropriately stop activities, jeopardized safety through actions". c. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1810) Current ability to dress upper body including undergarments, pullovers, front-opening shirts and blouses, managing zippers/buttons/snaps." that had a code of "02" placed in box. Code "02" stated "2 - Someone must help the patient put on upper body clothing." An area subtitled "(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes." that had a code of "03" placed in box. Code "03" stated "3 - Patient depends entirely upon another person to dress lower body." An area subtitled "(M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair)." that had a code of "05" placed in box. Code "05" stated "5 - Unable to use the shower/tub, able to participate in bathing self in bed/sink/bedside chair/commode with assistance or supervision." d. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten." that had a code of "01" placed in box. Code "01" stated "1 - Able to feed self but requires meal set-up, or intermittent assistance/supervision, or a liquid/pureed/ground meat diet." e. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1880) Current Ability to Plan and Prepare			

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	Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:" that had a code of "02" placed in box. Code "02" stated "2 - Unable to prepare any light meals or reheat any delivered meals." f. The agency document titled "OASIS-C2 START OF CARE" had an area subtitled "(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate." that had a code of "04" placed in box. Code "04" stated "4 - Unable to answer the telephone at all but can listen if assisted with equipment." 5. Clinical record review on 1/19/18 evidenced the skilled nurse initial/comprehensive assessment titled "OASIS-C2 START OF CARE" dated 12/19/17 and electronically signed by employee C. This document assessment provided by employee C evidenced the need for the patient to have occupational therapy and speech therapy as ordered by the physician. The home health agency failed to provide these services to patient #1 and failed to meet patient #1's needs in their place of residence.			
N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review, observation and interview the registered nurse failed to coordinate services with all health care providers serving their patients in 5 of 7 clinical records reviewed.	N 0545	N545. The Administrator and Director of Nursing (DON) reviewed the policy titled	02/08/2018

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	(#1, #2, #4, #5, #6) The findings include: 1. The undated agency policy titled "3.16 Case Conferences" stated "The purpose of case conferences is to: Determine the adequacy of the plan of treatment and appropriateness of continuation of care Assure coordination of services in patient-goal directed activity on the part of each home care staff member Evaluate patient progress and plans for future care Provide assistance to team members having difficulty planning care for specific problem cases Refer cases that require further study to the clinical record review committee Case conferences shall be held regularly to review problem cases and to review the plan of treatment for appropriateness and feasibility of continued services. Such conferences shall be documented separately or in the clinical record and should be held on each patient at the time of admission; prior to the date the plan of treatment is due for the review at least every 60 days and prior to discharge. However, if a problem arises, a case-specific conference would be indicated. All professional disciplines participating in the patient's care should have input at his [sic] conference. For personnel participating in the patient's care but unable to attend the conference, a telephone conference could be established. Documentation of the conference shall be the responsibility of the primary nurse or supervisor, or other professional as instructed by the supervisor. The documentation shall include a summary of progress, assessment of the need for continued care, plans and discharge goals. ... All staff delivering patient care services is encouraged to have at least weekly contact with their Case manager and as needed. Any conference related		"3.16 Case Conferences" for clarification and reeducation on coordinating services provided by all Healthcare Providers in the patient's home. All field staff were in-serviced by the DON on 2/8/18 on the importance of identifying all Healthcare providers; types, disciplines with frequencies and documenting and coordinating services with them. The DON or clinical designee will review all progress notes weekly to ensure compliance with Care Coordination. Also, during the monthly case conference meetings, Coordination of Care will be emphasized. The DON will be responsible to ensure that this deficiency does not recur.	

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	to an individual patient may be documented as a case conference...." 2. Clinical record review on 1/19/18 for patient #1 evidenced an agency document titled "OASIS-C2 START OF CARE" that was dated 12/19/17 and electronically signed by employee C. This document had an area subtitled "Coordination of Care" that stated "... Name: [agency #26] Regarding: Homemaker Services 9 Hours/Week". The registered nurse failed to provide any documentation that evidenced coordination of care with agency #26. During an interview on 1/19/18 at 1:35 p.m. the administrator indicated that they are not documenting coordination of care. The administrator also indicated that if everything is going ok they don't write anything down. 3. Clinical record review on 1/18/18 for patient #2 evidenced an agency document titled "OASIS-C2 START OF CARE" dated 11/25/17 and electronically signed by employee C. This document had an area subtitled "Coordination of Care" that stated "... Regarding: HHA [home health aide] services 5 days/week. This document failed to indicate what agency was providing home health aide services and failed to evidence any coordination of care with other agency. The registered nurse failed to coordinate care with the agency that provided their patient with a home health aide. 4. Clinical record review on 1/19/18 for patient #4 failed to evidence any coordination of care with the patient's primary care physician. The agency document titled "Home Health Certification And Plan Of Care" dated 11/30/17 and electronically signed by employee L indicated the patient's physician is physician #BB, which was a			

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	hospitalist affiliated with agency #29. This physician only practices inside the facility with admitted patients. The registered nurse failed to identify the patient's primary physician. 5. Clinical record review on 1/17/18 for patient #5, start of care 7/23/17, certification period 11/20/17 - 1/18/18, evidenced a document titled "Home Health Care Certification And Plan Of Care", electronically signed by employee C and undated, with no physician signature. This document had an area subtitled "21. Orders for Discipline and Treatment (Specify Amount/Frequency/Duration)" that stated "... Coordination of Care with agency #26 (HHA [Home Health Aide] services) and agency #27 (SN [Skilled Nursing] for wound care)". The agency failed to provide any clinical documentation to show coordination of care with the other health care agencies that provided care to their patient. During an interview on 1/19/18 at 2:16 p.m., employee C indicated that "the patient likes agency #26 because there is a home health aide at that agency that the patient really likes. We speak with both agencies and there have been no problems but I'm not sure if that has been documented." During the same interview employee G stated "agency #28 does that, they assign different companies for different reasons" in reference to the multiple health care agencies that cared for one patient. 6. Clinical record review on 1/19/18 for patient #6 evidenced an agency document titled "NON-OASIS START OF CARE" dated 1/9/18 and electronically signed by employee C. This document had an area subtitled "Dialysis" that indicated the patient was on dialysis, that the dialysis type is "Home dialysis Permacath and a statement that read "Patient receives home			

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	dialysis daily with Dialysis nurse". During a home visit on 1/19/18 observation was made of a home dialysis machine in the patient's bedroom. During an interview with patient #6 on 1/19/18 at 10:50 a.m. the patient indicated he/she received dialysis Monday - Friday from a home dialysis nurse. Patient #6 was unaware of the company that provided the in-home dialysis. During an interview with the family member on 1/19/18, he/she indicated he/she was not aware of the company name. Observation was made of a folder on patient #6 dining room table with agency #30 on the label; upon asking the family member what services they provided for patient #6 he/she indicated they offered the patient free home health aide hours and that they were considering employing agency #30. During an interview with the clinical supervisor and administrator on 1/19/18 at 1:42 p.m. the clinical supervisor indicated that their should probably be coordination because he/she gets home dialysis every day. During the interview the clinical supervisor indicated he/she did not remember the name of the company that provided the patient home hemodialysis. The registered nurse failed to coordinate care with the home hemodialysis company for patient #6.			
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice			

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	programs, and supervise and teach other nursing personnel. Based on record review and interview the skilled nurse failed to ensure the physician was notified for vital signs outside of parameters in 1 of 7 clinical charts reviewed. (#2) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. ... Changes in vital signs, or other significant out of range parameters and events must be reported immediately through the hierarchy to supervision RN [registered nurse] or physician ... COORDINATION OF PATIENT SERVICES FOR SN [skilled nurse] STANDARD PARAMETERS OR PARAMETERS ON CARE PLAN SPECIFIC TO PATIENT: BLOOD PRESSURE - SYSTOLIC READING - >160 DIASTOLIC READING - <60 HEART RATE - >100 OR <60 TEMPERATURE - >100 OR <96 RESPIRATIONS- >22 OR <12 PAIN LEVELS GREATER THAN PAIN THRESHOLD ON CARE PLAN CLINICAL STAFF TO RECHECK ABNORMAL VITALS BEFORE LEAVING PATIENT'S HOME SN to report the	N 0546	N546. The Administrator and Director of Nursing (DON) reviewed the Policy “3.9 Medical Supervision/Patient Plan of Care” for reeducation and clarification of procedures. The DON in-serviced the skilled staff on following the Physician’s orders (including disciplines requested with frequencies), performing only ordered tasks, providing instructions i.e. caregiver/patient instructions on employing non-pharmacological pain relief modalities, filling the medication box, patient positioning and repositioning, etc. in accordance with the plan of care. Staff to notify the patient’s physician of missed visits when they cannot be made up. The DON or clinical designee will review all progress notes weekly as part of the weekly quality assurance process to ensure compliance. The DON will be responsible	02/08/2018

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	following vital signs that are out of Parameter Range reported by the HHA [home health aide] or checked at visit to MD [medical doctor]. SN MUST DOCUMENT AND REPORT TO THE MD ALL SIGNIFICANT CHANGES IN THE PATIENT'S PHYSICAL STATUS, VITAL SIGNS, DISEASE PROCESSES, PAIN SYMPTOMS, AND OTHER SIGNS AND SYMPTOMS." 2. Clinical record review on 1/18/18 for patient #2, start of care 11/25/17, certification period 11/25/17 - 1/23/18, principle diagnosis essential hypertension, evidenced an agency document titled "LVN [licensed vocational nurse/LPN [licensed practical nurse] Visit" dated 1/10/18 and electronically signed by employee J. This document had an area subtitled "Vital Signs" that indicated the patient had a blood pressure while in a sitting position of 182/85. This blood pressure is outside of parameters. There was no documentation or indication that the physician was notified of the elevated blood pressure and that the skilled nurse reassessed the blood pressure. During an interview on 1/18/18 at 3: 25 p.m. the clinical supervisor indicated that he/she would write down the question to ask the skilled nurse at the visit. At 3:34 p.m the clinical supervisor indicated that the skilled nurse indicated to her that the patient was yelling and he/she couldn't understand him/her. The skilled nurse failed to notify the physician of vital sign outside of agency's established parameters.		to ensure that this deficiency does not recur.	
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:			

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	(H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review the skilled nurse failed to follow the plan of care establish by the physician in 4 of 7 clinical charts reviewed. (#1, #2, #3, #6) The findings include: 1. The agency policy dated 10/15/05 titled "3.9 Medical Supervision/Patient Plan Of Care" stated "... Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. Purpose To ensure the provision of quality and legally approved ProCare Home Health services. Procedure ProCare Home Health services are furnished to patients: Under the general supervision of a physician Based on a patient plan of care established and periodically reviewed by the physician to ensure appropriate application of the services to the patient's condition. The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff an interdisciplinary team members. Includes the following: ... Review of patient plan of care Physician initial documenting review of patient plan of care Date of review of patient plan of care Any other appropriate items 2. Is written by the physician and made available to the ProCare Home Health agency or is prepared as a written record by the ProCare Home Health agency based on the physicians verbal orders following Policy and Procedures re: Telephone Orders 3. Is incorporated into the patient clinical record. 4. Is reviewed by the attending physician in consultation with the home health staff and	N 0547	N547. The Director of Nursing (DON) reviewed the Policy "3.9 Medical Supervision/Patient Plan of Care" for reeducation and clarification of procedures. The DON in-serviced the skilled staffs on adhering to the Plan of Care; no intervention should be carried without the Physician's orders. Orders must be obtained for missed visits and all instructions to patients/caregivers must be given in accordance to the treatment plan. The DON or clinical designee will review the clinical notes weekly to ensure the orders and treatment plans are being followed. Also 10% of clinical records will be selected and reviewed quarterly for evidence that physician's orders are being followed. The DON will be responsible to ensure that this deficiency does not recur.	02/08/2018

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	interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of care are documented through written and signed plans of modifications or, if changes are requested orally, are reduced to writing, signed by a ProCare Home Health Registered Nurse, and countersigned by the attending physician as soon as possible, following Policy and Procedure re: Telephone orders, Medical orders and Patient care plans ... Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician If a physician refers a patient under a patient plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications in the original plan of care. ProCare Home Health staff members promptly inform the physician of changes that suggest a need to alter the patient plan of care...." 2. Clinical record review on 1/19/18 of patient #1, start of care 12/19/17, certification period 12/19/17 - 2/16/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN [skilled nurse] Frequency: 1W9 [once a week for 9 weeks]. PT [physical therapy] Frequency: 2W4 [2 times weekly for 4 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching,			

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	positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN to assess if the Caregiver can verbalize an understanding of the indication for each mediation. Physical therapist to evaluate and submit plan of treatment. SN to instruct the Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by: a. Clinical record review on 1/19/18 evidenced an agency document titled "LVN [licensed vocational nurse]/LPN [licensed practical nurse] Visit" dated 12/27/17 and electronically signed by employee E. This document had an area subtitled "Diabetic Care" that indicated patient #1's a.m. blood sugar was 109 mg/dl [milligram/deciliter] that the check was performed by the skilled nurse on the patient's left finger. The physician signed plan of care did not order for the skilled nurse to perform blood sugar checks on patient #1. The skilled nurse failed to follow the plan of care. b. Record review on 1/19/18 failed to evidence the skilled nurse instructed the patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs, failed to assess if the Caregiver can verbalize an understanding of the indication for each medication, and failed to instruct the caregiver to contact the agency to report any fall with or without minor injury and to call 911 for fall			

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	resulting is serious injury or causing severe pain or immobility as directed on the physician signed plan of care. 3. Clinical record review on 1/18/18 of patient #2, start of care 11/25/17, certification period 11/25/17 - 1/23/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 12/11/17 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W10 [once weekly for 10 weeks]. Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to assess skin for breakdown every visit. SN to assess/instruct on seizure disorder signs & symptoms and appropriate actions during seizure activity. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing sever pain or immobility. SN to assess caregiver filling mediation box to determine if caregiver is preparing correctly. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. Patient refused Physical Therapy services at this time." The physician signed plan of care failed to be followed by the skilled nurse as evidenced by: a. Clinical record review on 1/18/18 for patient #2 evidenced a missed visit the week of 12/31/17 - 1/6/18. During an interview on 1/18/18 at 3:23 p.m. employee C indicated the skilled nurse couldn't see the patient at a certain time the family requested. There was no evidence that another			

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	visit time was arranged or that the physician was notified for the missed visit. The skilled nurse failed to follow the physician signed plan of care. b. Record review on 1/18/18 for patient #2 failed to evidence the nurse assess/instructed on seizure disorder signs and symptoms and appropriate actions during seizure activity, assessed the caregiver filling the medication box to determine if the caregiver is preparing correctly, and determine if the caregiver is able to identify the correct dose route, and frequency of each medication on skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/22/17, 12/28/17 and 1/10/18. The skilled nurse failed to follow the physician signed plan of care. c. Record review on 1/18/18 for patient #2 failed to evidence the nurse instructed the caregiver on turning/repositioning every 2 hours on the skilled nurse visits dated 11/30/17, 12/7/17, 12/14/17, 12/28/17 and 1/10/18 as ordered on the physician signed plan of care. 4. Clinical record review on 1/19/18 of patient #3, start of care 12/28/17, certification period 12/28/17 - 2/25/18, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 1/10/18 and signed by the physician. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 1W1 [once a week for 1 week], 2W4 [2 times a week for 4 weeks], 1W5 [once a week for 5 weeks]. HHA [home health aide] Frequency: 1W1, 2W4. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; SN to assess pain eve and			

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	effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to instruct the Patient on methods to reduce friction and shear. SN to perform/instruct on wound care as follows: clean with NaCl [sodium chloride] apply Medihoney cover with Allevyn. SN to assess skin for breakdown every visit. May discontinue wound care when wound(s) have healed. SN to assess patient for diet compliance. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to use prescribed assistive device when ambulating. SN to instruct patient to change positions slowly. HHA to assist with ADL's [activities of daily living] & IADL's [instrumental activities of daily living] per HHA care plan. SN to assess patient filling medication box to determine if patient is preparing correctly. SN to determine if the Patient is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient can verbalize an understanding of the indication for each medication. Physical therapist to evaluate and submit plan of treatment." The physician signed plan of care failed to be followed as evidenced by: a. Clinical record review on 1/19/18 for patient #3 evidenced the skilled nurse had an extra visit during the week of 1/7/18 - 1/13/18. No extra visit order was evidenced in the clinical record and no prn [as needed] visits were ordered on the plan of care. During an interview on 1/19/18 at 1:55 p.m. employee C indicated he/she would have to write an order for the extra visit made to patient #3. The skilled nurse failed to follow the physician signed plan of care and failed to obtain			

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	a physician order for the extra visit. b. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse to instruct the patient on nonpharmacologic pain relief measures on the skilled nurse visits dated 1/2/18 and 1/5/18 as ordered on the physician signed plan of care. c. Clinical record review on 1/19/18 for patient #3 failed to evidence the skilled nurse instructed the patient to wear proper footwear when ambulating, instructed the patient to use prescribed assistive device when ambulating, assessed the patient filling medication box to determine if the patient was preparing correctly, determined if the patient is able to identify the correct dose, route, and frequency of each medication and assessed if the patient can verbalize an understanding of the indication for each medication on the skilled nurse visits dated 1/2/18, 1/5/18, 1/8/18, 1/10/18 and 1/12/18 as ordered on the physician signed plan of care. 5. Clinical record review on 1/19/18 for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced a document titled "Home Health Certification And Plan Of Care". This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "SN Frequency: 24visits. PT Frequency: 6 visits. OT [occupational therapy]: 3 visits. Homebound Status: Exhibits considerable & taxing effort to leave home; Requires the assistance of another to get up and move safely; Unable to safely leave home unassisted; Unable to leave home due to medical restriction(s); Other: Bilateral BKA [below knee amputation]; SN to assess pain level			

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	157538	A. BUILDING 00 B. WING	01/19/2018

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	and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient to take pain mediation before pain becomes severe to achieve better pain control. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 5, pain medications not effective, patient unable to tolerate pain mediations, pain affecting ability to perform patient's normal activities. SN to instruct Patient/Caregiver on turning/repositioning every 2 hours. SN to instruct the Patient/Caregiver on methods to reduce friction and shear. SN to instruct the Patient/Caregiver to pad all bony prominences. SN to perform/instruct on wound care as follows: SN to cleanse wound to sacral area with wound cleanser and apply Silver Alginate to wound bed and packed with gauze and tape 3XW [3 times weekly]. SN to assess skin for breakdown every visit. SN to instruct the Patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes. May discontinue wound care when wound(s) have healed. SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications. SN to prefill syringes with Levemir insulin as follows: 10units to be taken Q [every] HS [at bedtime]. Patient to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2GM [gram] Na+ [sodium] ADA [American diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver can verbalize an			

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	understanding of the indication for each medication. SN to assess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics. Physical therapist to evaluate and submit plan of treatment. Occupational therapist to evaluate and submit plan of treatment. Physical therapy to evaluate. Occupational therapy to evaluate. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The skilled nurse failed to follow the plan of care, this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/caregiver to pad all bony prominences, instruct the patient/caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in drainage, foul odor, redness, pain and any other significant changes, instruct the patient/caregiver on 2GM Na+ ADA diet, determine if the caregiver is able to identify the correct dose, route, and frequency of each medication, assess if the caregiver can verbalize an understanding of the indication for each medication, assess the caregiver administering injectable medications to determine if proper technique was utilized, instruct the caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics and to instruct the patient/caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility as ordered on			

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	the plan of care for the skilled nurse visits dated 1/11/18 and 1/12/18.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review,observation and interview the skilled nurse failed to ensure all the patient's medications were on the medication reconciliation during the comprehensive assessment in 2 of 6 clinical charts reviewed. (#4, #6) The findings include: 1. The agency policy dated 10/15/05 titled "4.13 Patient Record Contents" stated "... The agency shall maintain a clinical record for each patient, which is initiated at the time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patient's chart shall contain data	N 0608	N608. The Director of Nursing (DON) reviewed the policy titled “4.13 Patient Record Contents” for reeducation and clarification of procedures. Medication reconciliation, review and profile update was completed for Clinical Record #4, on 01-23-18. Medication reconciliation, review and profile update was completed for Patient	01/22/2018

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	including but not limited to: ... A complete physical assessment including: vital signs, height, weight, systems review, and other relevant information. ... Specific written orders as prescribed and signed by the attending physician ... Medication profile including action, allergies, effects, and side effects or prescribed and over-the-counter drugs ..." 2. Record review on 1/19/18 of clinical record #4 evidenced a pharmacy order for Daptomycin [antibiotic] 650 mg [milligrams] IV [intravenous] Q24 [every 24 hours]. This medication failed to be listed on the agency's plan of care or medication reconciliation. 3. Observation at a home visit on 1/19/18 at 10:30 a.m. for patient #6, start of care 1/9/18, certification period 1/9/18 - 3/9/18 evidenced patient's home medications on his/her kitchen table. Comparison of patient's home medications against ProCare's medication reconciliation evidenced the following medication discrepancies: a. Patient #6 home prescription bottle indicated: Clonidine [for blood pressure] 0.1 mg [milligram] by mouth three times a day. ProCare medication reconciliation indicated: Clonidine 0.1 mg oral tablet 1 tab daily by mouth (PO). The frequency on the agency's medication reconciliation was not congruent with patient's home prescription. b. Vitamin D2 [supplement] 50,000 IU [international unit] 1 capsule by mouth every week for 12 weeks. This prescription was ordered on 1/17/18 and had not been updated on the agency medication reconciliation. c. Potassium Cl [Chloride] [supplement]		#6 on 01-23-18. The DON has provided education to all staff involved in providing skilled care to the patient referred to in Record #4 and patient #6. The DON in-serviced the skilled staff on performing a comprehensive review of all medications the patient is currently using to identify adverse effects, drug reactions, ineffective drug therapy and non-compliance with drug therapy. Recording the patient's medications from discharge paperwork from another medical facility as an alternative is unacceptable. The DON or her clinical designee will review all start of cares and recertifications documentation weekly to ensure compliance. Also 10% of clinical records will be selected and reviewed quarterly for evidence that Medication reconciliation, review and profile update is being done. The DON will be responsible to ensure that this deficiency does not recur.	

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	micro 10 MEQ [milliequivalents] ER [extended release] tabs take 1 tablet by mouth daily. This medication failed to be on the agency's medication reconciliation. d. Niferex [iron supplement] take 1 tablet by mouth daily. This prescription was ordered 1/17/18 and had not been updated on the agency medication reconciliation. e. Patient #6 over-the-counter medication: Acetaminophen 500 mg as needed for pain. ProCare medication reconciliation indicated: Acetaminophen 160 mg oral tablet 1 tab q 6 hours by mouth (PO). The dosage of the medication in the patient's home was not congruent with the dosage on the agency's medication reconciliation. f. Levemir [insulin] 10 units subcutaneously at bedtime, caregiver indicated he/she administers at 9:00 p.m. every night. This medication failed to be on the agency's medication reconciliation. g. The following medication was on the agency's medication reconciliation but was not a medication in the patient's home medications: Calcium Acetate, Benadryl and Hydrocodone. 3. During an interview on 1/19/18 at 1:18 p.m. the clinical supervisor indicated he/she recorded the patient's medications from discharge paperwork received from another medical facility.			
N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.			

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	Based on record review and interview the home health agency failed to ensure the clinical record was clear and complete, and appropriately authenticated and dated with a physician signature in 2 of 7 clinical records reviewed. (#4, #5) The findings include: 1. The agency policy dated 10/15/05 titled "4.13 Patient Record Contents" stated "... The agency shall maintain a clinical record for each patient, which is initiated at the time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patient's chart shall contain data including but not limited to: Identifying date: name, address, date of birth, sex, patient number (Agency record number), health insurance claim number, the attending physicians name, address, telephone number, the status of the patient upon discharge for the hospital or institution (discharge report), and the patient's payment source such as Medicare, Medicaid, Private Insurance, or Private Pay A complete physical assessment including: vital signs, height, weight, systems review, and other relevant information. Primary diagnosis and secondary diagnosis Homebound status, activity permitted, and functional limitations Specific written orders as prescribed and signed by the attending physician Prognosis and length of time the services are projected to be needed An assessment of the home environment including safety factors the ability of the patient to perform activities of daily living Persons available in the home, if any, to assist with care Medication profile including action, allergies, effects, and side effect or prescribed and over-the-counter drugs An individualized plan of care for all disciplines providing services Clinical and progress notes	N 0610	N610. The Director of Nursing (DON) reviewed the policy titled “4.13 Patient Record Contents” for reeducation and clarification of procedures. All clinical records are now being reviewed weekly to make sure that all entries are legible, clear, complete and authenticated and dated. The DON or clinical designee will review all clinical records weekly as part of the weekly quality assurance process to ensure compliance. The DON will be responsible to ensure that this deficiency does not recur.	01/22/2018

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	(clinical notes are written the day of service delivery, and incorporated into the chart at least weekly [sic] A discharge summary shall be sent to the physician within 30 days of discharge and shall contain the patient's physical, mental and emotional status on admission and at discharge, date of discharge, extent to which the goals were met, and plans for follow-up or referral. A copy of the discharge summary sent to the physician is also retained in the clinical record...." 2. Clinical record review on 1/19/18 for patient #4, start of care 11/30/17, certification period 11/30/17 - 1/28/18, principal diagnosis bacterial infection, evidenced an agency document titled "Home Health Certification And Plan Of Care" dated 11/20/17 and electronically signed by employee L. This document failed to be signed by the physician. The home health agency failed to obtain a physician signature for the plan of care. During an interview on 1/19/18 at 2:10 p.m. the clinical supervisor indicated that they never got one. 3. Clinical record review on 1/17/18 for patient #5, start of care 7/23/17, certification period 11/20/17 - 1/18/18, evidenced a document titled "Home Health Care Certification and Plan of Care", electronically signed by employee C. The electronic signature of employee C did not include a date. On this same document, the agency failed to ensure a physician signature and date. During an interview on 1/19/18 at 2:17 p.m., employee C stated "okay". 4. Clinical record review on 1/17/18 for patient #5, evidenced a document titled "Home Health Care Certification and Plan of Care". This document evidenced a start of care date of 07/23/2017 and was not signed or dated by a physician. On a			

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	separate agency document titled "Physician Face to Face Encounter" signed and dated on 3/30/17, evidenced a Start of Care of 11/23/2016. A third agency document titled "Patient Profile" stated "Cert. [certification] Period: 11/23/2016 - 1/21/2017 ... SOC [Start of Care]: 11/23/2016 ... Referral Date 11/21/2016 ...". During an interview on 1/19/18 at 2:20 p.m., employee C stated "there must be a documentation error because the start of care for [patient #5] was 7/23/17".			