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	06/11/2021

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

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G 0000 Bldg. 00		G 0000		

This survey was a Federal Post Condition Revisit of a complaint survey, that was conducted on 2/25/2021-3/4/2021 for a home health agency.

Survey Dates: 6/9/2021, 6/10/2021, and 6/11/2021

Facility ID: 012828

Medicare ID: 157650

This deficiency report reflects State Findings cited in accordance with 410 IAC 17.

During this post condition visit, Noble Home Health Care LLC has 1 condition recited (484.60) and 1 new condition cited (484.45); 8 federal standard deficiencies were corrected, 10 federal standard deficiencies were recited; and 7 new federal standard deficiencies were cited.

Based on the Condition-level deficiences cited at the March 4, 2021 survey and pursuant to Section 1891(a)(D)(iii) of the Act, your agency continues to be precluded from operating home health aide training and/ or competency evaluation program for the two years beginning 3/4/2021 - 3/3/2023, due to being found out of compliance with Conditions of Participation 484.60 Care Planning, Coordination of Care and Quality of Care.

Quality Review Completed on 6/29/21 by Area 3

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

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G 0370 Bldg. 00	484.45 Reporting OASIS information Condition of participation: HHAs must electronically report all OASIS data collected in accordance with §484.55. Based on record review and interview, the home health agency failed to ensure they electronically transmitted each completed OASIS assessment to the CMS/ State system for each skilled nursing service being provided (See tag G372); completed assessment OASIS data was successfully transmitted and validated by a CMS approved system (see tag G378). These deficient practices affected all Medicaid patient who are receiving any skilled services. The cumulative effect of these problems resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.45 Reporting OASIS Information.	G 0370	**G370 Reporting OASIS** 1. Administrator/Clinical Manager reviewed the standard on inputting OASIS data for each skilled nursing and submitting forms. Downloaded and activated program regarding inputting service being provided. Oasis will be inputted into program and submitted. The AA has been in-serviced on inputting Oasis data and monthly submitting. Obtaining report that the submission has been accepted. Previous administration did not release password or access codes. 2. Completion Date 08-27-2021. 3. Administrator/ Clinical Manager reviewed the standard regarding inputting OASIS data for admissions, re-certifications, resumptions, hospitalizations and discharges. 4. The administrator will be responsible for ensuring the submission of OASIS data and will review monthly.	08/27/2021
G 0372 Bldg. 00	484.45(a) Encoding and transmitting OASIS Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system,			

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	regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. Based on record review and interview, the home health agency failed to ensure they electronically transmitted each completed OASIS assessment to the CMS/ State system for each skilled nursing service being provided for 2 of 2 clinical records reviewed of patients receiving a skilled nursing service which has the potential to affect all clinical records within the home health agency. (#3, #4) The findings include: 1. The undated agency policy, number 6.019.1, titled "Comprehensive Assessment of Patients (OASIS)" stated "... Purpose: To achieve measurable improvement in the quality of care provided focusing on patient outcomes and assessing that all critical information is routinely incorporated through timely assessments identifying a patient's initial and changing needs. 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 an acceptable referral; When the patient's condition warrants due to major decline or major improvement, but not less frequently than every second month; ... At discharge;..." 2. The undated agency policy, number 4.008.1, titled "Data Entry/Transmission of OASIS Information" stated "... Purpose: To ensure accurate and timely data entry of all Outcomes and Assessment Information Set (OASIS) patient	G 0372	**G372 Encoding and transmitting OASIS** 1. Administrator/Clinical Manager reviewed the standard regarding inputting OASIS data for admissions, re-certifications, resumptions, hospitalizations and discharges. Pt.#3 has a completed OASIS recertification and will be electronically transmitted to the CMS/State system. Pt.#4 has a completed OASIS recertification and this will be electronically transmitted to the CMS/State system. An Oasis submission log will be maintained by the administrative assistant and reviewed by the Administrator monthly. 2. Completion Date 08-27-2021. 3. An electronic log will be used to indicate the completed Oasis that needs to be transmitted. 4. Oasis submission will be performed monthly and the administrative assistant will maintain log.	08/27/2021

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	information. Policy: OASIS information collected at start of care, resumption of care follow-up, discharge and transfer to an inpatient facility will be encoded, edited and locked into the computer system within seven calendar days from the date the assessment is completed. The OASIS information will be sent electronically to the State and will match the data in the clinical record. Procedure: ... 3. The authorized Agency personnel will enter OASIS information into the computer once the comprehensive assessment is received and completed by the RN [registered nurse] or appropriate rehabilitation professional. ... 8. The OASIS information must be electronically transmitted with accurate, complete, encoded and locked OASIS data that accurately reflects the patient's status at the time of the assessment for all applicable patients to the State Agency or the CMS OASIS contractor at least monthly in a format that meets CMS electronic data and edit specifications. 9. Designated employees that transmit to the State will secure each "OASIS initial feed back report" and "validation report". These reports are to be filed with corrective action documentation. The administrator will ensure that follow-up on warnings/fatal errors are performed and documented as necessary. ... 10. In the event that the Agency is unable to submit OASIS data to the State Agency, the Administrator will guarantee secure access and confidentiality of patent information while transferring information via disk on a drive of an alternate computer. 11. Transmit each completed OASIS assessment to the State agency or the CMS OASIS contractor...." 3. A review of pre-survey information provided by the Indiana Department of Health, stated there was no OASIS data available for this agency.			

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	4. The clinical record of patient #3 was reviewed and contained a plan of care for the certification period of 5/2/21 to 6/30/21, with orders for skilled nursing 1 hour weekly for comprehensive assessment, education, and medication compliance. 5. The clinical record of patient #4 was reviewed and contained a plan of care for the certification period of 5/9/21 to 7/7/21, with orders for skilled nursing (no frequency or duration) for comprehensive assessment and education. 6. During an interview on 06/11/2021 at 11:00 a.m. the surveyor asked for an OASIS submission log. The clinical supervisor indicated they do not do this because they only have Medicaid patients and not Medicare. Employee H (administrative assistant) then indicated they did not submit Medicaid. 7. During an interview on 06/11/2021 at 11:14 a.m., the clinical supervisor then indicated she thought it may be something that their electronic medical record might automatically send. 8. During an interview on 06/11/2021 at 11:20 a.m., the administrator and clinical supervisor provided a printed email and emails on their computer of correspondence received from (HHCAHPS) Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS is a program which measures the experiences of people receiving home health care from Medicare-certified home health agencies). The administrator and clinical supervisor indicated they thought this was evidence of the confirmation of OASIS submissions. The agency failed to be any evidence that OASIS			

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	was submitted from this home health agency. This deficient practice affected all Medicaid patients receiving skilled services by this home health agency.			
G 0382 Bldg. 00	484.45(c)(2) Transmit data using compliant software Transmit data using electronic communications software that complies with the Federal Information Processing Standard (FIPS 140-2, issued May 25, 2001) from the HHA or the HHA contractor to the CMS collection site. Based on record review and interview, the home health agency failed to ensure an approved system was set up to transmit OASIS data to the CMS [Center for Medicare / Medicaid Services] system for all agency beneficiaries. The findings include: The undated agency policy, number 4.008.1, titled "Data Entry/Transmission of OASIS Information" stated "... 7. The Administrator must designate two (2) employees that will possess the Agency PASSWORD and knowledge of how to electronically transmit OASIS data to the State at least monthly. 8. The OASIS information must be electronically transmitted with accurate, complete, encoded and locked OASIS data that accurately reflects the patient's status at the time of the assessment for all applicable patients to the State Agency or the CMS OASIS contractor at least monthly in a format that meets CMS electronic data and edit specifications. ... 10. In the event that the Agency is unable to submit OASIS data to the State Agency, the Administrator will guarantee secure access and confidentiality of patent information while transferring information	G 0382	**G382 Transmit data using compliant software** 1. An approved system to transmit Oasis to the CMS system will be downloaded and activated. Two employees will be designated on how to review and transmit Oasis data. 2. Completion Date 08-27-2021. 3. The clinical manager will be responsible for providing oasis data to the administrative assistant. The administrative assistant or Administrator will transmit to CMS. 4. The Clinical Manager will be responsible for reviewing the program data. The EMR will electronically track and monitor Oasis submissions monthly.	08/27/2021

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	via disk on a drive of an alternate computer. 11. Transmit each completed OASIS assessment to the State agency or the CMS OASIS contractor...." A review of pre-survey information provided by the Indiana Department of Health, stated there was no OASIS data available for this agency. During an interview on 06/11/2021 at 11:00 a.m. the surveyor asked for an OASIS submission log. The clinical supervisor indicated they do not do this because they only have Medicaid patients and not Medicare. Employee H (administrative assistant) then indicated they did not submit Medicaid. During an interview on 06/11/2021 at 11:14 a.m., the clinical supervisor then indicated she thought it may be something that their electronic medical record might automatically send. During an interview on 06/11/2021 at 11:20 a.m., the administrator and clinical supervisor provided a printed email and emails on their computer of correspondence received from (HHCAHPS) Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS is a program which measures the experiences of people receiving home health care from Medicare-certified home health agencies). The administrator and clinical supervisor indicated they thought this was evidence of the confirmation of OASIS submissions. The agency failed to be any evidence they had a software that complies with the Federal Information Processing Standard from the home health agency or with the home health agency contractor to the CMS collection site. This			

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	deficient practice affected all Medicaid patients receiving skilled services by this home health agency.			
G 0530 Bldg. 00	484.55(c)(2) Strengths, goals, and care preferences The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the home health agency failed to ensure achievable goals were identified in conjunction with the services the patients received, in 1 of 4 clinical records reviewed. (#2) The findings include: 1. The undated agency policy, number 6.016.1, titled "Care Planning" stated "... Policy: 1. It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and/or service based on the patient's needs and goals with the input of the patient for the purpose of achieving positive outcomes. 2. Care planning is performed to ensure that care and services are appropriate to each patient specific needs and problems. 3. The care planning process will include the following: ... b. Identification of patient's goals and interventions to resolve the patient's problems and/or needs. ... Procedure: ... 4. The Plan of Care will be developed during and based on the initial and on-going assessments, including: ... b. Measurable and individualized goals. ... d. Actions to be taken to meet the patient goals. ... 9. The care planning decisions will be reflected in the specific services provided and the designated	G 0530	**G530 Strengths, goals, and care preferences** 1. Patient #2 has been discharged. All active patient plans of care will be reviewed for accuracy of services with achievable goals to be provided. POCs that included incorrect skilled nursing orders will be amended to include achievable goals and sent to physician for signature. 2. completion dates 8/27/2021. 3. The nursing staff will be in-serviced on developing plan of cares to reflect patient's health needs and achievable goals that can be adequately met. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for reviewing the POCs every 60 days for accuracy prior to submission to the physician for signature.	08/27/2021

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	actions planned and implemented to meet individualized patient problems and goals...." 2. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and signed by the clinical manager on 03/19/2021. This plan of care had an area subtitled "Goals and Outcomes" which stated "Patient to be pain free. Patient to achieve a pain relief rating of 0-2 by medication and/or nonpharmacologic pain relief measures. Patient skin integrity will remain intact during this episode. Patient will be free from signs and symptoms of respiratory distress during the episode. Patient will be free from cardiac complications during the certification period. Patient will be free from signs and symptoms of constipation during the episode. Patient will maintain 2gNa+ [2 gram sodium] Heart Healthy diet compliance during the episode. Patient's ADL [activities of daily living]/IADLs [instrumental activities of daily living] needs will be met with assistance of home health aide. Patient will remain free of adverse medication reactions during the episode. ... Discharge plans; Additional discharge plans: When reliable caregiver available willing and able to manage all aspects of patient's care...." This patient only seen a skilled nurse for comprehensive assessments once every certification period and only received services from a home health aide. These goals and outcomes would not be attainable with a patient documented with episodes of forgetfulness and having instructions once every certification period from a skilled nurse.			

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	During an interview on 06/11/2021 at 12:14 p.m., the clinical manager indicated a skilled nurse only visited the patient at the comprehensive assessment and then would see if goals were met in the 60 days. The surveyor they queried the clinical manager how could the patient achieve the plan of care goals with only one skilled nursing visit per episode, in which the clinical manager stated "I see what you're saying."			
G 0536 Bldg. 00	484.55(c)(5) A review of all current medications A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the home health agency failed to ensure all medications the patients were prescribed were reconciled and serious medication interactions were reported to the primary care physician during the medication reconciliation in 1 of 4 clinical records reviewed. (#2) The findings include: 1. The undated agency policy, number 4.009.2, titled "Medication Administration Record" stated ".... 11. To prevent and reduce the likelihood of adverse drug reactions, this agency checks the medication profile for interaction risks. Drug to drug reactions listed as potentially moderate or severe are reported to the prescribing physician prior to administration. Patients are educated on other types of adverse interactions possibilities, such as consuming alcohol while taking certain medications, or food and medication interactions.	G 0536	**G536 Review of all current medications** 1. Patient #2 has been discharged. 2. completion date 8/27/2021. 3. All active charts will be reviewed to ensure all medications prescribed are reconciled and serious medication interactions will be reported to PCP. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for reviewing the comprehensive assessment every 60 days to ensure the medication reconciliation is complete and action taken, if needed.	08/27/2021

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	Education will be documented on the visit note...." 2. The undated agency policy, number 4.009.1, titled "Medication Profile" stated "... Policy: It is the responsibility of the admitting therapist/nurse to record all medications that the patient is currently taking on a routine or PRN [as needed] basis. Documentation will include upon admission, the medication, route, amount and frequency. Procedure: ... 3. Nursing staff check all drug therapy a patient may be taking to identify possible effectiveness, ineffectiveness, actual or potential interactions, side effects, desired effects, toxic effects, unusual/unexpected effects, allergic reactions, duplicate drug therapy, non-adherence, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and drug recalls and promptly report any problems to the physician. 4. At time of discharge the patient/provider will be provided with a complete and current medication profile. Upon transfer the receiving agency will receive a complete and current medication profile (whenever, possible)...." 3. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Patient Medication Record" dated and signed by the clinical manager on 05/17/2021. This document had an area subtitled "Current Medications" which stated "... Duloxetine HCL[hydrogen chloride] [for depression and anxiety] Oral 30 MG [milligram] 1 Cap (s) PO [by mouth] Daily ... Zofran ODT [oral disintegrating tablet] [for nausea] Oral 8 MG 1 Tab (s) PO 1 Tablet Q [every]8 PRN [as needed] For Nausea Antiemetics ... traMADol HCl [for pain] Oral 50 MG 1 Tab (s) PO Q4 Hours PRN Analgesics - Opioid...." This document also			

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	indicated the physician was not contacted and there were no interactions. Record review evidenced the combination of Duloxetine and Zofran can cause a serious medication interaction by increasing the risk of serotonin syndrome, in which severe cases can result in coma or death. There failed to be evidence in the clinical record the primary care physician was notified of this possible severe medication interaction. Record review evidenced the combination of Duloxetine and Tramadol can cause a serious medication interaction by increasing the risk of serotonin syndrome, in which severe cases can result in coma or death. There failed to be evidence in the clinical record the primary care physician was notified of this possible severe medication interaction. During an interview on 06/11/2021 at 12:00 p.m., the clinical manager indicated "Kinnser" [electronic medical record] will tell you about interactions and if it doesn't flag it at high risk I don't take any actions. Clinical record review evidenced an agency document titled "Discharge Summary" dated and signed by the clinical manager on 05/20/2021, stated "Discharge Summary Addendum Page ... Patient wears a nitroglycerin patch for chest pain but states she really doesn't have chest pain at all and denies chest pain at time of assessment...." Clinical record review failed to evidence a nitroglycerin patch on the patient's plan of care or medication reconciliation documentation. During an interview on 06/11/2021 at !2:02 p.m.,			

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	the clinical manager indicated she didn't update the profile. 410 IAC 17-14-1(a)(1)(B)			
G 0546 Bldg. 00	484.55(d)(1)(i,ii,iii) Last 5 days of every 60 days unless: The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. Based on record review and interview, the home health agency failed to ensure a comprehensive assessment was completed timely and in accordance with the COVID-19 Emergency Declaration Waivers for home health agencies, in 1 of 4 clinical records reviewed. (#1) The findings include: According to the CMS COVID-19 Emergency Declaration Blanket Waiver dated March, 2020, the waiver indicated home health agencies 5-day completion requirement for the comprehensive assessment was extended to 30 days. Clinical record review for patient #1, start of care 08/13/2020, primary diagnosis of multiple sclerosis, failed to evidence a recertification comprehensive assessment for the certification period of 04/10/2021 - 06/08/2021, During an interview on 06/09/2021 at 2:40 p.m., the clinical manager stated she was still working on the patient's 4/9/2021 recertification	G 0546	**G546 Timely comprehensive assessments** 1. Pt. #1 comprehensive assessment is completed with physician's signature and filed in patient's EMR for cert period 4-10-21 to 6-08-21. 2. completion date 8/27/2021. 3. All active records will be reviewed to ensure a comprehensive assessment is completed timely. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for reviewing the comprehensive assessment to ensure it is completed within 30 days.	08/27/2021

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	comprehensive assessment. The clinical manager stated she performed the visit, but the recertification was not done and in turn the 485 [plan of care] was not complete. The clinical manager stated she was working on this document, but was behind. During an interview on 06/11/2021 at 11:27 a.m., the clinical manager stated "I'm sorry I'm still working on it." (in regards to completion of the comprehensive assessment conducted on 04/09/2021)			
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. Based on record review and interview the home health agency failed to ensure: the patients needs	G 0570	**G570 Care planning, coordination, quality of care** 1. Patient #2 has been	08/27/2021

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	were met in their home according to the plan of care (see tag G570); a plan of care was established by the physician and followed (see tag G572); the plan of care contained all required elements (see tag G574); services were only administered as ordered by a physician (see tag G580); the plan of care was reviewed by the physician a minimum of every 60 days (see tag G588); the primary care physician was informed of changes to services in the plan of care (see tag G590); coordination of care with outside healthcare entities which provided services to the agency patients (see tag G606); and an updated medication schedule was provided to agency patients (see tag G616). The cumulative effect of these problems resulted in the home health agency's 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. A standard citation was also cited . Based on record review and interview, the home health agency failed to ensure the patients needs were met in their home according to the plan of care 2 of 4 clinical records reviewed. (#2, #4) Findings include: 1. The undated agency policy, number 6.016.1, titled "Care Planning" stated "... Policy: 1. It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and/or service based on the patient's needs and goals with the input of the patient for the purpose of achieving positive outcomes. 2. Care planning is performed to ensure that care and		discharged. Pt.#4 a corrected POC has been sent to the physician that does not include skilled nursing services that were not ordered. 2. completion date 8/27/2021. 3. The Nursing staff will be in-serviced on developing patients' plan of care to reflect patient's health needs that can be adequately met. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for reviewing the POC after admission every 60 days for accuracy prior to submission to the physician for signature.	

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	services are appropriate to each patient specific needs and problems. 3. The care planning process will include the following: ... b. Identification of patient's goals and interventions to resolve the patient's problems and/or needs. c. Implementation of the planned care or services by appropriate clinicians and/or the patient/family. d. Monitoring the patient's response to the care provided and/or the outcome of the care provided will be ongoing. ... 8. The RN [registered nurse] will perform a comprehensive assessment in the formation of a care plan. ... Procedure: ... 4. The Plan of Care will be developed during and based on the initial and on-going assessments, including: a. Identification of appropriate patient problems and/or needs. ... 7. All qualified professionals involved in the patient's care, either directly or indirectly, will contribute to the Plan of Care, including consideration of the patient's problems, needs, condition and wishes and the patient's ability to respond to care services. ... 10. The Plan of Care is based upon the physician's orders and encompasses the equipment, supplies, disciplines, and services required to meet the patient's needs. ... 12. The frequency of the review of the Plan of Care is based on changes in the patient's health status, needs and the environmental factors affecting care. The qualified professional/Clinical Manager/Case Manager or Therapist is responsible for revising the Plan of Care or updating the Plan every 60 days if skilled care is determined to be needed. ... 16. The needs of the patient will be prioritized in order to identify the level of services to be provided...." 2. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, with a primary diagnosis of chronic obstructive pulmonary disease, evidenced an			

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	agency document titled "Home Health Certification and Plan of Care" dated and digitally signed by the clinical supervisor on 03/19/2021. This plan of care had an area subtitled "Order and Treatments" which stated "... Patient is a 66 year old female who lives alone and does not have a caregiver. Patient has had multiple hospitalization in the past six months. Patient at high risk for re-hospitalization. Patient noted with overall decline in health and requires additionally [sic] help. Patient suffers from multiple comorbidities. ... Patient at risk for skin breakdown. Patient at risk for falls. Patient requires assistance complying with medical treatment and regimen. ... SN [skilled nurse] to provide comprehensive assessments. ... SN to instruct patient to take pain medication before pain becomes severe to achieve better pain control. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs. SN to instruct patient on measure to prevent pressure ulcer formation and skin breakdown. SN to instruct the Patient on measures to recognize cardiac dysfunction and relieve complications. SN to instruct patient on measures to detect and alleviate edema. SN to instruct the patient the following symptoms could be signs of a heart attack: chest discomfort, discomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and symptoms that necessitate calling 911. SN to instruct the Patient on signs/symptoms of UTI [urinary tract infection] to report to MD [medical doctor]/SN. SN may obtain urinalysis and urine culture & sensitivity (C&S) test as needed for signs/symptoms of UTI, to include pain, foul odor, cloudy or blood-tinged urine and fever. SN to instruct Patient on 2gNA+ [2 gram sodium] Heart Healthy diet. SN to instruct			

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	the Patient to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. SN to instruct patient on fall precautions." Clinical record review failed to evidence any skilled nursing visit other than the comprehensive assessment to provide the education needed for the patient and caregiver as indicated in the plan of care. The skilled nurse failed to meet the patient's needs. 3. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/9/21 - 7/7/21, and signed by the clinical supervisor. This document stated "... SN [skilled nurse] to instruct patient to take pain medication before pain becomes severe ... SN to instruct patient on nonpharmacological [interventions that do not use medications to alleviate pain] pain relief measures ... SN to instruct patient/caregiver on measures to help prevent skin breakdown and pressure ulcer formation ... SN to instruct the patient/caregiver on factors that contribute to SOB [shortness of breath] ... SN to instruct patient/caregiver on measures to detect and alleviate edema ... SN to instruct the patient/caregiver the symptoms that could be signs of a heart attack ... SN to instruct the Patient/Caregiver on signs/symptoms of UTI [urinary tract infection] ... SN to instruct Patient/Caregiver on a well balanced regular diet ... SN to instruct the Patient/Caregiver to contact agency to report any fall ... SN to instruct the patient/caregiver on fall precautions ...." This			

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	document also stated "... Home Health Aide requesting to provide 6 hours a day, 5 days a week (Monday thru Friday) and 4 hours a day, 2 days a week (Saturday and Sunday) for 9 weeks. Respite HHA [home health aide] will be used if additional care/time is requested ...." Clinical record review failed to evidence any skilled nursing visit other than the comprehensive assessment to provide the education needed for the patient and caregiver as indicated in the plan of care. The skilled nurse failed to meet the patient's needs. 4. During an interview on 6/11/21 at 12:16 p.m., the clinical supervisor stated she does the skilled nursing services that are stated in the plan of care every certification period and stated she usually just asks how things have been since the last time she was out at the home. 410 IAC 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 original plan. Based on record review and interview, the home health agency failed to ensure the plan of care was established, individualized, followed and	G 0572	**G572 Plan of care** 1. Patient #1 cert period 4/10-21 – 6/08/21 has a completed and signed plan of	08/27/2021

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	reviewed periodically by the primary care physician in 2 of 4 clinical records reviewed. (#1, #2) The findings include: 1. The undated agency policy, number 6.016.1, titled "Care Planning" stated "... Purpose: To define a systematic process to the clinicians for planning, reviewing and revising 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 service based on the patient's needs and goals with the input of the patient for the purpose of achieving positive outcomes. 2. Care planning is performed to ensure that care and services are appropriate to each patient specific needs and problems. 3. The care planning process will include the following: a. Formulation of care based on the patient's assessment function. b. Identification of patient's goals and interventions to resolve the patient's problems and/or needs. c. Implementation of the planned care or services by appropriate clinicians and/or the patient/family. d. Monitoring the patient's response to the care provided and/or the outcome of the care provided will be ongoing. ... 6. The care planning process will be documented on the Plan of Care/Treatment ... Procedure: ... 4. The Plan of Care will be developed during and based on the initial and on-going assessments, including: a. Identification of appropriate patient problems and/or needs. b. Measurable and individualized goals. c. Specific services to be provided. d. Actions to be taken to meet the patient goals. e. Type, frequency and duration of the above actions. ... 6. The admitting SN [skilled nurse]/PT [physical therapist] will initiate the written Plan of Care at the start of care, and the		care. Patient #2 cert period 3/19/21 to 5/17/21 an addendum to the POC was completed and returned with signature. 2. completion date 8/27/2021. 3. All active patients' medical records will be reviewed and will have a current plan of care signed by the physician. All missed visit documentation will be completed and the physician will be notified. 4. To prevent this deficiency from recurring, the professional staff will be responsible for updating the POC every 60 days which include notifying the physician of missed visits.	

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	plan will e updated at least eery sixty (60) days or as needed. A summary of care will be sent every 60 days thereafter or more often as needed. ... 9. The care planning decisions will be reflected in the specific services provided and the designated actions planned and implemented to meet individualized patient problems and goals. 10. The Plan of Care is based upon the physician's orders and encompasses the equipment, supplies, disciplines, and services required to meet the patient's needs...." 2. The undated agency policy, number 4.004.1, titled "Physician Orders/ Plan of Care" stated "... Purpose: To ensure that each patient's care is under the direction of the physician. Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency's clinical record. Procedure: 1. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the Agency. 2. All orders on the CMS 485 will be specific to the client condition and 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. ... 10. The Agency provides written and oral reports to the physician regarding the patient's plan of treatment and appropriateness of the continuation of care. The Agency provides written and oral reports to the physician regarding the patient's condition at least every 60 days. Reports may be more frequent if there is an emergency, a need to alter the plan of care or a need to terminate services. ... 12. If the Agency does not receive a signed physician's orders within thirty (30) days of the date the order is sent to the physician for			

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	signature, the Agency contacts the physician's office to obtain the signed document or resends the order(s) to be signed. All follow-up contacts to obtain signed orders are documented." 3. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, and primary diagnosis of multiple sclerosis failed to evidence any plan of care for this certification period. During an interview on 06/09/2021 at 2:40 p.m., the clinical supervisor indicated she was still working on the patient's recertification for episode 04/10/2021 - 06/08/2021. She indicated she had done the visit, but the recertification was not done so in turn the 485/plan of care was not complete. She indicated she was working on this, but was behind. 4.. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, and primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and digitally signed by the clinical manager on 03/19/2021, but failed to have a physician's signature. This document had a section titled "Orders and Treatments" which stated "... Home Health Aide requesting to provide 6 hours a day up to 5 days week for 26 weeks. ... SN to provide comprehensive assessments...." A review of agency documents titled "HHA [home health aide] Visit" dated 4/16/21, 4/19/21, 4/20/21, 4/21/21, 4/22/21, and 4/23/21, failed to evidence the HHA provided services 6 hours a day as ordered on the plan of care.			

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	During an interview on 6/11/21 at 12:25 p.m., the clinical manager indicated she didn't see communication or anything documented for the reason the home health aide missed hours. 410 IAC 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; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.			

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	Based on record review and interview the home health agency failed to ensure the individualized plan of care included all the location to apply topical medications and failed to include implanted devices in 3 of 4 clinical records reviewed. (#2, #3, #4) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Client Records," stated "... To establish and maintain a client record system to assure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compliance and retrieval of information ... Upon processing of data related to a new client ... The client record will include but not be limited to all of the following information: ... Care plan that includes medications ...." 2. Review of the agency policy revised 6/10/21 titled "Physician Orders/Plan of Care," stated "... To ensure each patient's care is under the direction of the physician ... The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency's clinical record ... The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the agency ... All orders on the CMS 485 [Plan of Care] will be specific to the client condition and needs ...." 3. Clinical record review on 6/10/21 for patient #3, primary diagnosis: Chronic obstructive pulmonary disease (long-term inflammatory lung disease that	G 0574	**G574 Plan of care must include** 1. Pt.#3 the POC has been amended to include the location to apply the topical medications. Pt.#4 POC has been amended to include the location to apply the topical medications. A discharge summary addendum page was added to Pt.#2 discharge chart which states the patient has a pacemaker. 2. completion date 8/27/2021. 3. All active patients' POC and medication profiles were reviewed to ensure the patients conditions and needs are individualized and include all the locations to apply the topical medications and any implanted devices. 4. The clinical manager is responsible for reviewing on admission and every 60 days all POCs and medication for the accuracy of all medications, route and location and documentation of any implantable devices.	08/27/2021

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	causes obstructed airflow from the lungs, resulting in difficulty breathing), start of care 11/3/20, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/2/21 - 6/30/21, and signed by the primary care physician and clinical supervisor. This document stated "... Proctozone-HC [medication used to treat minor pain, itching, swelling, and discomfort] External 2.5% thin layer Apply thin layer twice a day ...." This document failed to include where to apply the medication. During an interview on 6/11/21 at 12:44 p.m., the clinical supervisor indicated the plan of care does not say where to apply the medication, but she is now adding to the plan of care to apply the medication to the external rectum area. 4. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/9/21 - 7/7/21, and signed by the clinical supervisor. This document stated "... Aloe Vesta [medication used as a moisturizer to treat and prevent dry, rough, scaly, itchy skin and minor skin irritations] Protective External 1-10ml [milliliters] Apply thin coat to affected area and PRN [as needed] to prevent skin breakdown ...." This document failed to include where the affected area was located to apply the medication. 5. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/21 - 05/17/21, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and digitally signed by the clinical manager on 03/19/2021. This document			

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	failed to evidence anything about the patient's implanted pacemaker. Clinical record review evidenced an agency document titled "Discharge Summary" dated and digitally signed by the clinical manager on 05/20/2021. This document had an area subtitled "Discharge Summary Addendum Page" which stated "... Patient has a pacemaker (inserted 05/04/2015)...." During an interview on 06/11/2021 at 12:10 p.m., the clinical supervisor indicated it was an oversight on her. 410 IAC 17-13-1(a)(1)(D)(xiii)			
G 0580 Bldg. 00	484.60(b)(1) Only as ordered by a physician Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure verbal orders were received prior to all services and treatments being administered by the agency in 1 of 4 clinical records reviewed. (#2) The findings include: The undated agency policy, number 4.004.1, titled "Physician Orders/ Plan of Care" stated "... Purpose: To ensure that each patient's care is under the direction of the physician. Policy: The physician establishes and reviews a plan of treatment for the patient. ... Procedure: 1. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of	G 0580	**G580 Physician Order** 1. Pt.#2 has been discharged. The POC was submitted to physician and returned signed. 2. completion date 8/27/2021. 3. All active patient charts will be reviewed to determine if the POC has been returned with a physician signature. The plan of care and other physician orders requiring a physician's signature will be filed in the patients EMR within 7 days of receipt in office. A second request for physician orders will be requested for physician orders not received within 14 days. 4. To prevent this deficiency	08/27/2021

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	drugs and equipment to be provided by the Agency. ... 5. Copies of the plan of care and other orders requiring a physician's signature should be filed in the client record within 7 days of receipt in office. ... 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. ... 12. If the Agency does not receive a signed physician's orders within thirty (30) days of the date the order is sent to the physician for signature, the Agency contacts the physician's office to obtain the signed document or resends the order(s) to be signed. All follow-up contacts to obtain signed orders are documented...." Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and digitally signed by the clinical manager on 03/19/2021. This document indicated the home health aide was to provide services 6 hours a day up to 5 days a week for 26 weeks, the skilled nurse was to provide comprehensive assessments, the skilled nurse was to instruct the patient of pain medication and non pharmacologic pain relief, instruct patient on prevention of pressure ulcers and skin breakdown, instruct patient to recognize cardiac dysfunction and relieve complications, instruct patient on how to detect and alleviate edema, instruct patient on signs and symptoms of a heart attack, instruct patient on signs and symptoms of a urinary tract infection and obtain urinalysis and urine culture if needed, instruct patient on diet, instruct patient to contacts agency for falls and instruct patient of fall precautions. This document failed to evidence the		from recurring, the administrative staff will be responsible for logging, monitoring and tracking physician orders.	

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	patient's primary care physicians signature prior to the administration of treatments, instruction and services. The clinical record failed to evidence that a verbal order was received from the prescribing physician by the agency clinician. During an interview on 06/11/2021 at 12:20 p.m., the clinical manager indicated the plan of care was sent off to the physician, but it was not returned and the agency did not have a plan of care that was signed by the physician. 410 IAC 17-13-1(a)			
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 home health agency failed to promptly alert the relevant physician to any changes in the patient's needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered in 1 of 4 clinical records reviewed. (#4) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Care Planning," stated "... Contains clinical information including pertinent diagnosis, mental status, types of services/equipment, frequency of visits, goals and interventions appropriate to each discipline, prognosis, rehabilitation potential, functional limitations, safety precautions, activities, nutritional requirements, medications,	G 0590	**G590 Promptly alert relevant physician of changes** 1. Pt.#4 has a signed addendum physician order to hold services when the patient and family member preferred home health aide is not available. 2. completion date 8/27/2021 3. The professional staff will be in-serviced on ensuring the relevant physician is notified when the POC needs to be altered, or there are significant changes to the patient's needs and of any missed visits. An electronic log will be used to track and monitor frequency of home visits.	08/27/2021

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	treatments, and instructions ... The Plan of Care will be developed during and based on the initial and on-going assessments, including ... Clinicians will inform the patient's physician of any changes that suggest a need to alter the Plan of Care ...." 2. Review of the agency policy revised 6/10/21 titled "Physician Orders/Plan of Care," stated "... To ensure that each patient's care is under the direction of the physician ... The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency's clinical record ... The Agency's professional staff continuously reviews clinical records to determine adequacy of the plan of treatment and appropriateness of the continuation of care ... The Agency provides written and oral reports to the physician regarding the patient's plan of treatment and appropriateness of the continuation of care ...." 3. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/9/21 - 7/7/21, and signed by the clinical supervisor. This document stated "... Home Health Aide requesting to provide 6 hours a day, 5 days a week (Monday thru Friday) and 4 hours a day, 2 days a week (Saturday and Sunday) for 9 weeks. Respite HHA [home health aide] will be used if additional care/time is requested ...." A record review evidenced agency documents titled "Missed Visit Form (HHA [home health		4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for weekly logging and monitoring home visit frequency.	

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	aide] Visit)," dated 5/15/21, 5/21/21, 5/22/21, 5/24/21, and 5/29/21, and signed by the administrator. These documents stated "... Patient/Caregiver declines services today; patient/caregiver only want a specific aide who is unavailable at this time. Patient family able to assist patient ... MD [Doctor of Medicine] Notified ... No ...." Clinical record review failed to evidence the agency notified the physician of the caregiver's continual refusal of services from 5/15/21 - 5/29/21. During an interview on 6/11/21 at 1:06 p.m., the administrator indicated the family member of patient #4 did not want anybody else besides employee C, home health aide due to her brother passing away from COVID. She indicated the family needed the help, but the family member could not accept having anyone else there, despite the agency offering another aide. The administrator indicated they did the best they could to honor the family member's refusal. She also indicated they did not notify the MD for all of the missed visits. 41- IAC 17-13-1(a)(2)			
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 of care provided by all disciplines. Based on record review and interview, the home health agency failed to ensure coordination of care with outside entities which provided healthcare services to agency patients, in 2 of 4 clinical records reviewed. (#1, #2)	G 0606	**G606 Integrate all services** 1. Pt.#2 has been discharged. Pt.#1 a letter of care coordination will be submitted to entity D. An amended plan of care has been submitted to the physician for	08/27/2021

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	The findings include: 1. The undated agency policy, number 3.009.1, titled "Coordination of Client Care" 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 clinical record. Each client will be assessed upon admission as to identify any other agencies providing services to the client. ... Procedure: 1. Upon admission, the SN [skilled nurse] will identify any agencies involved in providing care. ... 4. 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...." 2. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Discharge Summary" dated and signed by the clinical manager on 05/20/2021. This document had an area subtitled "Discharge Summary Addendum Page" which stated "... Patient states she continues to receive services from [name of home health agency] for homemaker, is receiving PT [physical therapy] from Entity B...."		signature with Entity D name, frequency and services provided. 2. completion date 8/27/2021 3. All active patients will be contacted to determine if they are receiving services from additional entities. The professional staff will be in-serviced on asking patients on admission and during the duration of care regarding any entity providing care. 4. To prevent this deficiency from recurring, the administrative staff will be responsible for including a letter of care coordination in all admission packets to identify other entities providing service in the home.	

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	Clinical record review failed to evidence any coordination of care with Entity B. During an interview on 06/11/2021 at 12:05 p.m., the clinical manager indicated the patient reported they (Entity B) provided physical therapy services and that she had 5 visits of PT. Employee H (administrative assistant) indicated she just asked what services they provided and when. 3. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, primary diagnosis of multiple sclerosis, evidenced an agency document titled "Missed Visit For (HHA [home health aide] Visit), dated and digitally signed by the administrator on 05/27/2021. This document indicated the patient was hospitalized. During an interview on 06/09/2021 at 2:00 p.m., the clinical manager indicated the patient was hospitalized at Entity C. During an interview on 06/09/2021 at 3:00 p.m., the clinical manager indicated Entity D [home health agency] provided the patient with her "home care". Then the clinical manager indicated they did not have any coordination of care with Entity D. 410 IAC 17-12-2 (h)			
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.	G 0616	**G616 Patient medication**	08/27/2021

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	Based on observation, record review, and interview the home health agency failed to provide to the patient medication schedule/instructions, including: medication name, dosage, and frequency and which medications will be administered by the home health agency personnel in 1 of 1 clinical records reviewed. (#4) The findings include: Review of the agency policy revised 6/10/21 titled "Medication Profile," stated "... To list and notify physician of medications that the patient is routinely taking on a PRN [as needed] basis ... Upon admission to the Agency, the admitting RN [Registered Nurse] or therapist is provided in the admission packet a sheet on which to record the medication(s) that the patient is taking on a routine or PRN basis. The medication profile must include at least the following ... All current medications ... Date prescribed or taken ... Name of medication ... Dose ... Frequency ... Drug classification ... Date discontinued ... Drug and/or food allergies ... The medication profile will be updated at least every 60 days or more often as needed. All new medications will be added to the Medication profile and checked for interaction risks by the case manager ...." During a home visit on 6/10/21 at 9:10 a.m. for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, the family member of patient #4 provided the admission packet. The admission packet was observed to include a medication profile with the dates 7/19/19 - 9/16/19. The agency failed to ensure the patient was provided with the most		**schedule/instructions** 1. Pt.#4 has received a copy of the medication profile. 2. completion date 8/27/2021 3. 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 reported. 4. The Clinical Manager will be responsible for providing a current written medication profile to patients at the start of each episode of care if there have been any medication changes.	

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	current medication profile. During an interview on 6/10/21 at 4:40 p.m., the clinical supervisor indicated the family member of patient #4 is very proactive about keeping the medication list up to date. She asked if they still need to provide a current medication list to the patient and family and the clinical supervisor was informed that the agency still needs to provide an updated medication profile at least every 60 days or as often as needed.			
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 home health agency failed to ensure an aide care plan was developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving home health aide services for all home health aide assignments, in 2 of 4 clinical records reviewed with a home health aide. (#1, #4) The findings include: 1. The undated agency policy, number 6.020.2, titled "Registered Nurse" stated "... Purpose: to	G 0798	**G798 Home Health aide assignments and duties** 1. Patient #1 the nurse has completed the Aide Care Plan. Patient #4 the nurse has completed the Aide Care Plan. All active patients Aide Care Plans were reviewed for completion by the Registered Nurse. 2. Completion Date 8/27/2021 3. The nursing staff will be in-serviced on establishing a written home health aide Care Plan on admission and updating the Aide Care Plan every 60 days at the time of recertification and	08/27/2021

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	ensure that all Registered Nurse responsibilities are clearly stated. Policy: Registered Nurse (RN). Skilled nursing services shall be provided by a registered nurse in accordance with the plan of treatment. These services shall include the following: Procedure: ... 4. The RN will make home health aide assignments, prepare written instructions for the aide, and supervise the aide in the home...." 2. Review of the agency policy revised 6/10/21 titled "Home Health Aide," stated "... To ensure that all home health aide visits responsibilities are clearly stated ... The agencies Director of Nursing, Alternate Director of Nursing, and/or Case manager are responsible for ... Written 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 patients plan of care and within the duties allowed to be permitted by a nurse aide ...." 3. Review of the agency policy revised 6/10/21 titled "Timeliness and Accuracy of Entries in the Clinical Record," stated "... 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 ... Each entry into the client record must be current, accurate, signed, legible, and dated with the date of the 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 ...." 4. Clinical record review for patient #1 on 06/09/2021 at 2:18 p.m., evidenced the home health agency's electronic medical record system (Wellsky). This electronic medical record system		whenever there is a change in the patient's physical status. 4. To ensure this deficiency does not recur, the Clinical Manager will be responsible for reviewing all Aide Care Plans on admission and every 60 days or as needed, to ensure that it is completed by the registered nurse, current, accurate, signed, and dated by the registered nurse.	

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	listed patient #1's name, episode of 04/10/2021 - 06/08/2021, and service calendar. Below the service calendar was a list of tasks. Entry #1 stated "Aide Care Plan" which indicated it was assigned to the clinical manager, had a target date of 04/10/2021 and indicated the status of the document was "not started". During an interview on 06/09/2021 at 2:52 p.m., the clinical manager indicated I know how it looks, but we just carry over from the last aide care plan. During an interview on 06/11/2021 at 11:20 a.m., the clinical manager indicated the aide care plan only needed to be signed by her, but since she had not signed it, it showed up as not signed on the agency's electronic medical record. 17-13-2(a)			
G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the home health agency failed to ensure the home health aides followed the aide care plan established by the registered nurse, in 2 of 4 clinical records reviewed with home health aides. (#1, #2) The findings include: 1. The undated agency policy, number 6.021.1, titled "Home Health Aide" stated "... Policy: The agencies Director of Nursing, Alternate Director	G 0800	**G800 Services provided by HH aide** 1. Pt.#2 was discharged. Aide was counseled for not following the aide care plan. Pt.#1 Aide was counseled on following the aide care plan. 2. Completion date 08/27/2021 3. All active charts will be reviewed to ensure the aide care plans are being followed. The	08/27/2021

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	of Nursing, and/or Case Manager are responsible for assigning and overseeing the home health aide visits. 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. ... d. Written 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 patients plan of care and within the duties allowed to be permitted by a nurse aide...." 2. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Aide Care Plan" dated and digitally signed by the clinical manager on 03/19/2021. This document indicated the home health aide was to provide temperature checks, incontinent care (when soiled), record bowel movement, assist in ambulation, assist in transfer, turn or position the patient, change linen (on Thursdays and when soiled), provide light housekeeping, make bed, assist to dress (per patient preference), provide back rub/massages (per patient preference), check pressure areas, comb hair (per patient preference), provide foot care (per patient preference), provide oral hygiene denture care (assist set up per patient preference), provide partial bath/sponge (per patients preference), provide pericare (per visit when soiled), shampoo hair (per patient's preference), provide skin care, provide tub (per patient's preference), and practice universal precautions. Clinical record review evidenced agency		Aides will be in-serviced on following the Aide Plan of Care and notifying the Clinical Manager when there are missed home visits and when they are unable to complete all tasks listed on the Aide Care Plan. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for weekly review of all Aides documentation for completion of tasks.	

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	157650	A. BUILDING 00 B. WING	06/11/2021

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	documents titled "HHA [home health aide] Visit" dated 04/16/2021, 04/22/2021 and 05/13/2021, which failed to evidence the following tasks were completed: assist to dress, comb hair, foot care, pericare, shampoo, back rub/massage, oral hygiene denture care, partial bath and tub. During an interview on 06/11/2021 at 12:31 p.m., the clinical manager stated "I see what you're saying. We need to coach them to put something in." (in reference to blank aide task areas) Clinical record review evidenced agency documents titled "HHA Visit" dated 04/20/21, 04/23/2021, 05/05/2021, 05/06/2021, 05/11/2021, and 05/12/2021, which failed to evidence the following tasks were completed: change linen, assist to dress, comb hair, foot care, pericare, shampoo, back rub/massage, oral hygiene denture care, partial bath, and tub. During an interview on 06/11/2021 at 12:33 p.m., the clinical manager indicated sometimes the patient just wanted to sleep. Clinical record review evidenced an agency document titled "HHA Visit" dated 04/21/2021, which failed to evidence the following tasks were completed: assist to dress, bomb hair, foot care, pericare, shampoo, back rub/massage, oral hygiene denture care, check pressure areas, partial bath and tub. 3. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, primary diagnosis of multiple sclerosis, evidenced an agency document titled "Aide Care Plan" dated and digitally signed by the clinical manager on 04/10/2021. This aide care plan indicated the home health aide was to			

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	provide: temperature, catheter care, incontinent care, record bowel movement, assist in transfer, range of motion, turn or position, change linen (Monday, Wednesday, Friday and when soiled), light housekeeping, make bed, assist to dress, back rub massage (per patient preference), check pressure areas, comb hair (per patient preference), complete bath (per patient preference), foot care (per patient preference), nail care (per patient preference), oral hygiene denture care, partial bath/sponge (per patient preference), pericare, shampoo hair (per patient preference), skin care and to practice universal precautions. Clinical record review evidenced an agency document titled "HHA Visit" dated 05/08/2021. This home health aide visit note failed to evidence nail care, partial bath or tub was provided to the patient as directed on the aide care plan. During an interview on 06/11/2021 at 11:29 a.m., the clinical manager indicated the patient may not have wanted to be bothered. Clinical record review evidenced an agency document titled "HHA Visit" dated 05/15/2021. This home health aide visit note failed to evidence range of motion, back rub/massage, tub, complete bath, comb hair and foot care was provided as directed on the aide care plan. During an interview on 06/11/2021 at 11:34 a.m., the clinical manager indicated if it was blank it wasn't done and indicated she personally wouldn't know if it was done by the home health aide or not. During an interview on 06/11/2021 at 11:37 a.m., the clinical manager indicated they do update the aide care plan as appropriate, but we have told			

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	them (home health aides) not to document if it was not done. Clinical record review evidenced an agency document titled "HHA Visit" dated 05/17/2021. This home health aide visit note failed to evidence if the linen was changed as directed on the aide care plan.			
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. 5. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, contained agency documents titled "HHA [home health aide] Visit" dated 04/16/2021, 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021, 04/23/2021, 05/05/2021, 05/06/2021, 05/11/2021, 05/12/2021 and 05/13/2021, which failed to evidence the aide care plan established by the registered nurse was followed.	G 0818	**G818 HH aide supervision elements** 1. Pt.#3 aide visit document 5/7, 5/28, 5/24 by Employee E failed to evidence following the POC. The supervisory visit 6/23 by clinical manager incorrectly documented. Both the aide and clinical manager have been counseled. Pt. #4 aide visits on 5/11, 5/13, 5/16, 5/18 5/19, 5/23,	08/27/2021

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	The clinical record also failed to evidence that home health aide visits were made on 04/26/2021, 04/27/2021, 04/28/2021, 04/29/2021, 04/30/2021, 05/03/2021, 05/04/2021, 05/07/2021, 05/10/2021 and 05/14/2021. The home health aide failed to follow the plan of care. The clinical record failed to evidence the home health provided 6 hours of home health aide services, as directed on the plan of care, for the dates of 04/16/2021, 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021 and 04/23/2021. The home health aide failed to follow the plan of care. A review of an agency document titled "Aide Supervisory Visit" dated and digitally signed by the clinical manager on 05/17/2021. This document stated "... Reports for duty as assigned Satisfactory ... Follows client plan of care as instructed: Satisfactory ... Documents appropriately: Satisfactory...." During an interview on 06/11/2021 at 12:25 p.m., the clinical manager stated she didn't see any communication or documented reason for the home health aide missed hours. During an interview on 06/11/2021 at 12:31 p.m., the clinical manager stated "We need to coach them to put in something." (in reference to blank areas on the home health aide visit notes) During an interview on 06/11/2021 at 12:39 p.m., after reviewing the concerns with the supervisory visit note, the clinical manager stated "I see what you're saying." 6. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 -		5/26, 5/27 5/30, 6/1, 6/3, 6/6, 6/8, 6/9, 6/10 Aide failed to follow plan of care and the aide supervisory visit on 6/7/21 failed to ensure that the aide followed the aide plan. Both aide and supervising nurse have been verbally counseled. Pt.#2 has been discharged but noted that in multiple occurrences the aide care plan was not followed. The aide supervisory visit on 5/17 was incorrectly documented as it did not indicate the aide not following the Aide Care Plan. Pt.#1 aide visits 5/8, 5/15 and 5/17 aide failed to follow aide care plan and supervisory visit on 6/8 incorrectly document the aide followed the POC. Both the aide and clinical supervisor were verbally counseled. 2. Completion date 08/27/2021 3. Timely case management of aide's care plan documentation will be done to ensure aide is following the aide care plan. 4. The Clinical Manager will be responsible for weekly reviewing all home health aides and professional documentation notes to ensure that this deficiency does not recur.	

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	06/08/2021, primary diagnosis of multiple sclerosis, which contained agency documents titled "HHA [home health aide] visit dated 05/08/2021, 05/15/2021, and 05/17/2021, the home health aide visit notes failed to evidence the aide care plan was followed. A review of an agency document titled "Aide Supervisory Visit" dated and digitally signed by the clinical manager on 06/08/2021. This document stated "... Follows client plan of care as instructed: Excellent...." This supervision element failed to be correct. Based on record review and interview the home health agency failed to ensure that aides furnished care in a safe and effective manner, incluidng, but not limited to: following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse in 4 of 4 clinical records reviewed. (#1, #2, #3, #4) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Home Health Aide," stated "... To ensure that all home health aide visits responsibilities are clearly stated ... The home health aide shall have the following responsibilities ... 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. Review of the agency policy revised 6/10/21			

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	titled "Nurse Supervision," stated "... To ensure that all daily operations and patient care are provided in a professional standard that meets state regulatory guidelines ... The supervising nurse will oversee that patient communication takes place on a continuous basis. The supervising nurse will ensure that all disciplines are aware of condition changes and evaluations in a timely manner ... The supervising nurse will ensure that the patient's POC [plan of care] is being followed through chart audits, note reviews, staff communication and patient communication ...." 3. Clinical record review on 6/10/21 for patient #3, primary diagnosis: Chronic obstructive pulmonary disease (long-term inflammatory lung disease that causes obstructed airflow from the lungs, resulting in difficulty breathing), start of care 11/3/20, evidenced an agency document titled "Aide Care Plan," dated 5/2/21 and signed by the clinical supervisor. This document stated "... Change Linen ... Fridays and when soiled ... Record bowel movement ... Per visit ...." A record review evidenced agency documents titled "HHA [home health aide] Visit," dated 5/7/21 and 5/28/21 and signed by employee E, home health aide. These documents indicated the linen was not changed on 5/7/21 and 5/28/21. Clinical record review failed to evidence the linen was changed every Friday as ordered in the Aide Care Plan. A record review evidenced an agency document titled "HHA Visit," dated 5/24/21 and signed by employee E, home health aide. This document failed to indicate the last bowel movement. Clinical record review failed to evidence the aide recorded the last bowel movement as ordered in			

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	the aide care plan. A record review evidenced an agency document titled "Aide Supervisory Visit," dated 5/3/21 and signed by the clinical supervisor. This document stated "... Follows client plan of care as instructed ... Excellent ...." The home health aide supervisor failed to ensure the aide followed the aide care plan by changing the linen every Friday and recording the last bowel movement every visit. During an interview on 6/10/21 at 12:48 p.m., the administrator staated the linen changes on 5/7/21 and 5/28/21 were not done if they were not documented. During an interview on 6/10/21 at 12:49 p.m., the clinical supervisor stated the aide did not document the bowel movement on 5/24/21. 4. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Aide Care Plan," dated 5/9/21 and signed by the clinical supervisor. This document stated "... Either partial bath or complete bath are completed per visit with patient's preference ...." A record review evidenced agency documents titled "HHA [home health aide] Visit," dated 5/11/21, 5/13/21, 5/16/21, 5/18/21, 5/19/21, 5/23/21, 5/26/21, 5/27/21, 5/30/21, 6/1/21, 6/3/21, 6/6/21, 6/8/21, 6/9/21, and 6/10/21. Clinical record review failed to indicated the patient received either a partial bath or complete bath on the aformentioned dates.			

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	A record review evidenced an agency document titled "Aide Supervisory Visit," dated 6/7/21 and signed by the administrator. This document stated "... Follows client plan of care as instructed ... Excellent ...." The home health aide supervisor failed to ensure the aide followed the aide care plan by providing either a partial bath or complete bath every visit. During an interview on 6/11/21 at 1:03 p.m., the clinical supervisor stated she is noting the days that the baths were not completed. She indicated the patient has multiple sclerosis and may be exhausted and declining the baths since the baths take a lot of energy from him, but this was not documented.			
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. Based on record review and interview the home health agency failed to ensure all entries were appropriately authenticated in 3 of 4 clinical records reviewed. (#1, #2, #3) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Home Health Aide," stated "... To ensure that all home health aide visits responsibilities are clearly stated ... The home health aide shall have the following responsibilities ... Completing	G 1024	**G1024 Authentication** 1. Pt.#3 The home health aide home visit dated 6-4-21 has been authenticated with the home health aide's signature. Pt.#2 The Patient Communication document dated 4-26-2021 has been authenticated with the Administrator's credentials. Pt.#1 The home health aide visits notes dated 04/19, 4/20, 4/21, 4/22, 4/26, 4/27 4/28, 5/3, 5/4, 5/5, 5/6, 5/10, 5/11, 5/12, 5/13,	08/27/2021

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	appropriate records ...." 2. Review of the agency policy revised 6/10/21 titled "Clinical Records," stated "... To establish and maintain a client record system to assure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compliance and retrieval of information ... All notes and reports in the patient's clinical record shall be typewritten or legibly written in ink, dated and signed by the recording person with his full name or first initial and surname and title ...." 3. Clinical record review on 6/10/21 for patient #3, primary diagnosis: Chronic obstructive pulmonary disease (long-term inflammatory lung disease that causes obstructed airflow from the lungs, resulting in difficulty breathing), start of care 11/3/20, evidenced an unsigned agency document titled "HHA [Home Health Aide] Visit," dated 6/4/21. This document failed to evidence the home health aide signed the document after completing the visit. During an interview on 6/11/21 at 12:55 p.m., the clinical supervisor indicated in the computer it says that it is completed but the document does not say digitally signed. 4. Clinical record review for patient #2, start of care 10/01/2020, certification period 03/19/2021 - 05/17/2021, evidenced an agency document titled "Patient Communication" dated 04/26/2021 and digitally signed by the administrator. This document failed to have the administrator's credentials. 5. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 -		5/14, 5/16, 5/17, 5/18, 5/20, 5/24, and 6/8, 2021. All have been authenticated with the home health aide's credentials. The home health aide home visit note dated 05/19/2021 has been authenticated with the home health aide's signature and credentials. The home health aide documentation note dated 05/11/2021 with an incorrect entry on 05/12/2021 has been corrected and authenticated. 2. Completion Date 08-27-2021 3. All active patient's home health aide home visit notes and professional clinical notes will be reviewed for signature, date, and credentials. All electronic staff notes of active employees were reviewed and include the employees' credentials, dates, and signatures. The home health aides and professional staff will be in-serviced on ensuring documentation notes are legible, clear, complete, and appropriately authenticated and dated which includes computer entry signatures. 4. The Clinical Manager will be responsible for weekly reviewing all home health aides and professional documentation notes to ensure that this deficiency does not recur.	

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	06/08/2021, primary diagnosis multiple sclerosis, evidenced agency documents titled "HHA [home health aide] Visit" dated 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021, 04/26/2021, 04/27/2021, 04/28/2021, 04/28/2021, 05/03/2021, 05/04/2021, 05/05/2021, 05/06/2021, 05/10/2021, 05/11/2021, 05/12/2021, 05/13/2021, 05/14/2021, 05/16/2021, 05/17/2021, 05/18/2021. 05/20/2021, 05/24/2021 and 06/08/2021. These home health aide visit notes failed to evidence the home health aide's credentials. Clinical record review evidenced an agency document titled "HHA Visit" dated 05/19/2021. This document failed to evidence the home health aide's signature and credentials. During an interview on 06/11/2021 at 11:26 a.m., the administrator indicated she never actually noticed that the home health aide credentials didn't show up on agency documents. Clinical record review evidenced an agency document titled "HHA Visit" dated 05/11/2021. This home health aide visit note indicated the patient's last bowel movement was 05/12/2021, one day after the visit. This note failed to be authentic. During an interview on 06/11/2021 at 11:38 a.m., the clinical manager indicated the date had to be a "typo error". 410 IAC 17-15-1(a)(7)			
N 0000 Bldg. 00	This visit was for a follow-up visit of a State	N 0000	n/a	

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	complaint survey that was conducted on 2/25/2021 - 3/4/2021. Survey Dates: 6/9/2021, 6/10/2021, and 6/11/2021 Facility ID: 012828 At this survey, 2 state deficiencies were corrected, 2 state deficiencies were recited, and 1 new state deficiency was cited. Quality Review Completed on 6/29/21 by Area 3			
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 registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview the administrator of the home health agency failed to ensure the accuracy of public information materials in 1 of 4 clinical records reviewed. (#4) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Administrative Control," stated "... To define the composition, structure and responsibilities of the Agency's key components ... The administrator shall be responsible for implementing and supervising the administrative policies of the Agency and administratively supervise the provision of all services. At a	N 0447	N0447 1. Patient #4 has received the corrected introduction letter with the Agency's hours of operation. 2. All current patients have received a corrected introduction letter with the correct hours of operation. A signature page signed by each patient confirming receipt of the corrected introduction letter has been placed in the patient chart. 3. To ensure the accuracy of public information, the agency's Admission packet which contains the hours of operation, has been	07/20/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	minimum, the Administrator must ... Ensure the accuracy of public information materials and activities ... Operating hours are 10:00 am til 5pm Monday through Friday ...." 2. During a home visit on 6/10/21 at 9:14 a.m. for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, the family member of patient #4 provided the admission packet. The admission packet was observed to include a welcome letter that indicated the hours of operation were 8:30 a.m. to 5:00 p.m. Monday through Friday. The administrator failed to ensure the hours of operation in the admission packet given to the patient indicated 10:00 a.m. until 5:00 p.m. Monday through Friday. During an interview on 6/10/21 at 4:40 p.m. the administrator indicated they did not change the hours of operation in the admission packets that were given to the patients.		corrected. The admission packet will be reviewed before admission to ensure the accuracy of public information. 4. The Clinical Manager will be responsible for reviewing all admission documents before patients are admitted for service to ensure this deficiency will not recur. Completion date 07-20-2021	
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.			

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	(3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview the home health agency failed to ensure personnel records of employees who deliver home health services were kept current and include a receipt of job description and a copy of the current license in 3 of 5 records reviewed. (employee C, F, I) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Personnel Records," stated "... To ensure a standard method for maintaining employee records ... A separate file for each employee will be maintained ... Each file shall contain, at a minimum, copies of items listed on the following page, gathered upon hire ... Items with expiration are reviewed periodically prior to assigning a patient to an employee. If an item is required, it must be received before patients are assigned to that employee ... Personnel Records include at least the following ... Job description ... Professional license ...." 2. Personnel record review on 6/10/21 for employee C, home health aide, evidenced a start date of 2/19/19, and an expired home health aide license. Record review evidenced a document printed from the in.gov website that stated "... License Information ... Expiration: 2/21/23 ...." received by the clinical supervisor on 6/10/21 at 1:12 p.m. Record review failed to evidence documentation of employee C current license information in their personnel record. During an interview on 6/10/21 at 1:10 p.m., the	N 0458	N458 1. Employee C current license has been filed in their personnel record. Employee F current license and signed and dated job description has been filed in their personnel record. Employee I signed and dated job description has been filed in their personnel record. 2. 100% of active employees' records have been reviewed to ensure that the current license and signed and dated job descriptions are in their personnel record. The administrative assistant has been in-serviced on maintaining, tracking, and logging employees' personnel records. 3. A Personnel Log has been developed in order to track and log employees required personnel documents. 4. The Administrative Assistant will be responsible for monthly reviewing the Personnel log to verify all licenses are current and that all active employees have a signed and dated job description in their personnel record. Completion Date 07-20-2021	07/20/2021

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	administrator indicated the current license for employee C was in the green book. She indicated sometimes it is in the green book and they do not put it in the personnel folder. 3. Personnel record review on 6/10/21 for employee F, home health aide, evidenced a start date of 8/7/20, and an expired home health aide license. Record review evidenced a document printed from the in.gov website that stated "... License Information ... Expiration: 7/6/23 ...." received by the administrator on 6/10/21 at 1:20 p.m. Record review failed to evidence documentation of employee F current license information in their personnel record. A record review on 6/10/21 evidenced an agency job description for the position of home health aide. Record review failed to evidence a signed and dated job description by both employee F and the administrator in the personnel record. During an interview on 6/10/21 at 1:19 p.m., the administrator walked off to get the license from a different location when the current license was requested. She indicated it was in the green binder in another room. She indicated it was not actually a green binder but a blue binder. During an interview on 6/10/21 at 1:22 p.m., the administrator indicated the job description was not signed for employee F. 4. Personnel record review on 6/10/21 for employee I, home health aide, evidenced a start date of 12/2/20 and an agency job description for the position of home health aide. Record review failed to evidence a signed and dated job description by both employee I and administrator in the personnel record.			

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	During an interview on 6/10/21 at 1:16 p.m., the administrator indicated there was not a signed job description in the personnel file for employee I.			
N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis			

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	screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview the home health agency failed to ensure all employees, staff members, and persons providing care on behalf of the agency were evaluated for tuberculosis in 1 of 5 records reviewed. (employee I) The findings include: Review of the agency policy revised 6/10/21 titled "Employee Health Assessments," stated "... To clearly define Health Assessments for employees ... Provide for a tuberculosis screening which shall be administered to all new employees who have direct patient contact and annually thereafter ... The home health agency must maintain documentation of tuberculosis evaluations showing that any person working for the home health agency or having direct patient contact has had a negative finding on a tuberculosis examination within the previous twelve (12)	N 0464	N464 1. Employee-I –has completed a Baseline Individual TB Risk Assessment and has received Step 1 of 2-step TB test and results will be placed in employee's file. 2. 100% of active employee files will be reviewed to ensure prior to patient contact, a Baseline 2-step TB Test was completed, if indicated. 100% of active employees have completed a Baseline Individual TB Risk Assessment. A signed copy was placed in the employees' file. 3. All new employees will be required to have a Baseline 2-step TB skin test prior to direct patient contact, if indicated. Current	08/27/2021

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	months .... " Personnel record review on 6/10/21 for employee I, home health aide, evidenced a start date of 12/2/20 and first patient contact on 12/4/20. Record review failed to evidence the agency conducted a tuberculosis national standard evaluation for employee I. During an interview on 6/11/21 at 12:30 p.m., the administrator and clinical manager indicated they had no nationally recognized program to screen for tuberculosis.		employees will have an annual TB screening. 4. To prevent this deficiency from recurring, the administrative staff will be responsible for monthly reviewing employees Medical Personnel record to ensure the annual TB assessment and annual personnel requirements are completed timely. Completion Date 08-27-2021	
N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the home health agency failed to ensure coordination of care with outside entities which provided healthcare services to agency patients, in 2 of 4 clinical records reviewed. (#1, #2) The findings include: 1. The undated agency policy, number 3.009.1, titled "Coordination of Client Care" 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	N 0486	N486 1. Patient #1 A letter of coordination will be submitted to the entity providing additional services for the patient. An addendum to the Plan of Care including the name of the entity and services being provided will be submitted to the physician for signature. Patient #2 has been discharged. 2. All active patients will be contacted to identify if they are receiving services from additional outside entities. If determined, a Coordination of Care will be documented and filed in patient's EMR. 3. The Professional staff will be in-serviced on identifying upon patient's admission all entities	08/27/2021

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	regarding the client. All such coordination of care will be documented in the clinical record. Each client will be assessed upon admission as to identify any other agencies providing services to the client. ... Procedure: 1. Upon admission, the SN [skilled nurse] will identify any agencies involved in providing care. ... 4. 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...." 2. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Discharge Summary" dated and signed by the clinical manager on 05/20/2021. This document had an area subtitled "Discharge Summary Addendum Page" which stated "... Patient states she continues to receive services from [name of home health agency] for homemaker, is receiving PT [physical therapy] from Entity B...." Clinical record review failed to evidence any coordination of care with Entity B. During an interview on 06/11/2021 at 12:05 p.m., the clinical manager indicated the patient reported they (Entity B) provided physical therapy services and that she had 5 visits of PT. Employee H (administrative assistant) indicated she just asked what services they provided and when. 3. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, primary diagnosis of multiple sclerosis, evidenced an agency document titled "Missed Visit For (HHA [home health aide] Visit),		providing services. A letter of coordination will be submitted to the entity for signature and filed in the patient's medical record. The name of the entity and services provided will be documented on the Plan of Care. The entity will be notified of any significant changes 4. To ensure this deficiency from recurring, the Clinical Manager will be responsible for reviewing all admission packets to identify other entities providing service, submitting a letter of coordination and notifying the entity of any significant changes. Completion Date 08-27-2021	

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	dated and digitally signed by the administrator on 05/27/2021. This document indicated the patient was hospitalized. During an interview on 06/09/2021 at 2:00 p.m., the clinical manager indicated the patient was hospitalized at Entity C. During an interview on 06/09/2021 at 3:00 p.m., the clinical manager indicated Entity D [home health agency] provided the patient with her "home care". Then the clinical manager indicated they did not have any coordination of care with Entity D.			
N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on record review and interview, the home health agency failed to ensure the patients needs were met in their home according to the plan of care 2 of 4 clinical records reviewed. (#2, #4) Findings include: 1. The undated agency policy, number 6.016.1, titled "Care Planning" stated "... Policy: 1. It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and/or service based on the patient's needs and goals with the input of the patient for the purpose of achieving positive outcomes. 2. Care planning is performed to ensure that care and services are appropriate to each patient specific needs and problems. 3. The care planning	N 0520	**N 520** 1. Patient #2 has been discharged. Patient #4 - A corrected Plan of care will be sent to the physician that does not include skilled nursing services that were not ordered. 2. All active patients' plan of cares will be reviewed for accuracy of services to be provided. Identified incorrect Plans of Care will be amended and sent to the physician for review and signature. 3. The Nursing staff will be in-serviced on developing patients' plan of care to reflect patient's health needs that can be	08/27/2021

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	process will include the following: ... b. Identification of patient's goals and interventions to resolve the patient's problems and/or needs. c. Implementation of the planned care or services by appropriate clinicians and/or the patient/family. d. Monitoring the patient's response to the care provided and/or the outcome of the care provided will be ongoing. ... 8. The RN [registered nurse] will perform a comprehensive assessment in the formation of a care plan. ... Procedure: ... 4. The Plan of Care will be developed during and based on the initial and on-going assessments, including: a. Identification of appropriate patient problems and/or needs. ... 7. All qualified professionals involved in the patient's care, either directly or indirectly, will contribute to the Plan of Care, including consideration of the patient's problems, needs, condition and wishes and the patient's ability to respond to care services. ... 10. The Plan of Care is based upon the physician's orders and encompasses the equipment, supplies, disciplines, and services required to meet the patient's needs. ... 12. The frequency of the review of the Plan of Care is based on changes in the patient's health status, needs and the environmental factors affecting care. The qualified professional/Clinical Manager/Case Manager or Therapist is responsible for revising the Plan of Care or updating the Plan every 60 days if skilled care is determined to be needed. ... 16. The needs of the patient will be prioritized in order to identify the level of services to be provided...." 2. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, with a primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and digitally		adequately met. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for reviewing the Plans of care after admission every 60 days for accuracy prior to submission to the physician for signature. **Completion Date 08-27-2021**	

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	signed by the clinical supervisor on 03/19/2021. This plan of care had an area subtitled "Order and Treatments" which stated "... Patient is a 66 year old female who lives alone and does not have a caregiver. Patient has had multiple hospitalization in the past six months. Patient at high risk for re-hospitalization. Patient noted with overall decline in health and requires additionally [sic] help. Patient suffers from multiple comorbidities. ... Patient at risk for skin breakdown. Patient at risk for falls. Patient requires assistance complying with medical treatment and regimen. ... SN [skilled nurse] to provide comprehensive assessments. ... SN to instruct patient to take pain medication before pain becomes severe to achieve better pain control. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs. SN to instruct patient on measure to prevent pressure ulcer formation and skin breakdown. SN to instruct the Patient on measures to recognize cardiac dysfunction and relieve complications. SN to instruct patient on measures to detect and alleviate edema. SN to instruct the patient the following symptoms could be signs of a heart attack: chest discomfort, discomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and symptoms that necessitate calling 911. SN to instruct the Patient on signs/symptoms of UTI [urinary tract infection] to report to MD [medical doctor]/SN. SN may obtain urinalysis and urine culture & sensitivity (C&S) test as needed for signs/symptoms of UTI, to include pain, foul odor, cloudy or blood-tinged urine and fever. SN to instruct Patient on 2gNA+ [2 gram sodium] Heart Healthy diet. SN to instruct the Patient to contact agency to report any fall with or without minor injury and to call 911 for fall			

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	resulting in serious injury or causing severe pain or immobility. SN to instruct patient on fall precautions." Clinical record review failed to evidence any skilled nursing visit other than the comprehensive assessment to provide the education needed for the patient and caregiver as indicated in the plan of care. The skilled nurse failed to meet the patient's needs. 3. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/9/21 - 7/7/21, and signed by the clinical supervisor. This document stated "... SN [skilled nurse] to instruct patient to take pain medication before pain becomes severe ... SN to instruct patient on nonpharmacological [interventions that do not use medications to alleviate pain] pain relief measures ... SN to instruct patient/caregiver on measures to help prevent skin breakdown and pressure ulcer formation ... SN to instruct the patient/caregiver on factors that contribute to SOB [shortness of breath] ... SN to instruct patient/caregiver on measures to detect and alleviate edema ... SN to instruct the patient/caregiver the symptoms that could be signs of a heart attack ... SN to instruct the Patient/Caregiver on signs/symptoms of UTI [urinary tract infection] ... SN to instruct Patient/Caregiver on a well balanced regular diet ... SN to instruct the Patient/Caregiver to contact agency to report any fall ... SN to instruct the patient/caregiver on fall precautions ...." This document also stated "... Home Health Aide requesting to provide 6 hours a day, 5 days a			

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	week (Monday thru Friday) and 4 hours a day, 2 days a week (Saturday and Sunday) for 9 weeks. Respite HHA [home health aide] will be used if additional care/time is requested ...." Clinical record review failed to evidence any skilled nursing visit other than the comprehensive assessment to provide the education needed for the patient and caregiver as indicated in the plan of care. The skilled nurse failed to meet the patient's needs. 4. During an interview on 6/11/21 at 12:16 p.m., the clinical supervisor stated she does the skilled nursing services that are stated in the plan of care every certification period and stated she usually just asks how things have been since the last time she was out at the home.			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the home health agency failed to ensure the plan of care was established, individualized, followed and reviewed periodically by the primary care physician in 2 of 4 clinical records reviewed. (#1, #2) The findings include: 1. The undated agency policy, number 6.016.1, titled "Care Planning" stated "... Purpose: To define a systematic process to the clinicians for planning, reviewing and revising patient care or	N 0522	N522 1. Patient #1 cert period 4/10-21 – 6/08/21 has a completed and signed plan of care. Patient #2 cert 3/19/21 to 5/17/21 has a completed and signed plan of care filed in their discharged chart. 2. All active patients' medical records will be reviewed to ensure they have a current plan of care signed by the physician. All missed visit documentation is completed and the physician has been notified.	08/27/2021

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	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 service based on the patient's needs and goals with the input of the patient for the purpose of achieving positive outcomes. 2. Care planning is performed to ensure that care and services are appropriate to each patient specific needs and problems. 3. The care planning process will include the following: a. Formulation of care based on the patient's assessment function. b. Identification of patient's goals and interventions to resolve the patient's problems and/or needs. c. Implementation of the planned care or services by appropriate clinicians and/or the patient/family. d. Monitoring the patient's response to the care provided and/or the outcome of the care provided will be ongoing. ... 6. The care planning process will be documented on the Plan of Care/Treatment ... Procedure: ... 4. The Plan of Care will be developed during and based on the initial and on-going assessments, including: a. Identification of appropriate patient problems and/or needs. b. Measurable and individualized goals. c. Specific services to be provided. d. Actions to be taken to meet the patient goals. e. Type, frequency and duration of the above actions. ... 6. The admitting SN [skilled nurse]/PT [physical therapist] will initiate the written Plan of Care at the start of care, and the plan will e updated at least eery sixty (60) days or as needed. A summary of care will be sent every 60 days thereafter or more often as needed. ... 9. The care planning decisions will be reflected in the specific services provided and the designated actions planned and implemented to meet individualized patient problems and goals. 10. The Plan of Care is based upon the physician's orders and encompasses the equipment, supplies, disciplines, and services required to meet the		3. All missed visit communication documentation will be completed by professional staff and includes notifying the physician. An electronic log for physician signatures was implemented to track and monitor outgoing and incoming physician signed orders. 4. To prevent this deficiency from recurring, the professional staff will be responsible for updating the POC every 60 days. The administrative assistant will be responsible for submitting a second request for Plans of Care not received within 30 days and document the contact attempts. Completion Date 08-27-2021	

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	157650	A. BUILDING 00 B. WING	06/11/2021

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	patient's needs...." 2. The undated agency policy, number 4.004.1, titled "Physician Orders/ Plan of Care" stated "... Purpose: To ensure that each patient's care is under the direction of the physician. Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency's clinical record. Procedure: 1. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the Agency. 2. All orders on the CMS 485 will be specific to the client condition and 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. ... 10. The Agency provides written and oral reports to the physician regarding the patient's plan of treatment and appropriateness of the continuation of care. The Agency provides written and oral reports to the physician regarding the patient's condition at least every 60 days. Reports may be more frequent if there is an emergency, a need to alter the plan of care or a need to terminate services. ... 12. If the Agency does not receive a signed physician's orders within thirty (30) days of the date the order is sent to the physician for signature, the Agency contacts the physician's office to obtain the signed document or resends the order(s) to be signed. All follow-up contacts to obtain signed orders are documented." 3. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, and primary diagnosis of multiple sclerosis failed to evidence any plan of care for this certification period.			

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	During an interview on 06/09/2021 at 2:40 p.m., the clinical supervisor indicated she was still working on the patient's recertification for episode 04/10/2021 - 06/08/2021. She indicated she had done the visit, but the recertification was not done so in turn the 485/plan of care was not complete. She indicated she was working on this, but was behind. 4.. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, and primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and digitally signed by the clinical manager on 03/19/2021, but failed to have a physician's signature. This document had a section titled "Orders and Treatments" which stated "... Home Health Aide requesting to provide 6 hours a day up to 5 days week for 26 weeks. ... SN to provide comprehensive assessments...." A review of agency documents titled "HHA [home health aide] Visit" dated 4/16/21, 4/19/21, 4/20/21, 4/21/21, 4/22/21, and 4/23/21, failed to evidence the HHA provided services 6 hours a day as ordered on the plan of care. During an interview on 6/11/21 at 12:25 p.m., the clinical manager indicated she didn't see communication or anything documented for the reason the home health aide missed hours.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the			

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	home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview the home health agency failed to ensure the individualized plan of care included all the location to apply topical medications and failed to include implanted devices in 3 of 4 clinical records reviewed. (#2, #3, #4) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Client Records," stated "... To establish and maintain a client record system to assure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compliance and retrieval of information ... Upon processing of data related to	N 0524	N524 1. The POC has been amended for Patient #3 to include the location to apply topical medications. The POC has been amended for Patient #4 to include the location to apply topical medications. A discharge summary addendum page was added to Patient #2 chart which states the patient has an implanted device. 2. All active patients POCs were reviewed to ensure the patient's conditions and needs are individualized and include all the locations to apply topical medications. 3. POC will be reviewed every 60	08/27/2021

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	a new client ... The client record will include but not be limited to all of the following information: ... Care plan that includes medications ...." 2. Review of the agency policy revised 6/10/21 titled "Physician Orders/Plan of Care," stated "... To ensure each patient's care is under the direction of the physician ... The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency's clinical record ... The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the agency ... All orders on the CMS 485 [Plan of Care] will be specific to the client condition and needs ...." 3. Clinical record review on 6/10/21 for patient #3, primary diagnosis: Chronic obstructive pulmonary disease (long-term inflammatory lung disease that causes obstructed airflow from the lungs, resulting in difficulty breathing), start of care 11/3/20, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/2/21 - 6/30/21, and signed by the primary care physician and clinical supervisor. This document stated "... Proctozone-HC [medication used to treat minor pain, itching, swelling, and discomfort] External 2.5% thin layer Apply thin layer twice a day ...." This document failed to include where to apply the medication. During an interview on 6/11/21 at 12:44 p.m., the clinical supervisor indicated the plan of care does not say where to apply the medication, but she is now adding to the plan of care to apply the medication to the external rectum area. 4. Clinical record review on 6/11/21 for patient #4,		days for the accuracy of medication application and implanted devices. 4. The Clinical Manager is responsible for reviewing on admission and every 60 days all POCs for accuracy of medications, route and location and documentation of implantable devices. Completion Date 08-27-2021	

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	primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/9/21 - 7/7/21, and signed by the clinical supervisor. This document stated "... Aloe Vesta [medication used as a moisturizer to treat and prevent dry, rough, scaly, itchy skin and minor skin irritations] Protective External 1-10ml [milliliters] Apply thin coat to affected area and PRN [as needed] to prevent skin breakdown ...." This document failed to include where the affected area was located to apply the medication.5. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/21 - 05/17/21, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and digitally signed by the clinical manager on 03/19/2021. This document failed to evidence anything about the patient's implanted pacemaker. Clinical record review evidenced an agency document titled "Discharge Summary" dated and digitally signed by the clinical manager on 05/20/2021. This document had an area subtitled "Discharge Summary Addendum Page" which stated "... Patient has a pacemaker (inserted 05/04/2015)...." During an interview on 06/11/2021 at 12:10 p.m., the clinical supervisor indicated it was an oversight on her.			
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care			

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	professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review, and interview the home health agency failed to promptly alert the relevant physician to any changes in the patient's needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered in 1 of 4 clinical records reviewed. (#4) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Care Planning," stated "... Contains clinical information including pertinent diagnosis, mental status, types of services/equipment, frequency of visits, goals and interventions appropriate to each discipline, prognosis, rehabilitation potential, functional limitations, safety precautions, activities, nutritional requirements, medications, treatments, and instructions ... The Plan of Care will be developed during and based on the initial and on-going assessments, including ... Clinicians will inform the patient's physician of any changes that suggest a need to alter the Plan of Care ...." 2. Review of the agency policy revised 6/10/21 titled "Physician Orders/Plan of Care," stated "... To ensure that each patient's care is under the direction of the physician ... The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency's clinical record ... The Agency's professional staff continuously reviews clinical records to determine adequacy of the plan of treatment and appropriateness of the	N 0527	N527 1. Patient #4 the primary physician has been notified the times the caregiver refused services. A signed order has been received to amend the POC. 2. All active patients' POCs will be reviewed to ensure the relevant physician is promptly alerted to the changes in the patient's needs. 3. The Professional staff will in serviced on completing all missed visit documentation which includes notifying the physician and clinical supervisor. 4. To ensure this deficiency does not recur, the Clinical Manager will be responsible for ensuring all missed visits are documented, physicians are notified, plans of care are amended and a communication note is entered into the EMR. Completion Date 08-27-2021	08/27/2021

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	continuation of care ... The Agency provides written and oral reports to the physician regarding the patient's plan of treatment and appropriateness of the continuation of care ...." 3. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 5/9/21 - 7/7/21, and signed by the clinical supervisor. This document stated "... Home Health Aide requesting to provide 6 hours a day, 5 days a week (Monday thru Friday) and 4 hours a day, 2 days a week (Saturday and Sunday) for 9 weeks. Respite HHA [home health aide] will be used if additional care/time is requested ...." A record review evidenced agency documents titled "Missed Visit Form (HHA [home health aide] Visit)," dated 5/15/21, 5/21/21, 5/22/21, 5/24/21, and 5/29/21, and signed by the administrator. These documents stated "... Patient/Caregiver declines services today; patient/caregiver only want a specific aide who is unavailable at this time. Patient family able to assist patient ... MD [Doctor of Medicine] Notified ... No ...." Clinical record review failed to evidence the agency notified the physician of the caregiver's continual refusal of services from 5/15/21 - 5/29/21. During an interview on 6/11/21 at 1:06 p.m., the administrator indicated the family member of patient #4 did not want anybody else besides employee C, home health aide due to her brother passing away from COVID. She indicated the			

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	family needed the help, but the family member could not accept having anyone else there, despite the agency offering another aide. The administrator indicated they did the best they could to honor the family member's refusal. She also indicated they did not notify the MD for all of the missed visits.			
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. Based on record review and interview, the home health agency failed to ensure an aide care plan was developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving home health aide services for all	N 0533	N533 1. Patient #1 the nurse has completed and signed the Aide Care Plan. Patient #4 the nurse has completed and signed the Aide Care Plan. 2. All active patient Aide Care	08/27/2021

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	home health aide assignments, in 2 of 4 clinical records reviewed with a home health aide. (#1, #4) The findings include: 1. The undated agency policy, number 6.020.2, titled "Registered Nurse" stated "... Purpose: to ensure that all Registered Nurse responsibilities are clearly stated. Policy: Registered Nurse (RN). Skilled nursing services shall be provided by a registered nurse in accordance with the plan of treatment. These services shall include the following: Procedure: ... 4. The RN will make home health aide assignments, prepare written instructions for the aide, and supervise the aide in the home...." 2. Review of the agency policy revised 6/10/21 titled "Home Health Aide," stated "... To ensure that all home health aide visits responsibilities are clearly stated ... The agencies Director of Nursing, Alternate Director of Nursing, and/or Case manager are responsible for ... Written 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 patients plan of care and within the duties allowed to be permitted by a nurse aide ...." 3. Review of the agency policy revised 6/10/21 titled "Timeliness and Accuracy of Entries in the Clinical Record," stated "... 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 ... Each entry into the client record must be current, accurate, signed, legible, and dated with the date of the		Plans will be reviewed for completion and signature. 3. The nursing staff will be in-serviced on establishing a written care plan on admission and updating the aide care plan every 60 days at the time of recertification. 4. To ensure this deficiency does not recur, the Clinical Manager will be responsible for reviewing all Aide Care Plans on admission and every 60 days or as needed, to ensure that it is current, accurate, signed, and dated by the registered nurse. Completion Date 08-27-2021	

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	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 ...." 4. Clinical record review for patient #1 on 06/09/2021 at 2:18 p.m., evidenced the home health agency's electronic medical record system (Wellsky). This electronic medical record system listed patient #1's name, episode of 04/10/2021 - 06/08/2021, and service calendar. Below the service calendar was a list of tasks. Entry #1 stated "Aide Care Plan" which indicated it was assigned to the clinical manager, had a target date of 04/10/2021 and indicated the status of the document was "not started". During an interview on 06/09/2021 at 2:52 p.m., the clinical manager indicated I know how it looks, but we just carry over from the last aide care plan. During an interview on 06/11/2021 at 11:20 a.m., the clinical manager indicated the aide care plan only needed to be signed by her, but since she had not signed it, it showed up as not signed on the agency's electronic medical record.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the home health agency failed to ensure all medications the patients were prescribed were reconciled and	N 0541	N541 1. Pt. #2 has been discharged. Pt. #1 Recertification comprehensive assessment is complete, signed	08/27/2021

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	serious medication interactions were reported to the primary care physician during the medication reconciliation and failed to ensure the comprehensive assessment was completed timely to meet the patient's nursing needs in 2 of 4 clinical records reviewed. (#1, #2) The findings include: 1. The undated agency policy, number 4.009.2, titled "Medication Administration Record" stated ".... 11. To prevent and reduce the likelihood of adverse drug reactions, this agency checks the medication profile for interaction risks. Drug to drug reactions listed as potentially moderate or severe are reported to the prescribing physician prior to administration. Patients are educated on other types of adverse interactions possibilities, such as consuming alcohol while taking certain medications, or food and medication interactions. Education will be documented on the visit note...." 2. The undated agency policy, number 4.009.1, titled "Medication Profile" stated "... Policy: It is the responsibility of the admitting therapist/nurse to record all medications that the patient is currently taking on a routine or PRN [as needed] basis. Documentation will include upon admission, the medication, route, amount and frequency. Procedure: ... 3. Nursing staff check all drug therapy a patient may be taking to identify possible effectiveness, ineffectiveness, actual or potential interactions, side effects, desired effects, toxic effects, unusual/unexpected effects, allergic reactions, duplicate drug therapy, non-adherence, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and drug recalls and promptly report any problems to the physician. 4. At time of discharge the patient/provider will be provided with a complete		by physician, and filed in patient's EMR. 2. All active charts will be reviewed to ensure all medications prescribed were reconciled and serious medication reactions were reported to the primary care physician. All client records will be reviewed to ensure the comprehensive assessment is completed in timely manner to meet the patient's needs. 3. A medication reconciliation will be conducted during the comprehensive assessment every 60 days or if there are any changes in the patient's condition. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for every 60 days reviewing the comprehensive assessment to ensure the medication reconciliation is complete and action taken, if needed, and ensure that the comprehensive assessments are completed timely. Completion Date 08-27-2021	

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	and current medication profile. Upon transfer the receiving agency will receive a complete and current medication profile (whenever, possible)...." 3. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Patient Medication Record" dated and signed by the clinical manager on 05/17/2021. This document had an area subtitled "Current Medications" which stated "... Duloxetine HCL[hydrogen chloride] [for depression and anxiety] Oral 30 MG [milligram] 1 Cap (s) PO [by mouth] Daily ... Zofran ODT [oral disintegrating tablet] [for nausea] Oral 8 MG 1 Tab (s) PO 1 Tablet Q [every]8 PRN [as needed] For Nausea Antiemetics ... traMADol HCl [for pain] Oral 50 MG 1 Tab (s) PO Q4 Hours PRN Analgesics - Opioid...." This document also indicated the physician was not contacted and there were no interactions. Record review evidenced the combination of Duloxetine and Zofran can cause a serious medication interaction by increasing the risk of serotonin syndrome, in which severe cases can result in coma or death. There failed to be evidence in the clinical record the primary care physician was notified of this possible severe medication interaction. Record review evidenced the combination of Duloxetine and Tramadol can cause a serious medication interaction by increasing the risk of serotonin syndrome, in which severe cases can result in coma or death. There failed to be evidence in the clinical record the primary care physician was notified of this possible severe medication interaction.			

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	157650	A. BUILDING 00 B. WING	06/11/2021

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	During an interview on 06/11/2021 at 12:00 p.m., the clinical manager indicated "Kinnser" [electronic medical record] will tell you about interactions and if it doesn't flag it at high risk I don't take any actions. Clinical record review evidenced an agency document titled "Discharge Summary" dated and signed by the clinical manager on 05/20/2021, stated "Discharge Summary Addendum Page ... Patient wears a nitroglycerin patch for chest pain but states she really doesn't have chest pain at all and denies chest pain at time of assessment...." Clinical record review failed to evidence a nitroglycerin patch on the patient's plan of care or medication reconciliation documentation. During an interview on 06/11/2021 at !2:02 p.m., the clinical manager indicated she didn't update the profile. 4. Clinical record review for patient #1, start of care 08/13/2020, primary diagnosis of multiple sclerosis, failed to evidence a recertification comprehensive assessment for the certification period of 04/10/2021 - 06/08/2021. During an interview on 06/09/2021 at 2:40 p.m., the clinical manager stated she was still working on the patient's 4/9/2021 recertification comprehensive assessment. The clinical manager stated she performed the visit, but the recertification was not done and in turn the 485 [plan of care] was not complete. The clinical manager stated she was working on this document, but was behind. During an interview on 06/11/2021 at 11:27 a.m.,			

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	the clinical manager stated "I'm sorry I'm still working on it." (in regards to completion of the comprehensive assessment conducted on 04/09/2021).			
N 0547 Bldg. 00	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview, the home health agency failed to ensure verbal orders were received prior to all services and treatments being administered by the agency in 1 of 4 clinical records reviewed. (#2) The findings include: The undated agency policy, number 4.004.1, titled "Physician Orders/ Plan of Care" stated "... Purpose: To ensure that each patient's care is under the direction of the physician. Policy: The physician establishes and reviews a plan of treatment for the patient. ... Procedure: 1. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the Agency. ... 5. Copies of the plan of care and other orders requiring a physician's signature should be filed in the client record within 7 days of receipt in office. ... 7. The physician and appropriate professional staff will review and recertify the written plan of care at least once per	N 0547	N547 1. Pt. #2 Discharged POC was submitted to physician and returned signed. 2. All active patient charts will be reviewed to determine completion of the POC with signatures. The plan of care and other orders requiring a physician's signature will be filed in the patients EMR within 7 days of receipt in office. If the Agency does not receive a signed physician orders within thirty (30) days, the order is resent. 3. An electronic tracking log system will be used to monitor and track all outstanding POC's without signatures. All follow-up contacts will be documented in patient's EMR. 4. To prevent this deficiency from recurring the administrative staff will be responsible for monthly monitoring and tracking physician	08/27/2021

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	episode and as warranted by the patient's condition. ... 12. If the Agency does not receive a signed physician's orders within thirty (30) days of the date the order is sent to the physician for signature, the Agency contacts the physician's office to obtain the signed document or resends the order(s) to be signed. All follow-up contacts to obtain signed orders are documented...." Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, evidenced an agency document titled "Home Health Certification and Plan of Care" dated and digitally signed by the clinical manager on 03/19/2021. This document indicated the home health aide was to provide services 6 hours a day up to 5 days a week for 26 weeks, the skilled nurse was to provide comprehensive assessments, the skilled nurse was to instruct the patient of pain medication and non pharmacologic pain relief, instruct patient on prevention of pressure ulcers and skin breakdown, instruct patient to recognize cardiac dysfunction and relieve complications, instruct patient on how to detect and alleviate edema, instruct patient on signs and symptoms of a heart attack, instruct patient on signs and symptoms of a urinary tract infection and obtain urinalysis and urine culture if needed, instruct patient on diet, instruct patient to contacts agency for falls and instruct patient of fall precautions. This document failed to evidence the patient's primary care physicians signature prior to the administration of treatments, instruction and services. The clinical record failed to evidence that a verbal order was received from the prescribing physician by the agency clinician. During an interview on 06/11/2021 at 12:20 p.m.,		orders. Completion Date 08-27-2021	

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	the clinical manager indicated the plan of care was sent off to the physician, but it was not returned and the agency did not have a plan of care that was signed by the physician.			
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on record review and interview the home health agency failed to ensure that aides furnished care in a safe and effective manner, incluidng, but not limited to: following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse in 4 of 4 clinical records reviewed. (#1, #2, #3, #4) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Home Health Aide," stated "... To ensure that all home health aide visits responsibilities are clearly stated ... The home health aide shall have the following responsibilities ... 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. Review of the agency policy revised 6/10/21 titled "Nurse Supervision," stated "... To ensure	N 0606	N606 1. Pt.#3-Aide has received verbal counseling regarding not following the Aide Plan of Care on 5/7, 5/28, and 5/24, 2021. Pt.#4 Aide was counseled on not following the written care plan on 5/11, 5/13, 5/16, 5/18, 5/19, 5/23, 5/26, 5/27, 5/30, 6/1, 6/3, 6/6, 6/8, 6/9 and 6/10, 2021. The Clinical Supervisor was counseled on failing to ensure that the Aide was following Aide Care Plan. Pt. #2 has been discharged. Aide was counseled for not following plan of care. The Clinical Supervisor was counseled on failing to ensure the aide followed the aide care plan. Pt. #1 - The clinical supervisor was counseled on failing to ensure the aide followed the aide care plan on 5/8, 5/15 and 5/17, 2021. 2. All active charts will be reviewed to ensure the aide care plans are being followed as assigned by the	08/27/2021

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	that all daily operations and patient care are provided in a professional standard that meets state regulatory guidelines ... The supervising nurse will oversee that patient communication takes place on a continuous basis. The supervising nurse will ensure that all disciplines are aware of condition changes and evaluations in a timely manner ... The supervising nurse will ensure that the patient's POC [plan of care] is being followed through chart audits, note reviews, staff communication and patient communication ...." 3. Clinical record review on 6/10/21 for patient #3, primary diagnosis: Chronic obstructive pulmonary disease (long-term inflammatory lung disease that causes obstructed airflow from the lungs, resulting in difficulty breathing), start of care 11/3/20, evidenced an agency document titled "Aide Care Plan," dated 5/2/21 and signed by the clinical supervisor. This document stated "... Change Linen ... Fridays and when soiled ... Record bowel movement ... Per visit ...." A record review evidenced agency documents titled "HHA [home health aide] Visit," dated 5/7/21 and 5/28/21 and signed by employee E, home health aide. These documents indicated the linen was not changed on 5/7/21 and 5/28/21. Clinical record review failed to evidence the linen was changed every Friday as ordered in the Aide Care Plan. A record review evidenced an agency document titled "HHA Visit," dated 5/24/21 and signed by employee E, home health aide. This document failed to indicate the last bowel movement. Clinical record review failed to evidence the aide recorded the last bowel movement as ordered in the aide care plan.		Clinical Manager to ensure the aide follows the aide care plan. 3. Nursing staff will be in-serviced on frequency of Aides supervisory visits, developing Aides Plan of Care and ensuring the Aide is following the Aide Plan of Care. The Aides will be in-serviced on following the Aide Plan of Care and notifying the Clinical Manager or Nursing Supervisor when there are missed home visits and when they are unable to complete are tasks listed on the Aide Plan of Care. 4. To prevent this deficiency from recurring, the Clinical Manager will be responsible for weekly review of all aide documentation for completion of tasks and the Aide Supervisory documentation for timeliness of Aide Supervisory visits. Completion Date 08-27-2021	

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	A record review evidenced an agency document titled "Aide Supervisory Visit," dated 5/3/21 and signed by the clinical supervisor. This document stated "... Follows client plan of care as instructed ... Excellent ...." The home health aide supervisor failed to ensure the aide followed the aide care plan by changing the linen every Friday and recording the last bowel movement every visit. During an interview on 6/10/21 at 12:48 p.m., the administrator staated the linen changes on 5/7/21 and 5/28/21 were not done if they were not documented. During an interview on 6/10/21 at 12:49 p.m., the clinical supervisor stated the aide did not document the bowel movement on 5/24/21. 4. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling disease of the brain and spinal cord causing problems with vision, arm or leg movement, sensation or balance), start of care 11/21/18, evidenced an agency document titled "Aide Care Plan," dated 5/9/21 and signed by the clinical supervisor. This document stated "... Either partial bath or complete bath are completed per visit with patient's preference ...." A record review evidenced agency documents titled "HHA [home health aide] Visit," dated 5/11/21, 5/13/21, 5/16/21, 5/18/21, 5/19/21, 5/23/21, 5/26/21, 5/27/21, 5/30/21, 6/1/21, 6/3/21, 6/6/21, 6/8/21, 6/9/21, and 6/10/21. Clinical record review failed to indicated the patient received either a partial bath or complete bath on the aformentioned dates. A record review evidenced an agency document			

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	titled "Aide Supervisory Visit," dated 6/7/21 and signed by the administrator. This document stated "... Follows client plan of care as instructed ... Excellent ...." The home health aide supervisor failed to ensure the aide followed the aide care plan by providing either a partial bath or complete bath every visit. During an interview on 6/11/21 at 1:03 p.m., the clinical supervisor stated she is noting the days that the baths were not completed. She indicated the patient has multiple sclerosis and may be exhausted and declining the baths since the baths take a lot of energy from him, but this was not documented.5. Clinical record review for patient #2, start of care 10/01/2018, certification period 03/19/2021 - 05/17/2021, primary diagnosis of chronic obstructive pulmonary disease, contained agency documents titled "HHA [home health aide] Visit" dated 04/16/2021, 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021, 04/23/2021, 05/05/2021, 05/06/2021, 05/11/2021, 05/12/2021 and 05/13/2021, which failed to evidence the aide care plan established by the registered nurse was followed. The clinical record also failed to evidence that home health aide visits were made on 04/26/2021, 04/27/2021, 04/28/2021, 04/29/2021, 04/30/2021, 05/03/2021, 05/04/2021, 05/07/2021, 05/10/2021 and 05/14/2021. The home health aide failed to follow the plan of care. The clinical record failed to evidence the home health provided 6 hours of home health aide services, as directed on the plan of care, for the dates of 04/16/2021, 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021 and 04/23/2021. The home health aide failed to follow the plan of care.			

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	A review of an agency document titled "Aide Supervisory Visit" dated and digitally signed by the clinical manager on 05/17/2021. This document stated "... Reports for duty as assigned Satisfactory ... Follows client plan of care as instructed: Satisfactory ... Documents appropriately: Satisfactory...." During an interview on 06/11/2021 at 12:25 p.m., the clinical manager stated she didn't see any communication or documented reason for the home health aide missed hours. During an interview on 06/11/2021 at 12:31 p.m., the clinical manager stated "We need to coach them to put in something." (in reference to blank areas on the home health aide visit notes) During an interview on 06/11/2021 at 12:39 p.m., after reviewing the concerns with the supervisory visit note, the clinical manager stated "I see what you're saying." 6. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, primary diagnosis of multiple sclerosis, which contained agency documents titled "HHA [home health aide] visit dated 05/08/2021, 05/15/2021, and 05/17/2021, the home health aide visit notes failed to evidence the aide care plan was followed. A review of an agency document titled "Aide Supervisory Visit" dated and digitally signed by the clinical manager on 06/08/2021. This document stated "... Follows client plan of care as instructed: Excellent...." This supervision element failed to be correct.			

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N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview the home health agency failed to ensure all entries were appropriately authenticated in 3 of 4 clinical records reviewed. (#1, #2, #3) The findings include: 1. Review of the agency policy revised 6/10/21 titled "Home Health Aide," stated "... To ensure that all home health aide visits responsibilities are clearly stated ... The home health aide shall have the following responsibilities ... Completing appropriate records ...." 2. Review of the agency policy revised 6/10/21 titled "Clinical Records," stated "... To establish and maintain a client record system to assure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compliance and retrieval of information ... All notes and reports in the patient's clinical record shall be typewritten or legibly written in ink, dated and signed by the recording person with his full name or first initial and surname and title ...." 3. Clinical record review on 6/10/21 for patient #3, primary diagnosis: Chronic obstructive pulmonary disease (long-term inflammatory lung disease that causes obstructed airflow from the lungs, resulting in difficulty breathing), start of care 11/3/20, evidenced an unsigned agency document	N 0610	N610 1. Pt.#3 The home health aide home visit dated 6-4-21 has been authenticated with the home health aide's signature. Pt.#2 The Patient Communication document dated 4-26-2021 has been authenticated with the Administrator's credentials. Pt.#1 The home health aide visits notes dated 04/19, 4/20, 4/21, 4/22, 4/26, 4/27 4/28, 5/3, 5/4, 5/5, 5/6, 5/10, 5/11, 5/12, 5/13, 5/14, 5/16, 5/17, 5/18, 5/20, 5/24, and 6/8, 2021. All have been authenticated with the home health aide's credentials. The home health aide home visit note dated 05/19/2021 has been authenticated with the home health aide's signature and credentials. The home health aide documentation note dated 05/11/2021 with an incorrect entry on 05/12/2021 has been corrected and authenticated. 2. All active patient's home health aide home visit notes and professional clinical notes will be reviewed for signature, date, and credentials. All electronic staff notes of active employees were reviewed and include the employees' credentials, dates,	08/27/2021

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	titled "HHA [Home Health Aide] Visit," dated 6/4/21. This document failed to evidence the home health aide signed the document after completing the visit. During an interview on 6/11/21 at 12:55 p.m., the clinical supervisor indicated in the computer it says that it is completed but the document does not say digitally signed.4. Clinical record review for patient #2, start of care 10/01/2020, certification period 03/19/2021 - 05/17/2021, evidenced an agency document titled "Patient Communication" dated 04/26/2021 and digitally signed by the administrator. This document failed to have the administrator's credentials. 5. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, primary diagnosis multiple sclerosis, evidenced agency documents titled "HHA [home health aide] Visit" dated 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021, 04/26/2021, 04/27/2021, 04/28/2021, 04/28/2021, 05/03/2021, 05/04/2021, 05/05/2021, 05/06/2021, 05/10/2021, 05/11/2021, 05/12/2021, 05/13/2021, 05/14/2021, 05/16/2021, 05/17/2021, 05/18/2021. 05/20/2021, 05/24/2021 and 06/08/2021. These home health aide visit notes failed to evidence the home health aide's credentials. Clinical record review evidenced an agency document titled "HHA Visit" dated 05/19/2021. This document failed to evidence the home health aide's signature and credentials. During an interview on 06/11/2021 at 11:26 a.m., the administrator indicated she never actually noticed that the home health aide credentials didn't show up on agency documents.		and signatures. 3. The home health aides and professional staff will be in-serviced on ensuring documentation notes are legible, clear, complete, and appropriately authenticated and dated which includes computer entry signatures. 4. The Clinical Manager will be responsible for weekly reviewing all home health aides and professional documentation notes to ensure that this deficiency does not recur. Completion Date 08-27-2021	

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	Clinical record review evidenced an agency document titled "HHA Visit" dated 05/11/2021. This home health aide visit note indicated the patient's last bowel movement was 05/12/2021, one day after the visit. This note failed to be authentic. During an interview on 06/11/2021 at 11:38 a.m., the clinical manager indicated the date had to be a "typo error".			