

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/06/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157452</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/09/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEW HORIZONS HOME HEALTH SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>621 BROADWAY NEW HAVEN, IN 46774</b>		
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G 000	INITIAL COMMENTS  This visit was for a Federal Home Health Recertification and Focused Infection Control surveys conducted 10/5/20 - 10/9/20 which was fully extended.  Survey dates: 10/5/2020 - 10/9/2020  Facility Number: IN009116  Medicare number: 157452  Census: 32 active patients  Active clinical records reviewed: 5  Discharged clinical records reviewed: 3  Records reviewed with home visits: 3  Home visits with no record review: 5  Total clinical records reviewed: 8  This deficiency report reflects State Findings cited in accordance with 410 IAC 17.	G 000			
G 520	Quality Review Completed 11/06/2020 Area 1 5 calendar days after start of care CFR(s): 484.55(b)(1)  The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure a direct, hands-on	G 520			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 520	<p>Continued From page 1</p> <p>comprehensive assessment was completed by the skilled nurse within 5 days in 1 of 3 discharge records reviewed, out of a total 8 clinical records reviewed. (#6)</p> <p>The findings include:</p> <p>An agency policy titled "New Horizons Home Health Services Clinical Records" revised 1/13/18, stated "New Horizons Home Health Services is responsible for the protection of clinical records ... All entries to the clinical records must be legible, clear, complete, and appropriately authenticated, dated and timed. Authentication must include a signature and title (occupation), or an electronic signature is accepted, or a secured computer entry by a unique identify, of a primary author who has reviewed and approved the entry...."</p> <p>Clinical record review on 10/9/2020 for patient #6, start of care 2/13/2020, evidenced an agency document titled "Adult Comprehensive Assessment-ROC/Recert" digitally signed by Employee C, RN [registered nurse] and dated 4/8/2020. This assessment stated "[patient #1] ... generalized weakness ... vision glasses ... sensation of touch no problems WNL [within normal limits] ... nose no problem ... ears no problem ... mouth no problem WNL ... speech no problem WNL ... throat No problem WNL ... pain sharp aching intermittent ... skin turgor good ... integumentary system No problem WNL ... respiratory No Problem WNL dyspnea [shortness of breath] minimal exertion ... Cardiovascular No problem WNL ... Genitourinary/Urinary Incontinence Adult Briefs One functioning kidney ... Genitalia No problem WNL ... Gastrointestinal No problem WNL ...</p>	G 520			

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G 520	<p>Continued From page 2</p> <p>Abdomen No problem WNL ... Neuro/Emotional/Behavioral Status weakness-generalized ... Hand Grips Equal Strong ... Evidence of Abuse or Neglect No observed/reported ... Instructions/Materials Provided CA [comprehensive assessment] completed per phone with client in agreement to comply with social distancing guidelines for Recertification per Client Comprehensive assessment remains unchanged since SOC [Start of Care] ... Notes: CA [comprehensive assessment] completed per phone with client in agreement to comply with social distancing guidelines for Recertification, Per Client Comprehensive assessment remains unchanged since SOC [start of care]...." This document evidenced the comprehensive assessment was conducted via phone call. There failed to be evidenced documentation of a "hands on" comprehensive assessment completed by the skilled nurse.</p> <p>Clinical record review on 10/9/2020 for patient #6, start of care 2/13/2020, evidenced an agency document titled "Adult Comprehensive Assessment-ROC/Recert" digitally signed by Employee C, RN and dated 5/19/2020. This assessment stated patient #6 had "generalized weakness ... sensation of touch no problems WNL ... nose no problem ... ears no problem ... mouth no problem WNL ... throat No problem WNL ... pain sharp aching intermittent ... skin turgor good ... integumentary system No problem WNL ... respiratory No Problem WNL dyspnea [shortness of breath] minimal exertion ... Cardiovascular No problem WNL ... Genitourinary/Urinary Incontinence Adult Briefs One functioning kidney ... Genitalia No problem WNL ... Gastrointestinal No problem WNL ...</p>	G 520			

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G 520	Continued From page 3 Abdomen No problem WNL ... nutritional status appetite good ... Neuro/Emotional/Behavioral Status weakness-generalized ... Hand Grips Equal Strong ... Evidence of Abuse or Neglect No observed/reported ... Instructions/Materials Provided CA for discharge do to client death assessment per last certification ... Notes: Notified by client's sister that client had a heart attack and died at home yesterday ...." There failed to be evidenced documentation of a "hands on" comprehensive assessment completed by the skilled nurse.  Clinical record review on 10/9/2020, for patient #6, failed to evidence telehealth as an order on the patient's plan of care for certification period (4/13/2020-6/11/2020) and failed to evidence a physician order authorizing the skilled nurse assessments by phone / telehealth methods.  During an interview on 9/10/2020 at 2:01 p.m., the administrator indicated there was no need for a physician order for a telephone visit as they do not need an order to do a comprehensive assessment. She also indicated the comprehensive assessment dated 5/19/2020 was for the discharge summary.	G 520			
G 572	Plan of care CFR(s): 484.60(a)(1)  Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a	G 572			

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G 572	<p>Continued From page 4</p> <p>plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the plan of care was established by the physician in 1 out 5 active clinical records reviewed, out of 8 total clinical records reviewed. (#4)</p> <p>The findings include:</p> <p>An agency policy titled "New Horizons Home Health Services Patient Care Plan/Medical Supervision," revision date 1/13/18 stated, "It is the policy of New Horizons Health Services that a plan of care initiated by RN [Registered Nurse] is established and reviewed by the physician in collaboration with the client/family/caregiver/representative (if any) and agency staff involved for all patients receiving care or treatment from New Horizons Home Health Services ... Each patient receives home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his/her state license, certification, or registration...."</p> <p>Clinical record review on 10/7/20 for patient #2, start of care 6/25/2020, evidenced an agency documents titled "New Horizons Home Health Services Plan of Care," for certification periods 6/25/2020- 8/23/2020, which was signed and dated 8/28/2020. This document failed to</p>	G 572			

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G 572	Continued From page 5 evidence it was established and reviewed by the primary physician until after the certification period.  During an interview on 10/8/2020 at 2:14 p.m., the administrator indicated it was very hard to get signed documents from physicians due to Covid-19 and the physicians not being in the office.	G 572			
G 574	410 IAC 17-13-1(a) Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi)  The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the	G 574			

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G 574	<p>Continued From page 6</p> <p>HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include.</p> <p>This ELEMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the plan of care medications were complete accurate and included indications for as needed medications in 2 of 5 active clinical records reviewed, out of a total of 8 clinical records reviewed. (#1, #2).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. An agency policy titled "New Horizons Home Health Services Patient Care Plan/Medical Supervision," revision date 1/13/18, stated, "The plan of care is reviewed by physician periodically and includes at least the following: ... All medications and treatments ... Revision/Recertification to the POC must include at least ... Updated medication profile ...."</li> <li>2. Clinical record review 10/8/2020 for patient #1, start of care 1/18/02, evidenced an agency document titled "New Horizons Home Health Services Plan of Care" for certification period 7/21/2020 - 9/18/2020 digitally signed by Employee C, RN [registered nurse] and dated 7/17/2020. This Plan of care had a section subtitled "Medications," which stated, " ... DM-Guaifenesin ER (Mucinex DM) 30-60 MG [milligram] tab PRN/As Needed daily [cough] ... Famotidine (Pepcid AC) 10 MG tab(s) oral 1 cap [capsule] PRN/As Needed [acid indigestion] ... Bisacodyl (Dulcolax 10 MG Suppository(ies) rectal 1 suppository PRN/As Needed QOD [every other day] as needed [constipation] ... Nystatin</li> </ol>	G 574			

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G 574	<p>Continued From page 7</p> <p>External apply to affected area PRN/As Needed BID [ twice a day] prn [antifungal] ... Emollient (Aquafor) External to affected areas PRN/As Needed daily [dry skin] ...</p> <p>Pseudoeph-Bromphen-DM 15-1-5 MG/5ML [milliliter] ml oral 5 ml PRN/As Needed q [every] 6 hr [hours] PRN [Cough/Congestion] Start Effective Date: 3/27/18 ...</p> <p>Pseudoeph-Bromphen-DM (Bromfed DM) 30-2-10 MG/5ML [milliliter] ml oral 5 ml PRN/As Needed every 6 hours Cough/Congestion Start effective Date: 11/28/2018. This plan of care failed to evidence indications for as needed medications, and failed to ensure no duplicate drug therapies.</p> <p>During an interview on 10/7/2020 at 1:47 p.m., the administrator stated, "I will look into this."</p> <p>During an interview on 10/8/2020 at 1:45 p.m., the administrator indicated the indication is in the class section of the med profile sheet.</p> <p>During an interview on 10/8/2020 at 2:00 pm., the administrator indicated the Bromfed DM orders were for different strengths ordered at different times from two doctors so it was okay for them to both be on there.</p> <p>3. Clinical Record review on 9/7/2020 for patient #2, start of care 11/2/2015, evidenced an agency document titled "New Horizons Home Health Services Plan of Care" for certification period 8/6/2020 - 10/4/2020 digitally signed by Employee C, RN and dated 8/6/2020. This Plan of care had a section subtitled "Medications," which stated, " ... Estradiol 0.1 MG/GM vaginal suppository on Tuesday and Saturday ...." This document failed to evidence the correct days patient #2 takes</p>	G 574			

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G 574	Continued From page 8 Estradiol.  During a home visit in 10/7/2020 at 10:50 a.m., employee S, HHA [Home Health Aide] was observed handing patient #2 her Estradiol.  During an interview on 10/7/2020 at 11:02 a.m., patient #2 indicated she always takes her Estradiol on Wednesdays and Sundays  During an interview on 10/8/2020 at 3:21 p.m., the administrator indicated patient #2 was competent to do her own medications on the days she chooses.	G 574			
G 590	410 IAC 17-13-1(a)1(D)(ix) Promptly alert relevant physician of changes CFR(s): 484.60(c)(1)  The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to promptly alert the physician for the need to alter the medical plan of care in 1 of 5 active patients, out of a total of 8 clinical records reviewed. (#4)  The findings include:  An agency policy titled "New Horizons Health Services Coordination of Care," revision date 1/13/18, stated, " New Horizons Home Health Service communicates with all physicians	G 590			

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G 590	<p>Continued From page 9</p> <p>involved on the plan of care to assure the development and implementation of a coordinated plan of care ... For coordination of care purposes physicians involved in the POC [plan of care] are the physicians who give orders that are directly related to hoe health skilled services ... The clinical manager or designated RN [Registered Nurse] will ensure: ... Coordination of services and interventions provided to the client ... Integration of services and coordination of care provided by all disciplines, provided direction or under arrangement, to endure identification of client needs and factors that could client safety and treatment effectiveness ... Coordinate care deliver [sic] to meet client's needs involve the client, representative (if any), and caregiver(s) as appropriate ...."</p> <p>An agency policy titled "New Horizons Home Health Services Patient Care Plan/Medical Supervision," revised 1/13/18, stated, " ... Revision for change in patient condition: RN/clinical manager or designee will ensure an relevant physicians (those issuing orders for the POC are contacted and those orders are integrated into the revision of the POC or approval from the responsible physician ...."</p> <p>Clinical record review on 10/7/2020 for patient #4, start of care 6/25/2020, evidenced an agency document titled "OASIS Nurse Recertification," dated 8/20/2020, and digitally signed by employee C, RN [Registered Nurse]. This recertification document had an area subtitled "Pain" which stated, " ... Pain Rating 4 ... Pain Location: Lower Back ... How often is medication used: 2-3 times per day ... Comments: Client reports lower back pain along with occasional</p>	G 590		

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G 590	<p>Continued From page 10</p> <p>right knee pain that reaches 8/10 [on a pain scale of 0 to 10 where 0 is no pain and 10 is worst pain possible]." This document failed to evidence the physician was notified the patient was having severe pain reaching 8/10.</p> <p>Clinical record review of an agency document titled "Adult Skilled Nursing Note," dated 9/3/2020, and digitally signed by employee C, RN evidenced a section subtitled "Pain Location &amp; Description," which stated, " Current 4/10 Best in 24 hours 4/10 worst in 24 hours 8/10 ... Client reports lower back pain along with occasional right knee pain that reached 8/10 in the mornings, decreases to 4/5 after being out of bed for awhile [sic] and taking Tylenol 2-3 times per day." This document failed to evidence the physician was notified the patient was having severe pain 8/10 in the mornings.</p> <p>Clinical record review of an agency document titled "Adult Skilled Nursing Note," dated 9/3/2020 and digitally signed by employee C, RN, Review of the skilled nursing note evidenced sections subtitled "Pain Location and Description" which stated Current 4/10 Best in 24 hours 4/10 worst in 24 hours 8/10. "Nursing Documentation/Shift Summary," which stated, " ... Her lower back pain continues and she states has periodically takes some Tylenol with slight relief." This document failed to evidence the physician was notified the patient was having severe pain of 8/10.</p> <p>Clinical record review of an agency document titled "Adult Skilled Nursing Note," dated 9/17/2020, and digitally signed by employee C, RN evidenced a section subtitled "Pain Location &amp; Description," which stated, " Current 4/10 Best</p>	G 590			

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G 590	<p>Continued From page 11</p> <p>in 24 hours 4/10 worst in 24 hours 8/10 ... Client reports lower back pain along with occasional right knee pain that reached 8/10 in the mornings, decreases to 4/5 after being out of bed for awhile [sic] and taking Tylenol 2-3 times per day." This document failed to evidence the physician was notified the patient was having severe pain 8/10.</p> <p>Clinical record review of an agency document titled "Adult Skilled Nursing Note," dated 9/29/2020, and digitally signed by employee C, RN, evidenced a section subtitled "Pain Location &amp; Description," which stated, " Current 4/10 Best in 24 hours 4/10 worst in 24 hours 8/10 ... Client reports lower back pain along with occasional right knee pain that reached 8/10 in the mornings, decreases to 4/5 after being out of bed for awhile [sic] and taking Tylenol 2-3 times per day." This document failed to evidence the physician was notified the patient was having severe pain 8/10 in the mornings.</p> <p>Clinical record review of an agency document titled "Adult Skilled Nursing Note," dated 9/29/2020, and digitally signed by employee C, RN, evidenced a section subtitled "Pain Location &amp; Description," which stated, " Current 4/10 Best in 24 hours 4/10 worst in 24 hours 8/10 ... Client reports lower back pain along with occasional right knee pain that reached 8/10 in the mornings, decreases to 4/5 after being out of bed for a while and taking Tylenol 2-3 times per day." This document failed to evidence the physician was notified the patient was having severe pain 8/10.</p> <p>During an interview on 10/8/2020 at 2:14 p.m., the administrator indicated the client was using Tylenol to relieve her pain and did not indicate she needed anything additional for pain, so there</p>	G 590			

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G 590	Continued From page 12 was no need to notify the physician.	G 590			
G 606	410 IAC 17-13-1(a)(2) Integrate all services CFR(s): 484.60(d)(3)  Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure they coordinated care with other health care providers that provided care to agency patients in and 1 of 1 record reviewed of patients receiving care by other agencies, out of a total of 8 clinical records reviewed. (#3)  The findings include:  An agency policy titled "New Horizons Health Services Intake Process and Guidelines," revision date 1/13/18 stated, "Guidelines evolve and will vary based on Federal and State rules and regulations and may include additional agency processes. The Guidelines are not intended to be "all-inclusive" but rather a guideline to assist in coordinating different aspects of patient admission, communication, coordination and documentation flow ... Follow Up Visits: As appropriate, return to the client home to perform skilled/non-skilled/supervisory visits as necessary ... Coordinate care ...."  An agency policy titled "New Horizons Health	G 606			

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G 606	<p>Continued From page 13</p> <p>Services Coordination of Care," revision date 1/13/18 stated, " New Horizons Home Health Service communicates with all physicians involved on the plan of care to assure the development and implementation of a coordinated plan of care ... For coordination of care purposes physicians involved in the POC [plan of care] are the physicians who give orders that are directly related to hoe health skilled services ... The clinical manager or designated RN [Registered Nurse] will ensure: ... Coordination of services and interventions provided to the client ... Integration of services and coordination of care provided by all disciplines, provided direction or under arrangement, to endure identification of client needs and factors that could client safety and treatment effectiveness ... Coordinate care deliver [sic] to meet client's needs involve the client, representative (if any), and caregiver(s) as appropriate ...."</p> <p>Clinical record review on 10/7/2020, for patient #3, evidenced an agency document titled "Adult Comprehensive Assessment-SOC [start of care]", dated 6/19/2020. This document had a section subtitled "Medication Management," which stated, "... Pill box utilized (specify who manages) [Entity A] skilled nurse sets medication and client administers." Review of patient #3 chart failed to evidence coordination of care with Entity A.</p> <p>During an interview on 9/7/2020 at 1:40 p.m., the administrator stated "I will look into this."</p> <p>During an interview on 9/8/2020 at 2:14 p.m., the administrator indicated she did not have any information on the coordination of care with Entity A.</p>	G 606			

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G 606	Continued From page 14	G 606			
G 800	<p>410 IAC 17-12-2(h) Services provided by HH aide CFR(s): 484.80(g)(2)</p> <p>A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is not met as evidenced by: Based on record review an interview, the home health agency failed to follow the plan of care for 1 of 4 active records receiving home health aide services out of a total of 8 records reviewed. (#2)</p> <p>The findings include:</p> <p>An agency policy titled "New Horizons Home Health Services Patient Care Plan/Medical Supervision," revision date 1/13/18, stated, "It is the policy of New Horizons Health Services that a plan of care initiated by RN [Registered Nurse] is established and reviewed by the physician in collaboration with the client/family/caregiver/representative (if any) and agency staff involved for all patients receiving care or treatment from New Horizons Home Health Services ... Each patient receives home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his/her state license, certification, or registration ...."</p>	G 800			

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G 800	<p>Continued From page 15</p> <p>Clinical record review on 10/7/2020, for patient #2, evidenced an agency document titled "Home Health Aide/ATTN [Attendant] Assignment Sheet" dated 11/2/2015, last reviewed and revised on 8/6/2020, by employee A, RN [Registered Nurse]. This document had a section subtitled, "Precautionary and Other Pertinent Information," which stated Fluids Limit Record Intake Assist client to track and log fluid intake, restricted to 64 oz [ounces]/day on in home log ...."</p> <p>Clinical record review on 10/7/2020, for patient #2 evidenced an agency documents titled HHA [Home Health Aide] Visit Note" dated 8/7/2020, 8/11/2020, 8/18/2020, 8/22/2020, 8/25/2020,8/30/2020, 9/8/2020, 9/15/2020, 9/17/2020, 9/22/2020, 9/24/2020, 9/29/2020 and electronically signed by employee M, HHA This document failed to evidence employee M assisted patient #2 with tracking her fluid intake.</p> <p>Clinical record review on 10/7/2020 for patient #2 evidenced an agency documents titled HHA [Home Health Aide] Visit Note" dated 8/17/2020, 9/10/2020, 9/24/2020 and electronically signed by employee U, HHA This document failed to evidence employee U assisted patient #2 with tracking her fluid intake.</p> <p>Clinical record review on 10/7/2020 for patient #2 evidenced an agency documents titled HHA [Home Health Aide] Visit Note" dated 8/13/2020 and electronically signed by employee U, HHA This document failed to evidence employee U assisted patient #2 with tracking and restricting her fluid intake.</p> <p>During an interview on 9/8/2020 at 1:20 p.m., the administrator indicated the patient is alert and</p>	G 800			

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G 800	Continued From page 16 oriented and tracks her own fluids.	G 800			
G1024	<p>410 IAC 17-3-2(b) Authentication CFR(s): 484.110(b)</p> <p>Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all records were authenticated and dated in 1 of 5 active clinical records, out of a total of 8 clinical records reviewed. (#5)</p> <p>The findings include:</p> <p>An agency policy titled "New Horizons Home Health Services Clinical Records" revised 1/13/18, stated "New Horizons Home Health Services is responsible for the protection of clinical records ... All entries to the clinical records must be legible, clear, complete, and appropriately authenticated, dated and timed. Authentication must include a signature and title (occupation), or an electronic signature is accepted, or a secured computer entry by a unique identify [sic], of a primary author who has reviewed and approved the entry...."</p> <p>Clinical record review on 10/7/20, for patient #5, start of care 9/21/2020, evidenced agency</p>	G1024			

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G1024	Continued From page 17 documents titled "New Horizons Home Health Services Plan of Care," for certification periods 9/21/2020- 11/19/2020. This document failed to evidence the name, signature or date of the nurse who developed the plan of care.  During an interview on 10/7/2020 at 2:10 p.m., the administrator indicated the electronic signature and date should have auto populated on to the plan of care.	G1024			
E 000	410 IAC 17-15-1(a)(7) Initial Comments  At this Emergency Preparedness survey, New Horizons Home Health Services was found to be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E 000			