

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
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NAME OF PROVIDER OR SUPPLIER  NOBLE HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2449 45TH STREET SUITE D HIGHLAND, IN 46322
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G 0000  Bldg. 00	<p>This was a Federal home health recertification survey.</p> <p>This survey was an extended home health recertification survey.</p> <p>Survey Dates: 6/30/15, 7/1/15, 7/2/15, 7/6/15, and 7/7/15.</p> <p>Facility #: 012829</p> <p>Medicaid Vendor #: 15K092</p> <p>Facility unduplicated census: 109</p> <p>Records reviewed without home visit: 5 Record reviews with home visits: 5 Total records reviewed: 10</p> <p>Noble Home Healthcare Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning July 7, 2015, - July 7, 2017, due to being found out of compliance with Conditions of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision and 484.55 Comprehensive Assessment of Patients.</p> <p>QR: JE 6/20/15</p>	G 0000		

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 0110  Bldg. 00	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on observation, clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 10 of 10 clinical records reviewed (#'s 1-10).</p> <p>Findings</p> <p>1. The admission folder given to patients failed to include an updated July 2013 version of the 2004 Indiana Advanced Directives document in the admission folder that was distributed to the patients at the start of care.</p> <p>2. Interview on 7/1/15 at 4:45 PM, Employee A, administrator, acknowledged the advanced directives</p>	G 0110	G 110 Corrective action already taken. Office staff went to Indiana State's web site and retrieved an updated copy of Advanced Directives. Updated copy was immediately added into patient's admission packet. In addition, all active patient's have received an updated copy of Advanced Directives, which were personally hand delivered to the patient's home by 07/24/2015. For patient's recently discharged in the last 30 days, copies of the updated Advanced Directive were mailed to the patient's home by 07/24/2015. Patient's Admission packet was updated by 7/24/2015 to reflect the 2013 version Advanced Directives listed on the State of Indiana's web site. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this	07/24/2015

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	<p>were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013).</p> <p>3. Clinical record #1, start of care (SOC) date 6/7/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 9:00 AM with patient #1, start of care (SOC) date 6/7/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>4. Clinical record #2, SOC date 2/1/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 10:00 AM with patient #2, SOC date 2/1/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>5. Clinical record #3, SOC date 2/16/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p>		deficiency will not reoccur	

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	<p>Home Visit observation on 7/1/15 at 11:30 AM with patient #3, SOC date 2/16/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>6. Clinical record #4, SOC date 1/21/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 1:00 PM with patient #4, SOC date 1/21/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>7. Clinical record #5, SOC date 2/10/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 3:45 PM with patient #5, SOC date 2/10/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p>			

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	8. Clinical record #6, SOC date 5/20/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.			
	9. Clinical record #7, SOC date 12/12/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.			
	10. Clinical record #8, SOC date 6/15/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.			
	11. Clinical record #9, SOC date 2/1/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.			
	12. Clinical record #10, SOC date 5/25/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.			
	13. Agency policy titled "Advance Directives", no date, states, "Purpose: To protect and honor the patient's right ... At the time of admission and prior to providing care, provide the patient with a written and verbal explanation of his/her rights ... including... the right to formulate Advance Directives.."			

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G 0141 Bldg. 00	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on Interview, employee record review, and agency policy and procedure review, the agency failed to ensure that personnel policies were followed for 1 of 9 employee records reviewed. (Employee E)</p> <p>Findings</p> <p>1. Personnel file E, physical therapist assistant (PTA), date of hire (DOH) 11/8/13 and first patient contact 12/16/13, failed to include a signed job description and a limited criminal history check. A criminal history check was requested from Crown Point Police Department, IN on 11/14/13, his city of residence. A criminal history report from the Indiana State Police was requested on 6/30/14, more than 3 months after date of hire.</p> <p>2. During an interview on 7/7/15 at 1:15 PM, employee A, administrator,</p>	G 0141	G 141 Director of Nursing inserviced office staff on 7/24/2015 that prior to patient contact, all employees INCLUDING contracted employees are to have a signed job description in their employee file. Also it was reinforced that office staff must follow policy and procedures regarding Criminal History Background checks. All employees hired before 07/08/2015 including contracted employees, have a signed job description and at minimal an Indiana State criminal background check in their employee files by 07/24/2015. To prevent this from reoccurring, all new hires, (persons hired on or after 7/8/2015), including contracted employees' folders will be doubled checked by Director of Nursing prior to first patient contact for accuracy and completion of all required documents effective 7/24/2015. If an employee's file is not accurate and/or complete, that employee will not be permitted to have	07/24/2015

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G 0156	<p>indicated that a job description was not signed upon hire for the agency for employee E, PTA. Employee C, office manager, indicated that a criminal history was requested several times from the contractor and they were unable to obtain a copy from the contractor. Employee C indicated a job description was not signed upon hire for the agency for employee E, PTA.</p> <p>3. Agency policy titled "Criminal History Checks", no date, states, "Purpose: To assure that staff have not been convicted of crimes which, might endanger client safety or security. Staff constitutes, full time employees, part time, and contracted individuals ... A criminal history check will be completed on all employees ... Information may be obtained by: Accessing the Indian State Police ... National Criminal Background check."</p> <p>4. Agency policy titled " Services Provided under Contract", no date, states, "Purpose: To clearly define the responsibilities of contract providers ... Provider shall conform to all applicable agency policies, including personnel contracted services."</p>	484.18	<p>patient contact. Additionally to prevent this from reoccurring, during quarterly QAPI meetings, 10% of active employee charts will be audited for compliance. Quarterly review to be initiated on July 27, 2015. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>		

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Bldg. 00	<p>ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on observation, clinical record review, policy review, and interview, it was determined the agency failed to ensure the plan of care was followed during home visit observations for 2 of 5 (# 2 and 4) home visit observations (see G 158); failed to ensure the plan of care (POC) specified amount, frequency, and duration of visits ordered for 10 of 10 clinical records reviewed (see G 159); and failed to ensure the plan of care was reviewed by the physician every 60 days for 3 out of 10 records reviewed (see G 163).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18 Acceptance of patients, plan of care &amp; medical supervision.</p>	G 0156	<p>G 156 Director of Nursing has inserviced all staff on 7/24/2015 that the Plan of Care (POC) must be reviewed by the physician at least every 60 days. Comprehensive assessments are assigned for each patient receiving care at least once every 60 days. POCs are generated at least once every 60 days and sent to the physician to be reviewed and signed. All patient's requiring a POC have been sent to the physician for review and signature.</p> <p>To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for evidence of compliance that the POC is reviewed by the physician at least once every 60 days.</p> <p>This is to be evident by having at least one physician signed POC in each patient's chart per 60 day certification period. Quarterly review to be initiated on July 27, 2015. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>	07/27/2015			
G 0158 Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on observation, clinical record</p>	G 0158	G 158 Director of Nursing has	07/27/2015			

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	<p>review, policy review, and interview, the agency failed to ensure the plan of care (POC) was followed during home visit observations for 2 of 5 (# 2 and 4) home visit observations.</p> <p>Findings:</p> <p>1. During a home visit on 7/1/15 at 10:00 AM for patient #2, the administrator, employee A, completed wound care on both lower extremities. Employee A, failed to check the patients pain level during the visit.</p> <p>A. Interview on 7/6/15 at 12:00 PM, employee A, administrator, agreed she did not assess the patient's pain during the visit.</p> <p>B. Clinical record #2, start of care (SOC) date 2/1/15, contained a POC dated 6/1/15-7/30/15, which stated, "SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. "</p> <p>2. During a home visit on 7/1/15 at 1:00 PM for patient #4, employee B, registered nurse, failed to assess lower extremities during home visit.</p> <p>A. Interview on 7/1/15, at 5:00 PM, employee B, RN, indicated she was</p>		<p>inserviced all clinical staff on 7/24/2015 regarding understanding and complying with a patient's Plan of Care (POC). To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for evidence of compliance. This is to be evident by clinical documentation correlating with patient's POC. Quarterly review to be initiated on July 27, 2015. Additionally to prevent this from reoccurring, clinical staff will be re-inserviced regarding understanding and complying with patient's POC on August 20, 2015. Additional Follow-up with clinical staff will be completed during annual evaluations. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>	

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G 0159  Bldg. 00	nervous during the visit.  B. Clinical record for patient #2, SOC date 2/1/15, contained a POC dated 6/1/15-7/30/15, that stated, "SN to perform inspection of patient's lower extremities every visit."  3. Agency policy titled "Care Planning", no date, states, "Purpose: To define a systematic process to the clinicians for planning, reviewing, and revising patient/client care or services either directly or through a written agreement ... Implementation of the planned care or services by appropriate clinicians."  484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.  Based on clinical record review, policy review, and interview, the agency failed	G 0159	G 159 Director of Nursing inserviced staff on July 24 2015 regarding the proper way to list frequency on the POC. All	07/27/2015			

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	<p>to ensure the plan of care (POC) specified amount, frequency, and duration of visits ordered for 10 of 10 clinical records reviewed (#1-10).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care (SOC) date 6/7/15, contained a POC dated 6/7/15 - 8/5/15, that failed to evidence the duration for services to be provided..</li> <li>2. Clinical record #2, SOC date 2/1/15, contained a POC dated 6/1/15 - 7/30/15 that failed to evidence the amount, frequency or duration listed for services to be provided.</li> <li>3. Clinical record #3, SOC date 2/16/15, contained a POC dated 2/16/15 - 8/16/15, that failed to evidence the amount, frequency or duration listed for services to be provided</li> <li>4. Clinical record #4, SOC date 1/21/15, contained a POC dated 5/21/15 - 7/19/15, that failed to evidence the duration for services to be provided</li> <li>5. Clinical record #5, SOC date 2/10/15, contained a POC dated 2/10/15 - 8/10/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</li> </ol>		<p>patients' admitted on or after 7/8/2015 frequency are doubled checked for accuracy prior to completion of POC. Inaccurately listed frequency on active patients have received an addendum to clarify frequency. To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for evidence of compliance. This is to be evident by the POC containing a properly documented frequency and when required an addendum to the POC to show changes in frequency. Quarterly review to be initiated on July 27, 2015. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>		

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	<p>6. Clinical record #6, SOC date 5/20/15, contained a POC dated 5/20/15 - 7/18/15, that failed to evidence the duration for services to be provided.</p> <p>7. Clinical record #7, SOC date 12/12/12, contained a POC dated 5/31/15 - 7/29/15, that failed to evidence the duration for services to be provided.</p> <p>8. Clinical record #8, SOC date 6/15/15, contained a POC dated 6/15/15 - 8/15/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</p> <p>9. Clinical record #9, SOC date 2/1/15, contained a POC dated 6/1/15 - 7/30/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</p> <p>10. Clinical record #10, SOC date 5/25/14, contained a POC dated 11/21/14 - 5/21/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</p> <p>11. Interview on 7/6/15, at 4:00 PM, employee A, administrator, and employee B, RN, agreed the POC's did not contain specified frequencies.</p>			

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G 0163 Bldg. 00	<p>12. Agency policy titled "Care Planning", no date, states, "Purpose: To define a systematic process to the clinicians for planning, reviewing, and revising patient/client care or services either directly or through a written agreement ... The plan of care, developed in accordance with the referring physician's orders, shall include ... Orders for all disciplines include amount, frequency, duration ... ."</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode. Based on clinical record review, interview, and agency policy and procedure review, the agency failed to</p>	G 0163	G 163 Director of Nursing has in-serviced all staff on 7/24/2015 that all patients total plan of care is to be reviewed by agency	07/27/2015

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NAME OF PROVIDER OR SUPPLIER  NOBLE HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2449 45TH STREET SUITE D HIGHLAND, IN 46322
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	<p>ensure the plan of care (POC) was reviewed by the physician every 60 days for 3 out of 10 (3, 5, and 10) records reviewed.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. Clinical record #3, start of care (SOC) date 2/16/15, contained a POC dated 2/16/15 - 8/16/15, signed by primary care physician on 2/11/15. The record failed to evidence any subsequent plans of care.</li> <li>2. Clinical record #5, SOC date 2/10/15, contained a POC dated 2/10/15 - 8/10/15, signed by primary care physician on 2/11/15. The record failed to evidence any subsequent plans of care.</li> <li>3. Clinical record #10, SOC date 5/25/14, contained a POC dated 11/21/14 - 5/21/15, signed by primary care physician on 12/4/14. The record failed to evidence any subsequent plans of care.</li> <li>4. Interview on 7/2/15, at 3:30 PM, employee A, administrator, and employee B, registered nurse (RN), indicated that they were unaware that medicaid patients had to have POC's reviewed every 60 days by physicians.</li> <li>5. Agency policy titled "Care Planning", no date, states, "Purpose: To define a</li> </ol>		<p>clinical staff and patient's physician at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a case-mix assignment; or a discharge and return to the same agency during the same 60 day episode. Comprehensive assessments are assigned for each patient receiving care at least once every 60 days. POCs are generated at least once every 60 days and sent to the physician to be reviewed and signed. To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for evidence of compliance that all patients total plan of care are reviewed at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a case- mix assignment; or a discharge and return to the same agency during the same 60 day episode. This is to be evident by completed comprehensive assessments and physician signed POC. Quarterly review to be initiated on July 27, 2015. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>	

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G 0330 Bldg. 00	<p>systematic process to the clinicians for planning, reviewing, and revising patient/client care or services either directly or through a written agreement ...</p> <p>The admitting SN/PT will initiate the written Plan of Care at the start of care, and the plan will be updated at least every 60 days."</p> <p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p>	G 0330	G 330 Director of Nursing has inserviced all staff on 7/24/2015 that all	07/27/2015

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G 0334  Bldg. 00	<p>Based on clinical record review, interview, and agency policy and procedure review, it was determined the agency failed to ensure the start of care (SOC) comprehensive assessment was completed within 5 days after the start of care for 2 of 10 records reviewed (see G 334); failed to ensure the medication profile was updated every 60 days for 3 of 10 records reviewed (see G 337); failed to ensure follow up assessments were completed every 60 days for 3 of 10 records reviewed (see G 339); and failed to ensure discharge comprehensive assessment was completed for 2 of 10 records reviewed (see G 341).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.55 Comprehensive Assessment of Patients.</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT 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</p>		<p>patients require a comprehensive assessment at least once every 60 days. Comprehensive assessments are assigned for each patient receiving care at least once every 60 days.</p> <p>To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for evidence of compliance that comprehensive assessments are completed at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a case-mix assignment; or a discharge and return to the same agency during the same 60 day episode. This is to be evident by completed comprehensive assessments and physician signed POC. Quarterly review to be initiated on July 27, 2015. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>	

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	<p>care.</p> <p>Based on clinical record review, interview, and agency policy and procedure review, the agency failed to ensure the start of care (SOC) comprehensive assessment was completed within 5 days after the start of care for 2 of 10 records reviewed (#3 and #5).</p> <p>Findings</p> <p>1. Clinical record #3, SOC date 2/16/15, contained a plan of care (POC) dated 2/16/15 - 8/16/15. A comprehensive assessment dated 2/6/15 was present in the clinical record, prior to the start of care.</p> <p>Interview on 7/2/15, at 4:00 PM, employee A, administrator, and employee B, registered nurse (RN), indicated the comprehensive assessment was not completed on or after the SOC date because it was completed on 2/6/15, 10 days before the SOC. They were unaware another comprehensive assessment needed to be done on the new start of care date.</p> <p>2. Clinical record #5, SOC date 2/10/15, contained a POC dated 2/10/15 - 8/10/15 and a discharge summary for 2/20/15 and a new initial SOC assessment dated</p>	G 0334	<p>G 334 Director of Nursing inserviced all staff on July 24, 2015 regarding Start of Care (SOC) Comprehensive Assessment requirements to be completed, consistent with the patient's immediate needs, no later than 5 calendar days after the start of care.</p> <p>To prevent this from reoccurring, the chart audit check list will be updated to specifically include a line to question for whether or not there is a SOC Comprehensive Assessment completed within 5 calendar days of the SOC. Chart audit check list form was updated on July 24, 2015.</p> <p>Additionally, to prevent this from reoccurring, during quarterly QAPI meetings, 10 charts will be audited using the updated chart audit check list form on July 27, 2015.</p> <p>Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>	07/27/2015	

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G 0337	<p>3/2/15. This record failed to evidence a comprehensive assessment on 3/2/15 or after that date.</p> <p>Interview on 7/2/15, at 4:05 PM, employee A, administrator, and employee B, registered nurse (RN), indicated the comprehensive assessment was not completed with 3/2/15's initial SOC assessment because the patient left the state and was discharged, but was expected to come back, so they felt as if she was not really discharged and no comprehensive assessment was completed upon patient's return to agency.</p> <p>3. The agency policy titled "Comprehensive Assessments of Patients" no date, states, "Purpose: To achieve measurable improvement in the quality of care provided ... A comprehensive assessment incorporating the outcomes and Assessment Information Set (OASIS) utilizing the most current approved version will be performed on qualified patients at: Start of care."</p> <p>484.55(c) DRUG REGIMEN REVIEW</p>			

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Bldg. 00	<p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record review, interview, and agency policy and procedure review, the agency failed to ensure the medication profile was updated every 60 days for 3 of 10 records reviewed (#3, #5 and #10).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) date 2/16/15, contained a medication profile dated 2/6/15. The next medication profile was updated on 5/1/15, a 3 month period between updated medication profiles. Two more medication profiles dated 6/12/15 and 6/29/15 were also present in this clinical record.</p> <p>2. Clinical record #5, SOC date 2/10/15, contained a medication profile dated 4/7/15, no other medication profiles were present after this date in this clinical record. The recertification comprehensive assessment was completed timely, but the medication profile was not updated.</p>	G 0337	G 337 - Director of Nursing inserviced staff on July 24, 2015 regarding regulations on Medication Profiles. Medication Profiles must be updated at least once every 60 days from SOC. Medication Profiles include a review of all medications that patient is currently using in order to identify any potential adverse effects, significant side effects, significant drug interactions, duplicate therapy, and high risk medications To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited using the updated chart audit checklist, specifically highlighted to whether or not a medication profile has been completed with every SOC, resumption of care, recertification. This is evident by a completed medication profile update at least once every 60 days within the patient's chart. Quarterly review to be initiated on July 27, 2015. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur.	07/27/2015

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G 0339 Bldg. 00	<p>3. Clinical record #10, SOC date 5/25/14, contained a medication profile dated 5/7/15 and another one dated 1/8/15, a 4 month period between updated medication profiles.</p> <p>4. Interview on 7/7/15, at 1:00 PM, employee A, administrator, and employee B, registered nurse (RN), agreed the medication profiles were not updated routinely every 60 days for these patients.</p> <p>5. Agency policy titled " Medication Profile", no date, states, "Purpose: To list and notify physician of medications ... The medication profile will be updated at least every 60 days or more often as needed."</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p>			

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NAME OF PROVIDER OR SUPPLIER  NOBLE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2449 45TH STREET SUITE D HIGHLAND, IN 46322		
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	<p>Based on clinical record review, interview, and agency policy and procedure review the agency failed to ensure follow up comprehensive assessments were completed every 60 days for 3 of 10 records reviewed (#3, #5 and #10).</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. Clinical record #3, start of care (SOC) date 2/16/15, failed to evidence any 60 day follow up assessments occurred since the SOC date.</li> <li>2. Clinical record #5, SOC date 2/10/15, failed to evidence any 60 day follow up assessments occurred since the SOC date.</li> <li>3. Clinical record #10, SOC date 5/25/14, failed to evidence any 60 day follow up assessments occurred since the SOC date.</li> <li>4. Interview on 7/2/15, at 3:00 PM, employee A, administrator, and employee B, registered nurse (RN), indicated that they were unaware follow-up comprehensive assessments needed to be completed every 60 days for these patients.</li> <li>5. The agency policy titled "Comprehensive Assessments of Patients" no date, states, "Purpose: To</li> </ol>	G 0339	<p>G339 - The Director of Nursing will inservice all staff on July 24, 2015 regarding State and Federal Regulations on Comprehensive Assessments that they must be updated and revised within the last 5 days of every 60 days beginning with the Start of Care date, unless there is a beneficiary elected transfer, significant change in condition, or discharge and readmission during a 60 day episode. Comprehensive assessments are assigned within the last 5 days of every 60 days beginning with SOC date (this may be subject to change if there is a beneficiary elected transfer, significant change in condition, or discharge and readmission during a 60 day episode). To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for compliance using the chart audit check list for evidence of compliance. This is evident by the timely completion of a comprehensive assessment scheduled within the last 5 days from the beginning of a SOC, unless there is a beneficiary elected transfer, significant change in condition, or discharge and readmission during a 60 day episode. Quarterly review to be initiated on July 27, 2015. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur.</p>	07/27/2015	

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G 0341 Bldg. 00	<p>achieve measurable improvement in the quality of care provided ... Every second calendar month at recertification, a follow-up OASIS assessment will be performed. The follow-up skilled visit assessment shall be performed no earlier than five days prior to the last day of the certification period."</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.</p> <p>Based on clinical record review and interview, the agency failed to ensure comprehensive assessments were completed at discharge for 2 of 10 records reviewed (#5 and #10).</p> <p>Findings</p> <p>1. Clinical record #5, start of care (SOC) date 2/10/15, evidenced a discharge summary dated 2/20/15. The record failed to evidence a comprehensive discharge assessment was completed with this discharge.</p> <p>Interview on 7/2/15, at 4:05 PM,</p>	G 0341	G 341 Director of Nursing will inservice staff on July 24, 2015 regarding discharge summaries to only be completed in conjunction with Oasis Discharge, Oasis Transfer, Oasis Death, or Skilled Nurse Assessments. Directing that no discharge summary will be completed alone. To prevent this from reoccurring, during quarterly QAPI meetings, 10 charts will be audited for evidence of compliance. This will be evident by discharge summaries only being completed in conjunction with Oasis Discharge, Oasis Transfer, Oasis Death, or Skilled Nurse Assessments. Quarterly review to be initiated on July 27, 2015. The Director of Nursing will	07/27/2015

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N 0000  Bldg. 00	<p>employee A, administrator, and employee B, registered nurse (RN), indicated the discharge comprehensive assessment was not completed because the patient left the state and was discharged, but was expected to come back, so they felt she was not really discharged and no comprehensive discharge assessment was completed with this discharge.</p> <p>2. Clinical record #10, SOC date 5/25/14, evidenced a discharge summary dated 11/20/14. The record failed to evidence a discharge assessment was completed with this discharge.</p> <p>Interview on 7/2/15, at 4:30 PM, employee A, administrator, and employee B, registered nurse (RN), indicated that no comprehensive discharge assessment was completed because the patient was only discharged for insurance purposes and restarted the following day.</p> <p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 6/30/15, 7/1/15, 7/2/15, 7/6/15, and 7/7/15.</p>	N 0000	be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur.	

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N 0458 Bldg. 00	<p>Facility #: 012829</p> <p>Facility unduplicated census: 109</p> <p>Records reviewed without home visit: 5 Record reviews with home visits: 5 Total records reviewed: 10</p> <p>QR: JE 6/20/15</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on Interview, employee record review, and agency policy and procedure review, the agency failed to ensure that personnel policies were followed for 1 of 9 employee records reviewed. (Employee E)</p>			N 0458	N 458 Misinterpretation of the regulation resulted in the deficiency. With a better understanding of the regulation, the Director of Nursing in-serviced office staff on 7/24/2015 and office staff are now aware that prior to patient contact, all employees		07/24/2015

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	<p><b>Findings</b></p> <p>1. Personnel file E, physical therapist assistant (PTA), date of hire (DOH) 11/8/13 and first patient contact 12/16/13, failed to include a signed job description and a limited criminal history check. A criminal history check was requested from Crown Point Police Department, IN on 11/14/13, his city of residence. A criminal history report from the Indiana State Police was requested on 6/30/14, more than 3 months after date of hire.</p> <p>2. During an interview on 7/7/15 at 1:15 PM, employee A, administrator, indicated that a job description was not signed upon hire for the agency for employee E, PTA. Employee C, office manager, indicated that a criminal history was requested several times from the contractor and they were unable to obtain a copy from the contractor. Employee C indicated a job description was not signed upon hire for the agency for employee E, PTA.</p> <p>3. Agency policy titled "Criminal History Checks", no date, states, "Purpose: To assure that staff have not been convicted of crimes which, might endanger client safety or security. Staff constitutes, full time employees, part time, and contracted</p>		<p>INCLUDING contracted workers are to have a signed job description in their employee file. Additionally, office staff must follow policy and procedures regarding Criminal History Background checks. All new hires, including contracted employees' folders will be checked by Director of Nursing prior to patient contact for accuracy and completion of all required documents effective 7/24/2015. 10% of active employee charts will be audited for compliance during annual evaluations, which is completed annually during the month of April and to be completed no later than April 30 of that year. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>		

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N 0518 Bldg. 00	<p>individuals ... A criminal history check will be completed on all employees ... Information may be obtained by: Accessing the Indian State Police ... National Criminal Background check."</p> <p>4. Agency policy titled " Services Provided under Contract", no date, states, "Purpose: To clearly define the responsibilities of contract providers ... Provider shall conform to all applicable agency policies, including personnel contracted services."</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on observation, clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 10 of 10 clinical records reviewed (#'s 1-10).</p>	N 0518	N 518 Corrective action already taken. Office staff went to Indiana State's web site and retrieved an updated copy of Advanced Directives. Updated copy was immediately added into patient's admission packet. In addition, all active patient's have received an updated copy of Advanced Directives, which were personally	07/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
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NAME OF PROVIDER OR SUPPLIER  NOBLE HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2449 45TH STREET SUITE D HIGHLAND, IN 46322
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	<p><b>Findings</b></p> <p>1. The admission folder given to patients failed to include an updated July 2013 version of the 2004 Indiana Advanced Directives document in the admission folder that was distributed to the patients at the start of care.</p> <p>2. Interview on 7/1/15 at 4:45 PM, Employee A, administrator, acknowledged the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013).</p> <p>3. Clinical record #1, start of care (SOC) date 6/7/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 9:00 AM with patient #1, start of care (SOC) date 6/7/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>4. Clinical record #2, SOC date 2/1/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p>		<p>hand delivered to the patient's home by 07/24/2015. For patient's recently discharged in the last 30 days, copies of the updated Advanced Directive were mailed to the patient's home by 07/24/2015. Patient's Admission packet was updated by 7/24/2015 to reflect the 2013 version Advanced Directives listed on the State of Indiana's web site.</p>	

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	<p>Home Visit observation on 7/1/15 at 10:00 AM with patient #2, SOC date 2/1/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>5. Clinical record #3, SOC date 2/16/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 11:30 AM with patient #3, SOC date 2/16/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>6. Clinical record #4, SOC date 1/21/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 1:00 PM with patient #4, SOC date 1/21/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p>			

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	<p>7. Clinical record #5, SOC date 2/10/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>Home Visit observation on 7/1/15 at 3:45 PM with patient #5, SOC date 2/10/15, home folder contained a document titled "Advance Directives" not dated that contained none of the underlined topics of the effective and current Indiana advanced directives.</p> <p>8. Clinical record #6, SOC date 5/20/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>9. Clinical record #7, SOC date 12/12/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>10. Clinical record #8, SOC date 6/15/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>11. Clinical record #9, SOC date 2/1/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>12. Clinical record #10, SOC date</p>			

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N 0522 Bldg. 00	<p>5/25/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>13. Agency policy titled "Advance Directives", no date, states, "Purpose: To protect and honor the patient's right ... At the time of admission and prior to providing care, provide the patient with a written and verbal explanation of his/her rights ... including... the right to formulate Advance Directives.."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care (POC) was followed during home visit observations for 2 of 5 (# 2 and 4) home visit observations.</p> <p>Findings:</p> <p>1. During a home visit on 7/1/15 at 10:00 AM for patient #2, the administrator, employee A, completed wound care on both lower extremities. Employee A, failed to check the patients pain level during the visit.</p>	N 0522	N 522 Director of Nursing has inserviced all clinical staff on 7/24/2015 regarding understanding and complying with a patient's Plan of Care (POC). To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for evidence of compliance. This is to be evident by clinical documentation correlating with patient's POC. Quarterly review to be initiated on July 27, 2015. Additionally to prevent this from reoccurring, clinical staff will be re-inserviced regarding understanding and complying with patient's POC on	07/27/2015

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NAME OF PROVIDER OR SUPPLIER  NOBLE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2449 45TH STREET SUITE D HIGHLAND, IN 46322		
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	<p>A. Interview on 7/6/15 at 12:00 PM, employee A, administrator, agreed she did not assess the patient's pain during the visit.</p> <p>B. Clinical record #2, start of care (SOC) date 2/1/15, contained a POC dated 6/1/15-7/30/15, which stated, "SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. "</p> <p>2. During a home visit on 7/1/15 at 1:00 PM for patient #4, employee B, registered nurse, failed to assess lower extremities during home visit.</p> <p>A. Interview on 7/1/15, at 5:00 PM, employee B, RN, indicated she was nervous during the visit.</p> <p>B. Clinical record for patient #2, SOC date 2/1/15, contained a POC dated 6/1/15-7/30/15, that stated, "SN to perform inspection of patient's lower extremities every visit."</p> <p>3. Agency policy titled "Care Planning", no date, states, "Purpose: To define a systematic process to the clinicians for planning, reviewing, and revising patient/client care or services either directly or through a written agreement ...</p>		August 20, 2015. Additional Follow-up with clinical staff will be completed during annual evaluations.		

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N 0524 Bldg. 00	<p>Implementation of the planned care or services by appropriate clinicians."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care (POC) specified amount, frequency, and duration of visits ordered for 10 of 10 clinical records reviewed (#1-10).</p>	N 0524	N 524 Director of Nursing inserviced staff on July 24 2015 regarding the proper way to list frequency on the POC. All patients' admitted on or after 7/8/2015 frequency are doubled checked for accuracy prior to completion of POC. Inaccurately	07/27/2015

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care (SOC) date 6/7/15, contained a POC dated 6/7/15 - 8/5/15, that failed to evidence the duration for services to be provided..</li> <li>2. Clinical record #2, SOC date 2/1/15, contained a POC dated 6/1/15 - 7/30/15 that failed to evidence the amount, frequency or duration listed for services to be provided.</li> <li>3. Clinical record #3, SOC date 2/16/15, contained a POC dated 2/16/15 - 8/16/15, that failed to evidence the amount, frequency or duration listed for services to be provided</li> <li>4. Clinical record #4, SOC date 1/21/15, contained a POC dated 5/21/15 - 7/19/15, that failed to evidence the duration for services to be provided</li> <li>5. Clinical record #5, SOC date 2/10/15, contained a POC dated 2/10/15 - 8/10/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</li> <li>6. Clinical record #6, SOC date 5/20/15, contained a POC dated 5/20/15 - 7/18/15, that failed to evidence the duration for services to be provided.</li> </ol>		<p>listed frequency on active patients have received an addendum to clarify frequency. To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for evidence of compliance. This is to be evident by the POC containing a properly documented frequency and when required an addendum to the POC to show changes in frequency. Quarterly review to be initiated on July 27, 2015. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>	

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	<p>7. Clinical record #7, SOC date 12/12/12, contained a POC dated 5/31/15 - 7/29/15, that failed to evidence the duration for services to be provided.</p> <p>8. Clinical record #8, SOC date 6/15/15, contained a POC dated 6/15/15 - 8/15/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</p> <p>9. Clinical record #9, SOC date 2/1/15, contained a POC dated 6/1/15 - 7/30/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</p> <p>10. Clinical record #10, SOC date 5/25/14, contained a POC dated 11/21/14 - 5/21/15, that failed to evidence the amount, frequency or duration listed for services to be provided.</p> <p>11. Interview on 7/6/15, at 4:00 PM, employee A, administrator, and employee B, RN, agreed the POC's did not contain specified frequencies.</p> <p>12. Agency policy titled "Care Planning", no date, states, "Purpose: To define a systematic process to the clinicians for planning, reviewing, and revising patient/client care or services either</p>			

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N 0526 Bldg. 00	<p>directly or through a written agreement ... The plan of care, developed in accordance with the referring physician's orders, shall include ... Orders for all disciplines include amount, frequency, duration ... ."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months. Based on clinical record review, interview, and agency policy and procedure review, the agency failed to ensure the plan of care (POC) was reviewed by the physician every 60 days for 3 out of 10 (3, 5, and 10) records reviewed.</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) date 2/16/15, contained a POC dated 2/16/15 - 8/16/15, signed by primary care physician on 2/11/15. The record failed to evidence any subsequent plans of care.</p> <p>2. Clinical record #5, SOC date 2/10/15,</p>	N 0526	N 526 Director of Nursing has in-serviced all staff on 7/24/2015 that all patients total plan of care is to be reviewed by agency clinical staff and patient's physician at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a case-mix assignment; or a discharge and return to the same agency during the same 60 day episode. Comprehensive assessments are assigned for each patient receiving care at least once every 60 days. POCs are generated at least once every 60 days and sent to the physician to be reviewed and signed. To prevent this from reoccurring, during quarterly QAPI meetings, 10	07/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157650	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  07/07/2015
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N 0541 Bldg. 00	<p>contained a POC dated 2/10/15 - 8/10/15, signed by primary care physician on 2/11/15. The record failed to evidence any subsequent plans of care.</p> <p>3. Clinical record #10, SOC date 5/25/14, contained a POC dated 11/21/14 - 5/21/15, signed by primary care physician on 12/4/14. The record failed to evidence any subsequent plans of care.</p> <p>4. Interview on 7/2/15, at 3:30 PM, employee A, administrator, and employee B, registered nurse (RN), indicated that they were unaware that medicaid patients had to have POC's reviewed every 60 days by physicians.</p> <p>5. Agency policy titled "Care Planning", no date, states, "Purpose: To define a systematic process to the clinicians for planning, reviewing, and revising patient/client care or services either directly or through a written agreement ... The admitting SN/PT will initiate the written Plan of Care at the start of care, and the plan will be updated at least every 60 days."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where</p>		<p>patient charts will be audited for evidence of compliance that all patients total plan of care are reviewed at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a case- mix assignment; or a discharge and return to the same agency during the same 60 day episode. This is to be evident by completed comprehensive assessments and physician signed POC. Quarterly review to be initiated on July 27, 2015. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur</p>		

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	<p>services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record review, interview, and agency policy and procedure review the agency failed to ensure the registered nurse reevaluated the patients needs at least every 60 days for 3 of 10 records reviewed (#3, #5 and #10).</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. Clinical record #3, start of care (SOC) date 2/16/15, failed to evidence any 60 day follow up assessments occurred since the SOC date.</li> <li>2. Clinical record #5, SOC date 2/10/15, failed to evidence any 60 day follow up assessments occurred since the SOC date.</li> <li>3. Clinical record #10, SOC date 5/25/14, failed to evidence any 60 day follow up assessments occurred since the SOC date.</li> <li>4. Interview on 7/2/15, at 3:00 PM, employee A, administrator, and employee B, registered nurse (RN), indicated that they were unaware follow-up assessments / evaluations needed to be</li> </ol>	N 0541	<p>N 541 The Director of Nursing will inservice all staff on July 24, 2015 regarding State and Federal Regulations on Comprehensive Assessments that they must be updated and revised within the last 5 days of every 60 days beginning with the Start of Care date, unless there is a beneficiary elected transfer, significant change in condition, or discharge and readmission during a 60 day episode. Comprehensive assessments are assigned within the last 5 days of every 60 days beginning with SOC date (this may be subject to change if there is a beneficiary elected transfer, significant change in condition, or discharge and readmission during a 60 day episode). To prevent this from reoccurring, during quarterly QAPI meetings, 10 patient charts will be audited for compliance using the chart audit check list for evidence of compliance. This is evident by the timely completion of a comprehensive assessment scheduled within the last 5 days from the beginning of a SOC, unless there is a beneficiary elected transfer, significant change in condition, or discharge and readmission during a 60 day episode. Quarterly review to be</p>	07/27/2015

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NAME OF PROVIDER OR SUPPLIER  NOBLE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2449 45TH STREET SUITE D HIGHLAND, IN 46322		
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	<p>completed every 60 days for these patients.</p> <p>5. The agency policy titled "Comprehensive Assessments of Patients" no date, states, "Purpose: To achieve measurable improvement in the quality of care provided ... Every second calendar month at recertification, a follow-up OASIS assessment will be performed. The follow-up skilled visit assessment shall be performed no earlier than five days prior to the last day of the certification period."</p>		<p>initiated on July 27, 2015. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency will not reoccur.</p>		