STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K157	A. BUILDING 00 B. WING	10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNITY HOME HEALTH CARE LLC	1740 N JACKSONBURG RD STE A CAMBRIDGE CITY, IN 47327

(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
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: October 19th-22nd of 2020 Facility Number: 014194 Provider Number: 15K157 Census = 30 (unduplicated last 12 months) At this Emergency Preparedness survey, Unity Home Health Care LLC, was found in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 484.102	E 0000		
G 0000 Bldg. 00	This visit was for a Federal Recertification and State Licensure survey, in conjunction with an Infection Control COVID-19 focused survey, of a home health agency. Survey Dates: Octobers 19th through October 22nd of 2020 Facility ID: 014194 Provider #: 15K157 Medicaid Vendor ID: 300009870 Medicaid Waiver ID: 300011435 12 month Unduplicated Census: 30	G 0000		

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

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

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	8 Active Records Reviewed 4 Closed Records Reviewed Home Visits: 3 Partially Extended on October 20, 2020 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. Quality Review completed on 11/5/2020 A4			
G 0416 Bldg. 00	484.50(a)(1)(iii) OASIS privacy notice (iii) An OASIS privacy notice to all patients for whom the OASIS data is collected. Based on record review and interview, the agency failed to ensure patients whom OASIS (Outcome and Assessment Information Set) data was reported on received an OASIS privacy notice in 6 of 6 adult patient's reviewed. (Patients 2, 8, 9, 10, 11, and 12) Findings include: 1. A policy titled "2.7 Guidelines for Assessment" was provided by the administrator on 10/22/2020 at 10:30 a.m. The policy indicated, but was not limited to, "1. The Initial Assessment form is utilized by the RN [Registered Nurse] for the initial evaluation and/or assessment in order to: ... d. Initiate the home health process and assure completion of all admission forms and documents." 2. A policy titled "2.13 Case Management and Assignments" was provided by employee E on 10/19/2020 at 1:57 p.m. The policy indicated, but	G 0416	(iii)Agency needs to document that the OASIS privacy notice in patient booklet was given to current patients. OASIS privacy notice is to be given to all new patients at the start of care. Quality Assurance nurse to audit patient charts 25% for 3 months once threshold is met, audit 10% for 6 months. Threshold is 100%. (1)Agency to ensure policy 2.7 is adhered by the RN at the time of the initial assessment. Agency to follow home health processes and confirm that initial assessment is completed and initiate process of completing all admission forms and documents. Review 25% of initial assessments for 6 months until threshold is met. Then review 10% annually. Threshold is 100%. (2)Agency will initiate admission	11/20/2020

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	was not limited to, "10. A. On Admission, each patient shall receive: A copy of the patient Bill of Rights and Responsibilities which includes the State Hotline number. B. A copy of the Agency's Patient Grievance Policy. C. A description of available services, service changes, payment sources, discharge planning process, and geographic area served. D. The Agency brochure. E. Information on Advance Directives. F. A copy of the Agency's policy on Abuse, Neglect, and Exploitation." The policy failed to include an OASIS privacy notice. 3. On 10/19/2020 at 10:33 a.m. an admission packet was provided by the administrator. The packed failed to include an OASIS privacy notice. 4. On 10/19/2020 the complete clinical record for patient 2, SOC (Start of Care) 07/13/2017, was reviewed. The record failed to include documentation evidencing patient 2 received an OASIS privacy notice. 5. On 10/22/2020 the clinical record for patient 8, SOC 01/19/2019, was reviewed. The record failed to include documentation evidencing patient 8 received an OASIS privacy notice. 6. On 10/22/2020 the clinical record for patient 9, SOC 07/15/2017, was reviewed. The record failed to include documentation evidencing patient 9 received an OASIS privacy notice. 7. On 10/22/2020 the clinical record for patient 10, SOC 05/31/2019, was reviewed. The record failed to include documentation evidencing patient 10 received an OASIS privacy notice. 8. On 10/22/2020 the clinical record for patient 11, SOC 12/11/2019, was reviewed. The record failed		and provide correct documentation to patient at the start of care in accordance to policy 2.13. This should be documented. Audit 25% of patient charts for 3 months to ensure correct documentation was provided at the start of care. After threshold is met, audit 10% of patient charts annually. Threshold is 100%. (3. - 4.) Audit 25% of patient charts for 3 months until threshold is met to ensure all documentation is provided to patient. After threshold is met audit 10% of patient charts per year. Threshold is 100%. (5. - 10.)Audit 25% of patient charts for 3 months until threshold is met to confirm that all documentation is provided to patient at the start of care. Patient should always receive OASIS privacy notice. After threshold is met audit 10% of client charts annually to ensure documentation that all documents are provided.	

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	to include documentation evidencing patient 11 received an OASIS privacy notice. 9. On 10/22/2020 the clinical record for patient 12, SOC 09/08/2020, was reviewed. The record failed to include documentation evidencing patient 12 received an OASIS privacy notice. 10. During an interview on 10/20/20 at 12:20 p.m., the administrator acknowledged OASIS privacy notices were not included in the admission packet and not provided to patients whom OASIS data is reported.			
G 0422 Bldg. 00	484.50(a)(4) Written notice within 4 business days Provide written notice of the patient's rights and responsibilities under this rule and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section to a patient-selected representative within 4 business days of the initial evaluation visit. Based on record review and interview, the agency failed to provide a written copy of the agency's discharge/transfer policy in 12 of 12 records reviewed. (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12) Findings include: 1. A policy titled "2.7 Guidelines for Assessment" was provided by the administrator on 10/22/2020 at 10:30 a.m. The policy indicated, but was not limited to, "1. The Initial Assessment form is utilized by the RN for the initial evaluation and/or assessment in order to: ... d. Initiate the home health process and assure completion of all admission forms and documents."	G 0422	(1) In adherence to policy 2.7, upon assessment, all appropriate documentation must be documented and provided to patient. Review 25% of assessments in client charts for 6 months to ensure correct documentation is provided. Once threshold is met, review 10% annually. Threshold is 100%. (2-3) In adherence to policy 2.13, it is necessary to include a discharge/transfer policy or procedure. Each patient should receive a Bill or Rights and Responsibilities, including the state hotline #. Also the Agency's Patient Grievance Policy, the	11/20/2020

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	2. A policy titled "2.13 Case Management and Assignments" was provided by employee E on 10/19/2020 at 1:57 p.m. The policy indicated, but was not limited to, "10. A. On Admission, each patient shall receive: A copy of the patient Bill of Rights and Responsibilities which includes the State Hotline number. B. A copy of the Agency's Patient Grievance Policy. C. A description of available services, service changes, payment sources, discharge planning process, and geographic area served. D. The Agency brochure. E. Information on Advance Directives. F. A copy of the Agency's policy on Abuse, Neglect, and Exploitation." The policy failed to include a discharge/transfer policy or procedure. 3. On 10/19/2020 at 10:33 a.m. an admission packet was provided by the administrator. The packet failed to include a discharge/transfer policy or procedure. 4. On 10/19/2020 the complete clinical record for patient 2, SOC (Start of Care) 07/13/2017, was reviewed. The record failed to evidence patient 2 received a copy of the agency's discharge/transfer policy. 5. On 10/19/2020 the complete clinical record for patient 1, SOC 01/10/2020, was reviewed. The record failed to evidence patient 1 received a copy of the agency's discharge/transfer policy. 6. On 10/19/2020 the complete clinical record for patient 3, SOC 07/29/2019, was reviewed. The record failed to evidence patient 3 received a copy of the agency's discharge/transfer policy. 7. On 10/19/2020 the complete clinical record for patient 4, SOC 03/09/2020, was reviewed. The record failed to evidence patient 4 received a copy		agency brochure; to include available services, service changes, payment sources, discharge planning processes and geographic area served. Need to Advanced Directives and policy on Abuse, Neglect and Exploitation. Audit 25% of patient charts for 6 months to ensure thorough material is included. After threshold is met, audit 10% of all patient charts for a year. Threshold is 100%. (4. - 16.) In adherence to policy 2.13, agency is to include a copy of the discharge/ transfer policy in the admission packet. Audit 10% of patient charts for 6 months. Once threshold is met, audit 10% annually.	

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	of the agency's discharge/transfer policy. 8. On 10/19/2020 the complete clinical record for patient 5, SOC 01/30/2020, was reviewed. The record failed to evidence patient 5 received a copy of the agency's discharge/transfer policy. Patient 5's admission packet was reviewed on 10/20/2020 at 9:45 a.m. The packet failed to include a copy of the agency's discharge/transfer policy. 9. On 10/19/2020 the complete clinical record for patient 6, SOC 06/17/2019, was reviewed. The record failed to evidence patient 6 received a copy of the agency's discharge/transfer policy Patient 6's admission packet was reviewed 10/20/2020 at 10:50 a.m. The packet failed to include a copy of the agency's discharge/transfer policy. 10. On 10/19/2020 the complete clinical record for patient 7, SOC 10/20/2018, was reviewed. The record failed to evidence patient 7 received a copy of the agency's discharge/transfer policy. 11. On 10/22/2020 the clinical record for patient 8, SOC 01/19/2019, was reviewed. The record failed to evidence patient 8 received a copy of the agency's discharge/transfer policy. 12. On 10/22/2020 the clinical record for patient 9, SOC 07/15/2017, was reviewed. The record failed to evidence patient 9 received a copy of the agency's discharge/transfer policy. 13. On 10/22/2020 the clinical record for patient 10, SOC 05/31/2019, was reviewed. The record failed to evidence patient 10 received a copy of			

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	the agency's discharge/transfer policy. 14. On 10/22/2020 the clinical record for patient 11, SOC 12/11/2019, was reviewed. The record failed to evidence patient 11 received a copy of the agency's discharge/transfer policy. 15. On 10/22/2020 the clinical record for patient 12, SOC 09/08/2020, was reviewed. The record failed to evidence patient 12 received a copy of the agency's discharge/transfer policy. 16. During an interview on 10/20/20 at 12:20 p.m., the administrator reviewed and acknowledged the patient's did not receive a copy of the agency's discharge/transfer policy.			
G 0436 Bldg. 00	484.50(c)(5) Receive all services in plan of care Receive all services outlined in the plan of care. Based on observation, record review, and interview the agency failed to ensure patients received all services as ordered in 1 of 3 home visits observed. (Patient 5). Findings include: A policy titled "2.8 Care Plan" was provided by the administrator on 10/20/2020 at 12:20 p.m. The policy indicated, but was not limited to, "In order to ensure that a patient's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient situation as needed, a care plan is essential. ... Home health services from members of the Agency staff, as well as under contractual arrangements, shall be provided in accordance with the plan of treatment and the patient care	G 0436	In accordance to policy 2.8, all services shall be provided in accordance with the plan of treatment and the patient care plan. Audit 25 % of patient charts for 6 months. Once threshold is met, audit 10% annually. Agency should ensure that all orders on the plan of care are completed as written. These spectrums of care are to be documented as well. Audit 25% of patient charts for 6 months until threshold is met. Once threshold is met, audit 10% of patient charts annually. Threshold is 100%. Agency should ensure that all orders on the plan of care are completed as written. These	11/20/2020

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	plan." The complete clinical record for patient 5 for the certification period 09/26/2020 to 11/24/2020 was reviewed on 10/19/2020. The record evidenced the following: A document titled "Home Health Certification and Plan of Care" for the certification period 09/26/2020 to 11/24/2020 indicated, but was not limited to, "21. Orders for Discipline and Treatments ... SN (Skilled Nurse) to complete ... care for colostomy (surgical opening from the large intestine to the abdomen) including emptying and changing bag and appliance every 2 days and PRN (As Needed)...10. Medications...Antifungal External Powder 2% - light dusting - with colostomy change - topical (applied directly to part of the body)...Ilex Skin Protectant External Paste 49.8 % - small - amount - after stoma (opening on the abdomen) powder - topical - ongoing..." A document titled "Skilled Nursing Visit Note" for visit date 10/03/2020 by employee F evidenced the following: "Gastrointestinal note: Colostomy Care- empty/change bag and appliance every 2 days and prn (as needed)... General notes ... 1500 (3:00 p.m.) Mom arrives home and patient is all smiles to see her. Let mom know low long patient napped, what patient ate, and about his diaper change. She states that she had changed a full BM (bowel movement) when changing his colostomy bag right before my [employee F] arrival..." A document titled "Appointment Calendar for Patient" indicated, but was not limited to, a missed visit on 10/05/2020 and 10/10/2020. A document titled "Skilled Nursing Visit Note" for		spectrums of care are to be documented as well. Audit 25% of patient charts for 6 months until threshold is met. Once threshold is met, audit 10% of patient charts annually. Threshold is 100%. Agency should ensure that medication that was ordered and on the plan of care is administered as written. This needs to be documented as well. Audit 10% of patient charts for 6 months until threshold is met. Once threshold is met, audit 10% of patient charts annually. Threshold is 100%.	

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	visit date 10/06/2020 by employee G evidenced the following: "Gastrointestinal note: Colostomy Care-empty/change bag and appliance every 2 days and prn (as needed)..." The document failed to evidence the last date patient 5's colostomy had been changed by the family or agency and failed to evidence employee G changed the colostomy bag indicating a 3 day lapse between bag changes. Skilled Nursing Visit Notes for 10/07/2020 and 10/08/2020 evidenced patient 5's colostomy bag was changed as ordered. A document titled "Skilled Nursing Visit Note" for visit date 10/12/2020 by employee G evidenced the following: "Gastrointestinal note: Colostomy Care-empty/change bag and appliance every 2 days and prn (as needed)..." The document failed to evidence the last date patient 5's colostomy had been changed by the family or agency and failed to evidence employee G changed the colostomy bag indicating a 4 day lapse between bag changes. A document titled "Medication Administration Log" for the period of 08/01/2020 to 10/18/2020 failed to evidence skilled nurse administered ordered Antifungal External Powder and Ilex external skin protectant paste with colostomy bag changes and stoma care for visit dates 10/01/2020, 10/07/2020, 10/08/2020, 10/13/2020, and 10/15/2020. During an interview on 10/20/2020 at 9:45 a.m. when asked how often patient 5's colostomy bag was changed employee G responded "Every 2 to 3 days and as needed" Employee G stated patient 5's stomas medications were only used with excoriation.			

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	On 10/20/2020 the administrator was asked about the discrepancy between the orders on the plan of care and how often the skilled nurses were changing the colostomy bag and stated she would speak with the nurses and get clarification on the order and update accordingly. The administrator stated all medications administered including topical medications should be entered in the medication administration log. 17-12-3(b)(2)(D)(iii)			
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to promptly notify the physician of changes in the patient's condition and outcomes not being met and failed to follow agency policy for pain assessment in 1 of 5 pediatric patient's reviewed. (Patient 7) Findings include: On 10/22/2020 at 10:30 a.m. a policy titled "2.7 Guidelines for Assessment" was provided by the administrator. The policy indicated, but was not limited to, "ix. Pain Assessment to include: 1. History of pain management 2. Intensity of pain 3. Descriptors of pain 4. Pattern of pain 5. Location and radiation of pain 6. Frequency, timing, and duration of pain 7. Impact on qualify of life 8. Activities, treatments, and or care that precipitates or exacerbates pain 9. Strategies and factors that reduce pain 10. Patient/Family goals for pain	G 0590	Agency should adhere to notifying the physician upon any changes in status of patient. All documentation needs to be thorough and completed. Audit 10% of all patient charts for 6 months until threshold is met. After being met, audit 10% of charts annually. Threshold is 100%. Agency to ensure all assessments are completed and documented thoroughly, including a thorough pain assessment. Audit 10% of charts for 3 months until threshold is met. Once threshold is met audit 10% of patient charts annually. Threshold is 100%.	11/20/2020

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	management and their satisfaction with the current level of pain control." On 10/20/2020 at 12:20 p.m. a policy titled "2.21 Physician's Plan of Treatment" was provided by the employee F. The policy indicated, but was not limited to, "12. In addition to required reports, the physician is immediately notified when: ... c. any significant adverse change in the patient's condition." On 10/19/2020 the complete clinical record for the certification period 09/26/2020 to 11/24/2020 was reviewed for patient 7. The record evidenced the following: An 08/20/2020 document titled "Skilled Nursing Visit Note" for the time period 09:00 a.m. - 3:00 p.m. authored by employee D indicated, but was not limited to, Pain Location: [blank], Pain Intensity: [blank], Pain acceptable level: [blank], Pain Duration days/intermittent, Medication last taken 08/20/2020 1:05 a.m., Pain Description "pt (patient) cries most of shift", Pain Management: "extreme oral pain, otc (over the counter) prn (as needed) pain reliever not helping to relieve pain, frequent care to mouth." General Notes: "1000 [10:00 a.m.] Patients pain has increased and crying has increased and become a daily concern in regards to the pain the patient is feeling and pt (patient) has become tolerant to pain treatment d/t (due to) the length of time ... expressed to parent frequently d/t frequent infections and pt inability to sleep at night as well as not being able to participate in activities and elearning or therapy rom [sic] d/t pain during shifts. 11. Patient irritable d/t ... Patient given Tylenol and Motrin prn as ordered see MAL (Medication Administration Log), given ibuprofen for pain ..."		If there is a change in patient's status, physician needs to be notified right away. Audit 25% of patient skilled nursing visit notes for 3 months. After threshold is met, audit 10% of patient skilled nursing visit notes every 6 months. Threshold is 100%	

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	A document titled "Patient Communication Log" for the date range 08/20/2020 - 10/19/2020 evidenced the first communication entry on 08/24/2020 authored by employee B that indicated, but was not limited to, "Pt admitted to [name of hospital] hospital." During an interview on 10/22/2020 at 11:44 a.m. the administrator was asked to review the record. After review the administrator stated employee D should have notified the patient's physician. 17-13-1(a)(2)			
G 0616 Bldg. 00	484.60(e)(2) Patient medication schedule/instructions Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to provide written medication instructions for 2 of 3 home visits potentially affecting all 25 active patients. (Patients #5, 6) Findings Include: 1. A policy titled "2.13 Case Management and Assignments" was provided by employee F on 10/19/2020 at 1:57 p.m. The policy indicated, but was not limited to, "10. A. On Admission, each patient shall receive: A copy of the patient Bill of Rights and Responsibilities which includes the State Hotline number. B. A copy of the Agency's Patient Grievance Policy. C. A description of available services, service changes, payment sources, discharge planning process, and geographic area served. D. The Agency brochure.	G 0616	(1) Agency to ensure that written documentation is to be thorough and complete. Agency should include all documentation as required. All documentation on medication schedule/instructions given to patient should be in layman's terms. Audit 10% of patient charts for 6 months until threshold is met. Once threshold is met, audit 10% of patient's charts annually. Threshold is 100%. (2. - 7.) All patients are to receive a copy of their written medication instructions in layman's terms along with a current Plan of Care at each recertification. Audit 25% of patient charts for 3 months until	11/20/2020

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	15K157	A. BUILDING 00 B. WING	10/22/2020

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UNITY HOME HEALTH CARE LLC	1740 N JACKSONBURG RD STE A CAMBRIDGE CITY, IN 47327

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	E. Information on Advance Directives. F. A copy of the Agency's policy on Abuse, Neglect, and Exploitation." The policy failed to include a written copy of the patient's medication instructions in plain language. 2. Patient 5's admission packet was reviewed on 10/20/2020 at 9:45 a.m. The packet failed to include a copy of the patient's written medication instructions. 3. Patient 6's admission packet was reviewed on 10/20/2020 at 10:50 a.m. The packet failed to include a copy of the patient's written medication instructions. 4. During an interview on 10/20/2020 at 9:17 a.m. patient 5's caregiver stated they were not provided a written medication list or plan of care from the facility. 5. During an interview on 10/20/2020 at 9:16 a.m. employee H stated the agency did not provide written plans of care or medication lists to the patient's as the agency staff has digital copies on their computers they bring to each visit. 6. During an interview on 10/20/2020 at 12:20 p.m., the administrator and employee F reviewed and acknowledged the patient's did not receive a copy of their written medication instructions. 7. During an interview on 10/20/2020 at 9:45 a.m. employee G stated she does not provide written plans of care or written medication instructions to the patients or their caregivers.		threshold is met. Threshold is 100%.	
G 0618 Bldg. 00	484.60(e)(3) Treatments and therapy services Any treatments to be administered by HHA			

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	personnel and personnel acting on behalf of the HHA, including therapy services. Based on record review and interview, the agency failed to provide a written plan of care in 2 of 3 home visits potentially affecting all 25 active patients. (Patient 5, 6) Finding's include: 1. A policy titled "2.8 Care Plan" was provided by the administrator on 10/20/2020 at 12:20 p.m. The policy indicated, but was not limited to, "In order to ensure that a patient's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient situation as needed, a care plan is essential. ... Home health services from members of the Agency staff, as well as under contractual arrangements, shall be provided in accordance with the plan of treatment and the patient care plan." 2. A policy titled "2.27 Patient Involvement in Care Planning" was provided by the administrator on 10/20/2020 at 12:20 p.m. The policy indicated, but was not limited to, "1. In order that patients (and families, as appropriate), admitted for home care services will be assured the right to make decisions regarding their care and to be involved in the care planning process, the Agency shall adopt, implement, and enforce a written policy to define patient involvement in care planning and decision-making. 2. This is done to optimize patient/family participation in care planning and decisions affecting patient care, including planning for transfer, referral or discharge, and executing advance directives ... 3. Patient 5's admission packet was reviewed on	G 0618	(1) Abiding by policy 2.8, all patients need to have a written plan of care in the home. This shall be provided in accordance with the plan of treatment and the patient care plan. Audit 25% of charts for 6 months on all new patients to be sure there is a plan of care written. After threshold is met, audit 10% of charts for every 6 months. Threshold is 100%. (2) An appropriate family member should be included in patient's care. This is to optimize patient / family participation in the care. Audit 25% of patient's charts for 3 months to make sure that family is in patient's care. Once threshold is met, audit 10% of patient charts annually. (3.-5.) Audit 25% of all patient's charts for 3 months to make sure that the patient's plan of care and medication list is provided. After threshold is met, audit 10% every 6 months. Threshold is 100%. (6. - 8.) Agency is expected to provide a written care plan as well as medication list to the patient. Audit 25% of patient charts for 3 months until threshold is met. Once threshold is met, audit 10% of patient's charts annually.	11/20/2020

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	10/20/2020 at 9:45 a.m. The packet failed to include a copy of the patient's plan of care. 4. Patient 6's admission packet was reviewed on 10/20/2020 at 10:50 a.m. The packet failed to include a copy of the patient's plan of care. 5. During an interview on 10/20/2020 at 9:17 a.m., patient 5's caregiver stated they were not provided a written medication list or plan of care from the facility. 6. During an interview on 10/20/2020 at 9:16 a.m., employee H stated the agency did not provide written plans of care or medication lists to the patient's as the agency staff has digital copies on their computers they bring to each visit. 7. During an interview on 10/20/2020 at 9:45 a.m. employee G stated she does not provide written plans of care or written medication instructions to the patients or their caregivers. 8. During an interview on 10/20/20 at 12:20 p.m., the administrator reviewed and acknowledged the patient's did not receive a copy of their written plan of care.			
G 0726 Bldg. 00	484.75(c)(1) Nursing services supervised by RN Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). Based on record review and interview, the agency failed to ensure documentation of RN (Registered Nurse) clinical supervision of LPNs (Licensed Practical Nurses) for 1 of 1 agencies. Findings Include:	G 0726	A Registered Nurse is to provide supervision of Licensed Practical Nurses providing care in the patient's home every 60 days. Agency will audit 25% of patient charts every 3 months to ensure the supervision of care is	11/20/2020

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	A policy titled "2.7 Patient Involvement in Care Planning" was provided by the administrator on 10/22/2020 at 10:30 a.m. The document indicated, but was not limited to, "Monitoring of Services Provided to a Patient ... 3. If the patient is receiving care from an LPN or Therapy Assistant, supervision will occur every 2 months by the appropriate discipline and the patient may be visited by both the LPN and Therapy Assistant and a Registered Nurse/Therapist or by the Registered Nurse/Therapist alone." During an interview on 10/20/2020 at 12:20 p.m. when asked for documentation of LPN supervision, the administrator stated that RNs do not supervise LPNs as they do all the same tasks, but most patients have an LPN and an RN on their case. Only an RN will perform the initial and comprehensive assessment. The agency refers to all skilled nurses as field nurses but if there are any issues the patients can express those concerns with the RN or Case Manger. 17-14-1(a)(1)(J)		completed by Registered Nurse only and every 60 days if applicable. After target threshold is met, audit 10% client's charts every 6 months. Target threshold is 100%.	
N 0000 Bldg. 00	This visit was for a state licensure survey. Survey Dates: October 19th through 22nd of 2020. Facility Number: 014194 Provider Number: 15K157 Medicaid Vendor ID: 300009870 Medicaid Waiver ID: 300011435 Census: 30 (Unduplicated last 12 months)	N 0000		

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N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the agency failed to develop a policy requiring a 15 calendar day notice of discharge before services were stopped which could affect all patients. Findings Include:	N 0488	As indicated in agency's policy 2.17, the Discharge /Transfer Policy, at least 15 days before the final visit the patient/client will receive the notice to discharge with instructions on the purpose of the form. Agency will review / audit 25% of discharged	11/20/2020

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	A document titled "2.17 Discharge/Transfer Policy" was provided by the employee F on 10/20/2020 at 12:20 p.m. The document indicated, but was not limited to, "Discharge/Transfer Procedure: 1. At least 5 days before the discharge (final) visit, the patient and Physician, PA or ARNP will be notified of discharge." During an interview on 10/20/2020 at 12:00 p.m. the administrator and employee F stated they were not aware the discharge requirement had changed from the 5 day notice requirement to the 15 day notice requirement and they would update their policy.		client's charts for 3 months until threshold is met. Then will audit 10% for every 6 months thereafter. Threshold is 100%. According to policy 2.17, physician, PA or ARNP will be notified 15 days prior to discharge. Policy manual updated. On all upcoming discharge patients, audit 25% for 3 months to confirm that physician, PA or ARNP is notified of the discharge. After threshold is met, continue to monitor 10% annually.	