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| | 15K086 | A. BUILDING 00<br>B. WING | 02/21/2019 |

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| FORTE HOME HEALTH CARE INC | 120 S LAKE STREET STE 50<br>WARSAW, IN 46580 |

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| G 0000<br><br>Bldg. 00 | | G 0000 | | |

This was a federal home health recertification survey, and a complaint investigation survey. This was a fully extended survey.

Survey Dates: February 11, 12, 13 14, 15, 18, 19, 20 and 21, 2019
Partial extended dates: February 13, 2019.
Fully extended dates: February 13, 14, 15, 18, 19, 20, and 21, 2019.

Facility Number: 012779
Medicaid Number: 201068710A

Complaint #: IN00176755- Unsubstantiated, lack of sufficient evidence

Census Service Type:
Skilled: 9
Home Health Aide Only: 147
Personal Care Only: 0
Total: 156

Sample:
RR w/HV: 4
RR w/o HV: 21
Total: 25

Forte Home Health Care, Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning February 21, 2019, for being found out of compliance with the Conditions of Participation 42 CFR 484.60 Care planning, coordination, quality of care.

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

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| G 0436<br><br>Bldg. 00 | Based on record review, and interview, the agency failed to adequately meet the home health aide (HHA) needs for 12 of 17 patients on hold for various reasons which included, the preferred staff was unavailable for 4 of 14 records reviewed (# 6, 14, 16, and 23); staff moved in with client so new staff pending for 1 of 14 records reviewed (#8); staff not working outside the home for 1 of 14 records reviewed (# 20); staff training was rescheduled due to weather for 3 of 14 records reviewed (# 10, 12, and 15); prior authorization approved for school breaks only for 2 of 14 records reviewed (# 21 and 22), and placing on hold for longer than one certification period without discharging the patient for 1 of 14 records reviewed (#9).<br><br>Findings include<br><br>1. The agency's undated policy titled "Documentation of Admission Qualifications," # 5.5, stated Clients will be admitted for provision of care if they meet the following qualifications: ... 2) Medical needs can be met with Forte staff. 3) Client is in the designated service area."<br><br>2. The agency's undated policy titled "Notice of Transfer," # 5.9 (b), stated "In the event that a client has a planned transferred [sic] to a facility, hospital, or to another agency, a transfer summary will be provided within 2 business days. If an unplanned transfer occurs, Forte HHC will provide a transfer summary within 2 business days if the client is still receiving care in a health care facility at the time Forte HHC is notified."<br><br>3. The agency's undated policy titled "Scheduling | G 0436 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. All clients previously on hold have resumed Home Health Care services with the exception of client # 20, whose discharge letter was sent 3.8.9 and discharged effective 3.23.19. Client # 11, and # 22 had discharge letters sent 3.18.19.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. In the event the client's preferred staff is unavailable, agency will offer alternate staff. If client refuses temporary alternate staff, these communications will be documented in the client's chart. Services will not be placed on hold due to lack of staff. If agency cannot provide client's preference of staff, Forte HHC will assist client to find another agency who can meet the client's needs. Client status will be reviewed during monthly nursing meeting. Home Health Care office staff and Nurse Case Managers received training related to this deficiency and corrective action plan on 4.11.19.<br>3. | 04/11/2019 |

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| | and Assignment of Home Health Staff," # 6.12, stated "Scheduling. The Clinical Manager identifies the dates and times staff is expected to work, in collaboration with the client and family, in accordance with the ordered services and approved plan of care. The Clinical Manager provides to the client and family with a list of eligible employees. ... Back-Up Staffing. Back-up staffs are hired in accordance with the Clinical Manager's directives. Each client and family will have as many back-up staff as the Clinical Manager deems necessary to cover emergency staffing needs. The Clinical Manager agrees to provide supervision in the event no staff is available. Missed Services. The Clinical Manager identifies the schedule of dates and times they want staff to work with the client within the allowable hours approved on each client and approved plan. In the event a scheduled sift is missed, the Clinical Manager is responsible to choose to reschedule the missed services or use the hours at a later date and time within each funding source's guidelines in collaboration with the client and family."<br><br>4. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Patients are accepted for treatment on the reasonable expectation that Forte Home Health Care (HHC) can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. ... Forte Home Health Care must: ... (4) 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."<br><br>5. During an interview on 2/15/19 at 10:30 AM, the director of nursing (DON) stated that patient #6 was on hold, along with some other patients. | | Administrator<br>4. 4.11.19 | |

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| | At that time, a list of patients on hold and the reasons for the holds were requested.<br><br>6. The list of hold patients was received on 2/15/19 at 12:32 PM and included the following patients: 8, 9, 10, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, and 29. Patients 24 and 29 were on hold pending prior authorization and #24 went to the hospital on 2/1/19. The other 14 patients had been placed on hold for various reasons as listed above, and had been recertified for new certification periods while services were on hold.<br><br>7. The clinical record for patient # 12 was reviewed on 2/18/19. The start of care date was 1/6/19. The plan of care dated 1/6-3/6/19 contained orders for HHA up to 8 hours a say, up to 5 days a week, for a total of up to 40 hours per week, for 60 days. The initial assessment dated 11/29/18 evidenced the patient was a pediatrics patient and dependent for oral hygiene, eating, bathing, dressing, toileting, mobility, transferring, bed mobility, and meal preparation. The PA approval evidenced services had been approved effective 1/6-7/6/19. The physician order dated 1/11/19 stated "Hold HHA services effective 1/6/19 until family preference of aide is available." The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>During an interview on 2/18/19 at 1;12 PM, the administrator stated this patient had not yet started care, as the staff had to be rescheduled for training due to the extreme cold weather at the end of January. The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>8. The clinical record for patient # 15 was | | | |

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| | reviewed on 2/15/19. The start of care date was 2/25/18. The patient's diagnosis was severe cerebral palsy. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The initial assessment dated 1/25/18 evidenced the patient was dependent for oral hygiene, eating, bathing, dressing, toileting, transferring, mobility, bed mobility, had adaptive devices, dependent for overnight supervision, medication management, and meal preparation. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18, and evidenced the last date of HHA services provided by employee V was 12/21/18. The record failed to evidence the information in the summary had been current and up to date. The record failed to evidence the agency attempted to place other staff with the patient to receive care while waiting for staff.<br><br>The progress note dated 1/24/19 at 1:55 PM, stated "NCM reached out to FA ... notifying [them] that agency is still waiting on requirements for new HHA staff [non-employee DD]. FA replied [they] would notify [non-employee DD] and gave NCM an update on HHa [employee V]." | | | |

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| | The progress note dated 2/18/19 at 1:21 PM stated "NCM reached out to FA [name] asking how they are and notifying FA what we need from [their] staff [non-employee DD]. 1:29 PM NCM sent HH staff [non-employee DD] a text message asking for CPR [cardiopulmonary resuscitation[ and TB [tuberculosis test result] ... NCM let [non-employee DD] know ... waiting on TB test results."<br><br>During an interview on 2/19/19 at 4:27 PM, patient # 15's parents returned a phone call and stated they have a relative currently providing care for the patient, but have to pay them out of pocket until Forte receives the documents required to train the parents' staff selection.<br><br>9. The clinical record for patient # 20 was reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The physician order dated 1/8/19 stated "Hold HHA services effective 12/29/18 per family request. See attached progress note." The progress note written by the alternate director of nursing (ADON) on 1/8/19 stated "Office staff notified nurse case manager that HHA did not work any home health hours for the week ending 1.15.19. ... staff reported that family advocate [advocate name] ... was not working at this time, but that [advocate] would be starting back to work in February or March. [Family advocate name] told staff that [family advocate] would not need HHA staff to care for client during this time. ... Will place home health services on hold at this time." The record failed to evidence the agency attempted to contact the patient or family advocate since 1/8/19 to inquire if services were | | | |

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| | still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>10. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." The physician order dated 1/14/19 stated "Hold HHA services effective 1/13/19 until family preference of aide is available. Resume care when this aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/13/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>11. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/19/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>The hold list of patients provided on 2/15/19 at 12:32 PM, stated "[identifier of patient # 22]- ... respite home health only, preference of staff is in | | | |

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| | college, but works on her breaks."<br>12. During the daily conference on 2/18/19 the agency President stated the family was responsible for identifying a caregiver, then the agency would hire and train them while Medicaid was being processed. "If agency doesn't have staff available, they would refer out to make sure family has a good fit." Requested agency policy regarding placing patient services on hold. The agency did not provide a policy prior to the survey exit conference on 2/21/19.<br><br>13. The agency's undated document titled, "Section 5 - Coordination of Service, Quality of Care, Client Documentation/Forms" evidenced "5.5 Documentation of Admission Qualifications ... 2. Medical needs can be met with Forte staff ...." and "5.10 Client Rights and Responsibilities ... (c) Rights of the Client ... (5) receive all services outlined in the plan of care ...."<br><br>14. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The physician order dated 8/9/18 and signed on 8/14/19 evidenced home health aide services were on placed on hold until family preference of aide was available.<br><br>The plan of care for certification period 9/21/18 to 11/19/18 was signed by the physician on 8/30/18 and failed to indicate services had been on hold since 8/10/18. No comprehensive assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The plan of care for certification period 11/20/18 to 1/18/19 was signed by the physician on 12/6/18. In the Summary Report section of the plan of care was the statement "client remains on hold." No | | | |

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| | comprehensive Assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The agency failed to complete a comprehensive assessment at least every 60 days, failed to provide services as identified in the individualized plan of care due to lack of staffing, and continued to recertify patients whose services had been placed on hold due to lack of staffing.<br><br>15. The clinical record for patient #8 was reviewed on 2/18/19. The start of care date was 4/1/18. This patient had orders for respite home health aide care for 60+ ( per month. An order written by Forte and sent to the physician for signature on 10/4/18 to "Hold services effective 10/3/18 d/t [due to] preferred HHA [home health aide] not available. Resume care when preferred HHA becomes available."<br><br>The plan of care for certification period 11/27/18 to 1/25/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>The plan of care for certification period 1/26/19 to 3/26/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>Interview on 2/19/19 at 08:50 AM with patient #8's family member regarding services being on hold. Family member acknowledged respite home health aide services were on hold. A different family | | | |

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| | member had previously been providing respite home health aide services but had to have knee surgery. Family member stated agency did not provide replacement staff and that family member had been in contact with the Aging & In Home Services case manager who suggested a referral to a different agency for respite services, but this was declined.<br><br>16. The clinical record for patient # 9 was reviewed on 5/20/18. The start of care date was 5/20/18. The patient was to receive home health aide services up to 8 hours/day, up to 5 days/week for school breaks only.<br><br>Medicaid approval (Authorization # X1811200289) had been received on 5/3/18 for services from 5/20/18 to 11/17/18. The Warsaw Community School Calendar for 2017-2018 and 2018-2019 was attached with circled days indicating days care was needed. July 2018 had 22 days circled. August 2018 had 10 days circled; September had 1 day circled; October had 3 days circled.<br><br>A comprehensive assessment was completed on 7/2/18 at 1010 by employee D.<br><br>The progress note dated 7/13/18 written by employee D states, "Place home health services on hold effective 7/9/18 due to HHA unavailable to work at this time. Will resume services when HHA is available." A review of home health aide documentation notes evidenced no services had been provided between 7/6/28 and 7/16/18.<br><br>On 7/16/18 the patient received a home health aide visit and the RNCM completed a resumption of care comprehensive nursing assessment. The plan of care certification for period 7/19/18 -9/16/18 was also faxed to physician for signature | | | |

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| | on this date.<br><br>A progress note dated 7/26/18 evidenced home health services were placed on hold effective 7/17/18 due to no staff available to work in home.<br><br>The plan of care for certification period 9/17/18 to 11/15/18 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The plan of care also stated "Pending Medicaid approval" when the agency had already received notice of Medicaid approval on 5/3/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify the patient while services were on hold due to lack of staffing.<br><br>The plan of care for certification period 11/16/18 to 1/14/19 stated home health aide frequency/duration of care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The summary report stated "Client remains on hold, per PA approval and Mothers request ...last supervisory visit was completed on 7/16/18." The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing. | | | |

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| | PA approval (Authorization # X1832000044) was received on 11/20/18 for services from 11/18/18 to 5/18/19. The 2018 Warsaw Community School calendar was attached identifying when the patient would be out of school and when care would be needed. School days were circled for care needs as follows: 3 days in November; 6 days in December; 5 days in January; 1 day in February; and 5 days in April.<br><br>Plan of care for certification period 1/15/19 to 3/15/19 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Supervisory visits every 30 days. Hours to be used on non-school days while mother works.<br><br>The summary report stated "Client remains on hold, per PA approval and parent request ...last supervisory visit was completed on 7/16/18." The agency had received notice of PA approval on 11/20/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>17. The clinical record for patient #10 was reviewed on 2/18/19. The start of care date was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 ordered home health aide care up to 4 hours/day, up to 7 days/wk. A Physician order written by the administrator on 12/26/18 and signed on 1/2/19 evidenced services were placed on hold due to family preference of aide not being available.<br>Plan of care for certification period 2/15/19 to | | | |

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| | 4/15/19 was faxed to physician and signed on 2/11/19 while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care.<br><br>Phone interview with patient #10 on 2/19/19 regarding services on hold. Patient was told if she had a family member or friend that would like to become the caregiver, that the agency would hire them and train them. Patient stated the home health aide bathed her or helped with showers, dressing, combed hair, helped with meals and did laundry.<br><br>18. The clinical record for Patient #14 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing.<br><br>19. The clinical record for Patient #16 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care | | | |

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| | certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing. | | | |
| G 0454<br><br>Bldg. 00 | Based on clinical record review the agency failed to transfer and/or discharge patients who were either hospitalized and/or sent to a rehabilitation center in 2 of 2 patients (# 17, and #19) who had agency services placed on hold due to hospitalization.<br><br>Findings include<br><br>1. The undated agency document, titled "Section 5 - Care Planning, Coordination of services, Quality of Care, Client Documentation/Forms" stated "Transfer and Discharge ... Forte Home Health Care may only transfer or discharge the client from Forte Home Health Care if ...(1) the transfer or discharge is necessary for the client's welfare because Forte Home Health Care and the physician who is responsible for the home health plan of care agree that Forte Home Health care can | G 0454 | 1. Forte Home Health Care no longer has any previously reviewed clients on hold due to facility placement. Current transfer of care (TOC) communication that may have been omitted cannot be sent at this time to facility, as all clients previously on hold in facilities have been discharged from facility, back to home, and Home Health Care services have resumed.<br>2. Transfer policy has been updated to include that Transfer of Care (TOC) communication must be completed/documented within 2 days of transfer or upon agency being notified of transfer if client remains in facility. Forte Home | 03/22/2019 |

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| | no longer meet the client's needs, based on client's acuity ...."<br><br>2. The clinical record for patient 17 was reviewed on 2/20/19. The start of care date was 10/27/17. The plan of care for certification period 12/16/18 to 2/13/19 was reviewed and the Discharge plan ordered discharge "when client requires increased level of care, per family/client request, or upon client death."<br><br>An order dated 1/28/19 was written placing home health aide services on hold effective 1/26/19 related to a hospital admission.<br><br>Aging and In-Home Services notified the agency via fax on 2/7/19 that there was an interruption of service effective 1/31/19 and that the patient had entered the nursing facility for rehabilitation therapy. The agency failed to discharge the patient upon hospitalization and need for increased level of care.3. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The record failed to evidence the agency HHA had provided any care since 12/31/18. The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note written by the administrator on 1/15/19 stated "1.14.1.9 9:25 am NCM [nurse case manager] notified via staff that client was taken to hospital ... 1.15.19 10:00 am [patient's spouse] contacted NCM to notify that client will be going to LTC [long term care] for rehab when released from | | Health Care will notify PCP of transfer. Current and upcoming TOC/hold orders sent to physician will include patient specific documentation. Training of all home health office staff and Nurse Case Managers completed on 3.22.19 including training on TOC procedures and orders sent to PCP. Measures will be monitored in monthly nurse meetings and quarterly in QAPI report to ensure this deficient practice does not reoccur.<br>3.<br>Administrator<br>4. 3.22.19 | |

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| | hospital. [Patient's spouse] agreed to notify agency upon d/c [discharge]." The next plan of care dated 2/4-4/4/19 summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." This plan of care was sent to the physician for signature on 2/1/19. The agency failed to complete a transfer and/or discharge for the patient once they knew the patient would be going to long term rehabilitation.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services. | | | |
| G 0546<br><br>Bldg. 00 | Based on clinical record review the agency failed to complete a comprehensive assessment every 60 days for 10 of 25 patients reviewed (6, 8, 9, and 10, 11, 15, 19, 20, 22, 23).<br><br>Findings include<br><br>1. The undated agency document titled "Section 5 - Care Planning, Coordination of Services, Quality of Care, Client Documentation/Forms" states "5.1 Comprehensive Assessments of Clients ... (d) Standard: Update of the comprehensive assessment ... must be updated and revised ... as frequently as the client's condition warrants due to a major decline or improvement in the client's health status, but not less frequently than - (1) every 60 days ...."<br><br>2. The clinical record for patient #6 was reviewed | G 0546 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. The required 60-day assessments (or 5-day window for OASIS) will be completed. This tag was based on review of clients that previously had services placed on hold, as our practice had been to not complete comprehensive assessments when we had an order to hold services. All clients that were previously on hold have resumed Home Health Care services in the home, with the exception of client # 20 whose discharge letter was sent 3.8.9, and discharge was | 04/11/2019 |

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| | on 2/12/19. The start of care date was 2/26/18. The record evidenced that no comprehensive assessment was completed for certification periods 9/21/18 to 11/19/19 and 11/20/18 to 1/18/19.<br><br>3. The clinical record for patient #8 was reviewed on 2/18/19. The patient's start of care date was 4/1/18. The record evidenced that no comprehensive assessment was completed for certification periods 11/27/18 - 1/25/19 and 1/26/19 -3/26/19.<br><br>4. The clinical record for patient #9 was reviewed on 2/19/19. The patient's start of care date was 5/20/18. The record evidenced that no comprehensive assessment was completed for certification periods 9/17/18 - 11/15/18; 11/16/18 - 1/14/19; and 1/15/19 - 3/15/19.<br><br>5. The clinical record for patient #10 was reviewed on 2/18/19. The patient's start of care date was 6/25/17. The record evidenced the comprehensive assessment that was completed on 12/4/18 was outside the 5 day time frame prior to recertification. The record evidenced that there was no comprehensive assessment completed for the certification period of 2/15/19 to 4/15/19. 6. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. The record failed to evidence the agency HHA had provided any care since 1/5/19. The physician order dated 1/7/19 stated "Hold HHA services effective 1/6/19 per family's request d/t [due to] client traveling outside the state." The next recertification plan of care dated 1/18-3/18/19 was sent to the physician for signature on 1/14/19, | | effective 3.23.19. Client # 11, and # 22 discharge letters were sent 3.18.19. Goals added to Plan of Care to be more specific to client.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. Forte Home Health Care will continue to complete comprehensive assessments at least every 60 days (or 5-day window for OASIS). Measures will be monitored in monthly nurse meetings and quarterly in QAPI audit and report to ensure this deficient practice does not reoccur. All visit dates are discussed and approved during nursing meetings to assure agency maintains compliance with 60 day (or 5-day window) required comprehensive assessments. If client's preference of staff is unavailable, Forte will attempt to offer client alternate staff. If client declines alternate staff, communication will be documented. Client's services will not be placed on hold due to lack of staff. If Forte cannot provide client's preference of staff, Forte will assist client to find another agency who can meet the client's needs. Auditor will audit charts for all active clients to monitor for comprehensive assessment compliance and maintain compliance with QAPI review and reporting. Home Health office staff | |

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| | nine days before the hold order had been sent, and stated "Client is currently on hold due to being in Florida for the winter. Last supervisory visit was completed on 01.02.19, see progress note below." The progress note dated 1/7/19 stated "NCM [nurse case manager] notified by [patient's significant other] that client had left for Florida after provided services on 1/5/19. ... Client/ [significant other] agreed to notify agency when client returns home to resume services." The progress note dated 1/23/19 stated "client was still out of state ... no need for home visit." The record failed to evidence the patient was back in Indiana to receive services and a comprehensive assessment to resume care.<br><br>7. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was 2/25/18. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHa is available."[sic] The current PA dated 8/26/18 was approved for 10 hours a day through 2/23/19. The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHa [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18.<br><br>8. The clinical record for patient # 19 was | | and Nurse Case Managers trained related to this deficiency and corrective action plan on 4.11.19.<br>3.<br>Administrator<br>4. 4.11.19 | |

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| | reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and the discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note dated 1/15/19 stated "1.14.1.9 9:25 am ... 1.15.19 10:00 am [patient's spouse] contacted NCM [nurse case manager] to notify that client will be going to LTC [long term care] for rehab when released from hospital. [Patient's spouse] agreed to notify agency upon d/c. [discharge]." This was signed by the administrator. The next plan of care was dated 2/4-4/4/19 and sent to the physician on 2/1/19, and the summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." The summary information failed to be up to date and accurate was from December 2018, the patient was still in long term care rehab, and failed to evidence a comprehensive assessment had been completed since 12/20/18.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services.<br><br>9. The clinical record for patient # 20 was reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 evidenced it had been sent to the physician on 2/1/19 for signature and contained orders for HHA up to 8 hours per day, up to 5 days per week for | | | |

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| | up to 40 hours per week, for 60 days. The summary on this plan of care stated "Client remains on hold. Last in home supervisory visit was on 12/11/18, see progress note from that visit below." This information failed to be current and was 2 months old. The record failed to evidence a comprehensive assessment had been completed since 12/11/18.<br><br>10. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 was sent to the physician for signature on 2/15/19 and contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." This was signed by the DON. This information failed to be current, and was 2 months old. The record failed to evidence a comprehensive assessment had been completed since 12/13/18.<br><br>11. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 was sent to the physician for signature on 1/29/19 and contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The summary section stated "Supervisory visit and comprehensive nursing assessment completed in client's home today. HHA, [name of aide] present and providing care as ordered. ... T [temperature]: 99.3 ... BP [blood pressure]: 93/63 ...." This was signed by employee W on 2/11/19. The Comprehensive Nursing Assessment dated 1/9/19 evidenced the vital signs listed in the summary were from that assessment, not from 2/11/19. The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until | | | |

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| | family preference of aide is available. Resume care when aide becomes available." The record failed to evidence a comprehensive assessment had been completed since 1/9/19. | | | |
| G 0570<br><br>Bldg. 00 | Based on record review, and interview, the agency failed to ensure it could provide services as needed by the patients on hold (see G570); failed to ensure the frequency range for services were individually matched to the patient's needs and failed to include all safety measures to protect patients against injury for patients with gastric feeding tubes (g-tubes) and nothing by mouth (See G574); and failed to ensure resumption of care orders were obtained after being on hold and that revised plans of care had been accurately requested and contained current and accurate information from the updated comprehensive assessments when sent to the physicians for approval for patients on hold, and failed to ensure the plan of care contained information about the patients' progress towards goals (see G 592).<br><br>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.60 Care planning, coordination, quality of care.<br><br>Based on record review, and interview, the agency failed to ensure it could provide services as needed by the patients for 13 of 17 patients on hold (# 6, 8, 9, 10, 11, 12, 14, 15, 16, 19, 20, 22, and 23).<br><br>Findings include | G 0570 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. The required 60-day assessments (or 5-day window for OASIS) will be completed. This tag was based on review of clients that previously had services placed on hold, as our practice had been to not complete comprehensive assessments when we had an order to hold services. All clients that were previously on hold have resumed Home Health Care services in the home, with the exception of client # 20 whose discharge letter was sent 3.8.9, and discharge was effective 3.23.19. Client # 11, and # 22 discharge letters were sent 3.18.19. Goals added to Plan of Care to be more specific to client.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. Forte Home Health Care will continue to complete comprehensive assessments at least every 60 days (or 5-day window for OASIS). Measures will be monitored in | 04/11/2019 |

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| | 1. The agency's undated policy titled "Documentation of Admission Qualifications," # 5.5, stated "Clients will be admitted for provision of care if they meet the following qualifications: ... 2) Medical needs can be met with Forte staff. 3) Client is in the designated service area."<br><br>2. The agency's undated policy titled "Notice of Transfer," # 5.9 (b), stated "In the event that a client has a planned transferred [sic] to a facility, hospital, or to another agency, a transfer summary will be provided within 2 business days. If an unplanned transfer occurs, Forte HHC will provide a transfer summary within 2 business days if the client is still receiving care in a health care facility at the time Forte HHC is notified."<br><br>3. The agency's undated policy titled "Scheduling and Assignment of Home Health Staff," # 6.12, stated "Scheduling. The Clinical Manager identifies the dates and times staff is expected to work, in collaboration with the client and family, in accordance with the ordered services and approved plan of care. The Clinical Manager provides to the client and family with a list of eligible employees. ... Back-Up Staffing. Back-up staffs are hired in accordance with the Clinical Manager's directives. Each client and family will have as many back-up staff as the Clinical Manager deems necessary to cover emergency staffing needs. The Clinical Manager agrees to provide supervision in the event no staff is available. Missed Services. The Clinical Manager identifies the schedule of dates and times they want staff to work with the client within the allowable hours approved on each client and approved plan. In the event a scheduled sift is missed, the Clinical Manager is responsible to choose to reschedule the missed services or use the hours at a later date and time within each | | monthly nurse meetings and quarterly in QAPI audit and report to ensure this deficient practice does not reoccur. All visit dates are discussed and approved during nursing meetings to assure agency maintains compliance with 60 day (or 5-day window) required comprehensive assessments. If client's preference of staff is unavailable, Forte will attempt to offer client alternate staff. If client declines alternate staff, communication will be documented. Client's services will not be placed on hold due to lack of staff. If Forte cannot provide client's preference of staff, Forte will assist client to find another agency who can meet the client's needs. Auditor will audit charts for all active clients to monitor for comprehensive assessment compliance and maintain compliance with QAPI review and reporting. Home Health office staff and Nurse Case Managers trained related to this deficiency and corrective action plan on 4.11.19.<br>3.<br>Administrator<br>4. 4.11.19 | |

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| | funding source's guidelines in collaboration with the client and family."<br><br>4. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Patients are accepted for treatment on the reasonable expectation that Forte Home Health Care (HHC) can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. ... Forte Home Health Care must: ... (4) 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."<br><br>5. During an interview on 2/15/19 at 10:30 AM, the director of nursing (DON) stated that patient #6 was on hold, along with some other patients. At that time, a list of patients on hold and the reasons for the holds was requested.<br><br>6. The list of hold patients was received on 2/15/19 at 12:32 PM and included the following patients: 8, 9, 10, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, and 29. Patients 24 and 29 were on hold pending prior authorization and #24 went to the hospital on 2/1/19. The other 14 patients had been placed on hold for various reasons as listed above, and had been recertified for new certification periods while services were on hold.<br><br>7. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. The record failed to evidence the agency HHA had provided any care since 1/5/19. The physician order dated 1/7/19 stated "Hold HHA services effective 1/6/19 per family's request d/t | | | |

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| | [due to] client traveling outside the state." This order was signed by the administrator and was not faxed to the physician until 1/23/19. The next recertification plan of care dated 1/18-3/18/19 was sent to the physician for signature on 1/14/19, nine days before the hold order had been sent, and stated "Client is currently on hold due to being in Florida of for the winter. Last supervisory visit was completed on 01.02.19, see progress note below."<br><br>The progress note dated 1/7/19 stated "NCM [nurse case manager] notified by [patient's significant other] that client had left for Florida after provided services on 1/5/19. ... Client/ [significant other] agreed to notify agency when client returned home to resume services." The progress note dated 1/23/19 stated "client was still out of state ... no need for home visit."<br><br>During an interview on 2/15/19 at 12:40 PM, the DON stated she did not know when patient # 11 would be coming back to Indiana.<br><br>During an interview on 2/15/19 at 12:41 PM, the administrator stated typically if the preferred aide was not available, the agency would place the patients on hold because the families chose their own staff, and the agency did not just send staff out.<br><br>During an interview on 2/18/19 at 2:48 PM, the alternate administrator stated if families/patients did not have staff selected, the agency would provide staff as long as there were staff in that area, and then make sure the staff was a good fit, otherwise the agency would refer the patients elsewhere.<br><br>During an interview on 2/21/19 at 9:20 AM, patient | | | |

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| | #11's physician nurse stated the physician was out of the office until Monday, but she was positive he was not aware this patient was in Florida, as they had not seen heard from the patent for awhile. The nurse stated she wondered then if the physician would want to cancel the recertification orders."<br><br>8. The clinical record for patient # 12 was reviewed on 2/18/19. The start of care date was 1/6/19. The plan of care dated 1/6-3/6/19 contained orders for HHA up to 8 hours a say, up to 5 days a week, for a total of up to 40 hours per week, for 60 days. The initial assessment dated 11/29/18 evidenced the patient was a pediatrics patient and dependent for oral hygiene, eating, bathing, dressing, toileting, mobility, transferring, bed mobility, and meal preparation. The PA approval evidenced services had been approved effective 1/6-7/6/19. The physician order dated 1/11/19 stated "Hold HHA services effective 1/6/19 until family preference of aide is available." The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>During an interview on 2/18/19 at 1;12 PM, the administrator stated this patient had not yet started care, as the staff had to be rescheduled for training due to the extreme cold weather at the end of January. The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>During an interview on 2/18/19 at 1:50 PM, the director of nursing stated the family wanted to hire staff from the daycare the patient attended, but that person was worried about having enough hours to change jobs. The DON stated that person still worked at the daycare currently. | | | |

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| | 9. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was 2/25/18. The patient's diagnosis was severe cerebral palsy. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The initial assessment dated 1/25/18 evidenced the patient was dependent for oral hygiene, eating, bathing, dressing, toileting, transferring, mobility, bed mobility, had adaptive devices, dependent for overnight supervision, medication management, and meal preparation. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18, and evidenced the last date of HHA services provided by employee V was 12/21/18. The record failed to evidence the information in the summary had been current and up to date. The record failed to evidence the agency attempted to place other staff with the patient to receive care while waiting for staff.<br><br>The progress note dated 1/24/19 at 1:55 PM, stated "NCM reached out to FA ... notifying [them] that agency is still waiting on requirements for new HH staff [non-employee DD]. FA replied | | | |

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| | [they] would notify [non-employee DD] and gave NCM an update on HHa [employee V]."<br><br>The progress note dated 2/18/19 at 1:21 PM stated "NCM reached out to FA [name] asking how they are and notifying FA what we need from [their] staff [non-employee DD]. 1:29 PM NCM sent HH staff [non-employee DD] a text message asking for CPR [cardiopulmonary resuscitation[ and TB [tuberculosis test result] ... NCM let [non-employee DD] know ... waiting on TB test results."<br><br>During an interview on 2/15/19 at 1:00 PM, the administrator stated the relative currently providing care had not yet turned in her tuberculosis (TB) screening paperwork so that she could be trained to become the HHA for patient # 15.<br><br>During an interview on 2/19/19 at 4:27 PM, patient # 15's parents returned a phone call and stated they have a relative currently providing care for the patient,but have to pay them out of pocket until Forte receives the documents required to train the parents' staff selection.<br><br>10. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The record failed to evidence the agency HHA had provided any care since 12/31/18. The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note written | | | |

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| | by the administrator on 1/15/19 stated "1.14.1.9 9:25 am NCM [nurse case manager] notified via staff that client was taken to hospital ... 1.15.19 10:00 am [patient's spouse] contacted NCM to notify that client will be going to LTC [long term care] for rehab when released from hospital. [Patient's spouse] agreed to notify agency upon d/c [discharge]." The next plan of care dated 2/4-4/4/19 summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." This plan of care was sent to the physician for signature on 2/1/19. The agency failed to complete a transfer and/or discharge for the patient once they knew the patient would be going to long term rehabilitation.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services.<br><br>11. The clinical record for patient # 20 was reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The physician order dated 1/8/19 stated "Hold HHA services effective 12/29/18 per family request. See attached progress note." The progress note written by the alternate director of nursing (ADON) on 1/8/19 stated "Office staff notified nurse case manager that HHA did not work any home health hours for the week ending 1.15.19. ... staff reported that family advocate [advocate name] ... was not working at this time, but that [advocate] would be starting back to work in February or March. [Family advocate | | | |

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| | name] told staff that [family advocate] would not need HHA staff to care for client during this time. ... Will place home health services on hold at this time." The record failed to evidence the agency attempted to contact the patient or family advocate since 1/8/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>12. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." The physician order dated 1/14/19 stated "Hold HHA services effective 1/13/19 until family preference of aide is available. Resume care when this aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/13/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>13. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/19/19 to inquire if services were still needed, and failed to evidence | | | |

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| | the agency attempted to provide other staff to care for the patient.<br><br>The hold list of patients provided on 2/15/19 at 12:32 PM, stated "[identifier of patient # 22]- ... respite home health only, preference of staff is in college, but works on her breaks." 14. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The physician order dated 8/9/18 and signed on 8/14/19 evidenced home health aide services were on placed on hold until family preference of aide was available.<br><br>The Plan of Care for certification period 9/21/18 to 11/19/18 was signed by the physician on 8/30/18 and failed to indicate services had been on hold since 8/10/18. No comprehensive assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The plan of care for certification period 11/20/18 to 1/18/19 was signed by the physician on 12/6/18. In the Summary Report section of the plan of care was the statement "client remains on hold." No Comprehensive Assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The agency failed to complete a comprehensive assessment at least every 60 days, failed to provide services as identified in the individualized plan of care due to lack of staffing, and continued to recertify patients whose services had been placed on hold due to lack of staffing.<br><br>15. The clinical record for patient #8 was reviewed on 2/18/19. The start of care date was 4/1/18. | | | |

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| | This patient had orders for respite home health aide care for 60+ hours per month. An order written by Forte and sent to the physician for signature on 10/4/18 to "Hold services effective 10/3/18 [due to] preferred HHA [was] not available. Resume care when preferred HHA becomes available."<br><br>The Plan of Care for certification period 11/27/18 to 1/25/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to the review/update of the Plan of Care. The last comprehensive assessment occurred on 9/18/18.<br><br>The Plan of Care for certification period 1/26/19 to 3/26/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>Interview with patient #8's family member regarding services being on hold. Family acknowledged respite home health aide services were on hold. Another family member had previously been providing respite home health aide services but had to have knee surgery. Family member stated agency did not provide replacement staff and that family member had been in contact with the Aging & In Home Services case manager who suggested a referral to a different agency for respite services, but this was declined.<br><br>16. The clinical record for patient # 9 was reviewed on 5/20/18. The start of care date was 5/20/18. The patient was to receive home health aide services up to 8 hours/day, up to 5 days/week for school breaks only. | | | |

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| | Medicaid approval (Authorization # X1811200289) had been received on 5/3/18 for services from 5/20/18 to 11/17/18. The Warsaw Community School Calendar for 2017-2018 and 2018-2019 was attached with circled days indicating days care was needed. July 2018 had 22 days circled. August 2018 had 10 days circled; September had 1 day circled; October had 3 days circled.<br><br>A comprehensive assessment was completed on 7/2/18 at 1010 by employee D.<br><br>The Progress Note dated 7/13/18 written by employee D states, "Place home health services on hold effective 7/9/18 due to HHA unavailable to work at this time. Will resume services when HHA is available." A review of home health aide documentation notes evidenced no services had been provided between 7/6/28 and 7/16/18.<br><br>On 7/16/18 the patient received a home health aide visit and the RNCM completed a resumption of care comprehensive nursing assessment. The plan of care certification for period 7/19/18 -9/16/18 was also faxed to physician for signature on this date.<br><br>A Progress Note dated 7/26/18 evidenced home health services were placed on hold effective 7/17/18 due to no staff available to work in home.<br><br>The plan of care for certification period 9/17/18 to 11/15/18 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The plan of care also stated "Pending Medicaid approval" when the agency had already received notice of Medicaid approval on 5/3/18. The | | | |

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| | agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify the patient while services were on hold due to lack of staffing.<br><br>The plan of care for certification period 11/16/18 to 1/14/19 stated home health aide frequency/duration of care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The summary report stated "Client remains on hold, per PA approval and Mothers request ...last supervisory visit was completed on 7/16/18." The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>PA approval (Authorization # X1832000044) was received on 11/20/18 for services from 11/18/18 to 5/18/19. The 2018 Warsaw Community School calendar was attached identifying when the patient would be out of school and when care would be needed. School days were circled for care needs as follows: 3 days in November; 6 days in December; 5 days in January; 1 day in February; and 5 days in April.<br><br>Plan of Care for certification period 1/15/19 to 3/15/19 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Supervisory visits every 30 | | | |

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| | 15K086 | A. BUILDING 00<br>B. WING | 02/21/2019 |

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| | days. Hours to be used on non-school days while mother works.<br>The summary report stated "Client remains on hold, per PA approval and parent request ...last supervisory visit was completed on 7/16/18."<br>The agency had received notice of PA approval on 11/20/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>17. The clinical record for patient #10 was reviewed on 2/18/19. The start of care date was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 ordered home health aide care up to 4 hours/day, up to 7 days/wk. A Physician order written by the administrator on 12/26/18 and signed on 1/2/19 evidenced services were placed on hold due to family preference of aide not being available.<br>Plan of Care for certification period 2/15/19 to 4/15/19 was faxed to physician and signed on 2/11/19 while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care.<br><br>Phone interview with patient #10 on 2/19/19 regarding services on hold. Patient was told if she had a family member or friend that would like to become the caregiver, that the agency would hire them and train them. Patient stated the home health aide bathed her or helped with showers, dressing, combed hair, helped with meals and did laundry.<br><br>18. The clinical record for Patient #14 was | | | |

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| | reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing.<br><br>19. The clinical record for Patient #16 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The | | | |

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| | agency failed to provide care as ordered in the plan of care due to lack of staffing. | | | |
| G 0574<br><br>Bldg. 00 | Based on clinical record review and interview the agency failed to ensure the frequency range for services were individually matched to the patient's needs in 10 of 25 records reviewed (#1, 2, 4, 5, 6, 8, 9, 10, 14 and 16), and failed to include all safety measures to protect patients against injury in 2 of 2 records reviewed for patients with gastric feeding tubes (g-tubes) and NPO (nothing by mouth) (#6 and #7).<br><br>Findings include<br><br>1. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Services must be furnished in accordance with accepted standards of practice. ... (2) The individualized plan of care must include the following: 9) Frequency and duration of visits. ... 15) Medications and treatments. ... 20) Client-specific interventions and education; measurable outcomes and goals identified by the HHA and patient. ... (c) Review and revision of the plan of care. ... (2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals ... (d) Coordination of care. Forte Home Health Care must: (1) Assure communication with all physicians involved in the plan of care. ... (4) 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. (5) Ensure that each patient, and his or her caregiver(s) where | G 0574 | 1. To ensure the POC contain all pertinent information, agency follows all required information per COP 484.60. To correct the deficiency, our client's POC has been developed per client's physician and per MCD approval through PA. The Plan of Care (POC) for each client has been updated to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Modification orders for client specific frequency/duration changes sent to PCP if required per client's needs starting 3.22.19 with training beginning on 3.22.19 as well for staff/family/client. POC changes implemented by 3.29.19. Staff will be trained on updated POC to ensure they are providing services as ordered and charting accordingly. These changes all completed by 4.5.19.<br>2. The agency will ensure the POC continues to contain all pertinent information by complying with requirements per COP 484.60. POC will be maintained by Nurse Case Manager during comprehensive assessments, and updated to | 04/05/2019 |

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| | applicable, receive ongoing education and training provided by Forte Home Health Care, as appropriate, regarding the care and services identified in the plan of care."<br><br>2. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The plans of care dated 11/20/18 to 1/18/19 and 1/19/19 to 3/19/19 ordered home health aide care up to 4-8 hours per week, up to 5 days per week, for up to 20-40 hours per week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br>and plan of care certification period was 1/19/19 to 3/19/19.<br><br>Patient had a gastric-tube for bolus feedings 5 times a day. The comprehensive nursing assessment on 2/26/18 documented that the patient was at risk for choking due to results of a swallow study. Patient had been NPO [nothing by mouth] and on tube feedings only since 2/26/18. The Plan of Care failed to include risk for aspiration as a safety measure.<br><br>3. The clinical record for patient #7 was reviewed on 2/19/19. The start of care date was 5/20/15. The plan of care dated 12/30/18 to 2/27/19 ordered skilled nursing care up to 16 hours per day, up to 3 to 7 days per week for a total of up to 91 hours per week for 60 days. This patient has consistently been receiving services 40-48 hours per week, over 5-6 days per week. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>The plan of care certification period dated 12/30/18 to 2/27/19 evidenced the patient was on a ventilator and NPO with G-tube feedings only. | | reflect client's needs/safety specifically, and more defined for new client admissions. POC will continue to be updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC updates as changes arise. Staff's daily notes will continue to be monitored by office staff to ensure that the services provided comply with POC orders. Frequency and duration based on client needs are monitored monthly with comprehensive assessment and updated with PCP order as needed. Agency will ensure that the client's plan of care contain all pertinent information through review in monthly nurse meetings and quarterly QAPI audit and report to ensure this deficient practice does not reoccur. All Home Health Care office staff and Nurse Case Managers trained related to this deficiency and corrective action plan during meeting on 3.28.19<br>3. Administrator<br>4. 4.5.19 | |

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| | Choking and aspiration risk were identified on the comprehensive assessments on 12/28/18, 10/29/18, and 6/28/18. The plan of care failed to include risk for aspiration as a safety measure.<br><br>4. The clinical record for patient #9 was reviewed on 2/18/19. The start of care date was 5/20/18. The plan of care for certification period 11/16/18 - 1/14/19 contained orders for home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while Mother works.<br><br>The Medicaid authorizations # X181200289 was for 504 hours and #X183200044 was for 160 hours from 11/18/18 to 5/18/19. Each authorization included a weekly summary of hours that were based on the school calendar and identified days the patient would need care. The frequencies failed to be specific to the patient's needs and care was not provided on all identified days of care needs. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>5. The clinical record for patient #10 was reviewed on 2/18/19. The start of care was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 included orders for home health aide care up to 4 hours a day, up to 7 days a week, up to 28 hours per week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>6. The clinical record for patient #14 was reviewed on 2/20/19. The start of care date was 5/1/16. The plan of care dated 2/15/19 to 4/15/19 included orders for home health aide care up to 4 hours per day, up to 7 day per week, for up to 20 hours per | | | |

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| | week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>7. The clinical record for patient #16 was reviewed on 2/20/19. The start of care date was 5/1/16. The plan of care for certification period 2/15/19 - 4/15/19 included orders for home health aide care up to 4 hours per day, up to 7 day per week, for up to 20 hours per week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.During an interview on 2/18/19 at 2"48 PM, the alternate administrator stated the frequency was based on the client needs/and physician orders.<br><br>8. The clinical record for patient # 1 was reviewed on 2/12/19. The plan of care dated 12/31/18-2/28/19 contained a diagnosis of mitochondrial myopathy, and orders for respite home health aide (RHHA) 60+ hours per month, and safety measures of fall precautions and skin integrity precautions, and one goal which stated "Client to remain safe in home with assistance of HHA for this certification period." HHA to bathe patient per patient/family choice, wash and comb hair as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, take vital signs (VS) blood pressure (BP), pulse, respirations (RR) and T (temperature) as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety.<br><br>The initial assessment dated 10/9/18, identified the patient needed assistance with oral hygiene, bathing, dressing, toileting, transfer, mobility, medication management, and meal preparation, and that the patient had a history of weight loss | | | |

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| | and inability to eat. The plan of care failed to evidence a patient-specific frequency for assistance with all tasks assigned to the HHA, except for monitor for safety, and failed to evidence a patient specific goal such as maintaining skin integrity.<br><br>9. The clinical record for patient # 2 was reviewed on 2/12/19. The plan of care dated 1/14-3/14/19 contained diagnoses of Lennox-Gastaut Syndrome and cerebral palsy, and orders for HHA up to 8 hours per day, up to 6 days per week, up to 40 hours per week, for 60 days. The HHA was ordered to provide the following tasks: bath of patient/family choice, hair was and comb as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, take VS BP, pulse, RR and T as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting/brief changes as needed, and monitor for safety. Monitor for seizures. The section titled "Other pertinent diagnoses" stated "Sleep Apnea, Urinary Incontinence; Bowel Incontinence; Seizure Disorder." The "Goals" section stated "Client will receive full assistance with personal care/ADL's (activities of daily living) to maintain optimum level of hygiene for this certification period."<br><br>The record failed to evidence a patient-specific frequency for assistance with all tasks assigned to the HHA, except for monitor for safety and seizures, failed to evidence other patient specific goals such as maintaining skin integrity, and be free from seizures, and failed to evidence the range of HHA services was patient specific. This patient had consistently been receiving services approximately 35 hours per week. | | | |

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| | 10. The clinical record for patient # 4 contained a plan of care dated 1/25-3/25/19 with a diagnosis of dementia and orders for HHA up to 12 hours a day, up to 6 days a week, up to 60 hours a week for 60 days. HHA to bathe patient per patient/family choice, wash and comb hair as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, VS as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The "Goals" section stated "Client to remain safe in home, with assistance of family and HHA for this certification period." The frequency of HHA tasks and services failed to be patient specific.<br><br>11. The clinical record for patient # 5 was reviewed on 2/13/19. The plan of care dated 12/20/18-2/17/19 contained a diagnosis of epilepsy, and orders for HHA up to 6 hours a day, up to 7 days a week, for up to 42 hours a week, for 60 days. HHA to bathe patient per patient/family choice, hair wash and comb as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, VS as needed, ambulation as required, assist to chair as needed, range of motion passive as needed, and monitor for seizures and safety. The client notes sections stated "has very limited mobility and is non-ambulatory." This patient had consistently been receiving 42 hours of service per week. The HHA tasks and frequency failed to be patient specific. | | | |
| G 0592<br><br>Bldg. 00 | Based on record review, and interview, the agency failed to ensure resumption of care orders were | G 0592 | 1. This tag is based on review of clients who were | 04/11/2019 |

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| | obtained after being on hold and that revised plans of care had been accurately requested and contained current and accurate information from the updated comprehensive assessment when sent to the physician for approval for 10 of 13 clinical records reviewed of patients on hold (# 6, 8, 9, 11, 15, 19, 20, 22, and 23); and failed to ensure the plan of care contained information about the patients' progress towards goals for 1 of 25 clinical records reviewed (#1).<br><br>Findings include:<br><br>1. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals ... (d) Coordination of care. Forte Home Health Care must: (1) Assure communication with all physicians involved in the plan of care. ... (4) 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."<br><br>2. The clinical record for patient # 1 was reviewed on 2/12/19. The plan of care dated 12/31/18-2/28/19 contained orders for respite home health aide (RHHA) 60+ hours per month. The summary section stated "[patient] is in [their] bedroom per [parent] upon nurse arrival. ... vital signs (VS) and assessment. BP [Blood pressure] 97/58, HR [heart rate] 76, RR [respiratory rate] 16-18 non-labored, T [temperature] 97.8. ... Last bowel movement 12.10.18." The summary failed to include the most current assessment's (1/8/19) vital signs and bowel movement. | | previously on hold. The deficiency has been corrected. All clients previously on hold have resumed Forte Health Care services with the exception of client # 20 whose discharge letter was sent 3.8.9 with discharge effective 3.23.19. Client # 11, and # 22 discharge letters sent 3.18.19. All active clients currently have updated 60-day comprehensive assessment.<br>2. Agency will ensure the POC is updated/revised at each recert and as needed. Forte will no longer place client's services on hold for lack of staff. In the event the client's preferred staff is unavailable, Forte will attempt to provide alternate staff. If agency is unable to provide client with preferred staff, agency will assist client to find another agency that can provide required services. Client will no longer have re-certifications completed without an updated 60-day comprehensive assessment. Client assessment dates are discussed and monitored in monthly nurse meetings and quarterly QAPI audit and report to ensure this deficient practice does not reoccur. All Home Health Care office staff and Nurse Case Managers trained related to this deficiency and corrective action plan on 4.11.19<br><br>3.Administrator | |

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| | The latest nursing assessment dated 1/8/19 evidenced BP 92/57, HR 88, RR 16, and T 97.1 and last bowel movement 1.7.19. The record failed to contain accurate and current summary information for the physician review.<br><br>3. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. The record failed to evidence the agency HHA had provided any care since 1/5/19. The physician order dated 1/7/19 stated "Hold HHA services effective 1/6/19 per family's request d/t [due to] client traveling outside the state." This order was signed by the administrator and was not faxed to the physician until 1/23/19.<br><br>The next recertification plan of care dated 1/18-3/18/19 was sent to the physician for signature on 1/14/19, nine days before the hold order had been sent, and stated "Client is currently on hold due to being in Florida for the winter. Last supervisory visit was completed on 01.02.19, see progress note below." The progress note dated 1/7/19 stated "NCM [nurse case manager] notified by [patient's significant other] that client had left for Florida after provided services on 1/5/19. ... Client/[significant other] agreed to notify agency when client returns home to resume services." The progress note dated 1/23/19 stated "client was still out of state ... no need for home visit." The record failed to evidence the patient was back in Indiana to receive services and a comprehensive assessment to resume care.<br><br>4. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was | | 4. 4.11.19 | |

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| | 2/25/18. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The current PA dated 8/26/18 was approved for 10 hours a day through 2/23/19. The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18, and evidenced the last date of HHA services provided by employee V was 12/21/18. The record failed to evidence the information in the summary had been current and up to date, and failed to evidence staff had been available to provide care.<br><br>5. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and the discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note dated 1/15/19 stated "1.14.1.9 9:25 am ... 1.15.19 10:00 am [patient's spouse] contacted NCM [nurse case manager] to notify that client will be going to | | | |

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| | LTC [long term care] for rehab when released from hospital. [Patient's spouse] agreed to notify agency upon d/c. [discharge]." This was signed by the administrator. The next plan of care was dated 2/4-4/4/19 and sent to the physician on 2/1/19, and the summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." The summary information failed to be up to date and accurate was from December 2018, and the patient was still in long term care rehab.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services.<br><br>6. The clinical record for patient # 20 was reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 evidenced it had been sent to the physician on 2/1/19 for signature and contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The summary on this plan of care stated "Client remains on hold. Last in home supervisory visit was on 12/11/18, see progress note from that visit below." This information failed to be current and was 2 months old.<br><br>The physician order dated 1/8/19 stated "Hold HHA services effective 12/29/18 per family request. See attached progress note." The progress note dated 1/8/19 stated "Office staff notifies nurse case manager that HHA did not work any home health hours for the week ending 1.15.19. ... Staff reported that family advocate [advocate name] ... was not working at this time, | | | |

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| | but that [advocate] would be starting back to work in February or March. [Family advocate name] told staff that [family advocate] would not need HHA staff to care for client during this time. ... Will place home health services on hold at this time." This was signed by the alternate director of nursing (ADON). The record failed to evidence the agency attempted to contact the patient or family advocate since 1/8/19. and failed to evidence the agency discharged the patient per policy.<br><br>7. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 was sent to the physician for signature on 2/15/19 and contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." This was signed by the DON. This information failed to be current, and was 2 months old.<br><br>The physician order dated 1/14/19 stated "Hold HHA services effective 1/13/19 until family preference of aide is available. Resume care when this aide becomes available."<br><br>8. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 was sent to the physician for signature on 1/29/19 and contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The summary section stated "Supervisory visit and comprehensive nursing assessment completed in client's home today. HHA, [name of aide] present and providing care as ordered. ... T [temperature]: 99.3 ... BP [blood pressure]: 93/63 | | | |

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| | ...." This was signed by employee W on 2/11/19. The Comprehensive Nursing Assessment dated 1/9/19 evidenced the vital signs listed in the summary were from that assessment, not from 2/11/19. The record failed to evidence the summary information had been current, and failed to evidence communication with staff/family about the HHA availability.<br><br>The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence any documentation of communication with any staff.9. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The physician order dated 8/9/18 and signed on 8/14/19 evidenced home health aide services were on placed on hold until family preference of aide was available.<br><br>The plan of care for certification period 9/21/18 to 11/19/18 was signed by the physician on 8/30/18 and failed to indicate services had been on hold since 8/10/18. No comprehensive assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The plan of care for certification period 11/20/18 to 1/18/19 was signed by the physician on 12/6/18. In the summary report section of the plan of care was the statement "client remains on hold." No comprehensive assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The agency failed to complete a comprehensive assessment at least every 60 days, and failed to | | | |

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| | reflect current information in the plan of care.<br><br>10. The clinical record for patient #8 was reviewed on 2/18/19. The start of care date was 4/1/18. This patient had orders for respite home health aide care for 60+ hours per month. An order written by Forte and sent to the physician for signature on 10/4/18 to "Hold services effective 10/3/18 d/t [due to] preferred HHA [home health aide] not available. Resume care when preferred HHA becomes available."<br><br>The plan of care for certification period 11/27/18 to 1/25/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>The plan of care for certification period 1/26/19 to 3/26/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br>The agency failed to provide current information from a comprehensive assessment.<br><br>11. The clinical record for patient # 9 was reviewed on 5/20/18. The start of care date was 5/20/18. The patient was to receive home health aide services up to 8 hours/day, up to 5 days/week for school breaks only.<br><br>Medicaid approval (Authorization # X1811200289) had been received on 5/3/18 for services from 5/20/18 to 11/17/18. The Warsaw Community School Calendar for 2017-2018 and 2018-2019 was attached with circled days indicating days care was needed. July 2018 had 22 days circled. | | | |

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| | August 2018 had 10 days circled; September had 1 day circled; October had 3 days circled.<br><br>A comprehensive assessment was completed on 7/2/18 at 1010 by employee D.<br><br>The progress note dated 7/13/18 written by employee D states, "Place home health services on hold effective 7/9/18 due to HHA unavailable to work at this time. Will resume services when HHA is available." A review of home health aide documentation notes evidenced no services had been provided between 7/6/28 and 7/16/18.<br><br>On 7/16/18 the patient received a home health aide visit and the RNCM (registered nurse case manager) completed a resumption of care comprehensive nursing assessment. The plan of care certification for period 7/19/18 -9/16/18 was also faxed to physician for signature on this date.<br><br>A progress note dated 7/26/18 evidenced home health services were placed on hold effective 7/17/18 due to no staff available to work in home.<br><br>The plan of care for certification period 9/17/18 to 11/15/18 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The plan of care also stated "Pending Medicaid approval" when the agency had already received notice of Medicaid approval on 5/3/18. There was no comprehensive assessment completed since 7/16/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide current information to the provider in the plan of care. | | | |

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| | The plan of care for certification period 11/16/18 to 1/14/19 stated home health aide frequency/duration of care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The summary report stated "Client remains on hold, per PA approval and Mothers request ...last supervisory visit was completed on 7/16/18." The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide current information to the provider in the plan of care.<br><br>PA approval (Authorization # X1832000044) was received on 11/20/18 for services from 11/18/18 to 5/18/19. The 2018 Warsaw Community School calendar was attached identifying when the patient would be out of school and when care would be needed. School days were circled for care needs as follows: 3 days in November; 6 days in December; 5 days in January; 1 day in February; and 5 days in April.<br><br>Plan of care for certification period 1/15/19 to 3/15/19 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Supervisory visits every 30 days. Hours to be used on non-school days while mother works.<br>The summary report stated "Client remains on hold, per PA approval and parent request ...last supervisory visit was completed on 7/16/18."<br>The agency had received notice of PA approval on 11/20/18. There was no comprehensive assessment completed since 7/16/19. The agency failed to revise the plan of care reflecting current information from a comprehensive assessment and failed to provide current information to the provider in the plan of care. | | | |

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| G 0684<br><br>Bldg. 00 | Based on observation, record review, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 1 of 3 home visit observations (# 18).<br><br>Findings include:<br><br>1. The agency's policy titled "Handwashing," # 12.8, dated 10/11/2018, stated "It is the policy of Forte HHC to provide care in a safe and sanitary manner. The following procedure will be applied to all health care providers ... Wash hands with soap and water before and after having direct contact with patients; after removing gloves; ... after contact with body fluids or excretions, mucous membranes, ... if moving from a contaminated body site to a clean body site during patient care ...."<br><br>2. The agency's policy titled "Proper Use of Medical Gloves," # 12.9, dated 10/11/2018, stated "The use of exam gloves in the medical filed is essential to prevent the spread of infection and diseases from patients to health-care workers and vice versa. Putting on Gloves Wash your hands thoroughly and dry them completely before putting on exam gloves ... Removing Gloves ... immediately wash hands thoroughly."<br><br>3. During a home visit observation with patient #18 on 2/18/19 at 9:30 AM, home health aide (HHA) employee J was observed providing toileting care. Employee J sat patient on toilet, then removed her gloves. Employee J failed to wash hands longer than 15 seconds after having removed the gloves. | G 0684 | 1. Retrain staff “employee J” on proper hand washing/glove use on 3.26.19. Nurse will observe “employee j” demonstrate hand washing and glove use. Additional training and quiz to be completed 4.15.19 as well.<br>2. All Home Health aides will participate in training on proper hand washing and proper use of medical gloves beginning 3.26.19. All staff will receive training on proper hand washing and medical glove use upon hire and annually. This deficient practice will be monitored with written examination of 100 % home health aides annually. Agency will periodically observe all staff to ensure they are following proper infection control. Additional infection control training to occur between 4.1.19 to 4.30.19.<br>3. Administrator<br>4. 4.15.19 | 04/15/2019 |

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| | Employee J then proceeded to assist patient to walk to the couch, returned to the bathroom and obtained the patient's toothbrush and a cup, and brushed the patient's teeth while patient was on the couch. Employee J failed to wear gloves while providing oral care for the patient.<br><br>During an interview on 2/18/19 at 10:15 AM, the administrator stated hand washing should be performed before and after providing care and donning and removing gloves, ant that the HHA should have used gloves while providing oral care. The administrator stated the hand washing policy is to wash hands for 30 seconds. | | | |
| G 0716<br><br>Bldg. 00 | Based on clinical record review the nurse failed to write an order to discontinue a medication after making a handwritten note to discontinue a medication in 1 of 25 clinical records reviewed (#6).<br><br>Findings include:<br><br>The agency's undated policy titled "Documentation of Services Provided," #6.20, stated "daily notes are to be submitted within 24 hours of provided service ...."<br><br>The agency's undated policy titled "Clinical Records & Documentation," Entries must be legible, clear, complete and authenticated, dated, and timed ... Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.<br><br>The clinical record for patient #6 was reviewed on 2/12/19. Patient signed consent forms to begin | G 0716 | 1. Medication list was updated immediately when order was located by auditor.<br>2. Office staff received training, that any time an update comes into the office, the Nurse Case Manager must be notified immediately so the update can be completed. This review training was completed on 3.13.19. Quarterly chart audits for 100% of client charts will enable agency to maintain compliance and to prevent the deficient practice from reoccurring.<br>3. Administrator<br>4. 3.13.19 | 03/13/2019 |

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| | home health services on 2/26/18. The start of care date was 3/25/18.<br><br>The Client Medication List dated 2/26/18, included Loratadine 10 mg (milligrams) per Gtube (gastric tube) PRN (as needed). Next to the medication was handwritten note which stated "d/c [discontinue] 10/18." The Client Medication list was evidenced as being reviewed by the Director of Nursing (DON) on 6/28/18; 7/25/18; 1/9/19; and 2/5/19.<br><br>The addendum to the plan of care for certification periods 7/23/18 to 9/20/18; 9/21/18 to 11/19/18; 11/20/18 to 1/18/19; and 1/19/19 to 3/19/19 listed Loratadine 10 mg per Gtube PRN for Allergies.<br><br>Progress notes by the DON on 7/25/18; 1/9/19; and 2/5/19 evidenced the plan of care was reviewed and there were no changes in the nursing plan of care or care needs. | | | |
| G 0798<br><br>Bldg. 00 | Based on record review, observation, and interview, the agency failed to ensure the home health aide (HHA) assignments were accurate based on patient assessments for 2 of 2 clinical records reviewed with HHA services ordered. (# 2, and 11)<br><br>Findings include:<br><br>1. The agency's undated policy titled "Nursing Plan of Care," # 5.3, stated "A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed client care provided through Forte HHC for clients receiving only home health aide services in the absence of a | G 0798 | POC=(medical, 485/487 plan of care) NPOC=(nursing/home health aide/HHa plan of care) POC & NPOC documents match related to services ordered and provided.<br>1. To correct the deficiency, Forte Home Health Care updated the client's POC & NPOC to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Orders sent to client's Physician starting 3.22.19 with training beginning on 3.22.19 as well for | 04/05/2019 |

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| | skilled service. The nursing plan of care must contain the following: 1) A plan of care and appropriate client identifying information. 2) The name of the client's physician. 3) Services to be provided. 4) The frequency and duration of visits. 5) Diet and activities. ... 9) The signature of the registered nurse who developed the plan."<br><br>2. The clinical record for patient # 2 was reviewed on 2/12/19. The plan of care dated 1/14-3/14/19 contained a diagnosis of cerebral palsy, and orders for HHA up to 8 hours per day, up to 6 days per week, up to 40 hours per week, for 60 days. The HHA was ordered to provide the following tasks: ambulation as required.<br><br>The HHA care plan dated 8/21/18 had the HHA assigned to monitor for safety and seizures every day, and all remaining tasks were ordered as needed and per client request which included ambulate.<br><br>During home visit observation with patient # 2 on 2/14/19 at 2:30 PM, durable medical equipment in the home included an electric wheel chair and a hoyer lift. The patient did not appear to be able to ambulate, as assigned on the HHA care plan.<br><br>3. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. HHA to provide bath of patient/family choice, hair wash and comb as patient allows, oral care brush teeth as patient allows, assist with meals or snacks if requested, take vital signs (VS) as needed, ambulation as required, assist to chair as needed, range of motion passive as needed, medication reminders as needed, and monitor for | | staff/family/client. All active client's orders were sent to client's physician for POC & NPOC changes by 3.29.19. All staff/family/client training must be completed when PCP orders are returned to agency. Staff will be trained on updated POC & NPOC to ensure they are providing services as ordered and charting accordingly. These changes completed by 4.5.19. Client #11/staff and family was re-trained on correct frequency/duration on 3.4.19.<br>2. POC & NPOC will be maintained and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC & NPOC will be updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC & NPOC updates. Staff trained to document if/when/why client declines services. Staff have been informed primary bathing shall occur on home health service time. Staff's daily notes will continue to be monitored to comply with POC & NPOC orders by office staff. Measures will be monitored in the monthly nurse meetings and quarterly QAPI audit and report to ensure this deficient practice does not reoccur. Nurse Case Managers are updating Plan of Care for their clients based on client's needs and safety. Nurse | |

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| | safety.<br><br>The HHA care plan dated 12/20/18 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing of patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting. The HHA visit notes for the certification period 11/19/18-1/17/19 evidenced the patient only received a bath or shower on 11/21, 11/28, 12/5, 12/12, 12/19, and 12/26/18, and the other dates all failed to evidence the patient/family refused bathing.<br><br>The HHA PA (prior authorization) visit notes dated 1/4 from 12:00 PM-4:00 PM, and 1/5/19 from 1:00 PM-9:00 PM failed to evidence the HHA provided bathing. During an interview on 2/18/19 at 1:00 PM, when inquired of the agency why the HHA would not provide this service, the director of nursing stated this patient also received residential services, and they probably gave the shower. At that time, the agency offered the residential side paperwork from those two days, and it evidenced the residential side provided the shower on 1/4 and 1/5/19 prior to the HHA arrival.<br><br>During an interview on 2/18/19 at 2:48 PM, the alternate administrator stated the HHAs should be doing the showers more than the residential side staff.<br><br>During interview on 2/19/19 at 1:09 PM, the director of nursing stated it looked like patient # 11 should not have been using 6 das a week, and that the residential side had been providing the patient's showers. At that time, the administrator | | Case Managers and office staff have been trained on updated POC & NPOC and required documentation on 3.25.19. Additional goals have been added to POC to be more specific and oriented to client's needs.<br>3. Administrator<br>4. 4.5.19 | |

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| | stated a patient would qualify for HHA services if they need assistance bathing, and that also this patient (#11) needed assistance being fed. The administrator stated that she thought sometimes all of the care provided had not been documented. | | | |
| G 0800<br><br>Bldg. 00 | Based on record review, and interview, the agency failed to ensure home health aide (HHA) services had been provided as ordered on the plan of care for 4 of 6 active HHA only clinical records reviewed. (#1, 2, 4, and 19)<br><br>Findings include:<br><br>1. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Patients are accepted for treatment on the reasonable expectation that Forte Home Health Care (HHC) 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 Forte HHC 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. ... (2) The individualized plan of care must include the following: 9) Frequency and duration of visits. ... 15) Medications and treatments. ... 20) | G 0800 | POC=(medical, 485/487 plan of care) NPOC=(nursing,home health aide/HHa plan of care) POC & NPOC documents match related to services ordered and provided.<br>1. To correct the deficiency, Forte Home Health Care updated the client's POC & NPOC to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Orders sent to client's Physician starting 3.22.19 with training beginning on 3.22.19 as well for staff/family/client. All active client's orders were sent to client's physician for Plan of Care changes by 3.29.19. All staff/family/client training must be completed when PCP orders are returned to agency. Staff will be trained on updated POC & NPOC to ensure they are providing services as ordered and charting accordingly. These changes will be completed by 4.5.19. Client #11/staff and family was re-trained on correct frequency/duration and to follow POC & NPOC on 3.4.19.<br>2. POC & NPOC will be | 04/05/2019 |

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| | Client-specific interventions and education; measurable outcomes and goals identified by the HHA and patient. ...."<br><br>2. The clinical record for patient # 1 was reviewed on 2/12/19. The plan of care dated 12/31/18-2/28/19 contained a diagnosis of mitochondrial myopathy, and orders for respite home health aide (RHHA) 60+ hours per month, HHA to bathe patient per patient/family choice, wash and comb hair as patient allows, oral care-brush teeth as patient allows, assist with meals or snacks if requested, take vital signs (VS) blood pressure (BP), pulse, respirations (RR) and T (temperature) as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The initial assessment dated 10/9/18, identified the patient needed assistance with oral hygiene, bathing, dressing, toileting, transfer, mobility, medication management, and meal preparation, and that the patient had a history of weight loss and inability to eat.<br><br>The HHA care plan last reviewed 1/8/19 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing, hair, oral care, assist with meals or snacks, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting. The HHA visit notes dated 1/7, 1/8, and 2/1/19 all failed to evidence the HHA provided all tasks as ordered and failed to evidence the patient/family had refused the ordered tasks.<br><br>The HHA visit note dated 1/7/19 stated "Caregiver Notes Breakfast & lunch ... hung out ... spent time together." | | maintained and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC & NPOC will be updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC & NPOC updates. Staff trained to document if/when/why client declines services. Staff have been informed primary bathing shall occur on home health service time. Staff's daily notes will continue to be monitored to comply with POC & NPOC orders by office staff. Measures will be monitored in the monthly nurse meetings and quarterly QAPI audit and report to ensure this deficient practice does not reoccur. Nurse Case Managers are updating POC & NPOC for their clients. Nurse Case Managers and office staff have been trained on updated POC & NPOC information and required documentation on 3.25.19. Additional goals have been added to POC to be more specific and oriented to client's needs.<br>3. Administrator<br>4. 4.5.19 | |

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The HHA visit note dated 1/8/19 stated "Caregiver Notes Breakfast & lunch ...."

The HHA visit note dated 2/1/19 stated "Caregiver Notes Made lunch ...."

3. The clinical record for patient # 2 was reviewed on 2/12/19. The plan of care dated 1/14-3/14/19 contained a diagnosis of cerebral palsy, and orders for HHA up to 8 hours per day, up to 6 days per week, up to 40 hours per week, for 60 days. The HHA was ordered to provide the following tasks: bath of patient/family choice, hair was and comb as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, take VS BP, pulse, RR and T as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting/brief changes as needed, and monitor for safety. Monitor for seizures. The "Goals" section stated "Client will receive full assistance with personal care/ADL's (activities of daily living) to maintain optimum level of hygiene for this certification period."

The HHA care plan dated 8/21/18 had the HHA assigned to monitor for safety and seizures every day, and all remaining tasks were ordered as needed and per client request which included bathing of patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting/brief changes. The HHA visit notes dated 1/14, 1/15, 1/17, 1/18, 1/19, 1/21, 1/22, 1/23, 1/24, 1/25, 1/28, 1/29, 1/31, 2/1, 2/2, 2/4, 2/5, 2/6, 2/7, 2/8, 2/11, and 2/12/19 all failed to evidence the HHA provided bathing to the patient and failed to evidence the patient/family refused the

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| | bathing.<br><br>4. The clinical record for patient # 4 contained a plan of care dated 1/25-3/25/19 with a diagnosis of dementia and orders for HHA up to 12 hours a day, up to 6 days a week, up to 60 hours a week for 60 days. HHA to bathe patient per patient/family choice, wash and comb hair as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, VS as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The "Goals" section stated "Client to remain safe in home, with assistance of family and HHA for this certification period." The frequency and goals failed to be patient specific.<br><br>The HHA care plan dated 7/29/18 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing of patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting.<br><br>5. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month for bathing of patient/family choice, hair wash and comb as patient allows, assist with meals or snacks if requested, take VS as needed, ambulation as required, assist to chair as needed, range of motion exercises passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The physician order dated | | | |

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| | 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The agency failed to discharge the patient.<br><br>The HHA care plan dated 12/20/18 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing of patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting. | | | |
| G 0962<br><br>Bldg. 00 | Based on record review, and interview, the clinical manager failed to ensure staff were available and assigned to patients to provide care for 11 of 17 patients on hold for various reasons which included, the preferred staff was unavailable for 7 of 13 records reviewed (# 6, 9, 14, 16, 22, and 23); staff moved in with client so new staff pending for 1 of 13 records reviewed (#8); staff not working outside the home for 1 of 13 records reviewed (# 20); and staff training was rescheduled due to weather for 3 of 13 records reviewed (# 10, 12, and 15).<br><br>Findings include:<br><br>1. The agency's undated policy titled "Scheduling and Assignment of Home Health Staff," # 6.12, stated "Scheduling. The Clinical Manager identifies the dates and times staff is expected to work, in collaboration with the client and family, in accordance with the ordered services and | G 0962 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. The required 60-day assessments (or 5-day window for OASIS) will be completed. This tag was based on review of clients that previously had services placed on hold, as our practice had been to not complete comprehensive assessments when we had an order to hold services. All clients that were previously on hold have resumed Home Health Care services in the home, with the exception of client # 20 whose discharge letter was sent 3.8.9, and discharge was effective 3.23.19. Client # 11, and # 22 discharge letters were sent | 04/11/2019 |

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| | approved plan of care. The Clinical Manager provides to the client and family with a list of eligible employees. ... Back-Up Staffing. Back-up staffs are hired in accordance with the Clinical Manager's directives. Each client and family will have as many back-up staff as the Clinical Manager deems necessary to cover emergency staffing needs. The Clinical Manager agrees to provide supervision in the event no staff is available. Missed Services. The Clinical Manager identifies the schedule of dates and times they want staff to work with the client within the allowable hours approved on each client and approved plan. In the event a scheduled sift is missed, the Clinical Manager is responsible to choose to reschedule the missed services or use the hours at a later date and time within each funding source's guidelines in collaboration with the client and family."<br><br>2. The agency's undated policy titled "Documentation of Admission Qualifications," # 5.5, stated Clients will be admitted for provision of care if they meet the following qualifications: ... 2) Medical needs can be met with Forte staff. 3) Client is in the designated service area."<br><br>3. The agency's job description titled "Clinical Manager/Alternate Clinical Manager," dated 1/16/18 stated "Summary: The Clinical Manager shall be responsible for the day-to-day operation of the healthcare entity ... Essential duties and responsibilities ... 1. Makes client and personnel assignments 2. Coordinates client care. ... 10. Assesses and assures the health and psychosocial needs of the client are met in accordance with the Plan of Care. 11. Ensures the client's care plan is periodically updated. 12. Ensures orders are completed as needed. 13. Ensures completion of monthly supervisory visits | | 3.18.19. Goals added to Plan of Care to be more specific to client.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. Forte Home Health Care will continue to complete comprehensive assessments at least every 60 days (or 5-day window for OASIS). Measures will be monitored in monthly nurse meetings and quarterly in QAPI audit and report to ensure this deficient practice does not reoccur. All visit dates are discussed and approved during nursing meetings to assure agency maintains compliance with 60 day (or 5-day window) required comprehensive assessments. If client's preference of staff is unavailable, Forte will attempt to offer client alternate staff. If client declines alternate staff, communication will be documented. Client's services will not be placed on hold due to lack of staff. If Forte cannot provide client's preference of staff, Forte will assist client to find another agency who can meet the client's needs. Auditor will audit charts for all active clients to monitor for comprehensive assessment compliance and maintain compliance with QAPI review and reporting. Home Health office staff and Nurse Case Managers trained related to this deficiency and corrective action plan on 4.11.19. | |

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| | and all other documentation required to meet the physical, reimbursement and regulatory requirements of the client. ... 26. Adheres to federal, state, local, and agency policies, guidelines and generally accepted practice standards."<br><br>4. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Patients are accepted for treatment on the reasonable expectation that Forte Home Health Care (HHC) can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. ... Forte Home Health Care must: ... (4) 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."<br><br>5. The agency's undated document titled, "Section 5 - Coordination of Service, Quality of Care, Client Documentation/Forms" evidenced "5.5 Documentation of Admission Qualifications ... 2. Medical needs can be met with Forte staff ...." and "5.10 Client Rights and Responsibilities ... (c) Rights of the Client ... (5) receive all services outlined in the plan of care ...."<br><br>6. During an interview on 2/15/19 at 10:30 AM, the director of nursing (DON) stated that patient #6 was on hold, along with some other patients. At that time, a list of patients on hold and the reasons for the holds was requested.<br><br>The list of hold patients was received on 2/15/19 at 12:32 PM and included the following patients: 8, 9, 10, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, and 29. Patients 24 and 29 were on hold pending prior authorization and #24 went to the hospital on 2/1/19. The other 14 patients had | | 3.<br>Administrator<br>4. 4.11.19 | |

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| | been placed on hold for various reasons as listed above, and had been recertified for new certification periods while services were on hold.<br><br>7. During an interview on 2/15/19 at 12:41 PM, the administrator stated typically if the preferred aide was not available, the agency would place the patients on hold because the families chose their own staff, and the agency did not just send staff out.<br><br>8. The clinical record for patient # 12 was reviewed on 2/18/19. The start of care date was 1/6/19. The plan of care dated 1/6-3/6/19 contained orders for HHA up to 8 hours a say, up to 5 days a week, for a total of up to 40 hours per week, for 60 days. The initial assessment dated 11/29/18 evidenced the patient was a pediatrics patient and dependent for oral hygiene, eating, bathing, dressing, toileting, mobility, transferring, bed mobility, and meal preparation. The PA approval evidenced services had been approved effective 1/6-7/6/19. The physician order dated 1/11/19 stated "Hold HHA services effective 1/6/19 until family preference of aide is available." The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>During an interview on 2/18/19 at 1:12 PM, the administrator stated this patient had not yet started care, as the staff had to be rescheduled for training due to the extreme cold weather at the end of January. The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>9. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was 2/25/18. The patient's diagnosis was severe | | | |

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| | cerebral palsy. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The initial assessment dated 1/25/18 evidenced the patient was dependent for oral hygiene, eating, bathing, dressing, toileting, transferring, mobility, bed mobility, had adaptive devices, dependent for overnight supervision, medication management, and meal preparation. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18, and evidenced the last date of HHA services provided by employee V was 12/21/18. The record failed to evidence the information in the summary had been current and up to date. The record failed to evidence the agency attempted to place other staff with the patient to receive care while waiting for staff.<br><br>The progress note dated 1/24/19 at 1:55 PM, stated "NCM reached out to FA ... notifying [them] that agency is still waiting on requirements for new HH staff [non-employee DD]. FA replied [they] would notify [non-employee DD] and gave NCM an update on HHa [employee V]."<br><br>The progress note dated 2/18/19 at 1:21 PM stated | | | |

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| | "NCM reached out to FA [name] asking how they are and notifying FA what we need from [their] staff [non-employee DD]. 1:29 PM NCM sent HH staff [non-employee DD] a text message asking for CPR [cardiopulmonary resuscitation[ and TB [tuberculosis test result] ... NCM let [non-employee DD] know ... waiting on TB test results."<br><br>During an interview on 2/19/19 at 4:27 PM, patient # 15's parents returned a phone call and stated they have a relative currently providing care for the patient,but have to pay them out of pocket until Forte receives the documents required to train the parents' staff selection.<br><br>10. The clinical record for patient # 20 was reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The physician order dated 1/8/19 stated "Hold HHA services effective 12/29/18 per family request. See attached progress note." The progress note written by the alternate director of nursing (ADON) on 1/8/19 stated "Office staff notified nurse case manager that HHA did not work any home health hours for the week ending 1.15.19. ... staff reported that family advocate [advocate name] ... was not working at this time, but that [advocate] would be starting back to work in February or March. [Family advocate name] told staff that [family advocate] would not need HHA staff to care for client during this time. ... Will place home health services on hold at this time." The record failed to evidence the agency attempted to contact the patient or family advocate since 1/8/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the | | | |

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| | patient.<br><br>11. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." The physician order dated 1/14/19 stated "Hold HHA services effective 1/13/19 until family preference of aide is available. Resume care when this aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/13/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>The hold list of patients provided on 2/15/19 at 12:32 PM, stated "[identifier of patient # 22]- ... respite home health only, preference of staff is in college, but works on her breaks."<br><br>12. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/19/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.13. During the daily conference on 2/18/19 at 2:48 PM, the agency | | | |

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| | President stated the family was responsible for identifying a caregiver, then the agency would hire and train them while Medicaid was being processed. "If agency doesn't have staff available, they would refer out to make sure family has a good fit." Requested agency policy regarding placing patient services on hold. The agency did not provide a policy prior to the survey exit conference on 2/21/19.<br><br>14. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The physician order dated 8/9/18 and signed on 8/14/19 evidenced home health aide services were on placed on hold until family preference of aide was available.<br><br>The plan of care for certification period 9/21/18 to 11/19/18 was signed by the physician on 8/30/18 and failed to indicate services had been on hold since 8/10/18. No comprehensive assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The plan of care for certification period 11/20/18 to 1/18/19 was signed by the physician on 12/6/18. In the Summary Report section of the plan of care was the statement "client remains on hold." No comprehensive Assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The agency failed to ensure the clinical manager coordinated patient care to include having a comprehensive assessment completed at least every 60 days; ensure staffing was available to cover all patient care needs as identified in the individualized plan of care; and ensure | | | |

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| | individualized plans of care accurately reflected current information prior to presentation to physician for signature.<br><br>15. The clinical record for patient #8 was reviewed on 2/18/19. The start of care date was 4/1/18. This patient had orders for respite home health aide care for 60+ hours per month. An order written by Forte and sent to the physician for signature on 10/4/18 to "Hold services effective 10/3/18 d/t [due to] preferred HHA [home health aide] not available. Resume care when preferred HHA becomes available."<br><br>The plan of care for certification period 11/27/18 to 1/25/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>The plan of care for certification period 1/26/19 to 3/26/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>Interview on 2/19/19 at 08:50 AM with patient #8's family member regarding services being on hold. Family member acknowledged respite home health aide services were on hold. A different family member had previously been providing respite home health aide services but had to have knee surgery. Family member stated agency did not provide replacement staff and that family member had been in contact with the Aging & In Home Services case manager who suggested a referral to a different agency for respite services, but this was declined. | | | |

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| | The agency failed to ensure the clinical manager coordinated patient care to include having a comprehensive assessment completed at least every 60 days; ensure staffing was available to cover all patient care needs as identified in the individualized plan of care; and ensure individualized plans of care accurately reflected current information prior to presentation to physician for signature.<br><br>16. The clinical record for patient # 9 was reviewed on 5/20/18. The start of care date was 5/20/18. The patient was to receive home health aide services up to 8 hours/day, up to 5 days/week for school breaks only.<br><br>Medicaid approval (Authorization # X1811200289) had been received on 5/3/18 for services from 5/20/18 to 11/17/18. The Warsaw Community School Calendar for 2017-2018 and 2018-2019 was attached with circled days indicating days care was needed. July 2018 had 22 days circled. August 2018 had 10 days circled; September had 1 day circled; October had 3 days circled.<br><br>A comprehensive assessment was completed on 7/2/18 at 1010 by employee D. The progress note dated 7/13/18 written by employee D states, "Place home health services on hold effective 7/9/18 due to HHA unavailable to work at this time. Will resume services when HHA is available." A review of home health aide documentation notes evidenced no services had been provided between 7/6/28 and 7/16/18.<br><br>On 7/16/18 the patient received a home health aide visit and the RNCM completed a resumption of care comprehensive nursing assessment. The | | | |

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| | plan of care certification for period 7/19/18 -9/16/18 was also faxed to physician for signature on this date.<br><br>A progress note dated 7/26/18 evidenced home health services were placed on hold effective 7/17/18 due to no staff available to work in home.<br><br>The plan of care for certification period 9/17/18 to 11/15/18 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The plan of care also stated "Pending Medicaid approval" when the agency had already received notice of Medicaid approval on 5/3/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify the patient while services were on hold due to lack of staffing.<br><br>The plan of care for certification period 11/16/18 to 1/14/19 stated home health aide frequency/duration of care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The summary report stated "Client remains on hold, per PA approval and Mothers request ...last supervisory visit was completed on 7/16/18." The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due | | | |

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| | to lack of staffing.<br><br>PA approval (Authorization # X1832000044) was received on 11/20/18 for services from 11/18/18 to 5/18/19. The 2018 Warsaw Community School calendar was attached identifying when the patient would be out of school and when care would be needed. School days were circled for care needs as follows: 3 days in November; 6 days in December; 5 days in January; 1 day in February; and 5 days in April.<br><br>Plan of care for certification period 1/15/19 to 3/15/19 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Supervisory visits every 30 days. Hours to be used on non-school days while mother works.<br><br>The summary report stated "Client remains on hold, per PA approval and parent request ...last supervisory visit was completed on 7/16/18." The agency had received notice of PA approval on 11/20/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>During an interview on 2/18/19 at 3:06 PM, the DON stated the family for patient #9 had been going through a difficult time, the agency did not want to discharge due to signing the patient back up would take a lot of time to get re-approved. The DON stated the agency had kept in contact with the family and patient since then. The record failed to evidence the agency had kept in contact | | | |

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| | with the family and patient.<br><br>17. The clinical record for patient #10 was reviewed on 2/18/19. The start of care date was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 ordered home health aide care up to 4 hours/day, up to 7 days/wk. A physician order written by the administrator on 12/26/18 and signed on 1/2/19 evidenced services were placed on hold due to family preference of aide not being available.<br>Plan of care for certification period 2/15/19 to 4/15/19 was faxed to physician and signed on 2/11/19 while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care.<br><br>During a phone interview with patient #10 on 2/19/19 regarding services on hold, patient stated he/she was told if there was a family member or friend that would like to become the caregiver, that the agency would hire them and train them. Patient stated the home health aide assisted with bathing, helped with showers, dressing, combed hair, helped with meals and did laundry.<br><br>The agency failed to ensure the clinical manager coordinated patient care to include having a comprehensive assessment completed at least every 60 days; ensure staffing was available to cover all patient care needs as identified in the individualized plan of care; and ensure individualized plans of care accurately reflected current information prior to presentation to physician for signature.<br><br>18. The clinical record for Patient #14 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care | | | |

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| | certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing.<br><br>The agency failed to ensure the clinical manager coordinated patient care to ensure staffing was available to cover all patient care needs as identified in the individualized plan of care.<br><br>19. The clinical record for Patient #16 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes | | | |

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| | available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing.<br>The agency failed to ensure the clinical manager coordinated patient care to ensure staffing was available to cover all patient care needs as identified in the individualized plan of care. | | | |
| G 0966<br><br>Bldg. 00 | Based on record review, and interview, the clinical manager failed to ensure patient needs were continually assessed, failed to ensure revised plans of care had been accurately requested and contained current and accurate information from the updated comprehensive assessment when sent to the physician for approval for 11 of 13 clinical records reviewed of patients on hold (# 8, 9, 10, 11, 14, 15, 16, 19, 20, 22, and 23); and failed to ensure the plan of care contained information about the patients' progress towards goals for 1 of 23 clinical records reviewed (#1).<br><br>Findings include:<br><br>1. The agency's job description titled "Clinical Manager/Alternate Clinical Manager," dated 1/16/18 stated "Summary: The Clinical Manager shall be responsible for the day-to-day operation of the healthcare entity ... Essential duties and responsibilities ... 2. Coordinates client care. ... 10. Assesses and assures the health and psychosocial needs of the client are met in accordance with the Plan of Care. 11. Ensures the client's care plan is periodically updated. 12. Ensures orders are completed as needed. 13. Ensures completion of monthly supervisory visits and all other documentation required to meet the | G 0966 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. The required 60-day assessments (or 5-day window for OASIS) will be completed. This tag was based on review of clients that previously had services placed on hold, as our practice had been to not complete comprehensive assessments when we had an order to hold services. All clients that were previously on hold have resumed Home Health Care services in the home, with the exception of client # 20 whose discharge letter was sent 3.8.9, and discharge was effective 3.23.19. Client # 11, and # 22 discharge letters were sent 3.18.19. Goals added to Plan of Care to be more specific to client.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. Forte Home Health Care will continue to | 04/11/2019 |

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| | physical, reimbursement and regulatory requirements of the client. ... 26. Adheres to federal, state, local, and agency policies, guidelines and generally accepted practice standards."<br><br>2. The clinical record for patient # 1 was reviewed on 2/12/19. The plan of care dated 12/31/18-2/28/19 contained orders for respite home health aide (RHHA) 60+ hours per month. The summary section stated "[patient] is in [their] bedroom per [parent] upon nurse arrival. ... vital signs (VS) and assessment. BP [Blood pressure] 97/58, HR [heart rate] 76, RR [respiratory rate] 16-18 non-labored, T [temperature] 97.8. ... Last bowel movement 12.10.18." The summary failed to include the most current assessment's (1/8/19) vital signs and bowel movement.<br><br>The latest nursing assessment dated 1/8/19 evidenced BP 92/57, HR 88, RR 16, and T 97.1 and last bowel movement 1.7.19. The record failed to contain accurate and current summary information for the physician review.<br><br>3. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. The record failed to evidence the agency HHA had provided any care since 1/5/19. The physician order dated 1/7/19 stated "Hold HHA services effective 1/6/19 per family's request d/t [due to] client traveling outside the state." This order was signed by the administrator and was not faxed to the physician until 1/23/19.<br><br>The next recertification plan of care dated 1/18-3/18/19 was sent to the physician for | | complete comprehensive assessments at least every 60 days (or 5-day window for OASIS). Measures will be monitored in monthly nurse meetings and quarterly in QAPI audit and report to ensure this deficient practice does not reoccur. All visit dates are discussed and approved during nursing meetings to assure agency maintains compliance with 60 day (or 5-day window) required comprehensive assessments. If client's preference of staff is unavailable, Forte will attempt to offer client alternate staff. If client declines alternate staff, communication will be documented. Client's services will not be placed on hold due to lack of staff. If Forte cannot provide client's preference of staff, Forte will assist client to find another agency who can meet the client's needs. Auditor will audit charts for all active clients to monitor for comprehensive assessment compliance and maintain compliance with QAPI review and reporting. Home Health office staff and Nurse Case Managers trained related to this deficiency and corrective action plan on 4.11.19.<br>3.<br>Administrator<br>4. 4.11.19 | |

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| | signature on 1/14/19, nine days before the hold order had been sent, and stated "Client is currently on hold due to being in Florida for the winter. Last supervisory visit was completed on 01.02.19, see progress note below." The progress note dated 1/7/19 stated "NCM [nurse case manager] notified by [patient's significant other] that client had left for Florida after provided services on 1/5/19. ... Client/[significant other] agreed to notify agency when client returns home to resume services." The progress note dated 1/23/19 stated "client was still out of state ... no need for home visit." The record failed to evidence the patient was back in Indiana to receive services and a comprehensive assessment to resume care.<br><br>4. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was 2/25/18. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The current PA dated 8/26/18 was approved for 10 hours a day through 2/23/19. The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18, and evidenced the last date of HHA services provided | | | |

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| | by employee V was 12/21/18. The record failed to evidence the information in the summary had been current and up to date, and failed to evidence staff had been available to provide care.<br><br>5. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and the discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note dated 1/15/19 stated "1.14.1.9 9:25 am ... 1.15.19 10:00 am [patient's spouse] contacted NCM [nurse case manager] to notify that client will be going to LTC [long term care] for rehab when released from hospital. [Patient's spouse] agreed to notify agency upon d/c. [discharge]." This was signed by the administrator. The next plan of care was dated 2/4-4/4/19 and sent to the physician on 2/1/19, and the summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." The summary information failed to be up to date and accurate was from December 2018, and the patient was still in long term care rehab.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services.<br><br>6. The clinical record for patient # 20 was reviewed on 2/20/19. Start of care date was | | | |

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| | 4/16/17. The plan of care dated 2/5-4/5/19 evidenced it had been sent to the physician on 2/1/19 for signature and contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The summary on this plan of care stated "Client remains on hold. Last in home supervisory visit was on 12/11/18, see progress note from that visit below." This information failed to be current and was 2 months old.<br><br>The physician order dated 1/8/19 stated "Hold HHA services effective 12/29/18 per family request. See attached progress note." The progress note dated 1/8/19 stated "Office staff notifies nurse case manager that HHA did not work any home health hours for the week ending 1.15.19. ... Staff reported that family advocate [advocate name] ... was not working at this time, but that [advocate] would be starting back to work in February or March. [Family advocate name] told staff that [family advocate] would not need HHA staff to care for client during this time. ... Will place home health services on hold at this time." This was signed by the alternate director of nursing (ADON). The record failed to evidence the agency attempted to contact the patient or family advocate since 1/8/19. and failed to evidence the agency discharged the patient per policy.<br><br>7. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 was sent to the physician for signature on 2/15/19 and contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." This was | | | |

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| | signed by the DON. This information failed to be current, and was 2 months old.<br><br>The physician order dated 1/14/19 stated "Hold HHA services effective 1/13/19 until family preference of aide is available. Resume care when this aide becomes available."<br><br>8. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 was sent to the physician for signature on 1/29/19 and contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The summary section stated "Supervisory visit and comprehensive nursing assessment completed in client's home today. HHA, [name of aide] present and providing care as ordered. ... T [temperature]: 99.3 ... BP [blood pressure]: 93/63 ...." This was signed by employee W on 2/11/19. The Comprehensive Nursing Assessment dated 1/9/19 evidenced the vital signs listed in the summary were from that assessment, not from 2/11/19. The record failed to evidence the summary information had been current, and failed to evidence communication with staff/family about the HHA availability.<br><br>The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence any documentation of communication with any staff.9. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The physician order dated 8/9/18 and signed on 8/14/19 evidenced home health aide (HHA) services were on placed on hold until family preference of aide was available. | | | |

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| | The plan of care for certification period 9/21/18 to 11/19/18 was signed by the physician on 8/30/18 and failed to indicate services had been on hold since 8/10/18. No comprehensive assessment was completed prior to completion of the updated plan of care.<br><br>10. The clinical record for patient #8 was reviewed on 2/18/19. The start of care date was 4/1/18. This patient had orders for respite home health aide care for 60+ hours per month. An order written by Forte and sent to the physician for signature on 10/4/18 to "Hold services effective 10/3/18 d/t [due to] preferred HHA [was] not available. Resume care when preferred HHA becomes available."<br><br>The plan of care for certification period 11/27/18 to 1/25/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>The plan of care for certification period 1/26/19 to 3/26/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>In an interview on 2/19/19 at 08:50 AM with patient #8's family member, services being placed on hold was discussed. Family member acknowledged respite home health aide services were on hold. A difference family member had previously been providing respite home health aide services but had to have knee surgery. The family member stated the agency did not provide replacement staff and that they had been in | | | |

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| | contact with the Aging & In Home Services case manager who suggested a referral to a different agency for respite services, but this was declined.<br><br>11. The clinical record for patient # 9 was reviewed on 5/20/18. The start of care date was 5/20/18. The patient was to receive home health aide services up to 8 hours/day, up to 5 days/week for school breaks only.<br><br>Medicaid approval (Authorization # X1811200289) had been received on 5/3/18 for services from 5/20/18 to 11/17/18. The Warsaw Community School Calendar for 2017-2018 and 2018-2019 was attached with circled days indicating days care was needed. July 2018 had 22 days circled. August 2018 had 10 days circled; September had 1 day circled; October had 3 days circled.<br><br>The progress note dated 7/13/18 written by employee D states, "Place home health services on hold effective 7/9/18 due to HHA unavailable to work at this time. Will resume services when HHA is available." A review of home health aide documentation notes evidenced no services had been provided between 7/6/28 and 7/16/18.<br><br>On 7/16/18 the patient received a home health aide visit and the RNCM (registered nurse case manager) completed a resumption of care comprehensive nursing assessment. The plan of care certification for period 7/19/18 -9/16/18 was also faxed to physician for signature on this date.<br><br>A progress note dated 7/26/18 evidenced home health services were placed on hold effective 7/17/18 due to no staff available to work in home.<br><br>The plan of care for certification period 9/17/18 to 11/15/18 stated home health aide care up to 8 | | | |

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| | hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The plan of care also stated "pending Medicaid approval" when the agency had already received notice of Medicaid approval on 5/3/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify the patient while services were on hold due to lack of staffing.<br><br>The plan of care for certification period 11/16/18 to 1/14/19 stated home health aide frequency/duration of care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The summary report stated "Client remains on hold, per PA approval and Mothers request ...last supervisory visit was completed on 7/16/18." The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>PA approval (Authorization # X1832000044) was received on 11/20/18 for services from 11/18/18 to 5/18/19. The 2018 Warsaw Community School calendar was attached identifying when the patient would be out of school and when care would be needed. School days were circled for care needs as follows: 3 days in November; 6 days in December; 5 days in January; 1 day in | | | |

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| | February; and 5 days in April.<br><br>Plan of Care for certification period 1/15/19 to 3/15/19 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Supervisory visits every 30 days. Hours to be used on non-school days while mother works.<br>The summary report stated "Client remains on hold, per PA approval and parent request ...last supervisory visit was completed on 7/16/18."<br>The agency had received notice of PA approval on 11/20/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>12. The clinical record for patient #10 was reviewed on 2/18/19. The start of care date was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 ordered home health aide care up to 4 hours/day, up to 7 days/wk. A Physician order written by the administrator on 12/26/18 and signed on 1/2/19 evidenced services were placed on hold due to family preference of aide not being available.<br>Plan of care for certification period 2/15/19 to 4/15/19 was faxed to physician and signed on 2/11/19 while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care.<br><br>A phone interview with patient #10 occurred on 2/19/19 at 1:00 PM regarding services on hold. Patient was told if she had a family member or friend that would like to become the caregiver, | | | |

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| | that the agency would hire them and train them. Patient stated the home health aide bathed her or helped with showers, dressing, combed hair, helped with meals and did laundry.<br><br>13. The clinical record for Patient #14 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing.<br><br>14. The clinical record for Patient #16 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week. | | | |

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| | The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing. | | | |
| G 0968<br><br>Bldg. 00 | Based on clinical record review the director of nursing failed to ensure the implementation of safety measures and updates to the plan of care to include all safety measures to protect patients against injury in 2 of 2 records reviewed for patients with G-tubes (gastric feeding tubes) (#6 and #7).<br><br>Findings include<br><br>1. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18 and plan of care certification period was 1/19/19 to 3/19/19. Patient has a diagnosis of Cerebral Palsy and has a G-tube for bolus feedings 5 times a day. The comprehensive nursing assessment on 2/26/18 documented that the patient was at risk for choking due to results of a swallow study. Patient had been NPO [nothing by mouth] and on tube feedings only since 2/26/18. The Plan of Care failed to include risk for aspiration as a safety measure.<br><br>2. The clinical record for patient #7 was reviewed on 2/19/19. The start of care date was 5/20/15 and plan of care certification period was 12/30/18 to 2/27/19. Patient was on a ventilator and NPO with G-tube feedings only. Choking and aspiration risk | G 0968 | 1. Plan of Care (POC) for each client have been updated to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Orders sent to client's Physician starting 3.22.19 with training to begin on 3.22.19 as well for staff/family/client. All active client's orders are to be sent to client's physician for Plan of Care changes by 3.29.19. All staff/family/client training must be completed when PCP orders are returned to agency. Staff will be trained on updated POC to ensure they are providing services as ordered and charting accordingly. These changes will be completed by 4.5.19.<br>2. POC will be maintained and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC will be updated with changes per physician's order as needed. Staff/client/family | 04/05/2019 |

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| | were identified on the comprehensive assessments on 12/28/18, 10/29/18, and 6/28/18. The plan of care failed to include risk for aspiration as a safety measure. | | training will be completed with all POC updates. Staff trained to document if/when/why client declines services. Staff have been informed primary bathing shall occur on home health service time. Staff's daily notes will continue to be monitored to comply with POC orders by office staff and reviewed by Clinical Manager as needed. Nurse Case Managers are updating Plan of Care for their clients. Nurse Case Managers and office staff have been trained on updated Plan of Care information and required documentation on 3.25.19. Additional goals have been added to POC to be more specific and oriented to client's needs/safety. In order to assure implementation of the POC, Nurse Case Managers will observe staff following POC orders in client's home during Supervisory Visit, and by discussing care provided by staff with FA/Family/client. Measures will be monitored in monthly nurse meetings, quarterly QAPI audit and report, quarterly chart audits of 100% of clients completed by Administrator and Clinical Manager will ensure this deficient practice does not reoccur.<br>3. Administrator/Clinical Manager<br>4. 4.5.19 | |

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| N 0000<br><br>Bldg. 00 | This was a home health state licensure survey, and a complaint investigation survey.<br><br>Survey Dates: February 11, 12, 13 14, 15, 18, 19, 20 and 21, 2019<br><br>Facility Number: 012779<br>Medicaid Number: 201068710A<br><br>Complaint #: IN00176755- Unsubstantiated, lack of sufficient evidence<br><br>Census Service Type:<br>Skilled: 9<br>Home Health Aide Only: 147<br>Personal Care Only: 0<br>Total: 156<br><br>Sample:<br>RR w/HV: 4<br>RR w/o HV: 21<br>Total: 25 | N 0000 | | |
| N 0444<br><br>Bldg. 00 | 410 IAC 17-12-1(c)(1)<br>Home health agency administration/management<br>Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following:<br>(1) Organize and direct the home health agency's ongoing functions.<br>Based on record review and interview the | N 0444 | 1. All active clients will receive all | 04/15/2019 |

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| | administrator failed to ensure the day to day operations of the agency.<br><br>Findings include:<br><br>1. The agency's job description titled "Administrator/Alternate Administrator," dated 1/16/18, stated "Summary: The administrator shall be responsible for the day to day functioning of the agency. ... Essential duties and responsibilities (Other duties may be assigned): 1. Implements appropriate infection control and standard precaution practices. ... 3. Monitors the quality of service, document service time and adherence to agency policy. ... 9. Adheres to agency and stat policy, guideline and generally accepted practice standards. ... 16... Places the needs of the client first at all times. Ensures that service delivery is completed with the goals of the client's healing and support in mind."<br><br>2. The administrator failed to ensure patients received care as ordered by the physician for 12 of 17 clinical records reviewed for patients with services on hold (See N522).<br><br>3. The administrator failed to ensure patients were discharged due to inability to provide skilled nurse coverage for more than 30 days for 2 of 2 patients hospitalized (See N488).<br><br>4. The administrator failed to ensure comprehensive assessments were completed every 60 days for 10 of 25 clinical records reviewed (See N541).<br><br>5. The administrator failed to ensure the plan of care was individualized for each patient regarding frequency/duration of visits in 10 of 25 clinical records reviewed and safety measures to protect | | ordered services in POC which includes all required information per COP 484.60. Clients that were previously on hold have been resumed with the exception of client #20 – discharged 3.23.19 after letter was sent 3.8.19. Client # 11 and client #22 discharge letters sent 3.18.19.<br>2. All active clients will receive all ordered services in POC which includes all information required in COP 484.60. If a client's preference of staff is not available to work, a temporary alternate staff will be offered to that client. Services will not be placed on hold due to lack of staff. Communications with the client will be documented in the client's chart. Comprehensive assessments will be completed with client at least every 60 days (or within 5 day window) as ordered per PCP. These measures will be monitored in monthly nurse meetings, where the services of each client are reviewed, as well as with quarterly QAPI audit and report to ensure this deficient practice does not reoccur. 100% of client charts to be audited quarterly. Office staff and Nurse Case Managers trained on 4.11.19.<br>3. Administrator<br>4. 4.11.19<br><br>1. POC=(medical, | |

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| | against injury for 2 of 2 records reviewed (See N524).<br><br>6. The administrator failed to ensure the revised plan of care reflected current information from the comprehensive assessment in 10 of 13 clinical records reviewed for patients with services on hold and contained information concerning patient's progress toward the measurable outcomes/goals as identified by the agency in 1 of 25 records reviewed (See N522).<br><br>7. The administrator failed to ensure all staff adhered to infection control procedures for 1 of 3 home visits (See N470).<br><br>8. The administrator failed to ensure the agency prepared clinical notes for 1 of 25 records reviewed (See N544).<br><br>9. The administrator failed to ensure the home health aide (HHA) assignments were accurate based on patient assessments for 2 of 2 clinical records reviewed with HHA services ordered. (See N602).<br><br>10. The administrator failed to ensure home health aide (HHA) services had been provided as ordered on the plan of care for 4 of 6 active HHA only clinical records reviewed. (See N603).<br><br>11. The administrator failed to ensure the implementation of safety measures and updates to the plan of care to include all safety measures to protect patients against injury in 2 of 2 records reviewed (See N543). | | 485/487 plan of care), NPOC= (nursing/home health aide or HHa plan of care). POC & NPOC for each client have been updated to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Orders sent to client's Physician starting 3.22.19 with training beginning on 3.22.19 as well for staff/family/client. All active client's orders were sent to client's physician for POC & NPOC changes by 3.29.19. All staff/family/client training must be completed when PCP orders are returned to agency. Staff will be trained on updated POC & NPOC to ensure they are providing services as ordered and charting accordingly. These changes all completed by 4.5.19.<br>2. POC & NPOC will be maintained and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC & NPOC will be audited with quarterly chart audits and updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC & NPOC updates. Staff trained to document if/when/why client declines services. This should prevent agency non-compliance. Staff have been informed primary bathing shall occur on home health service | |

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| | | | time. Staff's daily notes will continue to be monitored to comply with POC & NPOC orders by office staff. Nurse Case Managers and office staff have been trained on updated POC & NPOC information and required documentation on 3.25.19. Additional goals have been added to POC to be more specific and oriented to client's needs.<br>3. Administrator<br>4. 4.5.19<br><br>1. Infection Control training of "employee j" completed in person on 3.26.19. All home health aide staff are being retrained on handwashing and medical glove use beginning 3.26.19. These trainings will be completed by 4.15.19. Additional Infection control training will begin 4.1.19 and will be completed by 4.30.19.<br>2. Home Health Aides will receive annual training on handwashing and medical glove use. All new home health aide staff will be trained on proper handwashing, medical glove use, and infection control during initial training. This deficient practice will be monitored with written examination of 100 % home health aides annually as well as periodic observation of all home health aides to ensure they are following proper infection control. Additional infection control training to occur between 4.1.19 to | |

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| | | | 4.30.19.<br>3. Administrator<br>4. 4.15.19<br><br>1. Medication list was updated immediately when order located by auditor.<br>2. Office staff have been trained that any time an update comes into the office, the Nurse Case Manager must be notified immediately so the update can be completed. This was reviewed with all office staff on 3/13/19. Chart audits to be completed on a quarterly basis.<br>3. Administrator<br>4. 3.13.19 | |
| N 0466<br><br>Bldg. 00 | 410 IAC 17-12-1(j)<br>Home health agency administration/management<br>Rule 12 Sec. 1(j) The information obtained from the:<br>(1) physical examinations required by subsection (h); and<br>(2) tuberculosis evaluations and clinical follow-ups required by subsection (i)<br>must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k).<br>Based on observation, record review and interview, the agency failed to ensure all employee medical information was kept separate and confidential for 10 of 10 employee files reviewed (A, B, D, E, F, G, H, I, L, and N).<br><br>Findings include:<br><br>1. Employee files were reviewed on 2/19/19. | N 0466 | 1. Employee records had been maintained in binders in the locked chart room. This tag states the files were not separate and confidential. Employee health records have been moved to confidential folders, in a locked file cabinet, accessible to only Forte Home Health office staff. This is to | 03/22/2019 |

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| | During an interview 2/19/19 at 2:05 PM, the administrator stated all employee tuberculosis (TB) screenings, and physicals are together in big binders. The administrator stated these binders are kept in the clinical record room on the top shelf above the clinical records.<br><br>During an observation of the clinical record room on 2/12/19 at 1:00 PM, it was observed that there was a second door which led into another room with 2 desks, to which the administrator stated were for the nurse case managers. The clinical records sat on open wooden shelving.<br><br>2. During employee file review, the binders containing the employees' physicals and TB screenings were labeled as follows: "Employee Health Records," "A-K," "L-Z." These binders contained TBs, physicals, and drug screen results for all employees, alphabetically, and included those reviewed (A, B, D, E, F, G, H, I, L, and N). These binders failed to contain the medical information separately and confidentially for all employee files, and failed to evidence they were kept in a separate and confidential location from anyone who may have access to the clinical records. | | maintain compliance by keeping medical and personnel files separate and confidential, accessible only to Home Health office staff. This was completed on 3.22.19.<br>2. Employee records will continue to be maintained in a locked, separate and confidential cabinet, in confidential folders, accessible only to Home Health office staff. New practice has been enforced effective 3.22.19 and all office staff were trained on the new practice. Periodic checks on files per Office Manager will ensure compliance is maintained.<br>3. Administrator<br>4. 3.22.19 | |
| N 0470<br><br>Bldg. 00 | 410 IAC 17-12-1(m)<br>Home health agency administration/management<br>Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.<br>Based on observation, record review, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 1 of 3 home visit observations (# 18). | N 0470 | 1. Retrain staff “employee J” on proper hand washing and glove use on 3.26.19. Nurse will observe “employee j” demonstrate hand | 04/15/2019 |

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| | Findings include:<br><br>1. The agency's policy titled "Handwashing," # 12.8, dated 10/11/2018, stated "It is the policy of Forte HHC to provide care in a safe and sanitary manner. The following procedure will be applied to all health care providers ... Wash hands with soap and water before and after having direct contact with patients; after removing gloves; ... after contact with body fluids or excretions, mucous membranes, ... if moving from a contaminated body site to a clean body site during patient care ...."<br><br>2. The agency's policy titled "Proper Use of Medical Gloves," # 12.9, dated 10/11/2018, stated "The use of exam gloves in the medical filed is essential to prevent the spread of infection and diseases from patients to health-care workers and vice versa. Putting on Gloves Wash your hands thoroughly and dry them completely before putting on exam gloves ... Removing Gloves ... immediately wash hands thoroughly."<br><br>3. During a home visit observation with patient #18 on 2/18/19 at 9:30 AM, home health aide (HHA) employee J was observed providing toileting care. Employee J sat patient on toilet, then removed her gloves. Employee J failed to wash hands longer than 15 seconds after having removed the gloves.<br><br>Employee J then proceeded to assist patient to walk to the couch, returned to the bathroom and obtained the patient's toothbrush and a cup, and brushed the patient's teeth while patient was on the couch. Employee J failed to wear gloves while providing oral care for the patient. | | washing and glove use. Additional training and quiz to be completed 4.15.19 as well.<br>2. All Home Health aides will participate in training on proper hand washing and proper use of medical gloves beginning 3.26.19. All staff will receive training on proper hand washing and medical glove use upon hire and annually. This deficient practice will be monitored with written examination of 100 % home health aides annually. Agency will periodically observe all staff to ensure they are following proper infection control. Additional infection control training to occur between 4.1.19 to 4.30.19.<br>3. Administrator<br>4. 4.15.19 | |

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| | During an interview on 2/18/19 at 10:15 AM, the administrator stated hand washing should be performed before and after providing care and donning and removing gloves, ant that the HHA should have used gloves while providing oral care. The administrator stated the hand washing policy is to wash hands for 30 seconds. | | | |
| N 0488<br><br>Bldg. 00 | 410 IAC 17-12-2(i) and (j)<br>Q A and performance improvement<br>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.<br><br>(j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances:<br>(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.<br>(2) The patient refuses the home health agency's services.<br>(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<br>(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. | | | |

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| | Based on clinical record review the agency failed to transfer and/or discharge patients who were either hospitalized and/or sent to a rehabilitation center in 2 of 2 patients (# 17, and #19) who had agency services placed on hold due to hospitalization.<br><br>Findings include:<br><br>1. The undated agency document, titled "Section 5 - Care Planning, Coordination of services, Quality of Care, Client Documentation/Forms" stated "Transfer and Discharge ... Forte Home Health Care may only transfer or discharge the client from Forte Home Health Care if ...(1) the transfer or discharge is necessary for the client's welfare because Forte Home Health Care and the physician who is responsible for the home health plan of care agree that Forte Home Health care can no longer meet the client's needs, based on client's acuity ...."<br><br>2. The clinical record for patient 17 was reviewed on 2/20/19. The start of care date was 10/27/17. The plan of care for certification period 12/16/18 to 2/13/19 was reviewed and the Discharge plan ordered discharge "when client requires increased level of care, per family/client request, or upon client death."<br><br>An order dated 1/28/19 was written placing home health aide services on hold effective 1/26/19 related to a hospital admission.<br><br>Aging and In-Home Services notified the agency via fax on 2/7/19 that there was an interruption of service effective 1/31/19 and that the patient had entered the nursing facility for rehabilitation therapy.<br>The agency failed to discharge the patient upon | N 0488 | 1. Forte Home Health Care no longer has any previously reviewed clients on hold due to facility placement. Current transfer of care (TOC) communication that may have been omitted cannot be sent at this time to facility, as all clients previously on hold in facilities have been discharged from facility, back to home, and Home Health Care services have resumed.<br>2. Transfer policy has been updated to include that Transfer of Care (TOC) communication must be completed/documented within 2 days of transfer or upon agency being notified of transfer if client remains in facility. Forte Home Health Care will notify PCP of transfer. Current and upcoming TOC/hold orders sent to physician will include patient specific documentation. Training of all home health office staff and Nurse Case Managers completed on 3.22.19 including training on TOC procedures and orders sent to PCP. Measures will be monitored in monthly nurse meetings and quarterly in QAPI report to ensure this deficient practice does not reoccur.<br>3. Administrator<br>4. 3.22.19 | 03/22/2019 |

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| | hospitalization and need for increased level of care.3. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The record failed to evidence the agency HHA had provided any care since 12/31/18. The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note written by the administrator on 1/15/19 stated "1.14.1.9 9:25 am NCM [nurse case manager] notified via staff that client was taken to hospital ... 1.15.19 10:00 am [patient's spouse] contacted NCM to notify that client will be going to LTC [long term care] for rehab when released from hospital. [Patient's spouse] agreed to notify agency upon d/c [discharge]." The next plan of care dated 2/4-4/4/19 summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." This plan of care was sent to the physician for signature on 2/1/19. The agency failed to complete a transfer and/or discharge for the patient once they knew the patient would be going to long term rehabilitation.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services. | | | |
| N 0520 | 410 IAC 17-13-1(a)<br>Patient Care | | | |

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| Bldg. 00 | 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.<br>Based on record review, and interview, the agency failed to ensure it could provide services as needed by the patients for 13 of 17 patients on hold (# 6, 8, 9, 10, 11, 12, 14, 15, 16, 19, 20, 22, and 23).<br><br>Findings include:<br><br>1. The agency's undated policy titled "Documentation of Admission Qualifications," # 5.5, stated "Clients will be admitted for provision of care if they meet the following qualifications: ... 2) Medical needs can be met with Forte staff. 3) Client is in the designated service area."<br><br>2. The agency's undated policy titled "Notice of Transfer," # 5.9 (b), stated "In the event that a client has a planned transferred [sic] to a facility, hospital, or to another agency, a transfer summary will be provided within 2 business days. If an unplanned transfer occurs, Forte HHC will provide a transfer summary within 2 business days if the client is still receiving care in a health care facility at the time Forte HHC is notified."<br><br>3. The agency's undated policy titled "Scheduling and Assignment of Home Health Staff," # 6.12, stated "Scheduling. The Clinical Manager identifies the dates and times staff is expected to work, in collaboration with the client and family, in accordance with the ordered services and approved plan of care. The Clinical Manager provides to the client and family with a list of eligible employees. ... Back-Up Staffing. Back-up staffs are hired in accordance with the | N 0520 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. All clients previously on hold have resumed Home Health Care services with the exception of client # 20, whose discharge letter was sent 3.8.9 and discharged effective 3.23.19. Client # 11, and # 22 had discharge letters sent 3.18.19.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. In the event the client's preferred staff is unavailable, agency will offer alternate staff. If client refuses temporary alternate staff, these communications will be documented in the client's chart. Services will not be placed on hold due to lack of staff. If agency cannot provide client's preference of staff, Forte HHC will assist client to find another agency who can meet the client's needs.<br>Client status will be reviewed during monthly nursing meeting. Home Health Care office staff and Nurse Case Managers received training related to this deficiency and corrective action plan on 4.11.19.<br>3. | 04/11/2019 |

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| | Clinical Manager's directives. Each client and family will have as many back-up staff as the Clinical Manager deems necessary to cover emergency staffing needs. The Clinical Manager agrees to provide supervision in the event no staff is available. Missed Services. The Clinical Manager identifies the schedule of dates and times they want staff to work with the client within the allowable hours approved on each client and approved plan. In the event a scheduled sift is missed, the Clinical Manager is responsible to choose to reschedule the missed services or use the hours at a later date and time within each funding source's guidelines in collaboration with the client and family."<br><br>4. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Patients are accepted for treatment on the reasonable expectation that Forte Home Health Care (HHC) can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. ... Forte Home Health Care must: ... (4) 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."<br><br>5. During an interview on 2/15/19 at 10:30 AM, the director of nursing (DON) stated that patient #6 was on hold, along with some other patients. At that time, a list of patients on hold and the reasons for the holds was requested.<br><br>6. The list of hold patients was received on 2/15/19 at 12:32 PM and included the following patients: 8, 9, 10, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, and 29. Patients 24 and 29 were on hold pending prior authorization and #24 went to the hospital on 2/1/19. The other 14 patients had | | Administrator<br>4. 4.11.19 | |

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| | been placed on hold for various reasons as listed above, and had been recertified for new certification periods while services were on hold.<br><br>7. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. The record failed to evidence the agency HHA had provided any care since 1/5/19. The physician order dated 1/7/19 stated "Hold HHA services effective 1/6/19 per family's request d/t [due to] client traveling outside the state." This order was signed by the administrator and was not faxed to the physician until 1/23/19. The next recertification plan of care dated 1/18-3/18/19 was sent to the physician for signature on 1/14/19, nine days before the hold order had been sent, and stated "Client is currently on hold due to being in Florida of for the winter. Last supervisory visit was completed on 01.02.19, see progress note below."<br><br>The progress note dated 1/7/19 stated "NCM [nurse case manager] notified by [patient's significant other] that client had left for Florida after provided services on 1/5/19. ... Client/ [significant other] agreed to notify agency when client returned home to resume services." The progress note dated 1/23/19 stated "client was still out of state ... no need for home visit."<br><br>During an interview on 2/15/19 at 12:40 PM, the DON stated she did not know when patient # 11 would be coming back to Indiana.<br><br>During an interview on 2/15/19 at 12:41 PM, the administrator stated typically if the preferred aide was not available, the agency would place the | | | |

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| | patients on hold because the families chose their own staff, and the agency did not just send staff out.<br><br>During an interview on 2/18/19 at 2:48 PM, the alternate administrator stated if families/patients did not have staff selected, the agency would provide staff as long as there were staff in that area, and then make sure the staff was a good fit, otherwise the agency would refer the patients elsewhere.<br><br>During an interview on 2/21/19 at 9:20 AM, patient #11's physician nurse stated the physician was out of the office until Monday, but she was positive he was not aware this patient was in Florida, as they had not seen heard from the patent for awhile. The nurse stated she wondered then if the physician would want to cancel the recertification orders."<br><br>8. The clinical record for patient # 12 was reviewed on 2/18/19. The start of care date was 1/6/19. The plan of care dated 1/6-3/6/19 contained orders for HHA up to 8 hours a say, up to 5 days a week, for a total of up to 40 hours per week, for 60 days. The initial assessment dated 11/29/18 evidenced the patient was a pediatrics patient and dependent for oral hygiene, eating, bathing, dressing, toileting, mobility, transferring, bed mobility, and meal preparation. The PA approval evidenced services had been approved effective 1/6-7/6/19. The physician order dated 1/11/19 stated "Hold HHA services effective 1/6/19 until family preference of aide is available." The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>During an interview on 2/18/19 at 1;12 PM, the | | | |

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| | administrator stated this patient had not yet started care, as the staff had to be rescheduled for training due to the extreme cold weather at the end of January. The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>During an interview on 2/18/19 at 1:50 PM, the director of nursing stated the family wanted to hire staff from the daycare the patient attended, but that person was worried about having enough hours to change jobs. The DON stated that person still worked at the daycare currently.<br><br>9. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was 2/25/18. The patient's diagnosis was severe cerebral palsy. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The initial assessment dated 1/25/18 evidenced the patient was dependent for oral hygiene, eating, bathing, dressing, toileting, transferring, mobility, bed mobility, had adaptive devices, dependent for overnight supervision, medication management, and meal preparation. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been | | | |

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| | completed on 1/21/19, with the last one having been on 12/6/18, and evidenced the last date of HHA services provided by employee V was 12/21/18. The record failed to evidence the information in the summary had been current and up to date. The record failed to evidence the agency attempted to place other staff with the patient to receive care while waiting for staff.<br><br>The progress note dated 1/24/19 at 1:55 PM, stated "NCM reached out to FA ... notifying [them] that agency is still waiting on requirements for new HH staff [non-employee DD]. FA replied [they] would notify [non-employee DD] and gave NCM an update on HHA [employee V]."<br><br>The progress note dated 2/18/19 at 1:21 PM stated "NCM reached out to FA [name] asking how they are and notifying FA what we need from [their] staff [non-employee DD]. 1:29 PM NCM sent HH staff [non-employee DD] a text message asking for CPR [cardiopulmonary resuscitation[ and TB [tuberculosis test result] ... NCM let [non-employee DD] know ... waiting on TB test results."<br><br>During an interview on 2/15/19 at 1:00 PM, the administrator stated the relative currently providing care had not yet turned in her tuberculosis (TB) screening paperwork so that she could be trained to become the HHA for patient # 15.<br><br>During an interview on 2/19/19 at 4:27 PM, patient # 15's parents returned a phone call and stated they have a relative currently providing care for the patient,but have to pay them out of pocket until Forte receives the documents required to train the parents' staff selection. | | | |

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| | 10. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The record failed to evidence the agency HHA had provided any care since 12/31/18. The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note written by the administrator on 1/15/19 stated "1.14.1.9 9:25 am NCM [nurse case manager] notified via staff that client was taken to hospital ... 1.15.19 10:00 am [patient's spouse] contacted NCM to notify that client will be going to LTC [long term care] for rehab when released from hospital. [Patient's spouse] agreed to notify agency upon d/c [discharge]." The next plan of care dated 2/4-4/4/19 summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." This plan of care was sent to the physician for signature on 2/1/19. The agency failed to complete a transfer and/or discharge for the patient once they knew the patient would be going to long term rehabilitation.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services.<br><br>11. The clinical record for patient # 20 was reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 | | | |

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| | contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The physician order dated 1/8/19 stated "Hold HHA services effective 12/29/18 per family request. See attached progress note." The progress note written by the alternate director of nursing (ADON) on 1/8/19 stated "Office staff notified nurse case manager that HHA did not work any home health hours for the week ending 1.15.19. ... staff reported that family advocate [advocate name] ... was not working at this time, but that [advocate] would be starting back to work in February or March. [Family advocate name] told staff that [family advocate] would not need HHA staff to care for client during this time. ... Will place home health services on hold at this time." The record failed to evidence the agency attempted to contact the patient or family advocate since 1/8/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>12. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." The physician order dated 1/14/19 stated "Hold HHA services effective 1/13/19 until family preference of aide is available. Resume care when this aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/13/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient. | | | |

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| | 13. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/19/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>The hold list of patients provided on 2/15/19 at 12:32 PM, stated "[identifier of patient # 22]- ... respite home health only, preference of staff is in college, but works on her breaks."<br><br>14. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The physician order dated 8/9/18 and signed on 8/14/19 evidenced home health aide services were on placed on hold until family preference of aide was available.<br><br>The Plan of Care for certification period 9/21/18 to 11/19/18 was signed by the physician on 8/30/18 and failed to indicate services had been on hold since 8/10/18. No comprehensive assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The plan of care for certification period 11/20/18 to 1/18/19 was signed by the physician on 12/6/18. In the Summary Report section of the plan of care was the statement "client remains on hold." No | | | |

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| | Comprehensive Assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The agency failed to complete a comprehensive assessment at least every 60 days, failed to provide services as identified in the individualized plan of care due to lack of staffing, and continued to recertify patients whose services had been placed on hold due to lack of staffing.<br><br>15. The clinical record for patient #8 was reviewed on 2/18/19. The start of care date was 4/1/18. This patient had orders for respite home health aide care for 60+ hours per month. An order written by Forte and sent to the physician for signature on 10/4/18 to "Hold services effective 10/3/18 [due to] preferred HHA [was] not available. Resume care when preferred HHA becomes available."<br><br>The Plan of Care for certification period 11/27/18 to 1/25/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to the review/update of the Plan of Care. The last comprehensive assessment occurred on 9/18/18.<br><br>The Plan of Care for certification period 1/26/19 to 3/26/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>Interview with patient #8's family member regarding services being on hold. Family acknowledged respite home health aide services were on hold. Another family member had | | | |

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| | previously been providing respite home health aide services but had to have knee surgery. Family member stated agency did not provide replacement staff and that family member had been in contact with the Aging & In Home Services case manager who suggested a referral to a different agency for respite services, but this was declined.<br><br>16. The clinical record for patient # 9 was reviewed on 5/20/18. The start of care date was 5/20/18. The patient was to receive home health aide services up to 8 hours/day, up to 5 days/week for school breaks only.<br><br>Medicaid approval (Authorization # X1811200289) had been received on 5/3/18 for services from 5/20/18 to 11/17/18. The Warsaw Community School Calendar for 2017-2018 and 2018-2019 was attached with circled days indicating days care was needed. July 2018 had 22 days circled. August 2018 had 10 days circled; September had 1 day circled; October had 3 days circled.<br><br>A comprehensive assessment was completed on 7/2/18 at 1010 by employee D.<br><br>The Progress Note dated 7/13/18 written by employee D states, "Place home health services on hold effective 7/9/18 due to HHA unavailable to work at this time. Will resume services when HHA is available." A review of home health aide documentation notes evidenced no services had been provided between 7/6/28 and 7/16/18.<br><br>On 7/16/18 the patient received a home health aide visit and the RNCM completed a resumption of care comprehensive nursing assessment. The plan of care certification for period 7/19/18 -9/16/18 was also faxed to physician for signature | | | |

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| | on this date.<br><br>A Progress Note dated 7/26/18 evidenced home health services were placed on hold effective 7/17/18 due to no staff available to work in home.<br><br>The plan of care for certification period 9/17/18 to 11/15/18 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The plan of care also stated "Pending Medicaid approval" when the agency had already received notice of Medicaid approval on 5/3/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify the patient while services were on hold due to lack of staffing.<br><br>The plan of care for certification period 11/16/18 to 1/14/19 stated home health aide frequency/duration of care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The summary report stated "Client remains on hold, per PA approval and Mothers request ...last supervisory visit was completed on 7/16/18." The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing. | | | |

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| | PA approval (Authorization # X1832000044) was received on 11/20/18 for services from 11/18/18 to 5/18/19. The 2018 Warsaw Community School calendar was attached identifying when the patient would be out of school and when care would be needed. School days were circled for care needs as follows: 3 days in November; 6 days in December; 5 days in January; 1 day in February; and 5 days in April.<br><br>Plan of Care for certification period 1/15/19 to 3/15/19 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Supervisory visits every 30 days. Hours to be used on non-school days while mother works.<br>The summary report stated "Client remains on hold, per PA approval and parent request ...last supervisory visit was completed on 7/16/18."<br>The agency had received notice of PA approval on 11/20/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>17. The clinical record for patient #10 was reviewed on 2/18/19. The start of care date was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 ordered home health aide care up to 4 hours/day, up to 7 days/wk. A Physician order written by the administrator on 12/26/18 and signed on 1/2/19 evidenced services were placed on hold due to family preference of aide not being available.<br>Plan of Care for certification period 2/15/19 to 4/15/19 was faxed to physician and signed on | | | |

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| | 2/11/19 while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care.<br><br>Phone interview with patient #10 on 2/19/19 regarding services on hold. Patient was told if she had a family member or friend that would like to become the caregiver, that the agency would hire them and train them. Patient stated the home health aide bathed her or helped with showers, dressing, combed hair, helped with meals and did laundry.<br><br>18. The clinical record for Patient #14 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing.<br><br>19. The clinical record for Patient #16 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to | | | |

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| | 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing. | | | |
| N 0522<br><br>Bldg. 00 | 410 IAC 17-13-1(a)<br>Patient Care<br>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:<br>Based on record review, and interview, the agency failed to adequately meet the home health aide (HHA) needs for 12 of 17 patients on hold for various reasons which included, the preferred staff was unavailable for 4 of 14 records reviewed (# 6, 14, 16, and 23); staff moved in with client so new staff pending for 1 of 14 records reviewed (#8); staff not working outside the home for 1 of 14 records reviewed (# 20); staff training was rescheduled due to weather for 3 of 14 records reviewed (# 10, 12, and 15); prior authorization approved for school breaks only for 2 of 14 records reviewed (# 21 and 22), and placing on hold for longer than one certification period without discharging the patient for 1 of 14 records reviewed (#9). | N 0522 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. The required 60-day assessments (or 5-day window for OASIS) will be completed. This tag was based on review of clients that previously had services placed on hold, as our practice had been to not complete comprehensive assessments when we had an order to hold services. All clients that were previously on hold have resumed Home Health Care services in the home, with the | 04/11/2019 |

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| | Findings include:<br><br>1. The agency's undated policy titled "Documentation of Admission Qualifications," # 5.5, stated Clients will be admitted for provision of care if they meet the following qualifications: ... 2) Medical needs can be met with Forte staff. 3) Client is in the designated service area."<br><br>2. The agency's undated policy titled "Notice of Transfer," # 5.9 (b), stated "In the event that a client has a planned transferred [sic] to a facility, hospital, or to another agency, a transfer summary will be provided within 2 business days. If an unplanned transfer occurs, Forte HHC will provide a transfer summary within 2 business days if the client is still receiving care in a health care facility at the time Forte HHC is notified."<br><br>3. The agency's undated policy titled "Scheduling and Assignment of Home Health Staff," # 6.12, stated "Scheduling. The Clinical Manager identifies the dates and times staff is expected to work, in collaboration with the client and family, in accordance with the ordered services and approved plan of care. The Clinical Manager provides to the client and family with a list of eligible employees. ... Back-Up Staffing. Back-up staffs are hired in accordance with the Clinical Manager's directives. Each client and family will have as many back-up staff as the Clinical Manager deems necessary to cover emergency staffing needs. The Clinical Manager agrees to provide supervision in the event no staff is available. Missed Services. The Clinical Manager identifies the schedule of dates and times they want staff to work with the client within the allowable hours approved on each client and approved plan. In the event a scheduled sift is | | exception of client # 20 whose discharge letter was sent 3.8.9, and discharge was effective 3.23.19. Client # 11, and # 22 discharge letters were sent 3.18.19. Goals added to Plan of Care to be more specific to client.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. Forte Home Health Care will continue to complete comprehensive assessments at least every 60 days (or 5-day window for OASIS). Measures will be monitored in monthly nurse meetings and quarterly in QAPI audit and report to ensure this deficient practice does not reoccur. All visit dates are discussed and approved during nursing meetings to assure agency maintains compliance with 60 day (or 5-day window) required comprehensive assessments. If client's preference of staff is unavailable, Forte will attempt to offer client alternate staff. If client declines alternate staff, communication will be documented. Client's services will not be placed on hold due to lack of staff. If Forte cannot provide client's preference of staff, Forte will assist client to find another agency who can meet the client's needs. Auditor will audit charts for all active clients to monitor for comprehensive assessment compliance and maintain | |

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| | missed, the Clinical Manager is responsible to choose to reschedule the missed services or use the hours at a later date and time within each funding source's guidelines in collaboration with the client and family."<br><br>4. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Patients are accepted for treatment on the reasonable expectation that Forte Home Health Care (HHC) can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. ... Forte Home Health Care must: ... (4) 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."<br><br>5. During an interview on 2/15/19 at 10:30 AM, the director of nursing (DON) stated that patient #6 was on hold, along with some other patients. At that time, a list of patients on hold and the reasons for the holds was requested.<br><br>6. The list of hold patients was received on 2/15/19 at 12:32 PM and included the following patients: 8, 9, 10, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, and 29. Patients 24 and 29 were on hold pending prior authorization and #24 went to the hospital on 2/1/19. The other 14 patients had been placed on hold for various reasons as listed above, and had been recertified for new certification periods while services were on hold.<br><br>7. The clinical record for patient # 12 was reviewed on 2/18/19. The start of care date was 1/6/19. The plan of care dated 1/6-3/6/19 contained orders for HHA up to 8 hours a say, up to 5 days a week, for a total of up to 40 hours per week, for 60 days. The initial assessment dated | | compliance with QAPI review and reporting. Home Health office staff and Nurse Case Managers trained related to this deficiency and corrective action plan on 4.11.19.<br>3.<br>Administrator<br>4. 4.11.19 | |

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| | 11/29/18 evidenced the patient was a pediatrics patient and dependent for oral hygiene, eating, bathing, dressing, toileting, mobility, transferring, bed mobility, and meal preparation. The PA approval evidenced services had been approved effective 1/6-7/6/19. The physician order dated 1/11/19 stated "Hold HHA services effective 1/6/19 until family preference of aide is available." The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>During an interview on 2/18/19 at 1;12 PM, the administrator stated this patient had not yet started care, as the staff had to be rescheduled for training due to the extreme cold weather at the end of January. The record failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>9. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was 2/25/18. The patient's diagnosis was severe cerebral palsy. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The initial assessment dated 1/25/18 evidenced the patient was dependent for oral hygiene, eating, bathing, dressing, toileting, transferring, mobility, bed mobility, had adaptive devices, dependent for overnight supervision, medication management, and meal preparation. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately | | | |

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| | 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18, and evidenced the last date of HHA services provided by employee V was 12/21/18. The record failed to evidence the information in the summary had been current and up to date. The record failed to evidence the agency attempted to place other staff with the patient to receive care while waiting for staff.<br><br>The progress note dated 1/24/19 at 1:55 PM, stated "NCM reached out to FA ... notifying [them] that agency is still waiting on requirements for new HH staff [non-employee DD]. FA replied [they] would notify [non-employee DD] and gave NCM an update on HHA [employee V]."<br><br>The progress note dated 2/18/19 at 1:21 PM stated "NCM reached out to FA [name] asking how they are and notifying FA what we need from [their] staff [non-employee DD]. 1:29 PM NCM sent HH staff [non-employee DD] a text message asking for CPR [cardiopulmonary resuscitation[ and TB [tuberculosis test result] ... NCM let [non-employee DD] know ... waiting on TB test results."<br><br>During an interview on 2/19/19 at 4:27 PM, patient # 15's parents returned a phone call and stated they have a relative currently providing care for the patient, but have to pay them out of pocket until Forte receives the documents required to train the parents' staff selection.<br><br>10. The clinical record for patient # 20 was | | | |

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| | reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The physician order dated 1/8/19 stated "Hold HHA services effective 12/29/18 per family request. See attached progress note." The progress note written by the alternate director of nursing (ADON) on 1/8/19 stated "Office staff notified nurse case manager that HHA did not work any home health hours for the week ending 1.15.19. ... staff reported that family advocate [advocate name] ... was not working at this time, but that [advocate] would be starting back to work in February or March. [Family advocate name] told staff that [family advocate] would not need HHA staff to care for client during this time. ... Will place home health services on hold at this time." The record failed to evidence the agency attempted to contact the patient or family advocate since 1/8/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>11. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." The physician order dated 1/14/19 stated "Hold HHA services effective 1/13/19 until family preference of aide is available. Resume care when this aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/13/19 to inquire if services were still needed, and failed to evidence the agency | | | |

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| | attempted to provide other staff to care for the patient.<br><br>12. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence the agency attempted to contact the patient or family since 1/19/19 to inquire if services were still needed, and failed to evidence the agency attempted to provide other staff to care for the patient.<br><br>The hold list of patients provided on 2/15/19 at 12:32 PM, stated "[identifier of patient # 22]- ... respite home health only, preference of staff is in college, but works on her breaks." 13. During the daily conference on 2/18/19 the agency President stated the family was responsible for identifying a caregiver, then the agency would hire and train them while Medicaid was being processed. "If agency doesn't have staff available, they would refer out to make sure family has a good fit." Requested agency policy regarding placing patient services on hold. The agency did not provide a policy prior to the survey exit conference on 2/21/19.<br><br>14. The agency's undated document titled, "Section 5 - Coordination of Service, Quality of Care, Client Documentation/Forms" evidenced "5.5 Documentation of Admission Qualifications ... 2. Medical needs can be met with Forte staff ...." and "5.10 Client Rights and Responsibilities ... (c) Rights of the Client ... (5) receive all services | | | |

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| | outlined in the plan of care ...."<br><br>15. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The physician order dated 8/9/18 and signed on 8/14/19 evidenced home health aide services were on placed on hold until family preference of aide was available.<br><br>The plan of care for certification period 9/21/18 to 11/19/18 was signed by the physician on 8/30/18 and failed to indicate services had been on hold since 8/10/18. No comprehensive assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The plan of care for certification period 11/20/18 to 1/18/19 was signed by the physician on 12/6/18. In the Summary Report section of the plan of care was the statement "client remains on hold." No comprehensive Assessment was completed prior to completion of the updated plan of care. The last comprehensive assessment occurred on 7/25/18.<br><br>The agency failed to complete a comprehensive assessment at least every 60 days, failed to provide services as identified in the individualized plan of care due to lack of staffing, and continued to recertify patients whose services had been placed on hold due to lack of staffing.<br><br>16. The clinical record for patient #8 was reviewed on 2/18/19. The start of care date was 4/1/18. This patient had orders for respite home health aide care for 60+ ( per month. An order written by Forte and sent to the physician for signature on 10/4/18 to "Hold services effective 10/3/18 d/t [due to] preferred HHA [home health aide] not | | | |

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| | available. Resume care when preferred HHA becomes available."<br><br>The plan of care for certification period 11/27/18 to 1/25/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>The plan of care for certification period 1/26/19 to 3/26/19 was faxed to physician for signature while services remained on hold. No comprehensive assessment was completed prior to review/update of the plan of care. The last comprehensive assessment occurred on 9/18/18.<br><br>Interview on 2/19/19 at 08:50 AM with patient #8's family member regarding services being on hold. Family member acknowledged respite home health aide services were on hold. A different family member had previously been providing respite home health aide services but had to have knee surgery. Family member stated agency did not provide replacement staff and that family member had been in contact with the Aging & In Home Services case manager who suggested a referral to a different agency for respite services, but this was declined.<br><br>17. The clinical record for patient # 9 was reviewed on 5/20/18. The start of care date was 5/20/18. The patient was to receive home health aide services up to 8 hours/day, up to 5 days/week for school breaks only.<br><br>Medicaid approval (Authorization # X1811200289) had been received on 5/3/18 for services from 5/20/18 to 11/17/18. The Warsaw Community School Calendar for 2017-2018 and 2018-2019 was | | | |

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| | attached with circled days indicating days care was needed. July 2018 had 22 days circled. August 2018 had 10 days circled; September had 1 day circled; October had 3 days circled.<br><br>A comprehensive assessment was completed on 7/2/18 at 1010 by employee D.<br><br>The progress note dated 7/13/18 written by employee D states, "Place home health services on hold effective 7/9/18 due to HHA unavailable to work at this time. Will resume services when HHA is available." A review of home health aide documentation notes evidenced no services had been provided between 7/6/28 and 7/16/18.<br><br>On 7/16/18 the patient received a home health aide visit and the RNCM completed a resumption of care comprehensive nursing assessment. The plan of care certification for period 7/19/18 -9/16/18 was also faxed to physician for signature on this date.<br><br>A progress note dated 7/26/18 evidenced home health services were placed on hold effective 7/17/18 due to no staff available to work in home.<br><br>The plan of care for certification period 9/17/18 to 11/15/18 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The plan of care also stated "Pending Medicaid approval" when the agency had already received notice of Medicaid approval on 5/3/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of | | | |

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| | care and continued to recertify the patient while services were on hold due to lack of staffing.<br><br>The plan of care for certification period 11/16/18 to 1/14/19 stated home health aide frequency/duration of care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while mother works. The summary report stated "Client remains on hold, per PA approval and Mothers request ...last supervisory visit was completed on 7/16/18." The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>PA approval (Authorization # X1832000044) was received on 11/20/18 for services from 11/18/18 to 5/18/19. The 2018 Warsaw Community School calendar was attached identifying when the patient would be out of school and when care would be needed. School days were circled for care needs as follows: 3 days in November; 6 days in December; 5 days in January; 1 day in February; and 5 days in April.<br><br>Plan of care for certification period 1/15/19 to 3/15/19 stated home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Supervisory visits every 30 days. Hours to be used on non-school days while mother works.<br><br>The summary report stated "Client remains on hold, per PA approval and parent request ...last | | | |

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| | supervisory visit was completed on 7/16/18."<br>The agency had received notice of PA approval on 11/20/18. The agency failed to develop/review/update the plan of care based on a comprehensive assessment and failed to provide accurate information to the provider in the plan of care. The agency also failed to provide services as ordered in the plan of care and continued to recertify patients while services were on hold due to lack of staffing.<br><br>18. The clinical record for patient #10 was reviewed on 2/18/19. The start of care date was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 ordered home health aide care up to 4 hours/day, up to 7 days/wk. A Physician order written by the administrator on 12/26/18 and signed on 1/2/19 evidenced services were placed on hold due to family preference of aide not being available.<br>Plan of care for certification period 2/15/19 to 4/15/19 was faxed to physician and signed on 2/11/19 while services remained on hold. No comprehensive assessment was completed prior to the review/update of the plan of care.<br><br>Phone interview with patient #10 on 2/19/19 regarding services on hold. Patient was told if she had a family member or friend that would like to become the caregiver, that the agency would hire them and train them. Patient stated the home health aide bathed her or helped with showers, dressing, combed hair, helped with meals and did laundry.<br><br>19. The clinical record for Patient #14 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to | | | |

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| | 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing.<br><br>20. The clinical record for Patient #16 was reviewed on 2/20/18. Patient was diagnosed with Cohen Syndrome and Pica syndrome. Start of care date was 5/1/16 and the plan of care certification period reviewed was 2/15/19 to 4/15/19. Services have been on hold since 2/8/19 due to lack of staffing. Per addendum to the plan of care for each patient, "needs assistance to help watch one child while other child is being bathed and physical exercising." (Agency has 2 patients in this home.) Patient is to have home health aide services up to 4 hours a day, up to 7 days a week, up to 20 hours a week.<br><br>The order to "Hold HHA services effective 2/8/2019 until family preference of aide is available. Resume care when aide becomes available" was faxed to physician for signature on 2/13/18 and signed by physician on 2/18/19. The agency failed to provide care as ordered in the plan of care due to lack of staffing. | | | |

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| N 0524<br><br>Bldg. 00 | 410 IAC 17-13-1(a)(1)<br>Patient Care<br>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:<br>(A) Be developed in consultation with the home health agency staff.<br>(B) Include all services to be provided if a skilled service is being provided.<br>(B) Cover all pertinent diagnoses.<br>(C) Include the following:<br>(i) Mental status.<br>(ii) Types of services and equipment required.<br>(iii) Frequency and duration of visits.<br>(iv) Prognosis.<br>(v) Rehabilitation potential.<br>(vi) Functional limitations.<br>(vii) Activities permitted.<br>(viii) Nutritional requirements.<br>(ix) Medications and treatments.<br>(x) Any safety measures to protect against injury.<br>(xi) Instructions for timely discharge or referral.<br>(xii) Therapy modalities specifying length of treatment.<br>(xiii) Any other appropriate items.<br>Based on clinical record review and interview the agency failed to ensure the frequency range for services were individually matched to the patient's needs in 10 of 25 records reviewed (#1, 2, 4, 5, 6, 8, 9, 10, 14 and 16), and failed to include all safety measures to protect patients against injury in 2 of 2 records reviewed for patients with gastric feeding tubes (g-tubes) and NPO (nothing by mouth) (#6 and #7).<br><br>Findings include:<br><br>1. The agency's undated policy titled "Medical | N 0524 | 1. To ensure the POC contain all pertinent information, agency follows all required information per COP 484.60. To correct the deficiency, our client's POC has been developed per client's physician and per MCD approval through PA. The Plan of Care (POC) for each client has been updated to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific | 04/05/2019 |

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| | Plan of Care," # 5.2, stated "Services must be furnished in accordance with accepted standards of practice. ... (2) The individualized plan of care must include the following: 9) Frequency and duration of visits. ... 15) Medications and treatments. ... 20) Client-specific interventions and education; measurable outcomes and goals identified by the HHA and patient. ... (c) Review and revision of the plan of care. ... (2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals ... (d) Coordination of care. Forte Home Health Care must: (1) Assure communication with all physicians involved in the plan of care. ... (4) 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. (5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by Forte Home Health Care, as appropriate, regarding the care and services identified in the plan of care."<br><br>2. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The plans of care dated 11/20/18 to 1/18/19 and 1/19/19 to 3/19/19 ordered home health aide care up to 4-8 hours per week, up to 5 days per week, for up to 20-40 hours per week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br>and plan of care certification period was 1/19/19 to 3/19/19.<br><br>Patient had a gastric-tube for bolus feedings 5 times a day. The comprehensive nursing | | needs/safety. Modification orders for client specific frequency/duration changes sent to PCP if required per client's needs starting 3.22.19 with training beginning on 3.22.19 as well for staff/family/client. POC changes implemented by 3.29.19. Staff will be trained on updated POC to ensure they are providing services as ordered and charting accordingly. These changes all be completed by 4.5.19.<br>2. The agency will ensure the POC continues to contain all pertinent information by complying with requirements per COP 484.60. POC will be maintained by Nurse Case Manager during comprehensive assessments, and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC will continue to be updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC updates as changes arise. Staff's daily notes will continue to be monitored by office staff to ensure that the services provided comply with POC orders. Frequency and duration based on client needs are monitored monthly with comprehensive assessment and updated with PCP order as needed. Agency will ensure that the client's plan of care contain all pertinent information through | |

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| | assessment on 2/26/18 documented that the patient was at risk for choking due to results of a swallow study. Patient had been NPO [nothing by mouth] and on tube feedings only since 2/26/18. The Plan of Care failed to include risk for aspiration as a safety measure.<br><br>3. The clinical record for patient #7 was reviewed on 2/19/19. The start of care date was 5/20/15. The plan of care dated 12/30/18 to 2/27/19 ordered skilled nursing care up to 16 hours per day, up to 3 to 7 days per week for a total of up to 91 hours per week for 60 days. This patient has consistently been receiving services 40-48 hours per week, over 5-6 days per week. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>The plan of care certification period dated 12/30/18 to 2/27/19 evidenced the patient was on a ventilator and NPO with G-tube feedings only. Choking and aspiration risk were identified on the comprehensive assessments on 12/28/18, 10/29/18, and 6/28/18. The plan of care failed to include risk for aspiration as a safety measure.<br><br>4. The clinical record for patient #9 was reviewed on 2/18/19. The start of care date was 5/20/18. The plan of care for certification period 11/16/18 - 1/14/19 contained orders for home health aide care up to 8 hours per day, up to 5 days per week, for up to 40 hours per week, for 60 days. Hours were to be used on non-school days while Mother works.<br><br>The Medicaid authorizations # X181200289 was for 504 hours and #X183200044 was for 160 hours from 11/18/18 to 5/18/19. Each authorization included a weekly summary of hours that were based on the school calendar and identified days | | review in monthly nurse meetings and quarterly QAPI audit and report to ensure this deficient practice does not reoccur. All Home Health Care office staff and Nurse Case Managers trained related to this deficiency and corrective action plan during meeting on 3.28.19<br>3. Administrator<br>4. 4.5.19 | |

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| | the patient would need care. The frequencies failed to be specific to the patient's needs and care was not provided on all identified days of care needs. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>5. The clinical record for patient #10 was reviewed on 2/18/19. The start of care was 6/25/17. The plan of care for certification period 12/17/18 - 2/14/19 included orders for home health aide care up to 4 hours a day, up to 7 days a week, up to 28 hours per week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>6. The clinical record for patient #14 was reviewed on 2/20/19. The start of care date was 5/1/16. The plan of care dated 2/15/19 to 4/15/19 included orders for home health aide care up to 4 hours per day, up to 7 day per week, for up to 20 hours per week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.<br><br>7. The clinical record for patient #16 was reviewed on 2/20/19. The start of care date was 5/1/16. The plan of care for certification period 2/15/19 - 4/15/19 included orders for home health aide care up to 4 hours per day, up to 7 day per week, for up to 20 hours per week for 60 days. The agency failed to individualize the frequency ranges to meet the client's individualized care needs.During an interview on 2/18/19 at 2"48 PM, the alternate administrator stated the frequency was based on the client needs/and physician orders.<br><br>8. The clinical record for patient # 1 was reviewed on 2/12/19. The plan of care dated 12/31/18-2/28/19 contained a diagnosis of | | | |

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| | mitochondrial myopathy, and orders for respite home health aide (RHHA) 60+ hours per month, and safety measures of fall precautions and skin integrity precautions, and one goal which stated "Client to remain safe in home with assistance of HHA for this certification period." HHA to bathe patient per patient/family choice, wash and comb hair as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, take vital signs (VS) blood pressure (BP), pulse, respirations (RR) and T (temperature) as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety.<br><br>The initial assessment dated 10/9/18, identified the patient needed assistance with oral hygiene, bathing, dressing, toileting, transfer, mobility, medication management, and meal preparation, and that the patient had a history of weight loss and inability to eat. The plan of care failed to evidence a patient-specific frequency for assistance with all tasks assigned to the HHA, except for monitor for safety, and failed to evidence a patient specific goal such as maintaining skin integrity.<br><br>9. The clinical record for patient # 2 was reviewed on 2/12/19. The plan of care dated 1/14-3/14/19 contained diagnoses of Lennox-Gastaut Syndrome and cerebral palsy, and orders for HHA up to 8 hours per day, up to 6 days per week, up to 40 hours per week, for 60 days. The HHA was ordered to provide the following tasks: bath of patient/family choice, hair was and comb as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, take VS BP, pulse, RR and T as needed, ambulation as required, assist to chair as needed, | | | |

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| | range of motion exercises, passive as needed, assist with toileting/brief changes as needed, and monitor for safety. Monitor for seizures. The section titled "Other pertinent diagnoses" stated "Sleep Apnea, Urinary Incontinence; Bowel Incontinence; Seizure Disorder." The "Goals" section stated "Client will receive full assistance with personal care/ADL's (activities of daily living) to maintain optimum level of hygiene for this certification period."<br><br>The record failed to evidence a patient-specific frequency for assistance with all tasks assigned to the HHA, except for monitor for safety and seizures, failed to evidence other patient specific goals such as maintaining skin integrity, and be free from seizures, and failed to evidence the range of HHA services was patient specific. This patient had consistently been receiving services approximately 35 hours per week.<br><br>10. The clinical record for patient # 4 contained a plan of care dated 1/25-3/25/19 with a diagnosis of dementia and orders for HHA up to 12 hours a day, up to 6 days a week, up to 60 hours a week for 60 days. HHA to bathe patient per patient/family choice, wash and comb hair as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, VS as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The "Goals" section stated "Client to remain safe in home, with assistance of family and HHA for this certification period." The frequency of HHA tasks and services failed to be patient specific.<br><br>11. The clinical record for patient # 5 was reviewed on 2/13/19. The plan of care dated | | | |

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| | 12/20/18-2/17/19 contained a diagnosis of epilepsy, and orders for HHA up to 6 hours a day, up to 7 days a week, for up to 42 hours a week, for 60 days. HHA to bathe patient per patient/family choice, hair wash and comb as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, VS as needed, ambulation as required, assist to chair as needed, range of motion passive as needed, and monitor for seizures and safety. The client notes sections stated "has very limited mobility and is non-ambulatory." This patient had consistently been receiving 42 hours of service per week. The HHA tasks and frequency failed to be patient specific. | | | |
| N 0541<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(B)<br>Scope of Services<br>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:<br>(B) Regularly reevaluate the patient's nursing needs.<br>Based on clinical record review the agency failed to complete a comprehensive assessment every 60 days for 10 of 25 patients reviewed (6, 8, 9, and 10, 11, 15, 19, 20, 22, 23).<br><br>Findings include:<br><br>1. The undated agency document titled "Section 5 - Care Planning, Coordination of Services, Quality of Care, Client Documentation/Forms" states "5.1 Comprehensive Assessments of Clients ... (d) Standard: Update of the comprehensive assessment ... must be updated and revised ... as frequently as the client's condition warrants due to a major decline or improvement in the client's | N 0541 | 1. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. The required 60-day assessments (or 5-day window for OASIS) will be completed. This tag was based on review of clients that previously had services placed on hold, as our practice had been to not complete comprehensive assessments when we had an order to hold services. All clients that were previously on hold have resumed Home Health Care | 04/11/2019 |

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| | 15K086 | A. BUILDING 00<br>B. WING | 02/21/2019 |

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| | health status, but not less frequently than - (1) every 60 days ...."<br><br>2. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18. The record evidenced that no comprehensive assessment was completed for certification periods 9/21/18 to 11/19/19 and 11/20/18 to 1/18/19.<br><br>3. The clinical record for patient #8 was reviewed on 2/18/19. The patient's start of care date was 4/1/18. The record evidenced that no comprehensive assessment was completed for certification periods 11/27/18 - 1/25/19 and 1/26/19 -3/26/19.<br><br>4. The clinical record for patient #9 was reviewed on 2/19/19. The patient's start of care date was 5/20/18. The record evidenced that no comprehensive assessment was completed for certification periods 9/17/18 - 11/15/18; 11/16/18 - 1/14/19; and 1/15/19 - 3/15/19.<br><br>5. The clinical record for patient #10 was reviewed on 2/18/19. The patient's start of care date was 6/25/17. The record evidenced the comprehensive assessment that was completed on 12/4/18 was outside the 5 day time frame prior to recertification. The record evidenced that there was no comprehensive assessment completed for the certification period of 2/15/19 to 4/15/19.<br><br>6. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. The record failed to evidence the agency HHA had provided any care since 1/5/19. The | | services in the home, with the exception of client # 20 whose discharge letter was sent 3.8.9, and discharge was effective 3.23.19. Client # 11, and # 22 discharge letters were sent 3.18.19. Goals added to Plan of Care to be more specific to client.<br>2. All active clients will receive all ordered services in POC which contains all information required per COP 484.60. Forte Home Health Care will continue to complete comprehensive assessments at least every 60 days (or 5-day window for OASIS). Measures will be monitored in monthly nurse meetings and quarterly in QAPI audit and report to ensure this deficient practice does not reoccur. All visit dates are discussed and approved during nursing meetings to assure agency maintains compliance with 60 day (or 5-day window) required comprehensive assessments. If client's preference of staff is unavailable, Forte will attempt to offer client alternate staff. If client declines alternate staff, communication will be documented. Client's services will not be placed on hold due to lack of staff. If Forte cannot provide client's preference of staff, Forte will assist client to find another agency who can meet the client's needs. Auditor will audit charts for all active clients to monitor for comprehensive assessment | |

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| | physician order dated 1/7/19 stated "Hold HHA services effective 1/6/19 per family's request d/t [due to] client traveling outside the state." The next recertification plan of care dated 1/18-3/18/19 was sent to the physician for signature on 1/14/19, nine days before the hold order had been sent, and stated "Client is currently on hold due to being in Florida for the winter. Last supervisory visit was completed on 01.02.19, see progress note below." The progress note dated 1/7/19 stated "NCM [nurse case manager] notified by [patient's significant other] that client had left for Florida after provided services on 1/5/19. ... Client/ [significant other] agreed to notify agency when client returns home to resume services." The progress note dated 1/23/19 stated "client was still out of state ... no need for home visit." The record failed to evidence the patient was back in Indiana to receive services and a comprehensive assessment to resume care.<br><br>7. The clinical record for patient # 15 was reviewed on 2/15/19. The start of care date was 2/25/18. The plan of care dated 12/22/18-2/19/19 contained orders for HHA up to 10 hours a day, up to 5 days a week, for up to 40 hours a week, for 60 days. The physician order written by the administrator on 12/23/18 stated "Hold HHA services effective 12/23/18 per Medicaid approval for FA's work schedule. Resume care when FA returns to work, and preferred HHA is available."[sic] The current PA dated 8/26/18 was approved for 10 hours a day through 2/23/19. The next plan of care dated 2/20-4/20/19 was sent to the physician for approval and signature on 1/22/19, approximately 29 days early and the summary section stated "Supervisory visit and comprehensive nursing assessment completed in the Client's home today. HHA [name of employee V] present and providing care. ... RR 18 ...." The | | compliance and maintain compliance with QAPI review and reporting. Home Health office staff and Nurse Case Managers trained related to this deficiency and corrective action plan on 4.11.19.<br>3.<br>Administrator<br>4. 4.11.19 | |

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| | record failed to evidence a comprehensive nursing assessment had been completed on 1/21/19, with the last one having been on 12/6/18.<br><br>8. The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month, and the discharge plan stated "when client requires increased level of care, per family/client request, or upon client death." The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The progress note dated 1/15/19 stated "1.14.1.9 9:25 am ... 1.15.19 10:00 am [patient's spouse] contacted NCM [nurse case manager] to notify that client will be going to LTC [long term care] for rehab when released from hospital. [Patient's spouse] agreed to notify agency upon d/c. [discharge]." This was signed by the administrator. The next plan of care was dated 2/4-4/4/19 and sent to the physician on 2/1/19, and the summary stated "Client remains on hold. Last supervisory visit was completed on 12/20/18, see progress note from that visit below." The summary information failed to be up to date and accurate was from December 2018, the patient was still in long term care rehab, and failed to evidence a comprehensive assessment had been completed since 12/20/18.<br><br>During an interview on 2/21/19 at 9:29 AM, patient # 19's physician stated he did not see the plan of care signed on 2/1 in his computer, but if so, he did not notice the patient was in rehabilitation, but if the patient was not there, they should not have been recertified to receive home care services.<br><br>9. The clinical record for patient # 20 was | | | |

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| | reviewed on 2/20/19. Start of care date was 4/16/17. The plan of care dated 2/5-4/5/19 evidenced it had been sent to the physician on 2/1/19 for signature and contained orders for HHA up to 8 hours per day, up to 5 days per week for up to 40 hours per week, for 60 days. The summary on this plan of care stated "Client remains on hold. Last in home supervisory visit was on 12/11/18, see progress note from that visit below." This information failed to be current and was 2 months old. The record failed to evidence a comprehensive assessment had been completed since 12/11/18.<br><br>10. The clinical record for patient # 22 was reviewed on 2/20/19. The start of care date was 6/6/18. The plan of care dated 2/19-4/19/19 was sent to the physician for signature on 2/15/19 and contained orders for respite HHA 60 hours per month as directed on notice of action. The summary section stated "Client remains on hold, per family request. Last home visit was completed on 12/13/18, see progress note below." This was signed by the DON. This information failed to be current, and was 2 months old. The record failed to evidence a comprehensive assessment had been completed since 12/13/18.<br><br>11. The clinical record for patient #23 was reviewed on 2/20/19. The start of care date was 6/26/16. The plan of care dated 2/11-4/11/19 was sent to the physician for signature on 1/29/19 and contained orders for HHA 2-3 hours per day, 3-5 days per week, for up to 15 hours per week, for 60 days. The summary section stated "Supervisory visit and comprehensive nursing assessment completed in client's home today. HHA, [name of aide] present and providing care as ordered. ... T [temperature]: 99.3 ... BP [blood pressure]: 93/63 ...." This was signed by employee W on 2/11/19. | | | |

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| | The Comprehensive Nursing Assessment dated 1/9/19 evidenced the vital signs listed in the summary were from that assessment, not from 2/11/19. The physician order dated 1/29/19 stated "Hold HHA services effective 1/19/2019 until family preference of aide is available. Resume care when aide becomes available." The record failed to evidence a comprehensive assessment had been completed since 1/9/19. | | | |
| N 0543<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(D)<br>Scope of Services<br>Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br>(D) Initiate appropriate preventive and rehabilitative nursing procedures.<br>Based on clinical record review the director of nursing failed to ensure the implementation of safety measures and updates to the plan of care to include all safety measures to protect patients against injury in 2 of 2 records reviewed for patients with G-tubes (gastric feeding tubes) (#6 and #7).<br><br>Findings include:<br><br>1. The clinical record for patient #6 was reviewed on 2/12/19. The start of care date was 2/26/18 and plan of care certification period was 1/19/19 to 3/19/19. Patient has a diagnosis of Cerebral Palsy and has a G-tube for bolus feedings 5 times a day. The comprehensive nursing assessment on 2/26/18 documented that the patient was at risk for choking due to results of a swallow study. Patient had been NPO [nothing by mouth] and on tube feedings only since 2/26/18. The Plan of Care failed to include risk for aspiration as a safety | N 0543 | 1. POC=(medical, 485/487 plan of care), NPOC= (nursing/home health aide or HHa plan of care). POC & NPOC for each client have been updated to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Orders sent to client's Physician starting 3.22.19 with training beginning on 3.22.19 as well for staff/family/client. All active client's orders were sent to client's physician for POC & NPOC changes by 3.29.19. All staff/family/client training must be completed when PCP orders are returned to agency. Staff will be trained on updated POC & NPOC to ensure they are providing | 04/05/2019 |

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| | measure.<br><br>2. The clinical record for patient #7 was reviewed on 2/19/19. The start of care date was 5/20/15 and plan of care certification period was 12/30/18 to 2/27/19. Patient was on a ventilator and NPO with G-tube feedings only. Choking and aspiration risk were identified on the comprehensive assessments on 12/28/18, 10/29/18, and 6/28/18. The plan of care failed to include risk for aspiration as a safety measure. | | services as ordered and charting accordingly. These changes all completed by 4.5.19.<br>2. POC & NPOC will be maintained and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC & NPOC will be audited with quarterly chart audits and updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC & NPOC updates. Staff trained to document if/when/why client declines services. This should prevent agency non-compliance. Staff have been informed primary bathing shall occur on home health service time. Staff's daily notes will continue to be monitored to comply with POC & NPOC orders by office staff. Nurse Case Managers and office staff have been trained on updated POC & NPOC information and required documentation on 3.25.19. Additional goals have been added to POC to be more specific and oriented to client's needs.<br>3. Administrator<br>4. 4.5.19 | |
| N 0544<br><br>Bldg. 00 | 410 IAC 17-14-1(a)(1)(E)<br>Scope of Services<br>Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the | | | |

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| | following:<br>(E) Prepare clinical notes.<br>Based on clinical record review the nurse failed to write an order to discontinue a medication after making a handwritten note to discontinue a medication in 1 of 25 clinical records reviewed (#6).<br><br>Findings include:<br><br>The agency's undated policy titled "Documentation of Services Provided," #6.20, stated "daily notes are to be submitted within 24 hours of provided service ...."<br><br>The agency's undated policy titled "Clinical Records & Documentation," Entries must be legible, clear, complete and authenticated, dated, and timed ... Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.<br><br>The clinical record for patient #6 was reviewed on 2/12/19. Patient signed consent forms to begin home health services on 2/26/18. The start of care date was 3/25/18.<br><br>The Client Medication List dated 2/26/18, included Loratadine 10 mg (milligrams) per Gtube (gastric tube) PRN (as needed). Next to the medication was handwritten note which stated "d/c [discontinue] 10/18." The Client Medication list was evidenced as being reviewed by the Director of Nursing (DON) on 6/28/18; 7/25/18; 1/9/19; and 2/5/19.<br><br>The addendum to the plan of care for certification periods 7/23/18 to 9/20/18; 9/21/18 to 11/19/18; 11/20/18 to 1/18/19; and 1/19/19 to 3/19/19 listed Loratadine 10 mg per Gtube PRN for Allergies. | N 0544 | Clinical notes - During quarterly chart audits, an order to discontinue a medication was found filed in client chart. Medication list was not yet updated with medication change. Auditor notified client's Nurse Case Manager of order that was faxed to agency, from residential agency. Nurse Case Manager was not notified of medication change prior to fax being filed in client chart. Medication list has since been updated. In order to prevent this in the future, office staff have been trained that if any medication changes are received, Nurse Case Manager must be notified immediately to process the change. NCM=Nurse Case Manager.<br>1. Medication list was updated immediately when order was located by auditor.<br>2. Office staff received training, that any time an update comes into the office, the Nurse Case Manager must be notified immediately so the update can be completed. This review training was completed on 3.13.19. Quarterly chart audits for 100% of client charts will enable agency to maintain compliance and to prevent the deficient practice from reoccurring.<br>3. Administrator<br>4. 3.13.19 | 03/13/2019 |

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| | Progress notes by the DON on 7/25/18; 1/9/19; and 2/5/19 evidenced the plan of care was reviewed and there were no changes in the nursing plan of care or care needs. | | | |
| N 0602<br><br>Bldg. 00 | 410 IAC 17-14-1(m)<br>Scope of Services<br>Rule 14 Sec. 1(m) The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only cases).<br>Based on record review, observation, and interview, the agency failed to ensure the home health aide (HHA) assignments were accurate based on patient assessments for 2 of 2 clinical records reviewed with HHA services ordered. (# 2, and 11)<br><br>Findings include:<br><br>1. The agency's undated policy titled "Nursing Plan of Care," # 5.3, stated "A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed client care provided through Forte HHC for clients receiving only home health aide services in the absence of a skilled service. The nursing plan of care must contain the following: 1) A plan of care and appropriate client identifying information. 2) The name of the client's physician. 3) Services to be provided. 4) The frequency and duration of visits. 5) Diet and activities. ... 9) The signature of the registered nurse who developed the plan."<br><br>2. The clinical record for patient # 2 was reviewed on 2/12/19. The plan of care dated 1/14-3/14/19 contained a diagnosis of cerebral palsy, and orders for HHA up to 8 hours per day, up to 6 days per week, up to 40 hours per week, for 60 days. The HHA was ordered to provide the | N 0602 | POC=(medical, 485/487 plan of care) NPOC=(nursing/home health aide/HHa plan of care) POC & NPOC documents match related to services ordered and provided.<br>1. To correct the deficiency, Forte Home Health Care updated the client's POC & NPOC to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Orders sent to client's Physician starting 3.22.19 with training beginning on 3.22.19 as well for staff/family/client. All active client's orders were sent to client's physician for POC & NPOC changes by 3.29.19. All staff/family/client training must be completed when PCP orders are returned to agency. Staff will be trained on updated POC & NPOC to ensure they are providing services as ordered and charting accordingly. These changes completed by 4.5.19. Client #11/staff and family was re-trained on correct frequency/duration on | 04/05/2019 |

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| | following tasks: ambulation as required.<br><br>The HHA care plan dated 8/21/18 had the HHA assigned to monitor for safety and seizures every day, and all remaining tasks were ordered as needed and per client request which included ambulate.<br><br>During home visit observation with patient # 2 on 2/14/19 at 2:30 PM, durable medical equipment in the home included an electric wheel chair and a hoyer lift. The patient did not appear to be able to ambulate, as assigned on the HHA care plan.<br><br>3. The clinical record for patient # 11 was reviewed on 2/18/19. The start of care date was 10/14/14. The plan of care dated 11/19/18-1/17/19 contained orders for HHA up to 8 hours a day, up to 5 days a week for up to 40 hours per week, for 60 days. HHA to provide bath of patient/family choice, hair wash and comb as patient allows, oral care brush teeth as patient allows, assist with meals or snacks if requested, take vital signs (VS) as needed, ambulation as required, assist to chair as needed, range of motion passive as needed, medication reminders as needed, and monitor for safety.<br><br>The HHA care plan dated 12/20/18 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing of patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting. The HHA visit notes for the certification period 11/19/18-1/17/19 evidenced the patient only received a bath or shower on 11/21, 11/28, 12/5, 12/12, 12/19, and 12/26/18, and the other dates all | | 3.4.19.<br>2. POC & NPOC will be maintained and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC & NPOC will be updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC & NPOC updates. Staff trained to document if/when/why client declines services. Staff have been informed primary bathing shall occur on home health service time. Staff's daily notes will continue to be monitored to comply with POC & NPOC orders by office staff. Measures will be monitored in the monthly nurse meetings and quarterly QAPI audit and report to ensure this deficient practice does not reoccur. Nurse Case Managers are updating Plan of Care for their clients based on client's needs and safety. Nurse Case Managers and office staff have been trained on updated POC & NPOC and required documentation on 3.25.19. Additional goals have been added to POC to be more specific and oriented to client's needs.<br>3. Administrator<br>4. 4.5.19 | |

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| | 15K086 | A. BUILDING 00<br>B. WING | 02/21/2019 |

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| | failed to evidence the patient/family refused bathing.<br><br>The HHA PA (prior authorization) visit notes dated 1/4 from 12:00 PM-4:00 PM, and 1/5/19 from 1:00 PM-9:00 PM failed to evidence the HHA provided bathing. During an interview on 2/18/19 at 1:00 PM, when inquired of the agency why the HHA would not provide this service, the director of nursing stated this patient also received residential services, and they probably gave the shower. At that time, the agency offered the residential side paperwork from those two days, and it evidenced the residential side provided the shower on 1/4 and 1/5/19 prior to the HHA arrival.<br><br>During an interview on 2/18/19 at 2:48 PM, the alternate administrator stated the HHAs should be doing the showers more than the residential side staff.<br><br>During interview on 2/19/19 at 1:09 PM, the director of nursing stated it looked like patient # 11 should not have been using 6 das a week, and that the residential side had been providing the patient's showers. At that time, the administrator stated a patient would qualify for HHA services if they need assistance bathing, and that also this patient (#11) needed assistance being fed. The administrator stated that she thought sometimes all of the care provided had not been documented. | | | |
| N 0603<br><br>Bldg. 00 | 410 IAC 17-14-1(m)<br>Scope of Services<br>Rule 14 Sec. 1(m) The home health aide may not be assigned to perform additional tasks not included in the original competency evaluation until he or she has successfully been evaluated as competent in that task.<br>Based on record review, and interview, the agency | N 0603 | POC=(medical, 485/487 plan of | 04/05/2019 |

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| | failed to ensure home health aide (HHA) services had been provided as ordered on the plan of care for 4 of 6 active HHA only clinical records reviewed. (#1, 2, 4, and 19)<br><br>Findings include:<br><br>1. The agency's undated policy titled "Medical Plan of Care," # 5.2, stated "Patients are accepted for treatment on the reasonable expectation that Forte Home Health Care (HHC) 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 Forte HHC 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. ... (2) The individualized plan of care must include the following: 9) Frequency and duration of visits. ... 15) Medications and treatments. ... 20) Client-specific interventions and education; measurable outcomes and goals identified by the HHA and patient. ...."<br><br>2. The clinical record for patient # 1 was reviewed on 2/12/19. The plan of care dated 12/31/18-2/28/19 contained a diagnosis of mitochondrial myopathy, and orders for respite home health aide (RHHA) 60+ hours per month, HHA to bathe patient per patient/family choice, | | care) NPOC=(nursing,home health aide/HHa plan of care) POC & NPOC documents match related to services ordered and provided.<br>1. To correct the deficiency, Forte Home Health Care updated the client's POC & NPOC to reflect the client's needs more specifically and with more detail. Assignments are based on client's specific needs/safety. Orders sent to client's Physician starting 3.22.19 with training beginning on 3.22.19 as well for staff/family/client. All active client's orders were sent to client's physician for Plan of Care changes by 3.29.19. All staff/family/client training must be completed when PCP orders are returned to agency. Staff will be trained on updated POC & NPOC to ensure they are providing services as ordered and charting accordingly. These changes will be completed by 4.5.19. Client #11/staff and family was re-trained on correct frequency/duration and to follow POC & NPOC on 3.4.19.<br>2. POC & NPOC will be maintained and updated to reflect client's needs/safety specifically, and more defined for new client admissions. POC & NPOC will be updated with changes per physician's order as needed. Staff/client/family training will be completed with all POC & NPOC updates. Staff trained to document if/when/why client declines | |

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| | wash and comb hair as patient allows, oral care-brush teeth as patient allows, assist with meals or snacks if requested, take vital signs (VS) blood pressure (BP), pulse, respirations (RR) and T (temperature) as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The initial assessment dated 10/9/18, identified the patient needed assistance with oral hygiene, bathing, dressing, toileting, transfer, mobility, medication management, and meal preparation, and that the patient had a history of weight loss and inability to eat.<br><br>The HHA care plan last reviewed 1/8/19 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing, hair, oral care, assist with meals or snacks, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting. The HHA visit notes dated 1/7, 1/8, and 2/1/19 all failed to evidence the HHA provided all tasks as ordered and failed to evidence the patient/family had refused the ordered tasks.<br><br>The HHA visit note dated 1/7/19 stated "Caregiver Notes Breakfast & lunch ... hung out ... spent time together."<br><br>The HHA visit note dated 1/8/19 stated "Caregiver Notes Breakfast & lunch ...."<br><br>The HHA visit note dated 2/1/19 stated "Caregiver Notes Made lunch ...."<br><br>3. The clinical record for patient # 2 was reviewed on 2/12/19. The plan of care dated 1/14-3/14/19 contained a diagnosis of cerebral palsy, and | | services. Staff have been informed primary bathing shall occur on home health service time. Staff's daily notes will continue to be monitored to comply with POC & NPOC orders by office staff. Measures will be monitored in the monthly nurse meetings and quarterly QAPI audit and report to ensure this deficient practice does not reoccur. Nurse Case Managers are updating POC & NPOC for their clients. Nurse Case Managers and office staff have been trained on updated POC & NPOC information and required documentation on 3.25.19. Additional goals have been added to POC to be more specific and oriented to client's needs.<br>3. Administrator<br>4. 4.5.19 | |

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| | orders for HHA up to 8 hours per day, up to 6 days per week, up to 40 hours per week, for 60 days. The HHA was ordered to provide the following tasks: bath of patient/family choice, hair was and comb as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, take VS BP, pulse, RR and T as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting/brief changes as needed, and monitor for safety. Monitor for seizures. The "Goals" section stated "Client will receive full assistance with personal care/ADL's (activities of daily living) to maintain optimum level of hygiene for this certification period."<br><br>The HHA care plan dated 8/21/18 had the HHA assigned to monitor for safety and seizures every day, and all remaining tasks were ordered as needed and per client request which included bathing of patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting/brief changes. The HHA visit notes dated 1/14, 1/15, 1/17, 1/18, 1/19, 1/21, 1/22, 1/23, 1/24, 1/25, 1/28, 1/29, 1/31, 2/1, 2/2, 2/4, 2/5, 2/6, 2/7, 2/8, 2/11, and 2/12/19 all failed to evidence the HHA provided bathing to the patient and failed to evidence the patient/family refused the bathing.<br><br>---The clinical record for patient # 4 contained a plan of care dated 1/25-3/25/19 with a diagnosis of dementia and orders for HHA up to 12 hours a day, up to 6 days a week, up to 60 hours a week for 60 days. HHA to bathe patient per patient/family choice, wash and comb hair as patient allows, oral care- brush teeth as patient allows, assist with meals or snacks if requested, | | | |

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| | VS as needed, ambulation as required, assist to chair as needed, range of motion exercises, passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The "Goals" section stated "Client to remain safe in home, with assistance of family and HHA for this certification period." The frequency and goals failed to be patient specific.<br><br>The HHA care plan dated 7/29/18 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing of patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting.<br><br>----The clinical record for patient # 19 was reviewed on 2/18/19. The start of care date was 10/7/18. The plan of care dated 12/6/18-2/3/19 contained orders for respite HHA 60+ hours per month for bathing of patient/family choice, hair wash and comb as patient allows, assist with meals or snacks if requested, take VS as needed, ambulation as required, assist to chair as needed, range of motion exercises passive as needed, assist with toileting and perineal care as needed, and monitor for safety. The physician order dated 1/15/19 stated "Hold HHA services effective 1/14/19 due to client being admitted to hospital on 1/13/19. Resume care as ordered when client is discharged to home." The agency failed to discharge the patient.<br><br>The HHA care plan dated 12/20/18 had the HHA assigned to monitor for safety every visit, and all remaining tasks were ordered as needed and per client request which included bathing of | | | |

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| | patient/family choice if patient agreeable, hair wash, comb if patient agreeable, oral care- brush teeth, VS, ambulate, assist to chair, range of motion active and passive, and assist with toileting. | | | |