STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157650	A. BUILDING 00 B. WING	03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NOBLE HOME HEALTH CARE LLC	2449 45TH STREET SUITE D HIGHLAND, IN 46322

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G 0000 Bldg. 00	This visit was for a complaint survey which was fully extended. Survey Dates: 2/25/2021 to 3/4/2021 Complaints: IN00315216 - substantiated with related findings IN00332220 - substantiated with related findings IN00320943 - substantiated with related findings Facility ID: 012829 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Noble Home Health Care is precluded from providing its own home health training and competency evaluation for a period of two years beginning 3/4/2021 - 3/3/2023 due to being found out of compliance with the Conditions of Participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care. Quality Review completed on 4/7/2021 A4	G 0000		
G 0444 Bldg. 00	484.50(c)(9) State toll free HH telephone hotline Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs. Based on record review and interview, the agency failed to ensure patients were advised of the state toll free home health telephone hotline contact	G 0444	G444 – The state home health hotline document has been updated with	04/16/2021

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

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	information for 3 of 3 home visits out of a total sample of 10 patient records reviewed (#2, #3, #7). Findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled, "Client Conduct, Responsibility and Rights", number 3.001.1, which stated, " ... the agency must inform the patient and / or patient representative orally and in writing of the following: ... 49. Be informed of your state's home health agency hotline and the agencies contact information [sic] make suggestions or complaints, or present grievances on behalf of the patient to the agency, government agencies, or other persons without threat or fear of retaliation...." 2. Review of sample admission folder received on 2/25/2020 from employee A, RN [registered nurse], failed to evidence the state toll free home health hotline information. 3. Review of admission folder at a home visit for patient #2 on 2/26/2021 at 9:55 a.m. failed to evidence written information about the state toll free home health hotline. During an interview on 2/26/2021 at 10:00 a.m., person C, caregiver to patient #2, indicated she did not have any written information from the agency about the state home health hotline. 4. Review of admission folder at a home visit for patient #3 on 3/1/2021 at 12:00 p.m. failed to evidence written information about the state toll free home health hotline. 5. During an interview on 3/3/2021 at 3:55 p.m., the administrator indicated the agency failed to		contact information, its hours of operation and its purpose to file a complaint. The state home health hotline information will be a component of the agency's admission packet. Patients will be required to sign this document stating that they have received written and verbal instructions. The Administrative staff will be responsible for reviewing the admission packet to ensure receipt of this signed document. Completion date 04-16-2021.	

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	ensure patients had information about the state home health hotline. 6. Review of admission folder at a home visit for patient #7 on 2/26/2021 at 10:39 AM, failed to evidence written information about the state toll free home health hotline. 17-12-3(b)(2)(C)			
G 0548 Bldg. 00	484.55(d)(2) Within 48 hours of the patient's return Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner - ordered resumption date; Based on record review and interview, the agency failed to ensure a comprehensive assessment was performed within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more in 1 of 1 records of patients with hospitalization reviewed (#2). The findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled, "Comprehensive Assessment of Patients (OASIS)", number 6.019.1, which stated, " ... Policy: A comprehensive assessment incorporating the Outcomes and Assessment Information Set (OASIS) utilizing the most current approved version will be performed on qualified patients at: Start of care; Within 48 hours following a hospital discharge for any reason except diagnostic testing...." 2. Clinical record review on 3/2/2021 for patient #2, start of care 8/13/2020, certification period 12/11/2020 to 2/8/2021, primary diagnosis of Multiple Sclerosis, evidenced an agency document titled, "Post Hospital Order". This	G 0548	G548 - Based on the Surveyor's concern of the agency failing to ensure a comprehensive assessment was performed within 48 hours of a patient's return to home from a hospital admission of 24 hours or more, the deficiency has been corrected by entering the comprehensive assessment that was completed on paper into the patient's EMR. This deficiency will be prevented from recurring by discontinuing paper documentation and utilizing electronic documentation only. Comprehensive assessment is to be completed within 48 hours of patient's return home. Skill nursing staff has been in-serviced and is now aware to discontinue paper charting. Clinical manager is responsible to ensure that compliance is	04/16/2021

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	order indicated the patient was admitted to the hospital from 12/18/2020 to 12/27/2020. Review of the electronic medical record evidenced HHA [home health aide] visits resumed on 12/28/2020. Review of the electronic medical record failed to evidence a comprehensive assessment was performed following the hospitalization. 3. During an interview on 3/4/2021 at 11:00 a.m., the clinical manager indicated a comprehensive assessment should be done at start of care, resumption of care, and every 60 days. When queried, the clinical manager stated about the comprehensive assessment, "There is not an uploaded one. I am behind."		maintained.	
G 0570 Bldg. 00	484.60 Care planning, coordination, quality of care Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.			

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	Based on observation, record review and interview, the home health agency failed to ensure they were able to meet the patient needs (see tag G0570); failed to ensure each patient received home health services written in their plan of care, the plan of care was individualized, and the plan of care was signed by the patient's physician (see tag G0572); the plan of care contained all medications, medical equipment and patient-specific interventions and goals for their patients (see tag G0574); the home health agency staff promptly alerted the primary care physician to changes in the patients condition (see tag G0590); the plan of care was revised to reflect the current health status and nursing needs of the patient (see tag G0592); discharge plans were communicated to the patient and patient's physician (G0598); there was coordination of care amongst the different disciplines / entities that provided care to agency patients (see tag G0606); patients were provided a written schedule of visits (see tag 614); and patients were provided a current written patient medication list (see tag 616). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care. In regards to G0570, findings include: 1. An undated agency policy number 4.004.1, with a subject subtitled "Physician Orders/Plan of Care" stated, "Purpose: To ensure that each patient's care is under the direction of a physician ... Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is	G 0570	G570 – Patient #2. Plan of care has been updated. A signed addendum has been submitted and received from the physician that reflects correct number of hours the patient is receiving. Patient #5 was discharged from the agency. Returned to school. Home Health Services transferred to another agency. Patient #6. Patient was discharged from the agency. The plan of care has been resubmitted to the physician to cover the hours provided prior to the patient's discharge. Patient #7. An addendum to POC has been submitted to the physician to reflect the correct number of hours. Patient #9 was discharged and assisted with transferring services to another agency. All active medical charts have been reviewed to verify that hours requested on their POC are the number of hours being provided. All nursing notes will be reviewed weekly to ensure vital signs and services provided are completed. A log has been developed to track and monitor when plan of cares are submitted to physician and returned. The administrator has in-serviced the administrative staff regarding accepting patients for treatments only on the reasonable expectation that the patient's	04/16/2021

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	updated and maintained as part of the agency's clinical record ... Procedure: 1. The physician sets up a Plan of Care, which includes the diagnosis, prognosis, goals to be accomplished, in order for each service, an item of drugs and equipment to be provided by the agency. 2. All orders on the CMS 485 will be specific to the client condition in needs ... 5. Copies of the plan of care in other orders requiring a physician's signature should be filed in the client record within 60 days of receipt in office ... 7. The physician and appropriate professional staff will review an recertify the written plan of care at least once per episode and as warranted by the patient's condition... 9. The agency's professional staff will review the clinical records on a continuous basis to ensure each POC is specific to the patient and that additional orders for services are present in the clinical record .... " 2. An undated agency policy number 6.016.1, with a subject subtitled "Care Planning" stated, "Purpose: To define a systematic process to the clinicians for planning, reviewing and revisiting patient care or services either directly or through a written agreement ... Policy: 1. It is the policy of this Agency to provide individualized, planned, appropriate care, treatment and or services based on the patient's needs and goals with the input of the patient for the purpose of achieving positive outcomes." 3. An undated agency policy titled, "Rights, Responsibilities and Ethics", number 3.001.1, which stated, " ... 35. Receive the care necessary to assist you in attaining optimal levels of health...." 4. Clinical record review on for patient #2, start of care 8/13/2020, certification period of 12/11/2020 to		nursing and home health needs can be provided in their place of residency. To prevent this deficiency from recurring, the Administrator will be responsible for reviewing 50% of the plan of cares Quarterly to ensure each patient receives the home health services written in their plan of care and that the plan of care is individualized and signed by the patient's physician. Completion date 04-16-2021 =”” b=””>	

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	2/8/2021, primary diagnosis of Multiple Sclerosis, evidenced a document identified by the clinical manager as the prior authorization request for patient #2 for 1/26/2021 to 7/25/2021. This document stated, " ... HHA [home health aide] to provide assistance with all ADLS [activities of daily living] and safety measures 6 hr Mon to Sat [6 hours Monday to Saturday]...." During an interview on 3/4/2021 at 3:48, the clinical manager indicated the prior authorization request should be accurate to what the patient needed. Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 2/27/2021, which stated, " ... Home health aide requesting to provide 6 hours a day, up to 6 days a week, for 26 weeks...." Review of the patient's electronic clinical record, evidenced the agency provided the following HHA hours: for the week of 12/27/2020 to 1/2/2021, the patient received 6 hours per day for 3 days, the week of 1/3/2021 to 1/9/2021, the patient received 6 hours per day for 4 days, for the week of 1/10/2021 to 1/16/2021, the patient received 6 hours per day for 5 days, the week of 1/24/2021 to 1/30/2021, the patient received 6 hours per day for 5 days, and for the week 1/31/2021 to 2/6/2021, the patient received 6 hours per day for 5 days. During an interview on 2/26/2021 at 9:59 a.m., person C, caregiver to patient #2, indicated HHA hours were missed because staff did not show up. Person C indicated that HHA C is the only HHA who works as scheduled. When informed of the findings on 3/4/2021 at 11:12 p.m., the clinical manager stated, "It's not for			

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	lack of trying. We have offered. They refuse aides." The clinical manager indicated the agency failed to evidence documentation of communication with the family regarding staffing. 5. Clinical record review for patient #5, start of care 8/31/2020, certification period 12/29/2020 to 1/29/2021, primary diagnosis of legal blindness, evidenced an agency document titled, "Home Health Certification and Plan of Care", which stated, " ... Home Health Aide requesting to provide 6 (up to 12) hours a day, 5 days a week; based on patient need / request. Patient requires 12 hours of assistance a day; at this time she is utilizing her home making service for 6 of those 12 hours. On occasion, they are not available and when that happens, patient will request to use up to 12 hours on those days...." Review of the patient's electronic clinical record, evidenced the agency provided the following HHA hours: for the week of 12/29/2020 to 1/2/2021, the patient received 3.5 hours one day, and 6 hours a day for 2 days; for the week of 1/3/2021 to 1/9/2021, the patient received 6 hours per day for 3 days; for the week of 1/10/2021 to 1/17/2021, the patient received 2.5 hours one day, 3.5 hours one day, 5 hours per day for 2 days, 6 hours for one day; for the week of 1/17/2021 to 1/23/2021, the patient received 2 hours one day, 3.5 hours one day, and 6 hours per day for 3 days; for the week of 1/24/2021 to 1/30/2021, the patient received 3.5 hours one day, and 6 hours per day for 3 days. During an interview on 3/4/2021 at 1:43 p.m., the clinical manager indicated the agency was having difficulty staffing HHA visits due to not enough staff. She stated, "We are all struggling. We are trying to hire."			

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	6. Clinical record review on 3/4/2021, for patient #6, start of care 6/21/2019, failed to evidence a plan of care had been established and signed by the patient's physician, for certification period 2/16/2020 - 4/15/2020. Record review evidenced the patient received 48 hours per week during this certification period. Record review evidenced care being provided to the patient without a signed plan of care. Record review evidenced a document titled "Indiana Medicaid Prior Authorization Update Notification" dated 1/28/2020. This document had an area subtitled "Service Requested" which stated "Service Description: Home Visit NOS [not otherwise specified] ... Units Requested: 1416.00 [equivalent to 54.5 hours per week] ... Units Authorized: 1,280.00 [49.2 hours per week] .... " Record review failed to evidence the patient received the amount of service hours needed, as requested by the agency. During an interview on 3/4/2021, at 11:23 AM, the clinical manager indicated the patient was very hard to get a hold of and did not know if a plan of care was sent to the physician for an authorized signature. 7. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 1/14/2021 - 3/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 2 hrs [hours] per day, 7 days a week for 26 weeks [up to 14 hours per week] ... Frequency and/or duration may be decreased if/when an available caregiver is			

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	present, willing, and able to assist .... " Record review evidenced this patient received care for 2 hours per day, 3 days a week (6 hours per week), since 12/14/2020. Record review evidenced a document titled "Indiana Medicaid Prior Authorization Update Notification" dated 10/19/2020. This document had an area subtitled "Service Requested" which stated "Service Description: Home Visit NOS ... Units Requested: 364.00 [equivalent to 14 hours per week] ... Units Authorized: 338.00 [equivalent to 13 hours per week] .... " Record review failed to evidence the patient received the amount of service hours needed, as requested by the agency. During an interview on 3/4/2021, at 11:32 AM, the clinical manager indicated the patient's hours were not being met due to the caregiver's request for specific home health aides only. 8. Clinical record review on 3/4/2021, for patient #9, start of care 10/30/2019, primary diagnosis of encephalopathy (disease which alters brain function), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 6/26/2020 - 8/24/2020. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 10 hours a day, up to 7 days a week [70 hours per week] for 26 weeks .... " Record review evidenced an average of 46 hours per week of home health aide services provided for this certification period. Record review evidenced a document titled "Indiana Medicaid Prior Authorization Update Notification" dated 4/30/2020. This document had an area subtitled "Service Requested" which			

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	stated "Service Description: Home Visit NOS ... Units Requested: 1820.00 [equivalent to 70 hours per week] ... Units Authorized: 1820.00 .... " Record review failed to evidence the patient received the amount of service hours needed, as requested by the agency. During an interview on 3/4/2021, at 12:41 PM, the clinical manager indicated hours were not being met due to the tremendous difficulty the agency had staffing the patient's home for 10 hours a day. 9. During an interview on 3/4/2021, at 3:48 PM, the clinical manager indicated the PA [prior authorization for Medicaid] should be accurate to the patient's needs. 10. During an interview on 3/4/2021, at 3:53 PM, the clinical manager indicated they did not know the agency can use a skilled nurse to meet the needs of home health aide visits. 17-13-1(a)			
G 0572 Bldg. 00	484.60(a)(1) Plan of care 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			

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	original plan. Based on record review and interview, the agency failed to ensure each patient received home health services written in their plan of care in 2 of 10 records reviewed (#7, #4), failed to ensure the plan of care was individualized in 2 of 10 records reviewed (#9, #10), and failed to ensure plan of care was signed by the patient's physician in 2 of 10 clinical records reviewed. (#6, #3) The findings include: 1. An undated agency policy number 4.004.1, with a subject subtitled "Physician Orders/Plan of Care" stated, "Purpose: To ensure that each patient's care is under the direction of a physician ... Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is updated and maintained as part of the agency's clinical record ... Procedure: 1. The physician sets up a Plan of Care, which includes the diagnosis, prognosis, goals to be accomplished, in order for each service, an item of drugs and equipment to be provided by the agency. 2. All orders on the CMS 485 will be specific to the client condition in needs ... 5. Copies of the plan of care in other orders requiring a physician's signature should be filed in the client record within 60 days of receipt in office ... 7. The physician and appropriate professional staff will review an recertify the written plan of care at least once per episode and as warranted by the patient's condition... 9. The agency's professional staff will review the clinical records on a continuous basis to ensure each POC is specific to the patient and that additional orders for services are present in the clinical record .... " 2. An undated agency policy number 6.016.1, with	G 0572	G572 – Pt. #6. - Patient was discharged from the agency. The plan of care has been resubmitted to the physician to cover the hours provided prior to the patient's discharge. Pt #7. An addendum to POC has been submitted to the physician to reflect the correct number of hours. Pt #9 was discharged and assisted with transferring services to another agency. Pt #10 - An addendum was submitted to physician to reflect correct hours of service. Pt. #3 - The Plan of Care for has been signed and entered in chart. Pt #4 – The Administrator in-serviced the Skilled Nursing staff on documenting care provided to the patient in the narrative section of the skilled nursing visit note. All active medical charts have been reviewed to verify that the patient has received the home health services written in their plan of care, and that the plan of care was individualized, and was signed. To prevent this deficiency from recurring, the Administrator will review 50% of the plan of cares Quarterly to ensure each patient receives the home health services written in their plan of care and that the plan of care is individualized and signed by the	04/16/2021

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	a subject subtitled "Care Planning" stated, "Policy: 1. It is the policy of this Agency to provide individualized, planned, appropriate care, treatment and or services based on the patient's needs and goals with the input of the patient for the purpose of achieving positive outcomes..." 3. Clinical record review on 3/4/2021, for patient #6, start of care 6/21/2019, failed to evidence a plan of care had been established and signed by the patient's physician for certification period 2/16/2020 - 4/15/2020. During an interview on 3/4/2021, at 11:23 AM, the clinical manager indicated the lack of the patient's plan of care was an oversight. They further explained it was unknown if a plan of care had been sent to the physician for a signature. 4. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 1/14/2021 - 3/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 2 hrs [hours] per day, 7 days a week for 26 weeks ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced this patient received care for 2 hours per day, 3 days a week since 12/14/2020. Record review failed to evidence patient received home health services written in their plan of care. During an interview on 3/4/2021, at 11:32 AM, the clinical manager indicated the reason this patient did not receive the hours as ordered on the plan		patient's physician. To prevent this deficiency from recurring, the clinical manager will daily communicate any changes to the frequency, interventions and goals to the professional staff and will review and recertify the written plan of care at least once per episode and as warranted by the patient's condition. Completion date 04-16-2021	

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	of care, is due to Person D, caregiver for patient #7. It is their preference to only utilize HHA D to furnish care on behalf of the agency. 5. Clinical record review on 3/4/2021, for patient #9, start of care 10/30/2019, primary diagnosis of encephalopathy (disease which alters brain function), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 6/26/2020 - 8/24/2020. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 10 hours a day, up to 7 days a week for 26 weeks .... " Record review failed to evidence the plan of care was individualized to meet the patient's needs. 6. Clinical record review on 3/4/2021, for patient #10, start of care 2/26/2019, primary diagnosis of progressive mutifocal leukoenchalopathy (disease of the white matter of the brain), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 12/17/2020 - 2/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide 4 hours a day, 7 days a week ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced this patient received care for 6 hours a day, 7 days a week since 12/17/2020. Record review failed to evidence the plan of care was individualized to meet the patient's needs. During an interview on 3/4/2021, at 1:07 PM, the clinical manager indicated the duration stated on the plan of care was an oversight, and should written as 6 hours per day.			

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	7. Clinical record review on 3/2/2021 for patient #3, start of care 2/17/2020, certification period 1/12/2021 to 3/2/2021, primary diagnosis of chronic obstructive pulmonary disease [a disease that causes long-term breathing problems], evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care was not signed by the physician. On 3/4/2021 at 12:02 p.m., the clinical manager was informed of the findings and offered no additional documentation. 8. Clinical record review on 3/4/2021 for patient #4, start of care 9/10/2018, certification period 12/28/2021 to 2/25/2021, with diagnoses of legal blindness and cerebral palsy, evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care had a subcategory titled, "Orders and Treatments", which stated, " SN [skilled nurse] to change inner cannula [the inner tube that fits within a tracheostomy tube] daily in the a.m. ... SN [skilled nurse] to place rolled towel in hands as tolerated and off at HS [bedtime] ... SN to apply bilateral [left and right] hand splints daily as tolerated and off at HS...." During an interview on 3/4/2021 at 12:20 p.m., the clinical manager indicated applying hand splints and placing rolled towels in hands should be documented in the narrative section of the nursing visit notes. Clinical record review evidenced a group of agency documents titled, "Nursing Flow Sheet Shift Assessment", identified as the skilled nursing visit notes by the clinical manager. The notes with the following dates failed to evidence applying hand splints and placing rolled towels in			

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	hands: 12/28/2021, 12/29/2021, 12/30/2021, 1/1/2021, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/7/2021, 1/9/2021, 1/10/2021, 1/13/2021, 1/14/2021, 1/15/2021, 1/16/2021, 1/17/2021, 1/18/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/22/2021, 1/23/2021, 1/24/2021, 1/25/2021, 1/26/2021, 1/27/2021, 1/28/2021, 1/29/2021, 1/30/2021, 1/31/2021, 2/1/2021, 2/4/2021, 2/5/2021, 2/6/2021, 2/7/2021, 2/8/2021, 2/9/2021, 2/10/2021, 2/11/2021, 2/12/2021, 2/13/2021, 2/14/2021, 2/15/2021, 2/18/2021, 2/19/2021, 2/20/2021, 2/21/2021, 2/22/2021, 2/23/2021, 2/24/2021 and 2/25/2021. Review of the skilled nursing notes on the following dates failed to evidence changing the inner cannula of the tracheostomy tube: 12/28/2021, 12/29/2021, 12/30/2021, 1/1/2021, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/7/2021, 1/9/2021, 1/10/2021, 1/13/2021, 1/14/2021, 1/15/2021, 1/16/2021, 1/17/2021, 1/18/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/22/2021, 1/23/2021, 1/24/2021, 1/25/2021, 1/26/2021, 1/27/2021, 1/28/2021, 1/29/2021, 1/30/2021, 1/31/2021, 2/1/2021, 2/4/2021, 2/5/2021, 2/6/2021, 2/7/2021, 2/8/2021, 2/9/2021, 2/10/2021, 2/11/2021, 2/12/2021, 2/13/2021, 2/14/2021, 2/15/2021, 2/18/2021, 2/19/2021, 2/20/2021, 2/21/2021, 2/22/2021, 2/23/2021, 2/24/2021 and 2/25/2021. The subcategory "Orders and Treatments" also stated, " ... Notify physician of: Temperature greater than (>) or less than (<) 97. Pulse greater than (>) 110 or less than (<) 60. Respirations greater than (>) 24 or less than (<) 12. Systolic BP [blood pressure] greater than (>) 160 or less than (<) 90. Diastolic BP greater than (>) 90 or less than (<) 60...." This order failed to indicate how frequent vital signs were to be taken.			

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	During an interview on 3/4/2021 at 12:08 p.m., the clinical manager indicated vital signs should be checked on patient #4 every 4 hours at minimum. Review of the skilled nursing notes dated 1/9/2021, 1/10/2021, 1/24/2021, 2/6/2021, 2/7/2021, 2/20/2021, 2/21/2021, 2/24/2021, and 2/25/2021, each signed by employee E, RN [registered nurse], failed to evidence any patient blood pressures. 17-13-1(a)			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;			

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	(xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the individualized plan of care included all services, safety measures, medications and treatments in 6 out of 8 active patient records out of a total sample of 10 records reviewed (#1, #2, #3, #4, #8, #10). The findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled "Care Planning", Number 6.016.1, which stated, " ... The plan of care, developed in accordance with the referring physician's orders, may include, but not limited to: Name of the patient ... Medications: dose / frequency / route ... safety measures ... Treatments / orders...." 2. Clinical record review on 3/2/2021 for patient #1, start of care 12/26/2013, certification period 1/18/2021 to 3/18/2021, primary diagnosis of quadriplegia [paralysis from the neck down], evidenced a document titled, "Home Health Certification and Plan of Care". This plan of care was signed by the physician on 3/2/2021. The plan of care had a subcategory titled, "Medications" which stated, " ... Desitin Maximum Strength External 40% thin layer Apply thin layer to affected area PRN [as needed....]". This order failed to evidence an indication for use of the as needed medication. This subcategory also stated, " ... Promethazine VC / Codeine Oral [a cough syrup] 6.25 - 5 - 10 mg [milligram] / 5 mL	G 0574	G574 - Pt.#1 Medication profile has been updated to indicate treatment and medication purpose, as well as location for application of ointments. Pt.#2 A letter of coordination has been sent for signature to the agency providing skilled nursing services. An addendum has been submitted to physician to include all safety precautions. Pt.#3. Medication profile has been updated to include the route of administration of medication. An addendum has been submitted to physician to include all safety precautions. Pt.#4 Medication profile has been updated to indicate PRN use and location of application of creams or ointments. An addendum has been submitted to physician to update orders, treatment and frequency of vital signs. Pt.#10 An addendum has been submitted to physician to update all PRN medications. All active medical charts were reviewed and updated as needed to include care coordination of other agencies providing services. Safety measures have been added to home health aide care plan. The administrator in-serviced the	04/16/2021

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	[milliliter], 5 mL tid [three times a day] prn [as needed] (SN [skilled nurse] to administer PRN)...." This order failed to evidence an indication for use of the as needed medication. This subcategory also stated, " ... Bacitracin External [a topical antibiotic] 500 unit / gm [gram] 1 apply to affected area as needed (SN to administer PRN)...." This order failed to evidence an indication for use as well as a location for application. This subcategory also stated, " ... Santyl External [an ointment to help heal wounds] 250 unit / gm 1ml daily PRN (SN to administer PRN)...." This order failed to evidence an indication for use as well as a location for application. During an interview on 3/4/2021 at 10:50 a.m., the clinical manager indicated any medication ordered "as needed" should have an indication for use and all orders for all topical medications should include location for application. The subcategory of "Medications" in the plan of care also stated, " ... Naproxen Sodium Oral [an anti-inflammatory medication] 220 mg [milligram] 1 Tab (s) Take one tablet every 6-8 hours as needed for pain (SN to Administer PRN) ... Klonopin Oral [an anti-seizure medication] 1 mg 1 tab (s) daily (SN to Administer PRN) ... Trintellix [an anti-depressant] Oral 10 mg 1 tab (s) daily (SN to Administer PRN) ... Gabapentin Oral [a medication used to treat seizures or nerve pain] 300 mg 1 cap (s) 1 cap po [by mouth] nightly. (SN to Administer PRN) ... Cholecalciferol [vitamin D3] Oral 25 mcg [micrograms] (1000 UT) 1 cap (s) 1 caps po [by mouth] 2 x day (2000 units po daily). (SN to Administer PRN) ... Pantoprazole Sodium [a medication used to help control stomach acid] Oral 40 mg 1 tab (s) by mouth 2 x day (SN to Administer PRN) ... Baclofen [a muscle relaxant] Oral 20 mg 2 tab (s) 40 mg 4 times a day (SN to		nursing staff on documenting medications and treatments to include name of medication, purpose, frequency and route and location for application of ointments and creams. To prevent this deficiency from recurring, the clinical manager will be responsible for reviewing all clinical records once per episode and as warranted for safety measures, medications and treatments and that coordination of care is on plan of care. Completion Date 4-16-2021	

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	administer PRN) ... Dulcolax Rectal [a laxative] 10 mg 1 suppository(ies) Rectally every other day (SN to Administer PRN) ... Dronabinol [a medication used to treat nausea or lack of appetite] Oral 2.5 mg 1 cap (s) by mouth 2 times a day (SN to Administer PRN) ... Senna [a medication for constipation] Oral 2 tab (s) by mouth daily (SN to administer PRN)...." These orders failed to clearly indicate if the patient was to take the medication as needed, or if only the act of administering by the skilled nurse was as needed. During an interview on 3/4/2021 at 10:52 a.m., when informed of the findings, the clinical manager stated about the medication orders in the plan of care, "That needs to be more specific". The clinical manager indicated the agency failed to ensure the plan of care included complete, clear orders for each patient medication. 3. During a home visit for patient #2 on 2/26/2021 at 9:30 a.m., the patient was observed to have a PEG tube [a feeding tube directly inserted to the stomach through the abdomen], a Foley catheter [a tube inserted to drain the bladder], and a Wound VAC [vacuum-assisted closure][a device used to assist wound healing]. During an interview on 2/26/2021 at 9:59 a.m., employee C, HHA [home health aide], indicated skilled nursing service from entity A managed the PEG tube, Foley catheter, and Wound VAC. Clinical record review on 3/2/2021 for patient #2, start of care 8/13/2020, certification period 12/11/2020 to 2/8/2021, primary diagnosis of Multiple Sclerosis, evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care was signed by the			

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	physician on 2/27/2021. The plan of care had a subcategory titled, "Orders and Treatments". This subcategory failed to include the PEG tube, Foley catheter, and Wound VAC. The plan of care failed to mentioned skilled nursing service from entity A. On 3/4/2021 at 11:12 a.m., the clinical manager was informed of the findings and offered no further documentation. Review of the plan of care evidenced a subcategory titled, "Medications". This subcategory stated, "Apixaban [a blood thinner] Oral 5 mg [milligram] 1 tab (s) Take one tablet by mouth two times daily ... Aspirin [a pain and fever reducer and blood thinner] Oral 81 mg 1 tab (s) Take one tablet by mouth daily...." The plan of care had another subcategory titled, "Safety Measures". This subcategory failed to evidence Bleeding Precautions. During an interview on 3/4/2021 at 11:00 a.m., the clinical manager indicated Bleeding Precautions should be included in the plan of care for a patient taking blood thinners. 4. Clinical record review on 3/2/2021 for patient #3, start of care 2/17/2020, certification period 1/12/2021 to 3/2/2021, primary diagnosis of chronic obstructive pulmonary disease [a disease that causes long-term breathing problems], evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care had a subcategory titled, "Medications", which stated, " ... Fluticasone Furoate [an inhaled medication for breathing problems] Inhalation 200 mcg/act [micrograms per actuation] 200 mcg Inhale 200 mcg into the lungs daily ... Ipratropium-Albuterol [an inhaled medication for			

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	breathing problems] Inhalation 0.5-2.5 (3) mg/ml [milligrams per milliliter] 3 ml Inhale 3 mL into lungs every 4 hrs PRN [as needed] ... Proventil HFA [an inhaled medication for breathing problems] Inhalation 108 (90 base) mcg/act 2 puffs every 4 hours." The plan of care also contained a subcategory titled, "DME & Supplies" which indicated the patient used a nebulizer [a machine that turns liquid medicine into a mist that can be inhaled]. The inhaled medications on the plan of care failed to indicate if they were given by inhaler or nebulizer. The order for Ipratropium-Albuterol failed to evidence an indication for as needed use. When informed of the findings on 3/4/2021 at 11:48 a.m., the clinical manager stated, "I can see where we'd need to adjust that". The subcategory of the plan of care titled "Medications" also stated, " ... Eliquis [a blood thinner] Oral 2.5 mg [milligram] 1 tab(s) Take one tablet by mouth twice a day...." The plan of care had another subcategory titled, "Safety Measures". This subcategory failed to evidence Bleeding Precautions. During an interview on 3/4/2021 at 11:00 a.m., the clinical manager indicated Bleeding Precautions should be included in the plan of care for a patient taking blood thinners. 5. Clinical record review on 3/4/2021 for patient #4, start of care 9/10/2018, certification period 12/28/2021 to 2/25/2021, with diagnoses of legal blindness and cerebral palsy, evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care had a subcategory titled, "Medications", which stated, " ... Robitussin DM Sugar Free Oral 100-10 5 mg/5 mL 10 mL via feeding tube every			

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NOBLE HOME HEALTH CARE LLC	2449 45TH STREET SUITE D HIGHLAND, IN 46322

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	4-6 hours PRN [as needed] ... Dulcolax [a laxative] Rectal 10 mg 1 Suppository(ies) Rectally daily PRN ... Fleet Bisacodyl [a laxative] Rectal 10 mg/30 mL 30 mL 1 bottle Rectally daily PRN...." These medications failed to evidence an indication for as needed use. The subcategory of the plan of care titled "Medications" also stated, " ... Desitin External to coat apply topically to peri area PRN ... Triamcinolone Acetonide External 0.1% QS [a topical steroid cream] apply topically to peri area PRN ... A & D Zinc Oxide External QS [a topical cream for skin irritation] apply topically to affected peri area PRN...." These medications failed to evidence an indication for as needed use. The subcategory of the plan of care titled "Medications" also stated, " ... Bacitracin External [a topical antibiotic] 500 unit/gm QS apply topically to affected areas PRN ... Hydrocortisone Acetate [a topical steroid cream] External 2.5% QS apply topically PRN ... Ketoconazole Acetonide [a topical anti-fungal] 2% QS apply topically PRN...." These medications failed to evidence an indication for as needed use and a location for application. During an interview on 3/4/2021 at 12:05 p.m., the clinical manager indicated the location for application should be listed for all topical medications ordered.. When informed of the findings, the clinical manager stated, "It's unclear". Review of the plan of care evidenced a subcategory titled, "Orders and Treatments", which stated, " ... Notify physician of: Temperature greater than (>) or less than (<) 97. Pulse greater than (>) 110 or less than (<) 60.			

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	Respirations greater than (>) 24 or less than (<) 12. Systolic BP [blood pressure] greater than (>) 160 or less than (<) 90. Diastolic BP greater than (>) 90 or less than (<) 60...." This order failed to indicate how frequently vital signs were to be taken. During an interview on 3/4/2021 at 12:08 p.m., the clinical manager indicated vital signs should be checked on patient #4 every 4 hours at minimum. When informed of findings, the clinical manager was silent. 6. Clinical record review on 3/4/2021, for patient #8, start of care 6/10/2019, primary diagnosis of hemiplegia (paralysis or weakness on one side of the body), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/1/2020 - 1/29/2021. This document had an area subtitled "Medications" which stated " ... Xanax [sedative] Oral 300 MG [milligrams] 1 cap(s) [capsules] by mouth daily PRN [as needed] ... Docusate Sodium [stool softener] Oral 100 MG 1 Tab(s) [tablets] PO [by mouth] BID [two times a day] PRN .... " Record review failed to evidence indications for all PRN medications. 7. Clinical record review on 3/4/2021, for patient #10, start of care 2/26/2019, primary diagnosis of progressive multifocal leukoencephalopathy (disease of the white matter of the brain), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/17/2020 - 2/14/2021. This document had an area subtitled "Medications" which stated " ... Miralax [laxative] Oral 17 GM [gram] 1 packet(s) 1 packet daily PRN ... Tylenol [mild pain reliever/fever reducer] Oral 325 MG 2 Tab(s) PO Q[every]6 Hours PRN .... " Record review failed to evidence indications for all PRN medications.			

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	During an interview on 3/4/2021, at 11:48 AM, the administrator and clinical manager were notified the indications for all PRN medications were not listed on the plan of care. The clinical manager stated, "Okay." 17-13-1(a)(1)(D)(ii) 17-13-1(a)(1)(D)(ix) 17-13-1(a)(1)(D)(x)			
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes 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. Based on record review and interview, the agency failed to ensure relevant changes in the patient's plan of care were promptly alerted to the physician in 4 of 10 clinical records reviewed. (#7, #9, #5, #3) The findings include: 1. An undated agency policy, number 6.020.1, with a subject 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 agency's director of nursing, alternate director of nursing, and/or case manager are responsible for overseeing the clinical operations of patient care... 2. The DON 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.... "	G 0590	G590- Pt.#1 The patient's physician was notified of the deviation from the plan of care and this was documented in the clinical record. Pt.#9 The patient is no longer active. Pt.#5 The patient is no longer active. Pt.#3 The plan of care has been submitted to the correct primary physician for signature and received. All active medical charts have been reviewed to verify correct primary care physician The deficiency will be prevented from recurring by promptly alerting the primary care physician to	04/16/2021

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	2. An undated agency policy, number 6.016.1, with a subject titled "Care Planning" stated, "..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 ... 18. If person to person contact was not completed or if awaiting a return response, all Contacts and interactions shall be documented. The agency shall have a written policy regarding how the agency will intervene if the attending care provider cannot be contacted or does not respond timely ..." 3. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 11/15/2020 - 1/13/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 2 hrs [hours] per day, 7 days a week for 26 weeks ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced an agency document titled "Missed Visit Form (HHA Visit)" which was digitally signed by HHA H, on 11/24/2020. This document stated "Reason: ... Other (Specify) ... Comments: ... [left blank] ... MD [doctor of medicine] Notified: ... No .... " Record review failed to evidence the patient's physician was notified of the deviation from the plan of care. During an interview on 3/4/2021, at 11:40 AM, the clinical manager indicated notification to the physician of the missed visit was not documented in the clinical record.		changes in the patient's condition, including a requested deviation made by the patient/caregiver to the patient's scheduled hours. The primary physician will be notified and an order obtained to amend plan of care. Clinical Manager will promptly update plan of care and patient profile. The Clinical manager will be responsible to review all plan of cares and communicate any changes or updates to the frequency, interventions and goals to the professional staff and will review and recertify the written plan of care at least once per episode and as warranted. This will be added as a component of the quality improvement program. Completion Date 4-16-2021	

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	4. Clinical record review on 3/4/2021, for patient #9, start of care 10/30/2019, primary diagnosis of encephalopathy (disease which alters brain function), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 6/26/2020 - 8/24/2020. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 10 hours a day, up to 7 days a week for 26 weeks ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced agency documents titled "Missed Visit Form (HHA Visit)" for the following dates: 8/5/2020, and 8/12/2020. These documents stated "Reason: ... Other (Specify) ... Comments: ... [left blank] ... MD Notified: ... No .... " Record review failed to evidence the patient's physician was notified of the deviation from the plan of care. During an interview on 3/4/2021, at 12:43 PM, the clinical manager indicated notification to the physician of the missed visit was not documented in the clinical record. 5. Clinical record review for patient #5 with start of care 8/31/2020, certification period 12/29/2021 to 1/29/2021, primary diagnosis of legal blindness, evidenced an agency document titled, "Missed Visit Form" dated 11/3/2020, signed by employee N. This note stated, " ... MD [medical doctor] Notified: No...." During an interview on 3/4/2021 at 11:50 a.m., the clinical manager indicated only skilled nurse missed visits were reported to the physician by the agency, not missed home health aide visits. 6. Clinical record review on 3/2/2021 for patient #3, start of care 2/17/2020, certification period			

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	1/12/2021 to 3/2/2021, primary diagnosis of chronic obstructive pulmonary disease [a disease that causes long-term breathing problems], evidenced an agency document titled, "Missed Visit Form", dated 1/26/2021, signed by employee K, HHA [home health aide]. This form stated, " ... Reason: Cancellation of Care ... MD [medical doctor] Notified: Yes, by Phone. Physician: [person E, MD]...." Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", dated 12/28/2020 and signed by the clinical manager. This document had a subcategory titled, "Clinical Data" which stated, "Primary Physician [person B, MD]". During an interview on 3/4/2021 at 11:50 a.m., the clinical manager indicated person E was not the primary physician of patient #3. The patient's primary care physician, person B, was not notified of the missed visit. 17-13-1(d)			
G 0592 Bldg. 00	484.60(c)(2) Revised plan of care 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. Based on record review and interview, the agency failed to ensure the supervising nurse revised the plan of care to reflect the current frequencies that were provided in 2 of 10 clinical records reviewed. (#7, #10)	G 0592	G592 - pt.#7 notified physician, received order to amend plan of care per the caregiver's request. pt#10 Plan of Care has been amended to reflect the nursing	04/16/2021

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	The findings include: 1. An undated agency policy number 4.004.1, with a subject subtitled "Physician Orders/Plan of Care" stated, "Purpose: To ensure that each patient's care is under the direction of a physician ... Policy: the physician establishes and reviews a plan of treatment for the patient. The plan is updated and maintained as part of the agency's clinical record ... Procedure: 1. the physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, an item of drugs and equipment to be provided by the agency. 2. All orders on the CMS 485 will be specific to the client condition in needs ... 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... 9. The agency's professional staff will review the clinical records on a continuous basis to ensure each POC is specific to the patient and that additional orders for services are present in the clinical record .... " 2. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 1/14/2021 - 3/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 2 hrs [hours] per day, 7 days a week for 26 weeks ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced this patient received care for 2 hours per day, 3 days a week since 12/14/2020. Record review failed to evidence the		needs of the patient. All active medical charts were reviewed and the plan of care was revised to reflect the current health status and nursing needs of the patient. To prevent this deficiency from recurring, The agency's professional staff will review the clinical records on a continuous basis to ensure each plan of care is specific to the patient. The Clinical manager will ensure the supervising nurse revised the plan of care to reflect the frequencies that are provided. This will be added as a component of the quality improvement program. **Completion Date 4-16-2021**	

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	plan of care was revised as needed. During an interview on 3/4/2021, at 11:32 AM, the clinical manager indicated the reason this patient did not receive the hours as ordered on the plan of care, is due to Person D, caregiver for patient #7. It is their preference to only utilize HHA D to furnish care on behalf of the agency. 3. Clinical record review on 3/4/2021, for patient #10, start of care 2/26/2019, primary diagnosis of progressive mutifocal leukoenchalopathy (disease of the white matter of the brain), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 12/17/2020 - 2/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide 4 hours a day, 7 days a week ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced this patient received care for 6 hours a day, 7 days a week since 12/17/2020. Record review failed to evidence the plan of care was revised as needed. During an interview on 3/4/2021, at 1:07 PM, the clinical manager indicated the duration stated on the plan of care was an oversight, and should written as 6 hours per day. 17-14-1(a)(1(C)			
G 0598 Bldg. 00	484.60(c)(3)(ii) Discharge plans communication (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing			

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	orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview, the home health agency failed to ensure discharge plans were communicated to the patient and patient's physician for 2 of 3 discharged patients, in a total sample of 8 clinical records reviewed. (#6, #9) The findings include: 1. An undated agency policy number 4.003.2, with a subject subtitled "Client Records" stated, "... z. discharge summary with the agency's documented notice to the client, the client's physician and other individuals as needed that also includes: ... The care or services provided; the course of care and services; the reason for discharge or transfer; the name of the person receiving transfer report, date and time of report; the transfer of orders and instructions; the status of the patient at time of discharge .... " 2. An undated agency policy number 3.001.1, with a subject subtitled "Client Conduct, Responsibility and Rights" stated, "...The agency will advise you of changes, including the termination of services orally and in writing as soon as possible, but no later than fifteen (15) calendar days from the date that the agency becomes aware of a change. If an agency is changing /deleting /adding services or implementing a scheduled rate increase to all patients, the agency shall provide a written notice to each affected customer at least 30 days before implementation ... "	G 0598	G598 – Based on surveyor's concerns of the agency's failure to ensure discharge plans were communicated to the patient and the patient's physician. This deficiency cannot be corrected on inactive patients, however, EMR was updated to document the verbal notification given to patient's physician of discharge. The deficiency will be prevented from recurring by adhering to Policy 3.001.1 which states the agency will advise you (patient/physician) of changes, including the termination of services orally and in writing as soon as possible, but no later than 15 calendar days from the date the agency becomes aware of a change. In addition, such communication will be documented in EMR. At such time patient is notified, the physician will also be notified. The clinical manager is responsible to ensure the deficiencies have been corrected and that compliance is maintained.	04/16/2021

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	3. Clinical record review on 3/4/2021, for patient #6, start of care 6/21/2019, failed to evidence the patient was notified in writing of the discharge date on 3/16/2020. During an interview on 3/4/2021, at 11:24 AM, the clinical manager indicated patient #6 did not receive a discharge notice because the patient was difficult to get a hold of. They added the patient indicated wanting to go "somewhere warmer" and did not think to send a certified letter to the patient's home. 4. Clinical record review on 3/4/2021, for patient #9, start of care 10/30/2019, evidenced a letter to Person F, patient #9's caregiver, which was signed by the administrator and clinical manager on 7/29/2020. This letter stated "[Patient #7]'s physician, [Person G] has been made aware of the situation and will be updated when [his/her] services are transferred and discharged ... As a measure of good will, we will set your discharge date 30 days from the date of our conversation which will be August 24, 2020. ... " Record review failed to evidence the patient's physician was notified of the discharge on 8/24/2020. During an interview on 3/4/2021, at 12:41 PM, the clinical manager indicated physician notification of the patient's discharge was not documented in the clinical record.			
G 0606 Bldg. 00	484.60(d)(3) Integrate all services Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination			

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	of care provided by all disciplines. Based on observation, record review, interview, the home health agency failed ensure coordination of care provided by all disciplines who serviced their patients in 1 of 3 clinical records reviewed of patients receiving services from outside agencies out of a total sample of 10 clinical records reviewed. (#2) The findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled, "Coordination of Client Care", number 3.009.1, which stated, "Purpose: To ensure that all staff and agencies providing services to a client are engaged in effective interchange, reporting, and coordination of care regarding the client. Ensure that documentation in the patient's clinical record shows coordination of services. Policy: All service providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, reporting, and coordination of care regarding the client. All such coordination of care will be documented in the client record. Each client will be assessed upon admission as to identify any other agencies providing services to the client ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination including contracted health care professionals providing care ... The clinical record establishes that effective interchange, reporting, and coordination of patient care does occur through message documents, communication forms, and/or case conferences...." 2. During a home visit for patient #2 on 2/26/2021 at 9:30 a.m., the patient was observed to have a	G 0606	G606 - Pt#2 – updated plan of care to include the skilled nursing services the patient receives. The current case conference and 60-day summary dated 04-06-2021 has evidence that the patient has a Peg tube, foley catheter and wound vac. The summary includes the services shared with the skilled nursing service. All active medical records have been reviewed to ensure coordination of care with other disciplines in the home. All plan of cares will be updated, as appropriate, to include all agencies providing services. Patients have been advised to notify agency if/when additional services are provided by other agencies. The administrative staff will review the plan of cares quarterly for the coordination of care amongst the different disciplines/entities that provided care to agency patients. **Completion Date 4-16-2021**	04/16/2021

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	PEG tube [a feeding tube directly inserted to the stomach through the abdomen], a Foley catheter [a tube inserted to drain the bladder], and a Wound VAC [vacuum-assisted closure][a device used to assist wound healing]. During an interview on 2/26/2021 at 9:59 a.m., employee C, HHA [home health aide], indicated skilled nursing service from entity A managed the PEG tube, Foley catheter, and Wound VAC. Clinical record review on 3/2/2021 for patient #2, start of care 8/13/2020, certification period 12/11/2020 to 2/8/2021, primary diagnosis of Multiple Sclerosis, evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care was signed by the physician on 2/27/2021. The plan of care had a subcategory titled, "Orders and Treatments". This subcategory failed to include the PEG tube, Foley catheter, and Wound VAC. The plan of care failed to mentioned skilled nursing service from entity A. Clinical record review evidenced an agency document titled, "Case Conference and 60 Day Summary", dated 2/4/2021, signed by the clinical manager. This summary had a section titled, "Team Conference Reviewers", which listed person B, M.D., (medical doctor), the clinical manager, RN [registered nurse], employee J, HHA, employee C, HHA, and employee I, HHA. The summary failed to evidence the patient had a PEG tube, Foley catheter, and Wound VAC. The summary failed to evidence services shared with entity A. The summary stated, " ... Send to Physician [check-mark] Fax...." The agency failed to coordinate care with entity A. Review of the electronic medical record for patient			

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	#2 on 3/2/2021 failed to evidence any communication notes. During an interview on 3/4/2021 at 11:12 a.m., the clinical manager indicated care was coordinated via phone call or fax with the other agencies providing care. When informed of findings, the clinical manager indicated the agency did not document this communication. The agency failed to evidence any coordination of care with entity A for patient #2. 17-12-2(g)			
G 0614 Bldg. 00	484.60(e)(1) Visit schedule Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to ensure patients were provided a written schedule of visits in 3 of 3 home visits out of a total sample of 10 patient records reviewed (#2, #3, #7). The findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled, "Client Conduct, Responsibility and Rights", number 3.001.1, which stated, " ... the agency must inform a patient and/or patient representative orally and in writing of the following: ... 7. The nature and frequency of services to be delivered ... Patient Rights ... 17. Know when and how each service will be provided...." 2. During a home visit for patient #2 on 2/26/2021 at 9:55 a.m. failed to evidence a written schedule of visits from the agency.	G 0614	G614 - Patient #2, monthly schedule of services was mailed on 04/28/2021 for the month of May. Patient #3, monthly schedule was mailed on 04/28/2021 for the month of May. Patient #7, monthly schedule was mailed on 04/28/2021 for the month of May. Frequency of visits were reviewed, and all active patients have received a schedule of services for the month of May 2021. All active patients will receive by mail, the monthly schedule of services. To prevent this deficiency from recurring this practice will continue on a monthly	05/01/2021

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	3. During a home visit for patient #3 on 3/1/2021 at 12:00 p.m. failed to evidence a written schedule of visits from the agency. During an interview on 3/3/2021 at 3:55 p.m., the administrator indicated the agency failed to ensure patients received a written schedule of visits from the agency.4. During a home visit for patient #7 on 2/26/2021, failed to evidence a written schedule of visits from the agency.		basis. The scheduler is responsible to ensure the patients are provided a written schedule of visits from the agency. This will be added as a component of the quality improvement program. Completion Date 5-01-2021	
G 0616 Bldg. 00	484.60(e)(2) Patient medication schedule/instructions 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. Based on observation and interview, the agency failed to ensure patients were provided a current written patient medication list in 3 of 3 home visits conducted (#2, #3, #7). The findings include: 1. During a home visit for patient #2 on 2/26/2021 at 9:55 a.m., failed to evidence a current patient medication list provided by the agency. During an interview on 2/26/2021 at 11:08, person C, caregiver to patient #2, indicated the agency did not provide her a current patient medication list. 2. During a home visit for patient #3 on 3/1/2021 at 12:00 p.m., failed to evidence a current patient medication list provided by the agency. During an interview on 3/3/2021 at 4:02 p.m., the	G 0616	**G616 -** Patient #2, a current written medication list will be provided on 05/14/2021. Patient #3, a current written medication list will be provided on 05/14/2021. Patient #7, a current written medication list will be provided on 05/14/2021. Reviewed all active patients' current written medication list. All patients will receive a copy on 05/14/2021. The deficiency will be prevented from recurring by providing a current written medication list at the beginning of each episode following a resumption of care and anytime a change in medication is	05/15/2021

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	clinical manager indicated a medication list was part of the patient's home folder. When informed of the findings, the clinical manager stated, "OK". 3. During an home visit for patient #7 on 2/26/2021, failed to evidence a current medication list was provided by the agency.		reported. The Clinical Manager will be responsible for providing a current written medication list to patient at the start of each episode and with any medication changes. This will be added as a component of the quality improvement program. Completion Date 5-15-2021	
G 0768 Bldg. 00	484.80(c)(1)(2)(3) Competency evaluation Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in			

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	consultation with other skilled professionals, as appropriate. Based on record review and interview, the agency failed to ensure each home health aide (HHA) completed a competency evaluation prior to furnishing home health services for 1 of 4 HHA's, in a total sample of 8 personnel records reviewed. (employee H) The findings include: 1. An undated agency policy, number 2.009.1, with a subject subtitled "Competency Evaluations" stated, "Purpose: To assess competency of all field staff ... Policy: Newly hired and experienced field staff must demonstrate competency within the job description that applies to that staff member, prior to be permitted direct contact with patients... Testing may be used to assess competencies. Skills checklist may also be used in conjunction with testing ... Procedure: 1. All field staff must be evaluated for competency with relation to their job description prior to receiving patient assignments and prior to performing new tasks ... 2. Written tests are one method of evaluation it may be used in coordination with skills checklists ... 5. ... Competency will be determined prior to allowing the aid to work in dependently. Proof of competency will be kept in the employee's personnel file ... The minimum competency required for each job will be evaluated and a competency test given. This will be documented in the employee personnel file .... " 2. Personnel record review on 3/3/2021, for HHA H evidenced a first patient contact date of 4/9/2021. Record review failed to evidence HHA H completed a competency evaluation prior to patient contact.	G 0768	G768 - Employee H - This deficiency has been corrected by properly documenting and filing in employee file, the competency that was completed prior to the home health aide furnishing services. 100% of active employee records were reviewed to ensure that a completed competency evaluation was done prior to furnishing home health services. To prevent the deficiency from recurring, quarterly chart audits of employees' files will be completed to verify HHAs' competency forms are documented accordingly. A quarterly review of employee files by the Administrator will ensure this deficiency will not recur. This will be added as a component of the quality improvement program. Completion Date 04-16-2021	04/16/2021

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	During an interview on 3/3/2021, at 3:44 PM, the clinical manager indicated there was no explanation for why the competency exam was not in HHA H's personnel file. 17-14-1(l)(A)			
G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the registered nurse provided a complete care plan for the home health aide [HHA] in 3 out of a total sample of 10 clinical records reviewed (#2, #3, #6). The findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled, "Registered Nurse", number 6.020.2, which stated, " ... The RN [registered nurse] will make home health aide assignments, prepare written instructions for the aide, and supervise the aide in the home...." 2. Clinical record review on 3/2/2021 for patient #2, start of care 8/13/2020, certification period 12/11/2020 to 2/8/2021, primary diagnosis of Multiple Sclerosis, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on	G 0798	G798 - Based on surveyor's concerns of the agency's failure to ensure the registered nurse provided a complete care plan for the home health aide. The deficiency has been corrected by providing an updated/complete care plan for the Home Health Aide to include but not limited to safety measures, bleeding precautions, instructions for the aide not to use the Peg tube, aspiration precautions, to use extra caution when bathing any patient with wound dressing(s)/wound vac, to use extra precaution when turning or moving and to use proper positioning with any patients who have these devices or take anti-coagulant medication.	04/16/2021

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	2/27/2021. This plan of care evidenced a subcategory titled, "Medications". This subcategory stated, "Apixaban [a blood thinner] Oral 5 mg [milligram] 1 tab (s) Take one tablet by mouth two times daily ... Aspirin [a pain and fever reducer and blood thinner] Oral 81 mg 1 tab (s) Take one tablet by mouth daily...." Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 12/11/2020 and signed by the clinical manager. This care plan failed to evidence Bleeding Precautions. During an interview on 3/4/2021 at 11:00 a.m., the clinical manager indicated Bleeding Precautions should be included in the Aide Care Plan for a patient taking blood thinners. During a home visit for patient #2 on 2/26/2021 at 9:30 a.m., the patient was observed to have a PEG tube [a feeding tube directly inserted to the stomach through the abdomen], and a Wound VAC [vacuum-assisted closure][a device used to assist wound healing]. Review of the Aide Care Plan failed to evidence any HHA duties related to the PEG tube and Wound VAC. During an interview on 3/4/2021 at 11:05 a.m., the clinical manager indicated the Aide Care Plan for a patient with a PEG tube and a Wound VAC should include instruction for the aide not to use the PEG tube, to follow aspiration precautions, to use extra caution when turning or moving the patient, and proper positioning with these devices. The clinical manager indicated she failed to include these instructions in the Aide Care Plan.		Changes to aide care plans were reviewed and discussed with each patient/ caregiver; each patient/ caregiver verbalized an understanding and in agreement. All aide care plans dated and/or generated on or after 04/16/2021 will be reviewed by two clinicians for patient specifics. All skilled staff who create aide care plans have been in-serviced on the importance of individualized care plans to include any and all safety precautions. A review of all aide care plans was completed by 04/16/2021. The deficiency will be prevented from recurring by including these safety measures on all home health aide care plans as appropriate to patient condition. Additionally, quarterly patient chart audits will be completed to verify aide care plans are individualized and include any and all safety precautions that are appropriate. The clinical manager is responsible to ensure that compliance is maintained.	

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	3. Clinical record review on 3/2/2021 for patient #3, start of care 2/17/2020, certification period 1/12/2021 to 3/2/2021, primary diagnosis of chronic obstructive pulmonary disease [a disease that causes long-term breathing problems], evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care had a subcategory titled "Medications", which stated, " ... Eliquis [a blood thinner] Oral 2.5 mg [milligram] 1 tab(s) Take one tablet by mouth twice a day...." Clinical record review evidenced an agency document titled, "Aide Care Plan", dated 1/2/2021 and signed by the clinical manager. This care plan failed to evidence Bleeding Precautions. During an interview on 3/4/2021 at 11:00 a.m., the clinical manager indicated Bleeding Precautions should be included in the Aide Care Plan for a patient taking blood thinners. Review of the plan of care evidenced a subcategory titled "Patient Risk Profile", which stated, "Risk Factors: History of falls (2 or more falls - or any fall with an injury - in the past 12 months)...." The plan of care also contained a subcategory titled, "Safety Measures", which stated, "Keep Pathway Clear ... Slow Position Change ... Support During Transfer and Ambulation ... Safety in ADLs [activities of daily living] ... Fall Precautions...." Review of the Aide Care Plan failed to evidence fall prevention or safety precautions. When informed of the findings on 3/4/2021 at 11:55 a.m., the clinical manager stated, "OK", and offered no further documentation. 4. Clinical record review on 3/4/2021, for patient			

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	#6, start of care 6/21/2019, failed to evidence a home health aide care plan had been established by the supervising nurse for certification period 2/16/2020 - 4/15/2020. During an interview on 3/4/2021, at 11:23 AM, the clinical manager indicated the lack of the patient's home health aide care plan was an oversight which was probably due to the patient being admitted during the agency's administrative change. 17-14-1(m)			
G 0814 Bldg. 00	484.80(h)(2) Non-skilled direct observation every 60 days If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. Based on record review and interview, the agency failed to ensure an on-site home health aide (HHA) supervision was conducted at least every 60 days for 2 of 10 clinical records reviewed. (#7, #5) The findings include: 1. An undated agency policy, number 6.020.1, with a subject 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 ... 7. Home health aides will be supervised at least	G 0814	G814 – Pt.#7 – The completed home health aide supervisory visits were documented in the EMR. Pt.#5 – The completed home health aide supervisory visits were documented in the EMR. All active patient medical records were reviewed to ensure an onsite home health aide supervision visit was conducted at least every 30 days for non-skilled care. The deficiency will be prevented	04/16/2021

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	every 30 days by a RN [registered nurse] for non-skilled care .... " 2. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 1/14/2021 - 3/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 2 hrs [hours] per day, 7 days a week for 26 weeks .... " Record review failed to evidence HHA supervisory visits were completed as required, dating back to 11/15/2020. During an interview on 3/4/2021, at 11:41 AM, the clinical manager indicated the HHA supervisory visits were not in the documented clinical record.3. Clinical record review for patient #5 with start of care 8/31/2020, certification period 12/29/2021 to 1/29/2021, primary diagnosis of legal blindness, evidenced an agency document titled, "Home Health Certification and Plan of Care". This plan of care had a subcategory titled, "Orders and Treatments" which stated, " ... Home Health Aide requesting to provide 6 (up to 12) hours a day, 5 days a week; based on patient need/request...." Review of patient #5's electronic medical record from start of care (8/31/2020) to discharge (1/29/2021), failed to evidence any home health aide supervisory visits completed. During an interview on 3/4/2021 at 12:25 p.m., the clinical manager indicated home health aide supervisory visits should have been done every 30 days for patient #5.		from recurring by ensuring that supervisory visits are conducted and properly documented in the patient's EMR every 30 days for non-skilled car. The administrative staff will review all supervisory visits quarterly to ensure 100% compliance is maintained. Completion date 04-16-2021	

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G 0818 Bldg. 00	484.80(h)(4)(i-vi) HH aide supervision elements Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (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. Based on observation, record review and interview, the agency failed to ensure each home health aide (HHA) followed the care plan as assigned in 4 of 10 clinical records reviewed. (#7, #8, #10, #5) The findings include: 1. An undated agency policy, number 6.021.1, with a subject titled "Home Health Aide" 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. Home Health Aide Training... c. A home health aide is assigned to a particular patient by a registered nurse ... d. Written	G 0818	G818 – This deficiency has been corrected by reviewing with staff the importance of following each individualized care plan. Pt.# 7 the primary aide was verbally counseled on documentation of temperature and last bowel movement and the importance of following each individualized care plan. Pt.#8 the primary aide was verbally counseled on documenting and the importance of following each individualized care plan. Pt.#10 the primary aide was verbally counseled on documenting and the importance of following each individualized care plan.	04/16/2021

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	instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. Aide instructions are written in relation to the patient's plan of care and within the duties allowed to be permitted by a nurse aide.... " 2. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced documents titled "Home Health Certification and Plan of Care" for certification periods 11/15/2020 - 1/13/2021, and 1/14/2021 - 3/14/2021. These documents had an area subtitled "Orders and Treatments" which stated, "Home health aide duties may include but are not limited to: personal hygiene care, bathing, dressing, turning/positioning, assistance with wound prevention, incontinent care, checking integumentary [skin] status, and light housekeeping .... " Record review evidenced agency documents titled "Aide Care Plan" for the periods 11/15/2020 - 1/13/2021, and 1/14/2021 - 3/14/2021. These documents stated "Elimination ... Record bowel movement ... per visit ... Additional Comment ... Home health aides are to check temperature per visit during Covid-19 pandemic and report if not WNL [within normal limits] .... " Record review of the agency documents titled "HHA Visit" failed to evidence the patient's temperature was documented on the following dates: 12/9/2020, 12/11/2020, 12/14/2020, 12/16/2020, 12/18/2020, 12/21/2020, 12/23/2020, 12/25/2020, 12/28/2020, 12/30/2020, 1/1/2021, 1/18/2021, 1/20/2021, 1/22/2021, 1/25/2021, 1/27/2021, 1/29/2021, 2/1/2021, 2/3/2021, 2/5/2021, 2/8/2021, 2/10/2021, 2/11/2021, 2/17/2021, 2/19/2021, 2/22/2021, 2/24/2021, 2/26/2021, and		Pt.#5 the primary aide was verbally counseled on documenting and the importance of following each individualized care plan. All active patient medical records were reviewed to ensure that the home health aide followed the individualized care plan. This deficiency will be prevented from recurring by timely case management and repetitive review of such elements to include, but not limited to, prescribed exercises, elimination, linen change, last bowel movement and temperature. The Administrator will be responsible by timely case managing. to ensure the care plans are followed accurately. A quarterly chart review will be performed to ensure 100% compliance. **Completion Date 04/16/2021**	

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	3/1/2021. Record review of the agency documents titled "HHA Visit" failed to evidence the patient's last bowel movement was documented on the following dates: 11/23/2020, 11/24/2020, 11/25/2020, 11/30/2020, 12/6/2020, 12/18/2020, 12/21/2020, 12/23/2020, 12/25/2020, 12/28/2020, 12/30/2020, 1/1/2021, 1/18/2021, 1/20/2021, 1/22/2021, 1/25/2021, 1/27/2021, 1/29/2021, 2/1/2021, 2/3/2021, 2/5/2021, 2/8/2021, 2/10/2021, 2/11/2021, 2/17/2021, 2/19/2021, 2/22/2021, 2/24/2021, 2/26/2021, and 3/1/2021. During an interview on 3/4/2021, at 11:37 AM, the clinical manager and administrator were informed of the dates and tasks that not documented on the HHA Visit notes. The clinical manager replied, "Okay." 3. Clinical record review on 3/4/2021, for patient #8, start of care 6/10/2019, primary diagnosis of hemiplegia [weakness or paralysis on one side of the body], evidenced a document titled "Home Health Certification and Plan of Care" for certification period 12/1/2020 - 1/292021. This document had an area subtitled "Orders and Treatments" which stated, "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 [urinary catheter] care, ostomy [colostomy, surgical opening in the abdominal wall to bypass a damaged part of the colon] care, checking integumentary status, medication assistance and reminders, meal preparations, and light housekeeping .... " Record review evidenced an agency document titled "Aide Care Plan" for the period 12/1/2020 -			

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	1/29/2021. This document stated "Elimination ... Catheter Care ... per visit ... Empty Ostomy Bag ... per visit ... Activity ... Assist in Transfer ... per visit ... Turn or Position ... per visit ... Household ... Change Linen ... Wednesday visit and when soiled ... Light Housekeeping ... per visit ... Make Bed ... per visit ... Personal Care ... Check Pressure Areas ... per visit ... Oral Hygiene Denture Care ... per visit assist .... " Record review of the agency documents titled "HHA Visit" failed to evidence the patient's colostomy was emptied and documented on the following dates: 12/5/2020, 12/6/2020, 12/9/2020, 12/10/2020, 12/13/2020, 12/17/2020, 12/30/2020, 12/25/2020, 12/28/2020, 12/30/2020, and 1/5/2021. Record review of the agency documents titled "HHA Visit" failed to evidence the patient's bed was made on the following dates: 12/3/2021, 12/4/2021, 12/5/2020, 12/6/2020, 12/7/2021, 12/8/2021, 12/9/2020, 12/10/2020, 12/11/2021, 12/12/2021, 12/15/2020, 12/16/2020, 12/17/2020, 12/18/2020, 12/19/2020, 12/20/2020, 12/21/2020, 12/22/2020, 12/23/2020, 12/23/2020, 12/24/2020, 12/25/2020, 12/26/2021, 12/27/2020, 12/29/2020, 1/1/2021, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/7/2021, 1/8/2021, 1/9/2021, 1/10/2021, 1/12/2021, 1/13/2021, 1/14/2021, 1/16/2021, 1/17/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/23/2021, 1/24/2021, 1/26/2021, 1/27/2021, and 1/29/2021. Record review of the agency documents titled "HHA Visit" failed to evidence the patient received catheter care on the following dates: 12/11/2021, 12/17/2020, 12/22/2020, 12/27/2020, 1/21/2021, and 1/27/2021. Record review of the agency documents titled			

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	"HHA Visit" failed to evidence the patient's linens were changed on the following Wednesdays: 12/23/2021, 12/30/2020, 1/6/2021, 1/13/2021, and 1/20/2021. Record review of an agency document titled "HHA Visit" from 12/22/2020, which was digitally signed by HHA L. This document failed to evidence denture care and pressure ulcer check was performed. Record review of an agency document titled "HHA Visit" from 1/21/2021, which was digitally signed by HHA L. This document failed to evidence light housekeeping, assist with transfers, and turns/reposition was performed. During an interview on 3/4/2021, at 11:46 AM, the administrator and clinical manager were informed of the dates and tasks that were not documented on the HHA careplan. The clinical manager stated, "Thank you" in response. 4. Clinical record review on 3/4/2021, for patient #10, start of care 2/26/2019, primary diagnosis of progressive mutifocal leukoenchalopathy (disease of the white matter of the brain), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 12/17/2020 - 2/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide duties may include but are not limited to: personal hygiene care, bathing/showering, assisting with ambulation, assisting with transfers, turning/positioning, assistance with wound prevention, incontinent care, checking integumentary status, medication assistance and reminders, meal preparations and light housekeeping .... "			

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	Record review evidenced an agency document titled "Aide Care Plan" for the period 12/17/2020 - 2/14/2014, which stated "Additional Comment ... Home health aides are to check temperature per visit during Covid-19 pandemic and report if not WNL .... " Record review of the agency documents titled "HHA Visit" failed to evidence the patient's temperature was documented on the following dates: 12/17/2020, 12/19/2020, 12/21/2020, 12/22/2020, 12/25/2020, 12/26/2020, 12/28/2020, 12/30/2020, 12/31/2020, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/7/2021, 1/8/2021, 1/9/2021, 1/10/2021, 1/11/2021, 1/12/2021, 1/13/2021, 1/14/2021, 1/15/2021, 1/16/2021, 1/17/2021, 1/18/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/22/2021, 1/23/2021, 1/24/2021, 1/25/2021, 1/26/2021, 1/27/2021, 1/28/2021, 1/29/2021, 1/30/2021, 1/31/2021, 2/1/2021, 2/2/2021, 2/3/2021, 2/4/2021, 2/5/2021, 2/6/2021, 2/7/2021, 2/8/2021, 2/9/2021,2/10/2021, 2/11/2021, 2/12/2021, 2/13/2021, and 2/14/2021. On 3/4/2021, at 1:06 PM, the administrator and clinical manager were notified of dates the patient's temperature was not evidenced in the clinical record. 5. Clinical record review for patient #5 with start of care 8/31/2020, certification period 12/29/2021 to 1/29/2021, primary diagnosis of legal blindness, evidenced an agency document titled, "Aide Care Plan", dated 12/29/2020 and signed by the clinical manager. This document had a subcategory titled "Additional Comment", which stated, " ... Home Health Aide to assist patient with reminders to complete prescribed neck exercises ... patients temperature should be taken before starting care during Covid-19 pandemic...." Clinical record review evidenced a group of			

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	agency documents titled "HHA [home health aide] Visit". Review of the HHA visit notes from the following dates failed to evidence patient reminders to complete prescribed neck exercises: 12/29/2020, 12/30/2020, 12/31/2020, 1/4/2021, 1/10/2021, 1/11/2021, 1/13/2021, 1/15/2021, 1/18/2021, 1/19/2021, 1/22/2021, 1/25/2021, 1/26/2021, and 1/28/2021. Review of the HHA visit notes from the following dates failed to evidence a patient temperature: 12/29/2020, 12/30/2020, 12/31/2020, 1/4/2021, 1/11/2021, 1/14/2021, 1/18/2021, 1/19/2021, 1/25/2021. During an interview on 3/4/2021 at 12:26 p.m., the clinical manager indicated the patient's temperature should be recorded daily on each HHA visit note. Review of the HHA visit notes from 1/10/2021, 1/15/2021, 1/25/2021 and 1/28/2021, signed by employee M, HHA, failed to evidence completion of any assigned tasks. When informed of the findings, the clinical manager reviewed the note from 1/28/2021 and stated, "That is an incorrect note". 17-14-1(n)			
G 1024 Bldg. 00	484.110(b) Authentication 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.			

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	Based on record review and interview, the agency failed to ensure all clinical record entries were legible, clear, complete, and appropriately authenticated in 5 out of 10 total patient records reviewed (#1, #2, #3, #7, #9) The findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled, "Timeliness and Accuracy of Entries in the Clinical Record", number 4.003.1. This policy stated, "Purpose: To ensure that a current and accurate clinical record exists for each patient and to ensure documents are filed in the client's records in a timely manner. Policy: Each entry into the client record must be current, accurate, signed, legible, and dated with the date of entry by the individual making the entry. Documents must be filed into the client record timely and according to regulations and retrievable during operating hours. Procedure: 1. Complete clinical progress notes on the date service is rendered. Progress notes are to be recorded in Kinnser/WellSky Software [electronic medical record] no later than 14 days from the completion of the visit...." 2. Clinical record review on 3/2/2021 of the electronic medical record for patient #1, start of care 12/26/2013, certification period 1/18/2021 to 3/18/2021, primary diagnosis of quadriplegia [paralysis from the neck down], evidenced a calendar of visits. This calendar indicated the skilled nurse visits on the following dates were not yet started: 1/31/2021, 2/2/2021, 2/4/2021, 2/6/2021, 2/8/2021, 2/10/2021, 2/12/2021 and 2/14/2021. During an interview on 2/25/2021 at 11:54 a.m., the clinical manager indicated staff had 48 hours to	G 1024	G1024 - Pt.#1, The skilled nurse visits are documented in the EMR. Pt.#2, the administrative staff was educated on proper documentation for missed visits. Pt.#3, the administrative staff was educated on proper documentation for missed visits. Pt.#7, the administrative staff was educated on proper documentation for missed visits. Pt.#9, the administrative staff was educated on proper documentation for missed visits. The administrator in-serviced staff to ensure all clinical record entries were legible, clear, complete, and appropriately authenticated. The deficiency will be prevented from recurring by timely case management ensuring all clinical record entries are documented within 14 days of completed visit for accuracy and appropriateness of documentation. The Administrator will be responsible for timely case managing to ensure all clinical record entries are documented within 14 days of completed visit. Completion Date 04/16/2021	04/16/2021

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	enter documentation following a patient visit. During an interview on 3/4/2021 at at 10:44, the clinical manager indicated the skilled nurse visits were made on 1/31/2021, 2/2/2021, 2/4/2021, 2/6/2021, 2/8/2021, 2/10/2021, 2/12/2021 and 2/14/2021, but the nurse had not submitted documentation. Clinical record review evidenced a group of documents titled, "LPN [licensed practical nurse] / LVN [licensed vocational nurse] - Skilled Nursing Visit". The visit notes dated 1/19/2021, 1/21/2021, 1/31/2021, 2/2/2021, 2/6/2021, 2/8/2021, 2/10/2021, 2/16/2021, and 2/20/2021, signed by employee, F, LPN, contained a document titled, "Wound Care Worksheet". The area titled, "Comments", of this worksheet stated, " ... Ointment applied to coccyx [tailbone] area." The documentation failed to indicate what ointment the nurse applied. Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 3/2/2021. This plan of care had a subcategory titled, "Medications" which stated, " ... Desitin Maximum Strength External 40% thin layer Apply thin layer to affected area PRN [as needed] ... Bacitracin External [a topical antibiotic ointment] 500 unit / gm [gram] 1 apply to affected area as needed (SN to administer PRN) ... Santyl External [an ointment to help heal wounds] 250 unit / gm 1ml daily PRN (SN to administer PRN)...." During an interview on 3/4/2021 at 10:52 p.m., when informed of the findings, the clinical manager stated about the nurse's documentation, "we don't know what she used". The clinical manager indicated the skilled nurse should have documented specifically which topical medication			

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	was applied to the patient. 3. Clinical record review on 3/2/2021 for patient #2, start of care 8/13/2020, certification period 12/11/2020 to 2/8/2021, primary diagnosis of Multiple Sclerosis, evidenced a group of agency documents titled, "Missed Visit Form". A missed visit form dated 12/31/2020, signed by employee C, HHA [home health aide], stated, " ... Reason: Other (Specify) Comments: Approved day off...." The note failed to evidence a reason why the visit was missed. When informed of the findings, the clinical manager stated, "That's totally inappropriate". Missed visit notes dated 1/16/2021 and 1/30/2021 both stated, " ... Reason: Cancellation of Care...." During an interview on 3/4/2021 at 11:10 a.m., the clinical manager indicated all missed visit notes should include a reason for why the visit was missed. When informed of the findings, the clinical manager indicated the statement, "Cancellation of Care", failed to indicate who canceled the care and for what reason. 4. Clinical record review on 3/2/2021 for patient #3, start of care 2/17/2020, certification period 1/12/2021 to 3/2/2021, primary diagnosis of chronic obstructive pulmonary disease [a disease that causes long-term breathing problems], evidenced an agency document titled, "Missed Visit Form", dated 1/26/2021, signed by employee K, HHA [home health aide]. This form stated, " ... Reason: Cancellation of Care ... MD [medical doctor] Notified: Yes, by Phone. Physician: [person E, MD]...." Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", dated 12/28/2020 and signed by the			

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	clinical manager. This document had a subcategory titled, "Clinical Data" which stated, "Primary Physician [person B, MD]". During an interview on 3/4/2021 at 11:50 a.m., the clinical manager indicated person E was not the primary physician of patient #2. The clinical manager stated, "They [the HHA's] shouldn't be calling the doctor. It shouldn't even say that." When informed of the findings, the clinical manager indicated the statement, "Cancellation of Care", failed to indicate who canceled the care and for what reason. 5. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 11/15/2020 - 1/13/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 2 hrs [hours] per day, 7 days a week for 26 weeks ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced an agency document titled "Missed Visit Form (HHA Visit)" which was digitally signed by HHA H, on 11/24/2020. This document stated "Traveled to Patient: No ... Reason: Other (Specify) ... Comments: ... [left blank] ... MD [doctor of medicine] Notified: No ... Supervisor Notified: Yes, by Fax ...." Record review failed to evidence who canceled the patients care or an indication why. 6. Clinical record review on 3/4/2021, for patient #9, start of care 10/30/2019, primary diagnosis of encephalopathy (disease which alters brain function), evidenced a document titled "Home Health Certification and Plan of Care" for			

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	certification period 6/26/2020 - 8/24/2020. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 10 hours a day, up to 7 days a week for 26 weeks ... Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist .... " Record review evidenced agency documents titled, "Missed Visit Form (HHA Visit)" digitally signed by HHA O, from the following dates: 7/2/2020, 8/5/2020, and 8/12/2020. These documents stated "Traveled to Patient: No ... Reason: Cancellation of Care ... Comments: ... [left blank] ... MD Notified: No ... Supervisor Notified: No .... " Record review failed to evidence who canceled the patients care or an indication why. 17-15-1(a)(7)			
N 0000 Bldg. 00	This visit was a complaint survey with 3 complaints. The survey visit took place 2/25/2021 to 3/4/2021. Complaints: IN00315216 - substantiated with related findings IN00332220 - substantiated with related findings IN00320943 - substantiated with related findings Facility ID: 012829	N 0000		
N 0447 Bldg. 00	410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or			

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	registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on observation, record review, and interview, the administrator failed to ensure accuracy of public information for the home health agency. The findings include: 1. Record review on 3/2/2021 evidenced an agency policy titled, "Public Disclosure", number 1.020.1, which stated, " ... The following information, if known, shall be disclosed to members of the public ... Services Offered ... All documents must accurately represent the agency and its services offered." 2. Review of the agency's admission packet on 3/4/2021 evidenced a document titled, "Admission Criteria", which stated, " ... Our services include the following: Skilled Nursing Home Health Aide Physical Therapy Occupational Therapy Speech Therapy...." 3. Review of the website www.noble4care.com, identified by the clinical manager as the agency's public website, stated, " ... THERAPY SERVICES OFFERED Physical Therapy Occupational Therapy Speech Therapy...." 4. During an interview on 2/25/2021 at 11:45 a.m., the clinical manager indicated the agency provided only skilled nursing and home health aide services, no therapies. 5. On 3/3/2021 at 4:22 p.m., when informed of the findings, the clinical manager stated, "That needs to be updated".	N 0447	br="">N-0447 - Agency's New Admission Packet has been updated. PT ST OT have been removed from admission packet materials. Website --PT ST OT have been removed from Website. Office hours have been updated in all public documents to reflect hours of operation as Monday – Fri 10am to 5pm. The hours of operation has been corrected on the agency's front door to reflect 10am to 5pm All current patients will receive an updated Admission Criteria document that reflects the services offered and hours of operation Public information materials and activities will be a component for review at the agency's annual evaluation. The Administrator will be responsible to ensure this deficiency will not recur. Completion date 04-16-2021 ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	04/16/2021

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	157650	A. BUILDING 00 B. WING	03/04/2021

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	6. Record review evidenced an agency policy titled, "Hours of Operation", number 1.005.1, which stated, " ... The office will be open to the public and staff 10:00 am till 5:00 pm Monday through Friday." 7. On 2/25/2021 at 11:30 a.m., a sign was observed outside of the agency's front door which stated, " ... Office Hours 8:30 a.m.- 5:00 p.m. ...." 8. During an interview on 2/25/2021 at 11:45 a.m., the clinical manager indicated the office hours were 10:00 a.m. to 5:00 p.m. 9. On 3/3/2021 at 3:30 p.m., when informed of the findings, the clinical manager indicated the hours listed on the sign were incorrect.		=""> p=""> =""> b=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> b="">	
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.	N 0458	N0458- Based on surveyor's	04/16/2021

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	Based on record review and interview, the administrator failed to ensure all personnel files were kept current to include documentation of job description, criminal history check, current license, and annual evaluations in 3 of 8 personnel records reviewed. (employee A, D, G) The findings include: 1. An undated agency policy, number 2.002.1, with a subject titled "Personnel Records" stated, "Purpose: To ensure a standard method for maintaining employee records ... Policy: A separate file for each employee will be maintained. Personnel records are confidential. They are available for inspection by federal and state regulatory agencies ... Following are the procedures used in the management of personnel files and confidential personnel records ... Each file shall contain, at a minimum, copies of items listed on the following page [document listed below], gathered upon hire ... Items with expiration dates are reviewed periodically prior to assigning a patient to an employee. If an item is required, it must be reviewed before the patients are assigned to that employee ... A separate second personnel record for each employee with sensitive data shall include, but not be limited to: ... a. National Criminal History and related documents .... " 2. An undated, agency document titled "Personnel Records" stated, "Personnel Records include at least the following: ... k. Job description ... bb. Professional license ... cc. Verification of Professional license ... ee. Performance Evaluations ... ff. Criminal History Results .... " 3. An undated agency policy, number 2.013.1, with a subject titled "Performance Evaluation" stated,		findings, and the nature of the deficiency being in the past, we could not correct the deficiency of a criminal background check being performed prior to the home health's first patient contact. However, the balance of the surveyor's concern have been addressed; Administrator, Supervising Nurse, LPN, and HHA employee records now have the required job description, criminal history check, current license and annual performance evaluations. To prevent deficiency from recurring, prior to patient contact, all employees will have a signed job description, criminal history check and current license in their employee file. All new hire folders will be checked by Clinical Manager prior to patient contact for accuracy and completion of all required documents. Annual performance reviews will be immediately placed in employee files. Administrator will maintain compliance by auditing 20% of active employee files quarterly. Completion date 04-16-2021	

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	"Purpose: To provide for annual in periodic evaluation of an employee's production/performance ... Policy: The written performance of each employee shall be performed on at least an annual basis, by a qualified staff member ... Procedure: 1. Evaluations are performed by the person(s) who supervise the employee and should be signed by the person completing the evaluation ... 6. An evaluation is completed at the end of the first year of employment and annually ... 11. A copy of the evaluation signed by the employee is placed in the personnel file .... " 4. Personnel record review on 3/3/2021, for employee A, the administrator, evidenced a start date of 12/13/2019. Record review failed to evidence receipt of the required job description, criminal background check, and an annual performance evaluation. During an interview on 3/3/2021, at 3:50 PM, the administrator indicated they could not find their performance evaluation, but remembered it had been completed in April 2020. 5. Personnel record review on 3/3/2021, for home health aide (HHA) D, evidenced a first patient contact date of 3/26/19. Record review evidenced the criminal background check was conducted on 3/28/2019. Record review failed to evidence a criminal background check was completed prior to HHA D's first patient contact. 6. Personnel record review on 3/3/2021, for licensed practical nurse (LPN) G, evidenced a first patient contact date of 4/9/2019. Record review evidenced a document printed from the in.gov website that stated, "Licence Information ... Expiration: 10/31/2020 .... " Record review failed to			

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	evidence documentation of LPN G's current license information. On 3/3/2021, at 3:41 PM, the administrator and clinical manager offered no explanation for the missing items in HHA D and LPN G's personnel file.			
N 0460 Bldg. 00	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on record review and interview, the administrator failed to ensure the personnel file for the supervising nurse was kept current to include an annual performance evaluation. (employee B) The findings include: 1. An undated agency policy, number 2.002.1, with a subject titled "Personnel Records" stated, "Purpose: To ensure a standard method for maintaining employee records ... Policy: A separate file for each employee will be maintained. Personnel records are confidential. They are available for inspection by federal and state regulatory agencies ... Following are the	N 0460	br="">N0460 – Based on surveyor's concerns regarding Supervising Nurse's annual performance reviews, both current and past performance evaluations are in employee files. br="">This deficiency will be prevented by immediately filing Annual Performance Reviews in employee file. br="">Administrator will maintain compliance by auditing 20% of active employee files quarterly. br="">
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	procedures used in the management of personnel files and confidential personnel records ... Each file shall contain, at a minimum, copies of items listed on the following page [document listed below], gathered upon hire ... Items with expiration dates are reviewed periodically prior to assigning a patient to an employee. If an item is required, it must be reviewed before the patients are assigned to that employee .... " 2. An undated, agency document titled "Personnel Records" stated, "Personnel Records include at least the following: ... ee. Performance Evaluations .... " 3. An undated agency policy, number 2.013.1, with a subject titled "Performance Evaluation" stated, "Purpose: To provide for annual in periodic evaluation of an employee's production/performance ... Policy: The written performance of each employee shall be performed on at least an annual basis, by a qualified staff member ... Procedure: 1. Evaluations are performed by the person(s) who supervise the employee and should be signed by the person completing the evaluation ... 6. An evaluation is completed at the end of the first year of employment and annually ... 11. A copy of the evaluation signed by the employee is placed in the personnel file .... " 4. Personnel record review on 3/3/2021, for employee B, the clinical manager, evidenced a start date of 5/30/2018. Record review failed to evidence documentation of an annual performance evaluation for the clinical manager for 2020. During an interview on 3/3/2021, at 3:50 PM, the administrator indicated the performance		=”” span=””> =”” spanpast=”” annual=”” performance=”” reviews=”” have=”” been=”” filed=”” in=”” the=”” employee=”” charts. <=”” span=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” spanpast=”” annual=”” performance=”” reviews=”” have=”” been=”” filed=”” in=”” the=”” employee=”” charts.<=”” p=””> =”” span=””> =”” p=””> =”” span=””> =”” p=””> =”” p=””> =”” span=””> =”” p=””> =”” span=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””	

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	evaluation was conducted in April 2020, but was unable to locate it. The clinical manager added his/her copy of the performance evaluation is probably at home.			
N 0490 Bldg. 00	410 IAC 17-12-2(k) Q A and performance improvement Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the five (5) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Based on record review and interview, the agency failed to ensure home health services were provided, in good faith, and documented during the last 15 calendar day period prior to discharge in 1 of 3 discharged patients, in a total sample of 8 clinical records reviewed. (#9) The findings include: 1. An undated agency policy number 3.001.1, with a subject subtitled "Client Conduct, Responsibility and Rights" stated, "The agency will advise you of changes, including the termination of services orally and in writing as soon as possible, but no later than fifteen (15) calendar days from the date that the agency becomes aware of a change. If an agency is changing /deleting /adding services or implementing a scheduled rate increase to all patients, the agency shall provide a written notice to each affected customer at least 30 days before implementation ... " 2. Clinical record review on 3/4/2021, for patient #9, start of care 10/30/2019, primary diagnosis of	N 0490	N0490 Patient #9 has been discharged from this agency and assisted with transferring to another agency that could provide the needed hours of service. The administrative staff will document missed visits, rather than the home health aide. The agency's policy regarding documenting missed visits has been updated. To prevent a lapse of service prior to 15-day calendar period prior to discharge. An LPN/RN will be assigned to perform the duties of a home health aide if a home health aide is not available. The physician will be consulted re inability to provide services. The patient and caregiver will be notified by registered mail when the agency is unable to provide services as needed.	04/16/2021

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	encephalopathy [disease which alters brain function], evidenced a document titled "Home Health Certification and Plan of Care" for certification period 6/26/2020 - 8/24/2020. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 10 hours a day, up to 7 days a week for 26 weeks .... " Record review evidenced a letter to Person F, patient #9's caregiver, which was signed by the administrator and clinical manager on 7/29/2020. This letter stated "[Patient #7]'s physician, [Person G] has been made aware of the situation and will be updated when [his/her] services are transferred and discharged ... For clarification, since I know there was some confusion on your part, federal guidelines state an agency is required to give a 48 hour notice before discharging from services and Indiana regulations state a 15 day notice is required. As a measure of good will, we will set your discharge date 30 days from the date of our conversation which will be August 24, 2020. ... " Record review evidenced an agency document titled, "Missed Visit Form (HHA Visit)" from 8/12/2020, and digitally signed by HHA O. This document stated "Traveled to Patient: No ... Reason: Cancellation of Care ... Comments: ... [left blank] ... MD Notified: No ... Supervisor Notified: No .... " Record review failed to evidence an attempt was made to provide services on this date. Record review failed to evidence home health services were attempted for 5 of the last 15 calendar days prior to discharge, which include the following dates: 8/9/2020, 8/15/2020, 8/17/2020, 8/18/2020, and 8/21/2020.		The Administrator will be responsible for notifying if patients requiring services within a 15-day calendar period prior to discharge to ensure that this deficiency does not recur. Completion date 4/16/2021. ="" b=""> ="" b=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" span ="" b=""> ="" span<="" p=""> ="" span<="" p=""> ="" span<="" p=""> ="" span<="" p=""> ="" span=""> ="" spanall="" future=""> discharges="" will="" follow=""> policy="" #3.001.1.<="" p=""> ="" span=""> ="" p=""> br=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" spanall="" future=""> discharges="" will="" follow=""> policy="" #3.001.1.<="" p=""> ="" span=""> ="" p=""> ="" p=""> ="" span=""> ="" p=""> ="" p="">	

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	During an interview on 3/4/2021, at 12:39 PM, the clinical manager explained the agency had a hard time staffing the patient's home, due to the parameters given by Person F. The clinical manager indicated, based on the clinical record, it would appear the agency was not attempting to provide services during the 15 day calendar period prior to discharge. During an interview on 3/4/2021, at 3:53 PM, the clinical manager indicated the agency was unaware they had the ability to use a licensed practical nurse (LPN), or a registered nurse (RN), in the place of a home health aide, to ensure the patient's needs were met.		=""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p="">	