STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157647	A. BUILDING 00 B. WING	02/26/2021

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INDEPENDENCE HOME HEALTH LLC	8282 S NINEVEH RD NINEVEH, IN 46164

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102 during agency relicensure/recertification survey. Survey Date: 2/22/2021 - 2/26/2021 Facility #: 012830 Provider #: 15-7647 Medicaid #: 201079480 At this Emergency Preparedness survey, Independence Home Health Care, LLC was found to be in compliance with 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies.	E 0000		
G 0000 Bldg. 00	This visit was for a Federal Recertification and State Re-Licensure Survey of a Medicare Home Health provider. A partial-extended survey was announced on 2/24/2021 at 3:50 PM. Survey Date: 2/22/2021 - 2/26/2021 Facility #: 012830 Provider #: 15-7647 Medicaid #: 201079480	G 0000		

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

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	This deficiency reflects State Findings cited in accordance with 410 IAC 17. See the Statement of Deficiencies State Form for additional findings.			
G 0414 Bldg. 00	484.50(a)(1)(ii) HHA administrator contact information (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Based on observation, record review, and interview, the agency failed to ensure that patients and their representatives received the updated contact information for the agency administrator after a change in administration, confirmed on February 4, 2021, including the administrator's name, business address, and business phone number to receive complaints for 3 of 5 active patients. (patients #5, #6, #7) from a sample of 7. Findings include: 1. Review of a patient admission packet, provided by the administrator on 2-2-23-2021, at 2:30 p.m., failed to evidence a change in administrator and clinical manager effective 1-1-2021 and confirmed on 2/4/21 via letter from The Department of Health. 2. A review of a letter dated February 4, 2021, issued to the Administrator from Individual B, revealed, "As of the date of this letter the information that the Indiana Department of Health has on record for your agency's administrative staff is shown below: Administrator Name - [Name of Administrator]."	G 0414	G414: Agency administrator has provided the correct agency administrator information including administrator name, business address, and business phone to all agency clients as of 3/26/2021 with the exception of one client that is currently out of town. It is anticipated that this client will be available to receive the updated information no later than 04/02/2021. To prevent reoccurrence, all RNs that perform admissions and/or reassessment visits will be inserviced by agency Administrator no later than 04/02/2021 to ensure that all admission packets are reviewed during the admission and reassessment visit to ensure up to date information is provided to the patient. RNs will provide a case communication note for the chart indicating that the admission packet has been reviewed and updated at each admission and/or reassessment visit.	04/02/2021

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	3. On 2/23/2021 at 3 PM, during a home visit with patient #5, the surveyor requested to see the patient's agency admission folder. The folder evidenced the name of employee C (RN & Owner) as the administrator on the outside of the folder. During this time, the Administrator, who was present during the home visit, stated the agency had prepared new folders with updated information that reflected the correct administrator, however they had not had time to distribute them yet but had planned on doing so with each patient's recertification visit. Patient #5 was noted to have been recertified on 2/18/2021, 48 days after the effective date of the change in administrator and 14 days after the confirmation letter was received from the Department of Health. No further information was available at this time. On 2/23/2021 at 12:08 PM, a phone interview was conducted with Individual A, the guardian of patient #5. When queried about the patient's admission folder, Individual A stated, "What folder? That's been gone a long time. She's been getting services for quite a while now, so I'd be surprised if you could find it." The agency failed to provide the patient's guardian with the updated contact information, including the name, of the agency administrator after a confirmed change on February 4, 2021. 4. On 2/23/2021 at 2 PM, during a home visit with patient #6, the surveyor requested to see the patient's agency admission folder. The patient stated he had been on service for a long time and had no idea what happened to the folder. The patient was unsure if he was updated concerning a change in administration. During this time, Employee A, who was present during the home visit, stated the agency had prepared folders with the updated administrator and had planned to		Agency administrator will audit 100% of charts at the time of admission and/or reassessment to ensure that the RNs have updated the admission packet to prevent reoccurrence of this deficiency.	

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	distribute them with each patient's recertification visit so that there would be time to discuss any changes with the patient. The agency failed to provide the patient with the updated contact information, including the name, of the agency administrator after a confirmed change on February 4, 2021. 5. On 2/22/21 at 10:07 AM, during the entrance interview with the Administrator and Clinical Manager, the Administrator stated, "I'm thinking right now about the folders that need to be updated. We have them ready." The Administrator explained that the position of Administrator had changed effective January 1, 2021 but the confirmation letter was not received until February 4, 2021. The Administrator planned to issue a new folder upon the patient's next recertification so that there would be time to discuss any changes with the patient. 6. During an interview on 2/24/2021 at 11:23 AM, the Administrator was queried concerning updating the admission folders with the current administrator name and information, as well as the folders currently in the patient's homes. The Administrator stated there was a plan in place to provide an updated folder to each patient at the time of that patient's recertification, so that the clinician could take time to explain the changes in administration. The Administrator stated the example folder had the correct administrator information on the documents inside the folder, but agreed the administrator listed externally was incorrect. The Administrator confirmed the change in administration was effective January 1, 2021 with a confirmation letter from the Department of Health, dated February 4, 2021. When queried as to why updated folders were not distributed in the last 18 days, the Administrator			

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	stated that with Covid, the weather, and all the agency changes there wasn't time." The agency failed to ensure all patients received updated name and contact information of the agency administrator after a change in administration confirmed on February 4, 2021. 7. Review of admission packet during home visit, 2/23/2021 at 2:35 PM, provided by the home health aide, with patient #7 admission folder/ packet failed to evidence an updated/ current contact information for the HHA administrator, including administrator's name, business address, and business phone number.			
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment reflected the current health, psychosocial, and medical status in 3 of 5 active patients from a sample of 7. Findings include: 1. A review of an agency policy C-140 "Comprehensive Patient Assessment", last revised 1/1/2021, revealed "A thorough, well-organized, comprehensive, and accurate assessment, consistent with the patient [sic] immediate needs will be completed for all patient [sic]." The policy also listed the content of the comprehensive assessment to include patient's current health, psychosocial, function, and cognitive status. And policy C-149 revealed "Patient populations with specialized needs, i.e. mental health, pediatric, intrapartum, and hospice will be assessed by professionals with appropriate	G 0528	G528 Agency administrator will review and update Agency policy C-1040 "Comprehensive Patient Assessment" r/t the contents of the comprehensive assessment to clarify that the comprehensive assessment shall be age and developmentally appropriate for the patient no later than 03/28/2021. Agency administrator will inservice nursing staff r/t the updated policy and procedure, and expectations for complete and accurate documentation of assessment data, including documenting the assessment tools used to gather the data, within 5 business days of the policy update no later than 04/02/2021. Agency administrator will ensure	03/28/2021

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	skills and in accordance with specific policies developed for those services." 2. A review of the comprehensive assessment for patient #5, dated 12/21/20 for certification period 12/25/20 - 2/22/21, revealed the patient was a pediatric patient with the primary diagnosis of other reduction deformities of brain and secondary diagnoses of diabetes insipidus, cerebral palsy, dysphagia, developmental disorder of scholastic skills, encounter for attention to gastrostomy, unspecified convulsions, feeding difficulties, and communicating hydrocephalus. The patient was non-verbal but failed to evidence an assessment for method/ ability to make needs known. The patient utilized cochlear implants, was dependent for all forms of care. The patient received nothing by mouth and received all medications and nutrition via G-tube. (gastrostomy tube) The assessment revealed patient #5 was a slow learner, had limited educational background, reading and writing problems, and speech problems. The assessment revealed the patient denied pain, but failed to reveal how this was communicated or what tool was utilized to assess the pain level. The comprehensive assessment tool utilized was a non-oasis adult assessment form that included adult focused assessment questions such as # of pack years as a smoker, how the patient manages finances, and how many alcoholic beverages were consumed. This assessment document failed to evidence an individualized assessment criteria specific or pertinent for pediatric patients, including immunization dates, pediatric pain assessment, growth and development pertinent to pediatrics. 3. A review of the comprehensive assessment for		that population specific assessment tools are available, and implemented, for specialty populations served by the agency (i.e. pediatric assessment tool) no later than 3/28/2021. Agency administrator will inservice agency RNs currently assigned to pediatric patients r/t the use of special population assessment tools by 03/28/2021. Agency administrator will inservice all remaining agency RNs r/t the use of special population assessment tools by 04/02/2021. Agency administrator will inservice nursing staff r/t the use of population appropriate medication instructions for all clients by 04/02/2021. Agency administrator will inservice Employee “I” r/t clearly documenting that employee “I” is the client’s foster parent as well as the agency RN providing care to the client when documenting caregiver instruction, teaching, and transfer of care no later than 03/28/2021. Agency administrator will update policy C-1040 "Comprehensive Patient Assessment" to include language prohibiting employee RNs from performing comprehensive assessments for	

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	patient #3, dated 02/01/2021, for certification period 2/5/21 - 4/5/21, revealed patient #3 is a pediatric patient with a primary diagnosis of failure to thrive and secondary diagnoses of congenital tracheomalacia, congenital bronchomalacia, tracheotomy status, gastrostomy status, developmental disorder of motor function, congenital absence, atresia and stenosis of anus without fistula, congenital malformation syndromes predominately affecting facial appearance, and congenital hydronephrosis. The patient was unable to purposely move her extremities and was non-verbal and could attempt to open only her left eye after a hypoxic episode approximately 1 year ago, however the assessment stated the patient was a "slow learner" with "reading and writing problems." Patient #3 had an ongoing primary diagnosis of failure to thrive, a medical diagnosis directly related to physical growth and weight gain. A review of the patient's admission assessment evidenced a diagnosis of failure to thrive upon admission in 2018. The current assessment revealed a weight of 22, but failed to specify if the weight was in pounds or kilos, and offered no indication of how or when the weight was obtained, i.e. obtained at a recent physician visit. The assessment revealed patient #3, a toddler, had no drug or alcohol addiction. She was assessed as having no pain despite an inability to purposefully respond. There was no pain scale/tool used, however the clinician scored the patient's pain at 0/10, intermittently, and at it's best, worst, and average. The comprehensive assessment revealed detailed medication instructions including "Avoid alcohol while on medication, inducing medications with alcohol, caution driving and avoid hazardous activities ...." The clinical summaries reveal multiple times that the patient's caregiver was instructed and/or		clients for whom the RN is also a family member or legal custodian/caregiver by 03/28/2021. 100% of patient charts will be audited at the time of admission and reassessment by agency administrator and/or clinical manager to ensure that the above corrections are maintained and that the deficiency does not reoccur.	

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	received teaching including, but not limited to, safety, medications, infection control, pain management, and integumentary, but failed to evidence that the caregiver/ foster mother is also the registered nurse employed by the agency and providing all care, supervision, and care coordination on behalf of the agency. During an interview on 2/25/21 at 2:30 PM, the Administrator stated patient #3's caregiver (Employee I) was employed by the agency as a registered nurse and provided all care ordered for patient #3. Around October/ November 2020, Employee I refused all nurses other than herself in the home in order to minimize risk of patient #3 contracting Covid 19. The Administrator confirmed Employee I completed all comprehensive assessments and provided all skilled nurse visits, and communicated with the physician to obtain orders and address changes. The Administrator stated she provided "constant oversight" of this patient but failed to provide evidence of the oversight and did not document the contact in the patient's record. The Administrator stated Employee I provided the competency assessments for agency nurses caring for patient #3 but was unable to explain why the plan of care and visit notes documented frequent caregiver teaching and review when the caregiver and the nurse documenting the teaching were the same person. The Administrator acknowledged the patient's record, including plans of care, clinical summary, and skilled nurse visit notes, did not include evidence that she is the patient's foster mother, primary caregiver, and agency nurse The comprehensive assessment failed to accurately reflect the patient's current and pertinent health, psychosocial, and			

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	developmental, status, and failed to provide an appropriate and accurate assessment for a pediatric patient. 4. On 2/26/21 at 2:45 PM, an interview was conducted with the Clinical Manager and the Administrator was present during the interview. The Clinical Manager was queried as to why an adult assessment was used for a pediatric patient. The Administrator responded and stated "An OASIS is not required for pediatric patients." Further discussion followed concerning pertinent pediatric assessment criteria, including weight, height, blood pressure, play, motor development including crawling, pulling up, walking, babbling and the Administrator stated agreement that the adult non-OASIS does not include criteria specific to patients under the age of 18 and does not address the needs of a toddler. 410 IAC 17-14-1(a)(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;			

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	(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. Based on observation, record review, and interview, the agency failed to ensure the plan of care (POC) included individualized frequency and duration of visits to be made in 2 out of 5 (#3 & #4) active records reviewed in a sample of 7 and failed to evidence skilled nursing orders for medication set up for 1 of 1 home visits conducted/ observed. Findings Include: 1. Record review of the agency's policy titled, "C-1240 Plan of Care," dated 01/01/2018, revealed " PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs... PROCEDURE... 2. The Plan of Care shall be completed in full to include:...iv. The frequency and duration of visits to be made." 2. A review of the clinical record for patient #3, start of care 12/18/21 for certification period 2/5/21-4/5/21, revealed a plan of care with a skilled	G 0574	G574 Affected patients #3 and #4 POC will be updated by the agency administrator, in coordination with the overseeing physician, with the correct visit durations by 03/28/2021 and agency will eliminate the use of the term ‘up to’ in relation to visit duration immediately 03/28/2021. A 100% chart audit will be performed by the clinical manager by 04/02/2021 to ensure no other client’s POC uses the term ‘up to’ in relation to visit duration. Any POCs identified as having non-specific visit frequency and/or durations will be corrected by clinical manager in coordination with the physician within 5 business days of identification no later than 04/09/2021. Agency administrator will review	03/28/2021

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	nurse frequency of "1 day for 1 day, 3-5 days a week for 8 weeks, 1 visit per week for 1 week up to 8 hours per day." The agency failed to ensure the range of hours per day were not large and specific to patient needs. 3. A review of the clinical record for patient #4, start of care 5/26/15 for certification period 2/23/21-4/23/21 revealed a plan of care with skilled nurse frequency of "3-5 day a week for 1 week, 4-6 visit a week for 7 weeks, 3-5 visits a week for 1 week up to 12.5 hours per day." The agency failed to ensure the range of hours per day were not large and specific to patient needs. 4. During a home visit on 2/23/21 at 2 PM, Employee D, LPN (Licensed Practical Nurse) was observed setting up the patient's medication planner. A review of the plan of care for patient #6 for the certification period of 1/24/21-3/24/21, failed to evidenced orders for skilled nursing to set up the patient medications weekly. 5. An interview with the Administrator on 02/26/2021 at 2:45 p.m. when queried about frequency being not specific and individualized in duration, she indicated they thought they could them with a range to prevent missed visits.		and update Policy C-1240 “Plan of Care” and clarify the procedure for writing frequency and duration of visits by 03/28/2021. Agency administrator will inservice agency RNs r/t the updated “plan of care” policy and procedure by 04/02/2021 Agency respectfully submits that finding #4 G574 “failed to evidence orders for skilled nursing to set up the patient medications weekly” under this tag is in error and requests that the SA refer to Attachment A page 4, (Highlighted) Skilled Nursing Order on the physician signed POC for patient #6 in the certification period of 1/24/21 – 3/24/21 which does in fact contains the physician’s order for skilled nursing set up of the patient’s medications weekly. This same copy was given to the surveyor at the time of the survey when requested and another copy of the document not showing physician signature and printed from the EMR Tab "On-going plan of care" was also requested and given to the surveyor prior to going out to patient's home. Refer to Attachment B page 12 -7th Order listed on page (Highlighted). See Arrows pointing to order. Desk review submitted. 410 IAC 17-13-1(a)(1)(D)(iii) Also, not to be confused with SN frequency and duration which is also on both documents page 5 on physician	

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			signed document(Attachment A) and page 4 on document printed from the EMR Tab "On-going plan of care"(Attachment B).	
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to ensure case coordination with all agencies involved in the patient's home health care needs in 1 of 5 active records reviewed in a sample of 7. Findings include: A review of an agency policy C-1024 "Coordination of Patient Services", effective 3/9/2012, revealed "All personnel furnising services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care." A review of the clinical record for patient #6, start of care 12/6/18 for certification period 1/24/21-3/24/21, revealed a plan of care summary which stated the patient was receiving A&D (Aging and disabled) Waiver services. A review of the case coordination notes failed to evidence documentation of case coordination between agencies. On 2/26/21 at 2 PM, the Administrator stated the patient receives services through Entity A, a personal service agency, and stated the agency	G 0608	G608: Agency administrator will inservice all nursing staff r/t the importance of accurate documentation of care coordination between all entities and persons involved in the care of the client; including care coordination between the PSA and HHA that are both owned by the administrator, by 03/31/2021. 100% of charts will be audited at least every 62 days (i.e. at the time of recertification) by the agency administrator and/or clinical manager to ensure case coordination is performed and supports the objectives of the patient's plan of care.	03/31/2021

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(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
	does communicate every 60 days and as needed with them. The Administrator stated the record did not include case coordination notes to support this statement. 410 IAC 17-12-2(g)			
G 0952 Bldg. 00	484.105(b)(1)(iv) Ensure that HHA employs qualified personnel (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. Based on record review and interview, the agency failed to ensure it employed personnel qualified to provide care and clinical oversight to pediatric patients. Findings include: 1. During an interview on 2/26/21 at 2:45 PM, when queried concerning current and previous experience as a Registered Nurse, including whether she had any specific background or training in pediatrics, the Clinical Manager stated she did not have pediatric experience. The Clinical Manager was queried concerning patient #3's primary diagnosis of failure to thrive. The Clinical Manager stated failure to thrive was "where the patient doesn't adapt well, doesn't get along well or connect with other people." The Clinical Manager was queried concerning the importance of weight gain and growth as it related to failure to thrive and stated she was not aware of the connection. Further interview evidenced both the Administrator and Clinical Manager stated the reason a non-OASIS adult form was used for pediatric assessment was because an OASIS is	G 0952	G952: Agency administrator will ensure that the clinical manager and all skilled nurses currently assigned to pediatric patients complete a competency assessment related to the care of pediatric patients utilizing an industry accepted pediatric nursing competency assessment tool that reflects the complexity of the agency's pediatric clients by 04/02/2021. Agency administrator will ensure that the clinical manager is inserviced on pediatric nursing skills related to any knowledge gaps revealed during the competency assessment before the clinical manager is released from orientation, but no later than 04/16/2021. Agency administrator will ensure that all skilled nurses currently assigned to pediatric patients are	04/02/2021

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	157647	A. BUILDING 00 B. WING	02/26/2021

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	not required. When queried concerning items missing from an adult non-OASIS that would be included in a pediatric assessment, both the Administrator and Clinical Manager were unable to state the difference in a pediatric assessment and an adult assessment. When queried concerning whether she completes a head to toe assessment on all patients receiving a skill nurse visit, the Clinical Manager stated that head to toe assessments are completed at recertification visits only. When queried why a head to toe assessment was not competed during a skilled visit, the Clinical Manager stated, "I don't make the patient get naked at each visit. It isn't necessary." The Clinical Manager explained that a head to toe assessment included undressing the patient to look at the skin, which is only done every 60 days. During continued interview with the Administrator and Clinical Manager, revealed the Clinical Manager was still on orientation and has not been independent with the role yet. When queried if head to toe assessment process was an advanced skill for a clinical manager or a routine skill for expected for any field nurse, the Administrator agreed it was a routine skill and head to toe assessment was an expectation with every visit. 3. A review of the personnel file for the Clinical Manager revealed the employee received no specific training for care of the pediatric patient. The agency failed to ensure all registered nurses were qualified to care for pediatric patients, including patients utilizing tracheotomies, gastrostomy, and developmental delays. 410 IAC 17-12-1(d)(3)		inserviced on pediatric nursing skills related to any knowledge gaps revealed during their competency assessment no later than 04/16/2021. Agency administrator will review and update the competency assessment tool used for skilled nursing staff onboarding and annual skills assessments and ensure that the tool includes assessment of pediatric nursing skills appropriate to the complexity of the agency's pediatric population by 03/28/2021. Agency administrator will ensure that all skilled nurses that are not currently assigned to care for pediatric clients are competent to provide care to pediatric clients through skills assessment appropriate to the complexity of the assigned patient prior to assignment beginning immediately 02/27/2021. To ensure this deficiency does not reoccur, agency clinical manager will review all new pediatric referrals for complexity and the availability of appropriately trained and competent nursing staff prior to accepting the referral beginning immediately 02/27/2021.	

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N 0000 Bldg. 00	This visit was for a State Re-Licensure Survey of a Medicare Home Health provider. Survey Date: 2/22/2021 - 2/26/2021 Facility #: 012830 Provider #: 15-7647 Medicaid #: 201079480 IDR Committee met on 04/07/21. Tag N0524 modified.	N 0000	N524 Affected patients #3 and #4 POC will be updated by the agency administrator, in coordination with the overseeing physician, with the correct visit durations by 03/28/2021 and agency will eliminate the use of the term 'up to' in relation to visit duration immediately 03/28/2021. A 100% chart audit will be performed by the clinical manager by 04/02/2021 to ensure no other client's POC uses the term 'up to' in relation to visit duration. Any POCs identified as having non-specific visit frequency and/or durations will be corrected by clinical manager in coordination with the physician within 5 business days of identification no later than 04/09/2021. Agency administrator will review and update Policy C-1240 "Plan of Care" and clarify the procedure for writing frequency and duration of visits by 03/28/2021. Agency administrator will inservice agency RNs r/t the updated "plan of care" policy and procedure by 04/02/2021	
N 0518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform			

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	and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review and interview, the agency failed to inform patients and provide written materials which provided an accurate description of current Indiana law related to advance directives for 1 of 1 admission packet reviewed and 1 of 3 home visits conducted, which had the potential to affect all 56 patients receiving home health services from this agency. Findings include: Review of a patient admission packet that was provided on 2/22/2021, revealed the 7/1/2013 version of the "Your Right to Decide" Indiana Advance Directive law. The admission packet failed to evidence the 11/1/2018 updated description of current Indiana law. Review of admission packet during home visit with patient #7 on 2/23/2021 at 2:45 PM, revealed the 7/1/2013 version of the "Your Right to Decide" Indiana Advance Directive law. The admission packet failed to evidence the 11/1/2018 updated description of current Indiana law. On 2/24/2021, at 1:46 PM, the Administrator stated the agency clinicians used the patient admission packet as a guide to advise all agency patients of the current description of Indiana state law in relation to advance directives, and stated the packets in each patient home did not provide the	N 0518	N518: Agency administrator has provided the current version of "Your Right to Decide" Indiana Advance Directive Law (11/1/2018) to all agency clients as of 3/26/2021 with the exception of one client that is currently out of town. It is anticipated that this client will be available to receive the updated information no later than 04/02/2021. To prevent reoccurrence, all RNs that perform admissions and/or reassessment visits will be inserviced by agency Administrator no later than 04/02/2021 to ensure that all admission packets are reviewed during the admission and reassessment visit to ensure up to date information is provided to the patient. RNs will provide a case communication note for the chart indicating that the admission packet has been reviewed and updated at each admission and/or reassessment visit. Agency administrator will audit 100% of charts at the time of admission and/or reassessment to	04/02/2021

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	updated information in the 11-1-20218 description of current Indiana advance directive law. The Administrator stated she was unaware of 11/1/2018 updated description of current Indiana law.		ensure that the RNs have updated the admission packet to prevent reoccurrence of this deficiency.	