STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	201081670A	A. BUILDING B. WING	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE HOME HEALTH CARE LLC	, , ,

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This visit was a second post-condition re-visit survey of a home health agency. Dates: 09/03/2021, 09/07/2021, 09/08/2021 Facility #012829 Medicare ID: 157650 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. A complaint survey was conducted with an exit date of 03/04/2021 and found the home health agency to be out of compliance with Condition of Participation 42CFR 484.60 Care Planning, Coordination of Care, and Quality of Care. A post-condition revisit was conducted with an exit dated of 06/11/2021 and found the home health agency to be out of	G0000		2021-11-29

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

	compliance with Condition of Participation 42CFR 484.45 Reporting OASIS Information and 484.60 Care Planning, Coordination of Care, and Quality of Care. During this second post-condition visit, Noble Home Health Care LLC was found to be in compliance with 42CFR 484.45 Reporting OASIS information and 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care. Noble Home Health Care was found to have corrected 9 federal standard deficiencies, 7 standard deficiencies were recited and were cited for 5 new deficiencies. Based on the condition-level deficiencies cited during the 06/11/2021 survey and pursuant to Section 1891(a)(D)(iii) of the Act, Noble Home Health Care LLC continues to be precluded from providing home health aide training and/or a competency evaluation program for a period of 2 years beginning 06/11/2021 06/10/2023, due to being found out of compliance with the Condition of Participation at 42CFR 484.45 Reporting OASIS information and 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care.			
N0000	Initial Comments	N0000		2021-11-29

	This visit was a second re-licensure re-visit survey of a home health agency. Dates: 09/03/2021, 09/07/2021, 09/08/2021 Facility #012829			
N0466	Home health agency administration/management 410 IAC 17-12-1(j) 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). Review of an agency policy, updated 6/10/21, titled Personnel Records stated & A separate second personnel record for each employee with sensitive data shall include, but not be limited to: & b. Health status, including but not limited to: & Drug and Alcohol Screening &. Personnel record review on 09/07/2021 of RN [registered nurse] C s record, start date 09/17/14, evidenced an agency document with no title, dated 07/12/21, which evidenced drug test results. This employee s medical information was in the general personnel file and failed to be filed in a confidential	N0466	The deficiency has been corrected. Employee C personnel medical records arecurrently maintained in a separate confidential file. Employee personnel charts will be audited quarterly toensure confidential documents are maintained in a separate file. The Administrative Assistant will be responsible forquarterly audits to ensure confidential documents are maintained in separatefile.	2021-11-29

	medical information folder. During an interview on 09/07/2021 at 10:40 a.m., the administrator indicated to give her the drug screen paperwork that it should go in a manila folder.			
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Record review of an agency policy, updated 6/10/21, titled Universal Body Substance Precautions stated & Purpose: To reduce the risk of exposure to and transmission of infections when caring for patients. Policy: 1. Under Universal Body Substance Precautions, blood and certain body fluids of all patients are considered potentially infectious for bloodborne pathogens such as human immunodeficiency virus (HIV), and hepatitis B virus (HBV). Universal Body Substance Precautions apply to blood and other body fluids potentially containing blood or bloodborne pathogens. 2. These body fluids include emesis, sputum, feces, urine & 4. Agency personnel will adhere to the following precautions and will instruct patients/patient	N0470	HHA-I - has been verbally counseled and returneddemonstration observed on universal body substance precautions, and infectioncontrol, hand washing and bag technique.. Annual In-service on infection control and returned demonstrationwill be conducted on universal body substance precautions, hand washing and bagtechnique. The Clinical Manager and Alternate Clinical Manager will beresponsible for providing the in-service.	2021-11-29

	representatives and/or families/caregivers in infection control precautions as appropriate to the patient s needs. & Procedure: 1. General Precautions a. Handwashing is the single most important activity a staff member can undertake to help prevent the spread of infection. It will be performed at the following times: Before and after patient contact Before and after using gloves & After contact with soiled or contaminated items (i.e., bedpans, urinal, catheter, linens) & b. Use antimicrobial soap, warm water, and friction for hand washing. Lather and scrub for ten (10) seconds. Rinse well, beginning at fingertips so dirty water runs off at wrists. Dry hands on paper towels. Use dry paper towels to turn off faucets. & e. Gloves: The use of gloves (intact latex or latex-free if person is allergic) of appropriate size and quality) is important where the worker has cuts, abraded skin, chapped hands, dermatitis, etc., & Gloves are to be worn when handling soiled linen &. Record review of an agency policy, updated 6/10/21, titled Hand washing stated & Purpose: To cleanse the hands of germs and prevent contamination between patients and home care personnel. Hand washing before and after contact			

	most important means of preventing the spread of infection. When hands are not visibly soiled, waterless hand antiseptics are encouraged for routine hygiene between patient contacts Policy: 1. All personnel will wash their hands: a. Upon arrival to work b. Before and after EACH contact with a patient. c. After handling bed pans, urinals, catheters, linens & 2. Towels, either cloth or paper, and liquid soap will be used, if available. If not available, bar soap can be used but should be thoroughly rinsed between uses. Waterless hand washing products may also be used. & Hand washing Goal is for 100 percent compliance with this policy &. Record review of an agency policy, updated 6/10/21, titled Bag Technique stated & Purpose: To establish guidelines for the visiting home health care personnel regarding the appropriate use of the bag and transporting reusable equipment from house to house. Objective: To prevent contamination of reusable equipment carried by home health personnel from patient to patient. Responsible Personnel: All visiting staff. & Principles of Bag Technique: & 2. Hand washing supplies should be kept readily available either in a side-pocket of the bag, or in a zip lock baggie directly on			

	opening the bag. & Action: If the home environment does not pose a great risk of contamination to the bag, the staff will carry the bag into the home. After entering the home, the bag is placed on a clean area that isn t visibly soiled. Avoid using the floor. Disposable barriers may be used if the home environment poses a threat to the cleanliness of the bag. Rationale: To reduce the risk of contamination &. Observation was made of a home visit with patient #4 and HHA [home health aide] I on 09/07/2021 at 2:00 p.m. Upon entrance into the home the home health aide was observed placing his nursing bag upon the patient s couch with no barrier in between the couch and the nursing bag. HHA I then was observed going directly into the patient s bedroom, donned a pair of gloves, walked to the patient s bedside, and began emptying the patient s foley catheter bag into a pink wash basin. HHA I failed to wash his hands upon entry to the home and prior to donning gloves. HHA I then took the basin full of urine and emptied it into the patient s toilet, rinsed the basin out with water, then empties the water in the basin into the patient s toilet and flushed the toilet. HHA I then placed the basin back at the side of the patient s bed. At 2:05 p.m., HHA I was observed			

	removing his gloves and then placed on a clean pair of gloves, failing to be observed washing/sanitizing his hands prior to the donning of the new gloves. HHA then pulls the patient s linen down on the bed and checks the patient s colostomy bag and indicated it was empty. Observation was made of a very small amount of fecal matter next to the stoma. HHA I then turns the patient to her right side and observed a wound bandage on the patient s right upper leg. HHA I then straightens up the patient s chux pad and bed linen. HHA I failed to wash or sanitize his hands and change his gloves after he was observed touching the patient s colostomy bag and buttocks. HHA I then removed the old chux and disposed of it in the trash, lowered the patient s bed, turned the patient to her right side, touched her buttocks and observed the patient s skin. HHA then removed the patient s pillow from the bed, moved the patient s IV pole, and moved the patient s blankets. At 2:14 p.m., HHA I was observed pulling the patient up in her bed and then straightened up her bed linen. Then HHA begins to rifle through all the patient s paperwork, binders and folders looking for the home health agency s folder. HHA I was never observed to have washed his hands, perform hand antisepsis, or change his gloves after he emptied the basin			

	of urine. HHA I failed to follow universal precautions. During an interview on 09/07/21 at 2:14 p.m., patient #4 indicated she was on IV antibiotics for a urinary tract infection and finished her course of antibiotics on 09/02/2021.			
N0522	Patient Care 410 IAC 17-13-1(a) 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: 1. Record review evidenced an agency policy, updated on 06/10/21, titled Care Planning which stated & Policy: 1. It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and/or service based on the patient s needs and goals with the input of the patient for the purpose of achieving positive outcomes. & Procedure: & 10. The Plan of Care is based upon the physician s orders and encompasses the equipment, supplies, disciplines, and services required to meet the patient s needs &. 2. Clinical record review for patient #1, start of care	N0522	Pt.#1, Pt.#2, and Pt.#3 receives home health aide servicesas ordered in the Plan of Care. Orders have been sent to physician notifying ofchanges in hours provided. All active patients plan of cares havebeen reviewed to ensure the patients are receiving the services ordered byphysician. The Clinical Manager will be responsible for reviewing theplan of cares every 60 days to ensure the patientsare receiving the services ordered by physician.	2021-11-29

	08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/16/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA [home health aide] 10-12 hours per day, 5 days a week to assist with all IADL [instrumental activities of daily living], ADL [activities of daily living], . Home Health Aide to provide assistance with personal care and ADL as indicated by limitations on functional and physical status impeding self care. Assist with personal care, ADLS IADL light housekeeping supervision, fall prevention and meal prep, etc &. Clinical record review failed to evidence the home health aide was provided by the home health agency on 08/13/2021 and failed to evidence the home health agency ensured a home health aide was provided to the patient 5 days a week, the week of 08/15/2021 08/21/2021. The home health agency failed to ensure the plan of care was followed as directed by the primary care physician. During an interview on 09/03/2021 at 3:31 p.m., the administrator indicated they were			

	[prior authorization] approval prior to sending the home health aide to the patient s home to provide needed services. 3. Clinical record review for patient #2, start of care 04/26/2021, certification period 08/08/2021 10/06/2021, primary diagnosis of epilepsy with seizures, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/24/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA 7 hours a day, 7 days a week &. Clinical record review evidenced agency documents titled HHA Visit dated 8/8/21, 8/9/21, 8/10/21, 8/11/21, 8/12/21, 8/13/21, 8/14/21, 8/15/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/21/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/28/21, 8/29/21, 8/30/21, 8/31/21 and 9/1/21. Each of these home health aide visit notes indicated the home health aide provided services from 8:00 a.m. 2:30 p.m., this was a total of 6.5 hours each visit. The home health agency failed to ensure the home health aide provided services 7 hours a day as directed by the primary care physician in the plan of care.			

	During an interview on 09/03/2021 at 2:02 p.m., the administrator indicated the patient only wanted 6.5 hours a day because he wanted to take a nap. The administrator also indicated the physician was not aware of the change in home health aide hours from the plan of care orders. 4. Clinical record review for patient #3, start of care 01/28/2021, certification period 07/27/2021 09/24/2021, primary diagnosis of Parkinson s Disease, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 07/28/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA: 8 hours per day5 [sic] days a week to assist with all IADL, ADL &. Clinical record review evidenced agency documents titled HHA visit dated 08/09/2021 and 08/19/2021. The home health aide visit note dated 08/09/2021 and digitally signed by HHA G evidenced the home health aide was at the patient s residence from 08:00 13:00. The home health aide visit note dated 08/09/2021 and digitally signed by HHA F indicated the home health aide was at the patient s residence from 18:30 21:00.			

	This was a total of 7.5, the home health agency failed to ensure the home health aide followed the physician signed plan of care. The home health aide visit note dated 08/19/2021 and digitally signed by employee E indicated the home health aide was at the patient s residence from 08:00 12:00. The home health aide visit note dated 08/19/2021 and digitally signed by HHA D indicated the home health aide was at the patient s residence from 18:00 21:00. This was a total of 7.0 hours, the home health agency failed to ensure the home health aide followed the physician signed plan of care.			
N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Record review of an agency policy, updated 6/10/21, titled Physician Orders/Plan of Care stated & Purpose: To ensure that each patient s care is under the direction of the physician. & Procedure: 1. The physician sets up a plan of care, which includes the diagnosis,	N0527	Pt.#1 physician was notified and order received toprovide skilled nursing visits. RN staff have been in-serviced on promptly alerting therelevant physician to any changes in patient’s condition or needs that suggestthat outcomes are not being achieved and/or that the Plan of Care should be revised. All orders on CMS485 will be specific toclient’s condition and needs and signed by the physician. The Clinical Manager will be responsible for notifying the physician ofchanges in the patient’s needs.	2021-11-29

	prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the Agency. & 9. The Agency s professional staff will review the clinical records on a continuous basis to ensure that each POC [plan of care] is specific to the patient and that additional orders for services are present in the clinical record &. Record review of an agency policy, updated 6/10/21, titled Care Planning stated & 3. The care planning process will include the following: & e. Modification of the planned care based on reassessment of the patient s continual need for care or services. & 4. The Plan of Care will be developed during and based on the initial and on-going assessments, including: & c. Specific services to be provided & 14. Clinicians will inform the patient s physician of any changes that suggest a need to alter the Plan of Care. Changes will be written, timed/dated, and signed by the qualified clinician and physician making the changes. & 16. The needs of the patient will be prioritized in order to identify the level of services to be provided &. Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021			

	essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/16/2021. This document had an area subtitled Orders and Treatments which indicated the patient received skilled nursing services from home health agency A two times a week. During an interview on 09/03/2021 at 3:15 p.m., the administrator indicated home health skilled nursing services stopped at home health agency A on 08/31/2021, once the patient s PA [prior authorization] was approved. The administrator indicated that the patient s family member then indicated if Noble Home Health could provide skilled nursing to the patient. The administrator indicated they requested skilled nursing from the patient s insurance company of 09/02/2021 and indicated she assessed the need for skilled nursing services for the patient during the comprehensive assessment. The administrator indicated the patient needed skilled nursing services every other week. During an interview on 09/03/2021 at 3:22 p.m., the administrator was queried as to where the physician order was			

	stated, Why do you catch me on things I miss? There failed to be a physician order for skilled nursing services.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Record review of an agency policy, updated 6/10/21, titled Comprehensive Assessment of Patients (OASIS) stated & Procedure: & The OASIS data collected must accurately reflect the patient s status at the time of the assessment. & Components of a comprehensive assessment include, but is not limited to: & 2. The physical health component: & b. Vital signs &. Clinical record review for patient #3, start of care 01/28/2021, certification period 7/27/2021 09/24/2021, primary diagnosis of Parkinson s Disease, evidenced an agency document titled SN [skilled nurse] Assessment dated and signed by the administrator on 7/22/2021. This comprehensive assessment failed to evidence the patient s vital signs were obtained by the skilled nurse. During an interview on 09/08/2021 at 12:02 p.m., the administrator stated I know I took	G0528	Pt.#3 – Record on 7/22/2021 cannot be corrected. Skillednurse has been counseled. All comprehensive assessments will be reviewed for accuracyand completion prior to Oasis export. The Administrator will be responsible for reviewing allcomprehensive assessments for accuracy and completion.	2021-11-29

	there. 17-14-1(a)(1)(B)			
N0533	Nursing Plan of Care 410 IAC 17-13-2 Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. 1. Review of an agency policy, updated 6/20/21, titled Home Health Aide stated & Purpose: To ensure that all home health aide visits responsibilities are clearly stated. & Procedure: The home health aide shall have	N0533	Pt.#1 - HHA-D has been verbally counseled on aide care plandocumentation. Pt.#3 - Aide care plan has been corrected to reflect AM and PM specificresponsibilities. HHA-D, HHA-E, and HHA-F- have been verbally counseled on aide care plandocumentation. Pt.#4 - HHA-I and HHA-J have been verbally counseled on aide care plandocumentation. All active Home Health Aides will be in-serviced withreturned demonstration of documentation required of written instructions in theaide care plan. Writtenassignments and instructions will be reviewed every 60 days or more frequently,if changes in the patient’s status and needs occur. The Clinical Manager will be responsible for reviewing,updating, and revising the Aide Care Plan every 60 days or more frequently, if changes in the patient’sstatus and needs occur.	2021-11-29

	Provide services that are ordered by the physician in the plan of care, only those services written in the plan of care and received as written instructions from the registered nurse supervisor as permitted under State law &. 2. Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/16/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA [home health aide]: 10-12 hours per day, 5 days a week to assist with all IADL [instrumental activities of daily living], ADL [activities of daily living], . Home Health Aide to provide assistance with personal care and ADL as indicated by limitations on functional and physical status impeding self care. Assist with personal care, ADLs IADL light housekeeping supervision, fall prevention and meal prep, etc &. Clinical record review evidenced an agency document titled Aide Care Plan for certification period 08/13/2021 10/11/2021, created by the administrator. This document indicated the home			

	patient s temperature, provide incontinent care, record bowel movement, provide light housekeeping, make bed, assist to dress, check pressure areas, provide foot care, provide oral hygiene denture care, provide skin care, and practice universal precautions per visit. This aide care plan indicated the home health aide was to provide linen change and provide a shower on Monday, Wednesday and Friday, and shampoo hair per patient s preference. Clinical record review evidenced an agency document titled HHA [home health aide] Visit dated 08/24/2021 and indicated HHA D provided care. This document failed to evidence HHA D took the patient s temperature as instructed by the registered nurse. The administrator remained silent when this information was reviewed with her on 09/03/2021 at 3:15 p.m. 3. Clinical record review for patient #3, start of care 01/28/2021, certification period 07/27/2021 09/24/2021, primary diagnosis of Parkinson s disease, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/24/2021. This plan of care had an area subtitled Orders and Treatments			

	which stated & HHA: 8 hours per day5 [sic] days a week to assist with all IADL, ADL, & Patient is dependent on others for all ADL and IADL Home health aide duties may include but are not limited to: Personal hygiene care, transfers/turning, positioning, medication reminders, meal preparations, wound prevention, incontinent care, checking integumentary status and light housekeeping &. Clinical record review evidenced an agency document titled Aide Care Plan dated on signed by the administrator on 07/27/2021. This aide care plan indicated the home health aide was to provide temperature, incontinent care, record bowel movement, assist in ambulation, assist in transfer, range of motion, turn or position, light housekeeping, make bed, assist to dress, check pressure areas, oral hygiene denture care, pericare, skin care, shower, and universal precautions per visit. The home health aide was to provide a linen change on Wednesdays and as needed when soiled. The home health aide was to provide foot care, nail care, shampoo hair and a shave per the patient s preference. Clinical record review evidenced agency documents titled HHA [home health aide] Visit dated 7/28/21, 7/29/21, 8/2/21, 8/3/21,			

	8/11/21, 8/12/21, 8/13/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/30/21, 9/1/21, 9/2/21 and 9/3/21. These home health aide visits failed to evidence the patient was provided a shave or refused a shave. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 08/02/21 and digitally signed by HHA D. This home health aide visit note failed to evidence the home health aide took the patient s temperature as indicated on the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/02/21 (p.m. visit), 08/03/21, 08/06/21, 08/09/21, 08/20/21, 08/12/21, 08/13/21, 08/16/21, 08/17/21, 08/19/21, 08/20/21, 08/23/21, 08/24/21, 08/27/21 (p.m. visit), 08/30/21 (p.m. visit), 08/31/21, 09/01/21 (p.m. visit), 09/02/21 and 09/03/21. These home health aide notes failed to evidence if the home health aide provided a linen change as indicated on the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 08/02/21 (p.m. visit) and digitally signed by HHA D. This home health aide visit note failed to evidence if the home			

	health aide provided incontinent care as indicated on the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/05/21, 08/25/21 (p.m. visit), 08/26/21, 08/31/21 (p.m. visit), 09/01/21 (p.m. visit), 09/02/21 and 09/03/21 (p.m. visit). These home health aide notes failed to evidence if nail care was provided as indicated on the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/25/21, 08/30/21 (p.m. visit), 09/02/21 (p.m. visit) and 09/03/21 (p.m. visit). These home health aide notes failed to evidence if foot care was provided as indicated on the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/25/21 and 09/02/21. These home health aide notes failed to evidence if a shampoo was provided as indicated on the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/25/21 and 09/03/21 (p.m. visit). These home health aide notes failed to evidence if the patient was verbally reminded to turn and position as indicated on the aide care plan. Clinical record review evidenced			

	agency documents titled HHA Visit dated 08/25/21, 08/30/21 (p.m. visit) and 09/03/21 (p.m. visit). These home health aide notes failed to evidence the patient s last bowel movement was recorded as indicated on the plan of care. Clinical record review evidenced an agency document titled HHA Visit dated 09/30/21 (a.m. visit) and digitally signed by HHA E. This home health aide note failed to evidence the patient was provided assistance to dress as indicated on the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 08/30/21 (p.m. visit) and digitally signed by HHA F. This home health aide note failed to evidence range of motion was provided as indicated on the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 09/01/21 (a.m. visit) and digitally signed by HHA E. This home health aide note failed to evidence a shower was provided as indicated on the aide care plan. During an interview on 09/08/21 at 1:00 p.m., the administrator indicated she had counseled the home health aides about this. 4. Clinical record review for patient #4, start of care			

	07/29/2021 09/26/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the administrator on 07/29/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA: HHA 8-10 hours a day 7 days a week, & Home health aide requested to provide 8 10 hours per day, 7 days per week, for 26 weeks. & Home health aide duties may include but are not limited to: personal hygiene care, bathing/showering, assisting with transfers, turning/positioning, assistance with wound prevention, Foley care, ostomy care, checking integumentary status, medication assistance and reminders, meal preparations, and light housekeeping &. Clinical record review evidenced an agency document titled Aide Care Plan dated 07/29/2021 and digitally signed by the administrator. This aide care plan indicated the home health aide was to provide temperature check, catheter care, empty ostomy bag, record bowel movement, assist in transfer, range of motion, turn or position, light housekeeping, assist to dress, check pressure areas, foot care, oral hygiene denture care, skin care and practice universal			

	care plan indicated the home health aide was to provide a back rub/massage, comb hair, complete bath, partial bath/sponge, and shampoo hair per patient s preference, provide pericare when patient was soiled, and was to change linen on Wednesday and when soiled. Clinical record review evidenced agency documents titled HHA Visit dated 08/24/2021, 08/25/2021, 08/26/2021, 08/27/2021, 08/29/2021, 08/31/2021, 09/01/2021, 09/02/2021, 09/03/2021 and 09/04/2021. These home health aide visit notes failed to evidence the home health aide provided record bowel movement, complete bath, and back rub/massage. The home health aide failed to follow the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/24/2021, 08/25/2021, 08/26/2021, 08/27/2021, 08/28/2021, 08/29/2021, 08/31/2021, 09/01/2021, 09/02/2021, 09/03/2021 and 09/04/2021. These home health aide visit notes failed to evidence the home health aide provided the patient with shampoo hair. The home health aide failed to follow the aide care plan. Clinical record review evidenced			

	Visit dated 08/28/2021 and digitally signed by HHA J. This home health aide visit note failed to evidence the home health aide changed linen. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 09/05/2021 and digitally signed by HHA I. This home health aide visit note failed to evidence the home health aide provided assistance to dress, complete bath, comb hair, foot care, pericare, shampoo hair, skin care, universal precautions, back rub/massage, oral hygiene denture care, check pressure areas, partial bath and record last bowel movement. The home health aide failed to follow the aide care plan.			
G0536	A review of all current medications 484.55(c)(5) 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. Review of an agency policy, updated 6/10/21, titled Medication Profile stated & Policy: It is the responsibility of the admitting therapist/nurse to record all mediations that the patient is currently taking on a routine or PRN [as needed] basis. The medication profile	G0536	Pt.#1 –Physician order has been received for correctinsulin dose. Skilled nurse was counseledon accurate medication reconciliation. All active medication profiles will bereviewed to ensure all medications prescribed are reconciled. Skilled nurse staff will be in-serviced to review each newmedication for interaction risks using the EMR reconciliation tool. Any adverseinteractions will be communicated to the relevant	2021-11-29

	following: & d. dose & 7. The medication profile will be updated at least every 60 days or more often as needed. All new medications will be added to the Medication profile and checked for interaction risks by the case manager 8. High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/16/2021. This plan of care had an area subtitled Treatments which listed the patient s medications. This document indicated the patient s medications included, but was not limited to, Levemir [insulin, a high-alert medication for diabetes] FlexTouch Subcutaneous 100 unit/mL [milliliter] 5-8 units daily. This order failed to contain a sliding scale of when the patient was to administer 5, 6, 7 or 8 units. During an interview on		physician for review. The Clinical Manager will be responsible for reviewingthe comprehensive assessment every 60 days to ensure the medicationreconciliation is accurate and complete.	

	09/03/2021 at 3:38 p.m., the administrator indicated this medication needed to be a sliding scale. The administrator indicated at 3:43 p.m., she saw clinical notes which indicated the patient s Levemir dose was 8 units, and also indicated this was a documentation issue. 17-14-1(a)(1)(B)			
N0541	Scope of Services 410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Record review of an agency policy, updated 6/10/21, titled Admission Criteria stated & Procedure: & 4. & b. The plan of care must be developed in conjunction with agency staff and must cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits at the time of admission, prognoses, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, and any other appropriate items. The appropriate health care personnel must perform services as specified in the plan of care.	N0541	Pt.#2 – Plan of Care has been amended and signed byphysician to reflect the patient’s needs. All active Plan of Cares will be reviewed every 60 days oras needed if patient’s status change. The Clinical Manager will be responsible for reviewing,updating, and revising the Plan of Cares every 60 days or more frequently, if changes in the patient’sstatus and needs occur.	2021-11-29

	as necessary, but it must be reviewed and updated at least every sixty days. Record review of an agency policy, updated 6/10/21, titled Physician Orders/Plan of Care stated & Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency s clinical record. & 7. The physician and appropriate professional staff will review and recertify the written plan of care at least once per episode and as warranted by the patient s condition. & 10. The Agency provides written and oral reports to the physician regarding the patient s plan of treatment and appropriateness of the continuation of care. The Agency provides written and oral reports to the physician regarding the patient s condition at least every 60 days. Reports may be more frequent if there is an emergency, a need to alter the plan of care or a need to terminate services &. Record review of an agency policy, updated 6/10/21, titled Care Planning stated & 5. The patient s Plan of Care will be revised promptly upon reassessment of status changes in the patient. & 11. The Plan of Care is revised as frequently as deemed necessary by the			

	Manager/Therapist and the qualified professional based on on-going assessments of the patient &. Clinical record review for patient #2, start of care 04/26/2018, certification period 08/18/2021 10/06/2021, primary diagnosis of idiopathic epilepsy with seizures, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/24/21. This plan of care had an area subtitled Orders and Treatments which stated & HHA [home health aide] 7 hours a day, 7 days a week &. Clinical record review evidenced agency documents titled HHA Visit dated 8/8/21, 8/9/21, 8/10/21, 8/11/21, 8/12/21, 8/13/21, 8/14/21, 8/15/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/21/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/28/21, 8/29/21, 8/30/21, 8/31/21 and 9/1/21. Each of these home health aide visit notes indicated the home health aide provided services from 8:00 a.m. 2:30 p.m., this was a total of 6.5 hours each visit. The home health agency failed to ensure the home health aide provided services 7 hours a day as directed by the primary care physician in the plan of care.			

	During an interview on 09/03/2021 at 2:02 p.m., the administrator indicated the patient only wanted 6.5 hours of home health aide services, because he wanted to take a nap. During an interview on 09/03/2021 at 2:05 p.m., the administrator indicated they needed to update the plan of care.			
N0542	Scope of Services 410 IAC 17-14-1(a)(1)(C) Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Record review of an agency policy, updated 6/10/21, titled Admission Criteria stated & Procedure: & 4. & b. The plan of care must be developed in conjunction with agency staff and must cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits at the time of admission, prognoses, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, and any other appropriate items. The appropriate health care	N0542	Pt.#2 – Plan of Care has been amended and signed byphysician to reflect the patient's need. All active Plan of Cares will be reviewed every 60 days oras needed if patient's status change. The Clinical Manager will be responsible for reviewing,updating, and revising the Plan of Cares every 60 days or more frequently, if changes in the patient'sstatus and needs occur.	2021-11-29

	as specified in the plan of care. The plan of care must be revised as necessary, but it must be reviewed and updated at least every sixty days. Record review of an agency policy, updated 6/10/21, titled Physician Orders/Plan of Care stated & Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency s clinical record. & 7. The physician and appropriate professional staff will review and recertify the written plan of care at least once per episode and as warranted by the patient s condition. & 10. The Agency provides written and oral reports to the physician regarding the patient s plan of treatment and appropriateness of the continuation of care. The Agency provides written and oral reports to the physician regarding the patient s condition at least every 60 days. Reports may be more frequent if there is an emergency, a need to alter the plan of care or a need to terminate services &. Record review of an agency policy, updated 6/10/21, titled Care Planning stated & 5. The patient s Plan of Care will be revised promptly upon reassessment of status changes in the patient. & 11. The Plan			

	as deemed necessary by the Clinical Manager/Case Manager/Therapist and the qualified professional based on on-going assessments of the patient &. Clinical record review for patient #2, start of care 04/26/2018, certification period 08/18/2021 10/06/2021, primary diagnosis of idiopathic epilepsy with seizures, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/24/21. This plan of care had an area subtitled Orders and Treatments which stated & HHA [home health aide] 7 hours a day, 7 days a week &. Clinical record review evidenced agency documents titled HHA Visit dated 8/8/21, 8/9/21, 8/10/21, 8/11/21, 8/12/21, 8/13/21, 8/14/21, 8/15/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/21/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/28/21, 8/29/21, 8/30/21, 8/31/21 and 9/1/21. Each of these home health aide visit notes indicated the home health aide provided services from 8:00 a.m. 2:30 p.m., this was a total of 6.5 hours each visit. The home health agency failed to ensure the home health aide provided services 7 hours a day as directed by the			

	plan of care. During an interview on 09/03/2021 at 2:02 p.m., the administrator indicated the patient only wanted 6.5 hours of home health aide services, because he wanted to take a nap. During an interview on 09/03/2021 at 2:05 p.m., the administrator indicated they needed to update the plan of care.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. 1. Record review evidenced an agency policy, updated on 06/10/21, titled Care Planning which stated & Policy: 1. It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and/or service based on the patient s needs and goals with the input of the patient for the purpose of achieving positive outcomes. & Procedure: & 10. The Plan of Care is based upon the physician s orders and	G0572	Pt.#1, Pt.#2, and Pt.#3 receives home health aide servicesas ordered in the Plan of Care. The physician will be notified of any change inhours provided. All active patients plan of cares havebeen reviewed to ensure the patients are receiving the services ordered byphysician. The Clinical Manager will be responsible for reviewing theplan of cares every 60 days to ensure the patientsare receiving the services ordered by physician.	2021-11-29

	encompasses the equipment, supplies, disciplines, and services required to meet the patient s needs &. 2. Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/16/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA [home health aide] 10-12 hours per day, 5 days a week to assist with all IADL [instrumental activities of daily living], ADL [activities of daily living], . Home Health Aide to provide assistance with personal care and ADL as indicated by limitations on functional and physical status impeding self care. Assist with personal care, ADLS IADL light housekeeping supervision, fall prevention and meal prep, etc &. Clinical record review failed to evidence the home health aide was provided by the home health agency on 08/13/2021 and failed to evidence the home health agency ensured a home health aide was provided to the patient 5 days a week, the week of 08/15/2021 08/21/2021. The			

ensure the plan of care was followed as directed by the primary care physician.

During an interview on 09/03/2021 at 3:31 p.m., the administrator indicated they were waiting for PA [prior authorization] approval prior to sending the home health aide to the patient s home to provide needed services.

3. Clinical record review for patient #2, start of care 04/26/2021, certification period 08/08/2021 10/06/2021, primary diagnosis of epilepsy with seizures, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/24/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA 7 hours a day, 7 days a week &.

Clinical record review evidenced agency documents titled HHA Visit dated 8/8/21, 8/9/21, 8/10/21, 8/11/21, 8/12/21, 8/13/21, 8/14/21, 8/15/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/21/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/28/21, 8/29/21, 8/30/21, 8/31/21 and 9/1/21. Each of these home health aide visit notes indicated the home health aide provided

p.m., this was a total of 6.5 hours each visit. The home health agency failed to ensure the home health aide provided services 7 hours a day as directed by the primary care physician in the plan of care.

During an interview on 09/03/2021 at 2:02 p.m., the administrator indicated the patient only wanted 6.5 hours a day because he wanted to take a nap. The administrator also indicated the physician was not aware of the change in home health aide hours from the plan of care orders.

4. Clinical record review for patient #3, start of care 01/28/2021, certification period 07/27/2021 09/24/2021, primary diagnosis of Parkinson s Disease, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 07/28/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA: 8 hours per day5 [sic] days a week to assist with all IADL, ADL &.

Clinical record review evidenced agency documents titled HHA visit dated 08/09/2021 and 08/19/2021. The home health aide visit note dated 08/09/2021 and digitally signed by HHA G

	was at the patient s residence from 08:00 13:00. The home health aide visit note dated 08/09/2021 and digitally signed by HHA F indicated the home health aide was at the patient s residence from 18:30 21:00. This was a total of 7.5, the home health agency failed to ensure the home health aide followed the physician signed plan of care. The home health aide visit note dated 08/19/2021 and digitally signed by employee E indicated the home health aide was at the patient s residence from 08:00 12:00. The home health aide visit note dated 08/19/2021 and digitally signed by HHA D indicated the home health aide was at the patient s residence from 18:00 21:00. This was a total of 7.0 hours, the home health agency failed to ensure the home health aide followed the physician signed plan of care. 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Record review of an agency policy, updated 6/10/21, titled Physician Orders/Plan of Care stated & Purpose: To ensure that each patient s care is under	G0590	Pt.#1 physician was notified and order received toprovide skilled nursing visits. All active plan of cares will be reviewed toensure that the physician has been notified of changes in the patient’s needs. RN staff have been in-serviced on promptly alerting therelevant physician to any changes in	2021-11-29

	the direction of the physician. & Procedure: 1. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the Agency. & 9. The Agency s professional staff will review the clinical records on a continuous basis to ensure that each POC [plan of care] is specific to the patient and that additional orders for services are present in the clinical record &. Record review of an agency policy, updated 6/10/21, titled Care Planning stated & 3. The care planning process will include the following: & e. Modification of the planned care based on reassessment of the patient s continual need for care or services. & 4. The Plan of Care will be developed during and based on the initial and on-going assessments, including: & c. Specific services to be provided & 14. Clinicians will inform the patient s physician of any changes that suggest a need to alter the Plan of Care. Changes will be written, timed/dated, and signed by the qualified clinician and physician making the changes. & 16. The needs of the patient will be prioritized in order to identify the level of services to be provided &.		suggestthat outcomes are not being achieved and/or that the Plan of Care should be revised. All orders on CMS485 will be specific toclient's condition and needs and signed by the physician. The Clinical Manager will be responsible for notifyingthe physician of changes in the patient's needs.	

	Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/16/2021. This document had an area subtitled Orders and Treatments which indicated the patient received skilled nursing services from home health agency A two times a week. During an interview on 09/03/2021 at 3:15 p.m., the administrator indicated home health skilled nursing services stopped at home health agency A on 08/31/2021, once the patient s PA [prior authorization] was approved. The administrator indicated that the patient s family member then indicated if Noble Home Health could provide skilled nursing to the patient. The administrator indicated they requested skilled nursing from the patient s insurance company of 09/02/2021 and indicated she assessed the need for skilled nursing services for the patient during the comprehensive assessment. The administrator indicated the patient needed skilled nursing services every other week. Clinical record review failed to			

	evidence a physician order for skilled nursing services. During an interview on 09/03/2021 at 3:22 p.m., the administrator was queried as to where the physician order was located, the administrator then stated, Why do you catch me on things I miss? 17-13-1(a)(2)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Record review of an agency policy, updated 6/10/21, titled Admission Criteria stated & Procedure: & 4. & b. The plan of care must be developed in conjunction with agency staff and must cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits at the time of admission, prognoses, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, and any other appropriate items. The appropriate health care personnel must perform services as specified in the plan of care. The plan of care must be revised	G0592	Pt.#2, receives home health aide services asordered in the Plan of Care. The physician will be notified of any change inhours provided. All active patients plan of careshave been reviewed to ensure the patients are receiving the services ordered byphysician. RN staff have been in-serviced on the processof revising the plan of care based on any changes in patient’s condition orneeds. Plan of Care will be revised asfrequently as deemed necessary by the Clinical Manager, based on ongoingassessments of the patient. The Clinical Manager will be responsible forreviewing the plan of cares every 60 days to ensure the patients are receiving the services ordered by physician.	2021-11-29

	as necessary, but it must be reviewed and updated at least every sixty days. Record review of an agency policy, updated 6/10/21, titled Physician Orders/Plan of Care stated & Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency s clinical record. & 7. The physician and appropriate professional staff will review and recertify the written plan of care at least once per episode and as warranted by the patient s condition. & 10. The Agency provides written and oral reports to the physician regarding the patient s plan of treatment and appropriateness of the continuation of care. The Agency provides written and oral reports to the physician regarding the patient s condition at least every 60 days. Reports may be more frequent if there is an emergency, a need to alter the plan of care or a need to terminate services &. Record review of an agency policy, updated 6/10/21, titled Care Planning stated & 5. The patient s Plan of Care will be revised promptly upon reassessment of status changes in the patient. & 11. The Plan of Care is revised as frequently as deemed necessary by the			

	Manager/Therapist and the qualified professional based on on-going assessments of the patient &. Clinical record review for patient #2, start of care 04/26/2018, certification period 08/18/2021 10/06/2021, primary diagnosis of idiopathic epilepsy with seizures, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/24/21. This plan of care had an area subtitled Orders and Treatments which stated & HHA [home health aide] 7 hours a day, 7 days a week &. Clinical record review evidenced agency documents titled HHA Visit dated 8/8/21, 8/9/21, 8/10/21, 8/11/21, 8/12/21, 8/13/21, 8/14/21, 8/15/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/21/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/28/21, 8/29/21, 8/30/21, 8/31/21 and 9/1/21. Each of these home health aide visit notes indicated the home health aide provided services from 8:00 a.m. 2:30 p.m., this was a total of 6.5 hours each visit. The home health agency failed to ensure the home health aide provided services 7 hours a day as directed by the primary care physician in the plan of care.			

	During an interview on 09/03/2021 at 2:02 p.m., the administrator indicated the patient only wanted 6.5 hours of home health aide services, because he wanted to take a nap. During an interview on 09/03/2021 at 2:05 p.m., the administrator indicated they needed to update the plan of care. 17-14-1(a)(1)(c)			
N0606	Scope of Services 410 IAC 17-14-1(n) Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Record review of an agency policy, updated 6/10/21, titled Nurse Supervision stated & Purpose: To ensure that all daily operations and patient care are provided in a professional standard that meets state regulatory guidelines. Policy: The agencies Clinical Manager, Alternate Clinical Manager, and/or Case Manager are responsible for overseeing the clinical operations of patient care and the Clinical Manager/Administrator are responsible for overseeing the	N0606	Pt.#3 – HHA-H has been counseled for not following the Aide Care Plan. The Clinical Manager has been counseled on failing to ensure the aide followed the aide care plan on 8/17/21. All active charts will be reviewed to ensure the aide care plans are being followed as assigned by the clinical manager. Home Health Aides will be in-serviced on following the aide care plan and notifying the clinical manager when they are unable to complete any task listed on the aide care plan. The Clinical Manager will be responsible for weekly reviewing aide documentation and accurately completing the aide supervised visits as scheduled.	2021-11-29

	daily operations, newly hired and experienced personnel of Noble Home Health Care, LLC as it pertains to Medicare/State regulations. & 2. The Clinical Manager will oversee all services that work under the licensure of the agency and provide in-services on an ongoing basis to ensure agency compliance to state and federal regulations. The supervising nurse will ensure that the patient s POC [plan of care] is being followed through chart audits, note reviews, staff communication and patient communication. & 7. Home Health Aides will be supervised at least every 30 days by a RN [registered nurse] for non-skilled care &. Clinical record review for patient #3, start of care 01/28/2021, certification period 07/27/2021 09/24/2021, primary diagnosis of Parkinson s disease, evidenced an agency document titled Aide Care Plan dated on signed by the administrator on 07/27/2021. This aide care plan indicated the home health aide was to provide temperature, incontinent care, record bowel movement, assist in ambulation, assist in transfer, range of motion, turn or position, light housekeeping, make bed, assist to dress, check pressure areas, oral hygiene denture care, pericare, skin care, shower, and universal precautions per visit. The home health aide was to			

	Wednesdays and as needed when soiled. The home health aide was to provide foot care, nail care, shampoo hair and a shave per the patient s preference. Clinical record review evidenced an agency document titled HHA [home health aide] Visit dated 08/17/2021 and digitally signed by HHA H. This home health aide visit note failed to evidence the home health aide performed change linen or provided the patient with a shave. The home health aide failed to follow the aide care plan established by the registered nurse. Clinical record review evidenced an agency document titled Aide Supervisory Visit dated 08/17/2021 and digitally signed by the administrator which indicated a supervisory visit was conducted for HHA H. This supervisory visit indicated satisfactory for the home health aide follows the client plan of care as instructed. This supervisory visit note failed to be evidenced as correct and congruent with the aide care plan which was established by the administrator. This concern was shared with the administrator on 09/08/2021 at 12:23 p.m., in which the administrator nodded.			

N0610	Clinical Records 410 IAC 17-15-1(a)(7) 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. 1. Record review of an agency policy, updated 6/10/21, titled Client Records stated & Purpose: To establish and maintain a client record system to assure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compliance and retrieval of information. & h. Clinical progress notes for all disciplines providing services, dated, and signed. & 4. All notes and reports in the patient s clinical record shall be typewritten or legibly written in ink, dated and signed by the recording person with his full name or first initial and surname and title &. 2. Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Aide Care Plan dated 08/13/2021. This document failed to evidence the signature of the clinician who created the document.	N0610	Pt.#1 – The record has been authenticated on 8/24/2021. Pt.#3 - The record has been amended toreflect the correct date. Pt.#4 – This deficiency cannot be corrected. Notation has been made of theincorrectly documented blood pressure. RNs have been in-serviced on record review toensure each note has accurate date and information is authenticated. All active patient notes will be reviewed foraccuracy of documentation and proper authentication. The Clinical Manager will be responsible forweekly reviewing all home health aides and professional notes to ensure thisdeficiency does not recur.	2021-11-29

	Clinical record review evidenced an agency document titled HHA [home health aide] Visit dated 08/24/2021. This agency document failed to evidence the signature of the home health aide. 3. Clinical record review for patient #3, start of care 01/28/21, certification period 07/27/2021 09/24/2021, primary diagnosis of Parkinson s Disease, evidenced an agency document titled HHA [home health aide] Visit dated 08/02/2021 and digitally signed by HHA H. This home health aide visit note indicated the patient s last bowel movement was 08/03/2021. This was one day past this home health aide visit. During an interview on 09/08/21 at 12:10 p.m., the administrator indicated this was a documentation error. Clinical record review evidenced an agency document titled HHA Visit dated 07/27/2021. This home health aide visit failed to evidence a signature of the home health aide who completed the visit. 4. Clinical record review for patient #4, start of care 06/10/2019, certification period 07/29/2021 09/26/2021, primary diagnosis of essential hypertension, evidenced an agency document titled			

	&. dated 08/24/2021, and digitally signed by the administrator. This resumption of care indicated the patient s blood pressure was 1436/81. During an interview on 09/08/2021 at 11:28 a.m., the administrator stated, Oh well, that s me.			
G0612	Written instructions to patient include: 484.60(e) Standard: Written information to the patient. The HHA must provide the patient and caregiver with a copy of written instructions outlining: During a home visit with patient #4 and home health aide (HHA) I, on 09/07/2021 at 2:30 p.m., HHA I was observed searching the patient s entire bedroom for the home health agency s home folder. The home health aide did find some Noble Home Health documents in a clear sleeve. Review of these documents evidenced a complaint hotline document, patient rights document and an advanced directive document. There was no evidence of a plan of care. During an interview on 09/07/2021 at 3:20 p.m., the administrator indicated she knew everyone was given all those things for their folder.	G0612	Pt.#4 the admission packet has been replaced and a clearsleeve with patient's written instructions outlining their care has been placedin the home. An updated version of the written instructions outlining theircare will be provided after each recertification. 100% of all active patient home folders were reviewed toensure all patients had written instructions outlining their care. An updated written instruction to patients willbe provided to the patient every 60 days. The Clinical Manager will be responsible to ensure thisdocument is accessible to patient/caregiver.	2021-11-29
G0614	Visit schedule	G0614	Pt.#4 the admission packet has	2021-11-29

	484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. During a home visit with patient #4 and home health aide (HHA) I, on 09/07/2021 at 2:30 p.m., HHA I was observed searching the patient s entire bedroom for the home health agency s home folder. The home health aide did find some Noble Home Health documents in a clear sleeve. Review of these documents evidenced a complaint hotline document, patient rights document and an advanced directive document. There was no evidence of a visit schedule. During an interview on 09/07/2021 at 2:25 p.m., patient #4 indicated she always knew when the home health aide was coming, because he is always on time. During an interview on 09/07/2021 at 3:20 p.m., the administrator indicated she knew everyone was given all those things for their folder.		been replaced and a clearsleeve with patient's visit schedule has been placed in the home. 100% of all active patient home folders were reviewed toensure all patients had a visit schedule. An updated visit schedule will be provided to the patient every 60 days. The Clinical Manager will be responsible to ensure thisdocument is accessible to patient/caregiver.	
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.	G0616	Pt.#4 the admission packet has been replaced and a clearsleeve with patient's medication schedule/instructions has been placed in thehome.	2021-11-29

	Record review of an agency policy, updated 6/10/21, titled Client Records stated & Procedure: & i. Instructions to the patient and caregiver or guardian, including administration of and adverse reactions to medications &. During a home visit with patient #4 and home health aide (HHA) I, on 09/07/2021 at 2:30 p.m., HHA I was observed searching the patient s entire bedroom for the home health agency s home folder. The home health aide did find some Noble Home Health documents in a clear sleeve. Review of these documents evidenced a complaint hotline document, patient rights document and an advanced directive document. There was no evidence of a medication schedule/instructions. During an interview on 09/07/2021 at 3:20 p.m., the administrator indicated she knew everyone was given all those things for their folder.		100% of all active patient home folders were reviewed toensure all patients had a medication schedule/instructions in their homefolder. An updated medicationschedule/instructions will be provided to the patient every 60 days. The Clinical Manager will be responsible to ensure thisdocument is accessible to patient/caregiver.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Record review of an agency policy, updated 6/10/21, titled	G0682	HHA-I - has been verbally counseled and returneddemonstration observed on universal body substance precautions, infectioncontrol, hand washing and bag technique. Annual In-service on infection control and returned	2021-11-29

	Precautions stated & Purpose: To reduce the risk of exposure to and transmission of infections when caring for patients. Policy: 1. Under Universal Body Substance Precautions, blood and certain body fluids of all patients are considered potentially infectious for bloodborne pathogens such as human immunodeficiency virus (HIV), and hepatitis B virus (HBV). Universal Body Substance Precautions apply to blood and other body fluids potentially containing blood or bloodborne pathogens. 2. These body fluids include emesis, sputum, feces, urine & 4. Agency personnel will adhere to the following precautions and will instruct patients/patient representatives and/or families/caregivers in infection control precautions as appropriate to the patient s needs. & Procedure: 1. General Precautions a. Handwashing is the single most important activity a staff member can undertake to help prevent the spread of infection. It will be performed at the following times: Before and after patient contact Before and after using gloves & After contact with soiled or contaminated items (i.e., bedpans, urinal, catheter, linens) & b. Use antimicrobial soap, warm water, and friction for hand washing. Lather and scrub for ten (10) seconds. Rinse well, beginning at fingertips so dirty		demonstrationwill be conducted on universal body substance precautions, hand washing and bagtechnique. The Clinical Manager and Alternate Clinical Manager will beresponsible for providing the in-service.	

	water runs off at wrists. Dry hands on paper towels. Use dry paper towels to turn off faucets. & e. Gloves: The use of gloves (intact latex or latex-free if person is allergic) of appropriate size and quality) is important where the worker has cuts, abraded skin, chapped hands, dermatitis, etc., & Gloves are to be worn when handling soiled linen &. Record review of an agency policy, updated 6/10/21, titled Hand washing stated & Purpose: To cleanse the hands of germs and prevent contamination between patients and home care personnel. Hand washing before and after contact with each patient is the single most important means of preventing the spread of infection. When hands are not visibly soiled, waterless hand antiseptics are encouraged for routine hygiene between patient contacts Policy: 1. All personnel will wash their hands: a. Upon arrival to work b. Before and after EACH contact with a patient. c. After handling bed pans, urinals, catheters, linens & 2. Towels, either cloth or paper, and liquid soap will be used, if available. If not available, bar soap can be used but should be thoroughly rinsed between uses. Waterless hand washing products may also be used. & Hand washing Goal is			

	this policy &. Record review of an agency policy, updated 6/10/21, titled Bag Technique stated & Purpose: To establish guidelines for the visiting home health care personnel regarding the appropriate use of the bag and transporting reusable equipment from house to house. Objective: To prevent contamination of reusable equipment carried by home health personnel from patient to patient. Responsible Personnel: All visiting staff. & Principles of Bag Technique: & 2. Hand washing supplies should be kept readily available either in a side-pocket of the bag, or in a zip lock baggie directly on top of the bag contents upon opening the bag. & Action: If the home environment does not pose a great risk of contamination to the bag, the staff will carry the bag into the home. After entering the home, the bag is placed on a clean area that isn t visibly soiled. Avoid using the floor. Disposable barriers may be used if the home environment poses a threat to the cleanliness of the bag. Rationale: To reduce the risk of contamination &. Observation was made of a home visit with patient #4 and HHA [home health aide] I on 09/07/2021 at 2:00 p.m. Upon entrance into the home the home			

	his nursing bag upon the patient s couch with no barrier in between the couch and the nursing bag. HHA I then was observed going directly into the patient s bedroom, donned a pair of gloves, walked to the patient s bedside, and began emptying the patient s foley catheter bag into a pink wash basin. HHA I failed to wash his hands upon entry to the home and prior to donning gloves. HHA I then took the basin full of urine and emptied it into the patient s toilet, rinsed the basin out with water, then empties the water in the basin into the patient s toilet and flushed the toilet. HHA I then placed the basin back at the side of the patient s bed. At 2:05 p.m., HHA I was observed removing his gloves and then placed on a clean pair of gloves, failing to be observed washing/sanitizing his hands prior to the donning of the new gloves. HHA then pulls the patient s linen down on the bed and checks the patient s colostomy bag and indicated it was empty. Observation was made of a very small amount of fecal matter next to the stoma. HHA I then turns the patient to her right side and observed a wound bandage on the patient s right upper leg. HHA I then straightens up the patient s chux pad and bed linen. HHA I failed to wash or sanitize his hands and change his gloves after he was observed touching the patient s			

	colostomy bag and buttocks. HHA I then removed the old chux and disposed of it in the trash, lowered the patient s bed, turned the patient to her right side, touched her buttocks and observed the patient s skin. HHA then removed the patient s pillow from the bed, moved the patient s IV pole, and moved the patient s blankets. At 2:14 p.m., HHA I was observed pulling the patient up in her bed and then straightened up her bed linen. Then HHA begins to rifle through all the patient s paperwork, binders and folders looking for the home health agency s folder. HHA I was never observed to have washed his hands, perform hand antisepsis, or change his gloves after he emptied the basin of urine. HHA I failed to follow universal precautions. During an interview on 09/07/21 at 2:14 p.m., patient #4 indicated she was on IV antibiotics for a urinary tract infection and finished her course of antibiotics on 09/02/2021. 17-12-1(m)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care;	G0800	Pt.#1 - HHA-D has been verbally counseled on aide careplan documentation. Pt.#3 - Aide care plan has been corrected to reflect AM andPM specific responsibilities. HHA-D,HHA-E, and HHA-F- have been verbally counseled on care plan	2021-11-29

	(iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. 1. Review of an agency policy, updated 6/20/21, titled Home Health Aide stated & Purpose: To ensure that all home health aide visits responsibilities are clearly stated. & Procedure: The home health aide shall have the following responsibilities: 1. Provide services that are ordered by the physician in the plan of care, only those services written in the plan of care and received as written instructions from the registered nurse supervisor as permitted under State law &. 2. Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/16/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA [home health aide]: 10-12 hours per day, 5 days a week to assist with all IADL [instrumental activities of daily living], ADL [activities of daily living], . Home Health Aide to provide assistance with personal care and ADL as indicated by limitations on functional and		documentation. Pt.#4- HHA-I and HHA-J have been verbally counseled on aide care plan documentation. 100% of all active patient home folders were reviewed toensure a copy of the aide care plan was included. An updated aide care plan willbe provided to the patient every 60 days or more frequently if patient's needschange. All active Home Health Aides will be in-serviced withreturned demonstration of documentation required of written instructions in theaide care plan. Writtenassignments and instructions will be reviewed every 60 days or more frequentlyif changes in the patient's status and needs occur. The Clinical Manager will be responsible for reviewing,updating, and revising the Aide Care Plan every 60 days or more frequently, if changes in the patient's status andneeds occur.	

	care. Assist with personal care, ADLs IADL light housekeeping supervision, fall prevention and meal prep, etc &. Clinical record review evidenced an agency document titled Aide Care Plan for certification period 08/13/2021 10/11/2021, created by the administrator. This document indicated the home health aide was to take the patient s temperature, provide incontinent care, record bowel movement, provide light housekeeping, make bed, assist to dress, check pressure areas, provide foot care, provide oral hygiene denture care, provide skin care, and practice universal precautions per visit. This aide care plan indicated the home health aide was to provide linen change and provide a shower on Monday, Wednesday and Friday, and shampoo hair per patient s preference. Clinical record review evidenced an agency document titled HHA [home health aide] Visit dated 08/24/2021 and indicated HHA D provided care. This document failed to evidence HHA D took the patient s temperature as instructed by the registered nurse. The administrator remained silent when this information was reviewed with her on 09/03/2021 at 3:15 p.m. 3. Clinical record review for			

	patient #3, start of care 01/28/2021, certification period 07/27/2021 09/24/2021, primary diagnosis of Parkinson s disease, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the primary care physician on 08/24/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA: 8 hours per day5 [sic] days a week to assist with all IADL, ADL, & Patient is dependent on others for all ADL and IADL Home health aide duties may include but are not limited to: Personal hygiene care, transfers/turning, positioning, medication reminders, meal preparations, wound prevention, incontinent care, checking integumentary status and light housekeeping &. Clinical record review evidenced an agency document titled Aide Care Plan dated on signed by the administrator on 07/27/2021. This aide care plan indicated the home health aide was to provide temperature, incontinent care, record bowel movement, assist in ambulation, assist in transfer, range of motion, turn or position, light housekeeping, make bed, assist to dress, check pressure areas, oral hygiene denture care, pericare, skin care, shower, and universal precautions per visit. The home health aide was to provide a linen change on			

	when soiled. The home health aide was to provide foot care, nail care, shampoo hair and a shave per the patient s preference. Clinical record review evidenced agency documents titled HHA [home health aide] Visit dated 7/28/21, 7/29/21, 8/2/21, 8/3/21, 8/4/21, 8/5/21, 8/9/21, 8/10/21, 8/11/21, 8/12/21, 8/13/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/30/21, 9/1/21, 9/2/21 and 9/3/21. These home health aide visits failed to evidence the patient was provided a shave or refused a shave. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 08/02/21 and digitally signed by HHA D. This home health aide visit note failed to evidence the home health aide took the patient s temperature as indicated on the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/02/21 (p.m. visit), 08/03/21, 08/06/21, 08/09/21, 08/20/21, 08/12/21, 08/13/21, 08/16/21, 08/17/21, 08/19/21, 08/20/21, 08/23/21, 08/24/21, 08/27/21 (p.m. visit), 08/30/21 (p.m. visit), 08/31/21, 09/01/21 (p.m. visit), 09/02/21 and 09/03/21. These home health			

aide notes failed to evidence if the home health aide provided a linen change as indicated on the aide care plan.

Clinical record review evidenced an agency document titled HHA Visit dated 08/02/21 (p.m. visit) and digitally signed by HHA D. This home health aide visit note failed to evidence if the home health aide provided incontinent care as indicated on the aide care plan.

Clinical record review evidenced agency documents titled HHA Visit dated 08/05/21, 08/25/21 (p.m. visit), 08/26/21, 08/31/21 (p.m. visit), 09/01/21 (p.m. visit), 09/02/21 and 09/03/21 (p.m. visit). These home health aide notes failed to evidence if nail care was provided as indicated on the aide care plan.

Clinical record review evidenced agency documents titled HHA Visit dated 08/25/21, 08/30/21 (p.m. visit), 09/02/21 (p.m. visit) and 09/03/21 (p.m. visit). These home health aide notes failed to evidence if foot care was provided as indicated on the aide care plan.

Clinical record review evidenced agency documents titled HHA Visit dated 08/25/21 and 09/02/21. These home health aide notes failed to evidence if a shampoo was provided as indicated on the aide care plan.

	Clinical record review evidenced agency documents titled HHA Visit dated 08/25/21 and 09/03/21 (p.m. visit). These home health aide notes failed to evidence if the patient was verbally reminded to turn and position as indicated on the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/25/21, 08/30/21 (p.m. visit) and 09/03/21 (p.m. visit). These home health aide notes failed to evidence the patient s last bowel movement was recorded as indicated on the plan of care. Clinical record review evidenced an agency document titled HHA Visit dated 09/30/21 (a.m. visit) and digitally signed by HHA E. This home health aide note failed to evidence the patient was provided assistance to dress as indicated on the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 08/30/21 (p.m. visit) and digitally signed by HHA F. This home health aide note failed to evidence range of motion was provided as indicated on the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 09/01/21 (a.m. visit) and digitally signed by HHA E. This home health aide note failed			

	provided as indicated on the aide care plan. During an interview on 09/08/21 at 1:00 p.m., the administrator indicated she had counseled the home health aides about this. 4. Clinical record review for patient #4, start of care 06/10/2019, certification period 07/29/2021 09/26/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Home Health Certification and Plan of Care dated and signed by the administrator on 07/29/2021. This plan of care had an area subtitled Orders and Treatments which stated & HHA: HHA 8-10 hours a day 7 days a week, & Home health aide requested to provide 8 10 hours per day, 7 days per week, for 26 weeks. & Home health aide duties may include but are not limited to: personal hygiene care, bathing/showering, assisting with transfers, turning/positioning, assistance with wound prevention, Foley care, ostomy care, checking integumentary status, medication assistance and reminders, meal preparations, and light housekeeping &. Clinical record review evidenced an agency document titled Aide Care Plan dated 07/29/2021 and digitally signed by the			

	plan indicated the home health aide was to provide temperature check, catheter care, empty ostomy bag, record bowel movement, assist in transfer, range of motion, turn or position, light housekeeping, assist to dress, check pressure areas, foot care, oral hygiene denture care, skin care and practice universal precautions each visit. This aide care plan indicated the home health aide was to provide a back rub/massage, comb hair, complete bath, partial bath/sponge, and shampoo hair per patient s preference, provide pericare when patient was soiled, and was to change linen on Wednesday and when soiled. Clinical record review evidenced agency documents titled HHA Visit dated 08/24/2021, 08/25/2021, 08/26/2021, 08/27/2021, 08/29/2021, 08/31/2021, 09/01/2021, 09/02/2021, 09/03/2021 and 09/04/2021. These home health aide visit notes failed to evidence the home health aide provided record bowel movement, complete bath, and back rub/massage. The home health aide failed to follow the aide care plan. Clinical record review evidenced agency documents titled HHA Visit dated 08/24/2021, 08/25/2021, 08/26/2021, 08/27/2021, 08/28/2021,			

	09/01/2021, 09/02/2021, 09/03/2021 and 09/04/2021. These home health aide visit notes failed to evidence the home health aide provided the patient with shampoo hair. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 08/28/2021 and digitally signed by HHA J. This home health aide visit note failed to evidence the home health aide changed linen. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled HHA Visit dated 09/05/2021 and digitally signed by HHA I. This home health aide visit note failed to evidence the home health aide provided assistance to dress, complete bath, comb hair, foot care, pericare, shampoo hair, skin care, universal precautions, back rub/massage, oral hygiene denture care, check pressure areas, partial bath and record last bowel movement. The home health aide failed to follow the aide care plan.			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements:	G0818	Pt.#3 – HHA-H has been counseledfor not following the aide care plan. The Clinical Manager has been counseledon failing to ensure the aide followed the aide care plan on	2021-11-29

	(i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Record review of an agency policy, updated 6/10/21, titled Nurse Supervision stated & Purpose: To ensure that all daily operations and patient care are provided in a professional standard that meets state regulatory guidelines. Policy: The agencies Clinical Manager, Alternate Clinical Manager, and/or Case Manager are responsible for overseeing the clinical operations of patient care and the Clinical Manager/Administrator are responsible for overseeing the daily operations, newly hired and experienced personnel of Noble Home Health Care, LLC as it pertains to Medicare/State regulations. & 2. The Clinical Manager will oversee all services that work under the licensure of the agency and provide in-services on an ongoing basis to ensure agency compliance to state and federal regulations. The supervising nurse will ensure that the patient s POC [plan of care] is being followed		8/17/21. All active charts will bereviewed to ensure the aide care plans are being followed as assigned by theclinical manager. Home Health Aides will be in-serviced on following the aidecare plan and notifying the clinical manager when they are unable to completeany task listed on the aide care plan. The Clinical Manager will beresponsible for weekly reviewing aide documentation and accurately completingthe aide supervised visits as scheduled.	

	through chart audits, note reviews, staff communication and patient communication. & 7. Home Health Aides will be supervised at least every 30 days by a RN [registered nurse] for non-skilled care &. Clinical record review for patient #3, start of care 01/28/2021, certification period 07/27/2021 09/24/2021, primary diagnosis of Parkinson s disease, evidenced an agency document titled Aide Care Plan dated on signed by the administrator on 07/27/2021. This aide care plan indicated the home health aide was to provide temperature, incontinent care, record bowel movement, assist in ambulation, assist in transfer, range of motion, turn or position, light housekeeping, make bed, assist to dress, check pressure areas, oral hygiene denture care, pericare, skin care, shower, and universal precautions per visit. The home health aide was to provide a linen change on Wednesdays and as needed when soiled. The home health aide was to provide foot care, nail care, shampoo hair and a shave per the patient s preference. Clinical record review evidenced an agency document titled HHA [home health aide] Visit dated 08/17/2021 and digitally signed by HHA H. This home health aide visit note failed to evidence			

	change linen or provided the patient with a shave. The home health aide failed to follow the aide care plan established by the registered nurse. Clinical record review evidenced an agency document titled Aide Supervisory Visit dated 08/17/2021 and digitally signed by the administrator which indicated a supervisory visit was conducted for HHA H. This supervisory visit indicated satisfactory for the home health aide follows the client plan of care as instructed. This supervisory visit note failed to be evidenced as correct and congruent with the aide care plan which was established by the administrator. This concern was shared with the administrator on 09/08/2021 at 12:23 p.m., in which the administrator nodded. 17-14-1(n)			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. 1. Record review of an agency policy, updated 6/10/21, titled Client Records stated &	G1024	Pt.#1 – The record has been authenticated on 8/24/2021. Pt.#3 - The record has been amended toreflect the correct date. Pt.#4 – This deficiency cannot be corrected, but RN has been counseled.	2021-11-29

	maintain a client record system to assure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compliance and retrieval of information. & h. Clinical progress notes for all disciplines providing services, dated, and signed. & 4. All notes and reports in the patient s clinical record shall be typewritten or legibly written in ink, dated and signed by the recording person with his full name or first initial and surname and title &. 2. Clinical record review for patient #1, start of care 08/13/2021, certification period 08/13/2021 10/11/2021, primary diagnosis of essential hypertension, evidenced an agency document titled Aide Care Plan dated 08/13/2021. This document failed to evidence the signature of the clinician who created the document. Clinical record review evidenced an agency document titled HHA [home health aide] Visit dated 08/24/2021. This agency document failed to evidence the signature of the home health aide. 3. Clinical record review for patient #3, start of care 01/28/21, certification period 07/27/2021 09/24/2021, primary diagnosis of		All active patients visit notes will be reviewed forsignatures, dates, and credentials. The Clinical Manager will be responsible for weeklyreviewing all home health aides and professional notes to ensure thisdeficiency does not recur.	

Parkinson s Disease, evidenced an agency document titled HHA [home health aide] Visit dated 08/02/2021 and digitally signed by HHA H. This home health aide visit note indicated the patient s last bowel movement was 08/03/2021. This was one day past this home health aide visit.

During an interview on 09/08/21 at 12:10 p.m., the administrator indicated this was a documentation error.

Clinical record review evidenced an agency document titled HHA Visit dated 07/27/2021. This home health aide visit failed to evidence a signature of the home health aide who completed the visit.

4. Clinical record review for patient #4, start of care 06/10/2019, certification period 07/29/2021 09/26/2021, primary diagnosis of essential hypertension, evidenced an agency document titled OASIS-D1 Resumption of Care &. dated 08/24/2021, and digitally signed by the administrator. This resumption of care indicated the patient s blood pressure was 1436/81.

During an interview on 09/08/2021 at 11:28 a.m., the administrator stated, Oh well, that s me.

	17-15-1(a)(7)			