	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	ľ í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 03/04/	ETED
NAME OF F	PROVIDER OR SUPPLIE		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D	<u> </u>	
NOBLE H	HOME HEALTH CA	RE LLC		HIGHL	AND, IN 46322		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
G 0000							
This visit was for a complaint survey which was fully extended.		G 0	000				
	Survey Dates: 2/25	/2021 to 3/4/2021					
	Complaints: IN00315216 - substantiated with related findings IN00332220 - substantiated with related findings IN00320943 - substantiated with related findings						
	Facility ID: 01282	9					
These deficiencies refle		reflect State Findings cited in 0 IAC 17. Refer to State Form Findings.					
	Noble Home Health Care is precluded from providing its own home health training and competency evaluation for a period of two years beginning 3/4/2021 - 3/3/2023 due to being found out of compliance with the Conditions of Participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care.						
	Quality Review con	mpleted on 4/7/2021 A4					
G 0444 Bldg. 00	484.50(c)(9) State toll free HH telephone hotline Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to						
	receive complaint HHAs. Based on record refailed to ensure pat	s or questions about local view and interview, the agency ients were advised of the state th telephone hotline contact	G 0	444	G444 – The state home health hotline document has been updated		04/16/2021

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey eted 2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
TAG	information for 3 of sample of 10 patient.  Findings include:  1. Record review of agency policy titled. Responsibility and stated, " the age and / or patient representations of the followyour state's home he agencies contact into suggestions or component of the patent of the p	Rights", number 3.001.1, which ney must inform the patient resentative orally and in wing: 49. Be informed of ealth agency hotline and the formation [sic] make plaints, or present grievances ient to the agency, es, or other persons without diation"  The admission folder received on ployee A, RN [registered nurse], he state toll free home health resion folder at a home visit for 2021 at 9:55 a.m. failed to formation about the state toll of the plaints.  The on 2/26/2021 at 10:00 a.m., to patient #2, indicated she ritten information from the late home health hotline.  The sion folder at a home visit for 2021 at 12:00 p.m. failed to formation about the state toll formation about the state toll		TAG	contact information, its hours of operation and its purpose to fill complaint. The state home here hotline information will be a component of the agency's admission packet. Patients will required to sign this document stating that they have received written and verbal instructions.  The Administrative staff will be responsible for reviewing the admission packet to ensure receipt of this signed document. Completion date 04-16-2021.	of e a alth	DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/04/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ΓE	(X5) COMPLETION DATE
G 0548	Within 48 hours of the patient's return						
Bldg. 00	home from a hosp or more for any re tests, or on physic ordered resumption Based on record revisible to the home from a or more in 1 of 1 rechospitalization revisible. The findings included 1. Record review of agency policy titled Assessment of Paties which stated, " I assessment Information most current approving on qualified patients hours following a horeason except diagnormal patients and the patients of the patients o	ital admission of 24 hours ason other than diagnostic ian or allowed practitioner - on date; iew and interview, the agency emprehensive assessment was 8 hours of the patient's return thospital admission of 24 hours cords of patients with ewed (#2).  e:  in 3/2/2021 evidenced an proper comprehensive ints (OASIS)", number 6.019.1, Policy: A comprehensive ints (OASIS) utilizing the every version will be performed as at: Start of care; Within 48 pospital discharge for any	G 0	548	G548 - Based on the Surveyor concern of the agency failing to ensure a comprehensive assessment was performed with 48 hours of a patient's return to home from a hospital admission 24 hours or more, the deficienthas been corrected by entering the comprehensive assessment that was completed on paper in the patient's EMR.  This deficiency will be prevent from recurring by discontinuing paper documentation and utilizelectronic documentation and utilizelectronic documentation and utilizelectronic documentation only. Comprehensive assessment is be completed within 48 hours patient's return home. Skill nursing staff has been in-serviand is now aware to discontinuity paper charting.  Clinical manager is responsible ensure that compliance is	thin o on of cy g nt nto ed d zing s to of ced ue	04/16/2021

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

PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING <u>00</u> COM			COMPL	MPLETED /04/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION	
TAG	order indicated the phospital from 12/18 the electronic medic [home health aide]. Review of the electre evidence a compreh performed following.  3. During an intervithe clinical manager assessment should be resumption of care, queried, the clinical	patient was admitted to the //2020 to 12/27/2020. Review of cal record evidenced HHA visits resumed on 12/28/2020. Conic medical record failed to ensive assessment was go the hospitalization.  The word of the w		TAG	maintained.		DATE	
Bldg. 00	Condition of partice coordination of see Patients are accept reasonable expectment the patient's rehabilitative, and place of residence receive an individual including any revisindividualized plant care and services patient-specific network comprehensive as identification of the and the measurable anticipates will occimplementing and care. The individualso specify the paeducation and trainteres coordinates and trainteres with the paeducation and trainteres according to the paeducation according to the paeducat	social needs in his or her  Each patient must calized written plan of care, sions or additions. The of care must specify the necessary to meet the eds as identified in the esessment, including e responsible discipline(s), le outcomes that the HHA cur as a result of coordinating the plan of lalized plan of care must atient and caregiver ning. Services must be dance with accepted						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/04/2021		
		157650	B. W.			03/04/	2021
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
TAG	Based on observation interview, the home they were able to m G0570); failed to enhome health service the plan of care was of care was signed by tag G0572); the plan medications, medicipatient-specific interpatients (see tag G0 staff promptly alerte to changes in the particular (see tag G0590); the plan of current health status patient (see tag G05 communicated to the physician (G0598); amongst the differency provided care to agree patients were provided care to agree to the provide	on, record review and health agency failed to ensure eet the patient needs (see tag assure each patient received as written in their plan of care, a individualized, and the plan by the patient's physician (see an of care contained all all equipment and arventions and goals for their 574); the home health agency ed the primary care physician tients condition (see tag and nursing needs of the sand nursing needs of the sean and patient's there was coordination of care and disciplines / entities that ency patients (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag et ag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag et ag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag et ag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag et ag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag et ag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication list (see tag G0606); ded a written schedule of visits atients were provided a ent medication of care at the plant was a schedule of visits atients were provided a ent medication of the plant was a schedule of visits atients were provided a ent medication of the plant was a schedule	G 0		G570 — Patient #2. Plan of care has be updated. A signed addendum been submitted and received for the physician that reflects corroumber of hours the patient is receiving. Patient #5 was discharged from the agency. Returned to school Home Health Services transfer to another agency. Patient #6. Patient was discharged from the agency. Plan of care has been resubmit to the physician to cover the hipprovided prior to the patient's discharge. Patient #7. An addendum to Phas been submitted to the physician to reflect the correct number of hours. Patient #9 was discharged and assisted with transferring servito another agency.  All active medical charts have been reviewed to verify that he requested on their POC are the number of hours being provided. All nursing notes will be review weekly to ensure vital signs an services provided are completed. A log has been developed to the and monitor when plan of care are submitted to physician and returned. The administrative is regarding accepting patients for	een has from ect mol. rred The fitted ours OC dices eed. eed. eed. eed. eed. eed. eed. ee	DATE 04/16/2021
		ician establishes and reviews a r the patient. The plan is			treatments only on the reasons expectation that the patient's		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157650	B. W	ING		03/04/	2021
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
NOBLET	IOME LIEALTILOA	DELLO			TH STREET SUITE D		
NOBLE F	HOME HEALTH CA	RE LLC		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	updated and mainta	ined as part of the agency's			nursing and home health need	ls	
	clinical record Pr	ocedure: 1. The physician sets			can be provided in their place	of	
	up a Plan of Care, v	which includes the diagnosis,			residency.		
	prognosis, goals to	be accomplished, in order for			•		
	each service, an item of drugs and equipment to				To prevent this deficiency from	ı	
	be provided by the	agency. 2. All orders on the			recurring, the Administrator wil	ll be	
	CMS 485 will be sp	pecific to the client condition in			responsible for reviewing 50%		
	needs 5. Copies	of the plan of care in other			the plan of cares Quarterly to		
	orders requiring a p	hysician's signature should be			ensure each patient receives t	he	
	filed in the client re	cord within 60 days of receipt			home health services written in		
	in office 7. The	physician and appropriate			their plan of care and that the		
		ill review an recertify the			of care is individualized and si		
	written plan of care	at least once per episode and			by the patient's		
	as warranted by the	patient's condition 9. The			physician. Completion date		
	agency's profession	al staff will review the clinical			04-16-2021 ="" b="">		
	records on a continu	uous basis to ensure each					
		he patient and that additional					
	_	are present in the clinical					
	record "	1					
	2. An undated agen	cy policy number 6.016.1, with					
	_	Care Planning" stated,					
		e a systematic process to the					
	_	ing, reviewing and revisiting					
	•	ices either directly or through a					
	1 ^	Policy: 1. It is the policy of					
	_	ride individualized, planned,					
		eatment and or services based					
		ds and goals with the input of					
		urpose of achieving positive					
	outcomes."	arpose of acmeving positive					
	outcomes.						
	3 An undated ager	ncy policy titled, "Rights,					
	_						
	Responsibilities and Ethics", number 3.001.1,						
	which stated, " 35. Receive the care necessary						
	to assist you in attaining optimal levels of						
	health"						
	4 60 1 1 1 1 1 6 1 1 10 1 10						
		eview on for patient #2, start of					
	care 8/13/2020, cert	tification period of 12/11/2020 to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		157650	B. WING		03/04/2021		
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D			
NOBLE H	HOME HEALTH CA	RE LLC	HIGHLAND, IN 46322				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION liagnosis of Multiple Sclerosis,	TAG	DEFICIENCE?	DATE		
		ent identified by the clinical					
	manager as the prio	r authorization request for					
	*	2021 to 7/25/2021. This					
	document stated, " HHA [home health aide] to						
	provide assistance with all ADLS [activities of						
	daily living] and safety measures 6 hr Mon to Sat						
	[6 hours Monday to Saturday]"						
	During an interview on 3/4/2021 at 3:48, the						
		dicated the prior authorization					
		ccurate to what the patient					
	needed.						
	Clinical record revi	ew evidenced an agency					
		ome Health Certification and					
	Plan of Care", signe	ed by the physician on					
	2/27/2021, which st	tated, " Home health aide					
		de 6 hours a day, up to 6 days					
		ks" Review of the patient's					
		ecord, evidenced the agency					
	_	ring HHA hours: for the week					
		2/2021, the patient received 6 days, the week of 1/3/2021 to					
		nt received 6 hours per day for 4					
		of 1/10/2021 to 1/16/2021, the					
		ours per day for 5 days, the					
	_	to 1/30/2021, the patient					
	_	r day for 5 days, and for the					
		2/6/2021, the patient received 6					
	hours per day for 5	days.					
	During an interview	v on 2/26/2021 at 9:59 a.m.,					
	person C, caregiver to patient #2, indicated HHA hours were missed because staff did not show up.						
		that HHA C is the only HHA					
	who works as scheduled.						
	When informed of t	the findings on 3/4/2021 at					
		ical manager stated. "It's not for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPL 03/04/	ETED	
	ROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	I IATE	(X5) COMPLETION DATE
TAG	lack of trying. We aides." The clinical failed to evidence d communication with 5. Clinical record r care 8/31/2020, cert 1/29/2021, primary evidenced an agenc Health Certification stated, " Home provide 6 (up to 12) based on patient new 12 hours of assistant utilizing her home rehours. On occasion when that happens, to 12 hours on those Review of the patien evidenced the agence HHA hours: for the 1/2/2021, the patien and 6 hours a day for 1/3/2021 to 1/9/202 per day for 3 days; 1/17/2021, the patien 3.5 hours one day, a for the week of 1/24 received 3.5 hours one day, a for the week of 1/24 received 3.5 hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day. So hours one day, a for the week of 1/24 received 3.5 hours one day.	have offered. They refuse I manager indicated the agency ocumentation of the the family regarding staffing.  eview for patient #5, start of tification period 12/29/2020 to diagnosis of legal blindness, y document titled, "Home and Plan of Care", which Health Aide requesting to ) hours a day, 5 days a week; ed / request. Patient requires tice a day; at this time she is making service for 6 of those 12 to, they are not available and patient will request to use up	IAG	DEPCIENCE		DATE
	aying winte.					

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AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER  157650	A. BUILDING B. WING	G <u>00</u>	COMP	LETED L/2021
	PROVIDER OR SUPPLIER		2449	EET ADDRESS, CITY, STATE, ZIP COI 9 45TH STREET SUITE D GHLAND, IN 46322	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE
	#6, start of care 6/2 plan of care had bee the patient's physici 2/16/2020 - 4/15/20 the patient received certification period. being provided to the plan of care.  Record review evid "Indiana Medicaid Indiana Ind	eview on 3/4/2021, for patient 1/2019, failed to evidence a en established and signed by an, for certification period 1/20. Record review evidenced 4/8 hours per week during this Record review evidenced care the patient without a signed 1/28/2020. This document had ervice Requested" which cription: Home Visit NOS [not 1] Units Requested: 1/416.00 hours per week] Units 1/20 [49.2 hours per week] " do to evidence the patient to of service hours needed, as ency.  1/2 on 3/4/2021, at 11:23 AM, the dicated the patient was very found and plan of physician for an authorized 1/2017, primary diagnosis of the enced a document titled iffication and Plan of Care" for 1/14/2021 - 3/14/2021. This eas subtitled "Orders and stated, "Home health aide the up to 2 hrs [hours] per day, 6 weeks [up to 14 hours per y and/or duration may be an available caregiver is				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/04/2021	
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	present, willing, and able to assist "Record review evidenced this patient received care for 2 hours per day, 3 days a week (6 hours per week), since 12/14/2020.  Record review evidenced a document titled "Indiana Medicaid Prior Authorization Update Notification" dated 10/19/2020. This document had an area subtitled "Service Requested" which stated "Service Description: Home Visit NOS				
	Units Requested: 36 per week] Units to 13 hours per wee evidence the patient	cription: Home Visit NOS 64.00 [equivalent to 14 hours Authorized: 338.00 [equivalent ck] " Record review failed to treceived the amount of cd, as requested by the			
	clinical manager in	on 3/4/2021, at 11:32 AM, the dicated the patient's hours were to the caregiver's request for h aides only.			
	#9, start of care 10/2 encephalopathy (disfunction), evidenced Health Certification certification period document had an ar Treatments" which requesting to provid 7 days a week [70 h	eview on 3/4/2021, for patient 30/2019, primary diagnosis of sease which alters brain d a document titled "Home and Plan of Care" for 6/26/2020 - 8/24/2020. This rea subtitled "Orders and stated, "Home health aide de up to 10 hours a day, up to hours per week] for 26 weeks idenced an average of 46 hours health aide services provided a period.			
	Record review evidenced a document titled "Indiana Medicaid Prior Authorization Update Notification" dated 4/30/2020. This document had an area subtitled "Service Requested" which				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 03/04/2021	
	ROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP CO 5TH STREET SUITE D AND, IN 46322	D	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION cription: Home Visit NOS	TAG	DEFICIENCY)		DATE
	Units Requested: 18	Authorized: 1820.00 "				
	Record review failed to evidence the patient received the amount of service hours needed, as requested by the agency.					
	During an interview on 3/4/2021, at 12:41 PM, the clinical manager indicated hours were not being					
	met due to the tremendous difficulty the agency					
	had staffing the patient's home for 10 hours a day.					
	9. During an interview on 3/4/2021, at 3:48 PM, the clinical manager indicated the PA [prior authorization for Medicaid] should be accurate to the patient's needs.					
	the clinical manager	view on 3/4/2021, at 3:53 PM, r indicated they did not know a skilled nurse to meet the h aide visits.				
	17-13-1(a)					
G 0572	484.60(a)(1)					
Bldg. 00	services that are very plan of care that icomeasurable outcomes is established, per signed by a doctor or podiatry acting their state license, of a physician or all patient under a plat completed until after physician or allowers.	receive the home health written in an individualized dentifies patient-specific mes and goals, and which iodically reviewed, and of medicine, osteopathy, within the scope of his or certification, or registration. lowed practitioner refers a an of care that cannot be ter an evaluation visit, the ed practitioner is consulted ans or modifications to the				

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i f		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650		JILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>03/04</b> /	ETED	
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322				
	(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
		failed to ensure each services written in the records reviewed (# of care was individuated and the findings included of care was signed by 10 clinical records in the findings included of the findi	, ,	G 0	572	G572 – Pt. #6 Patient was discharged from the agency. plan of care has been resubm to the physician to cover the h provided prior to the patient's discharge. Pt #7. An addendum to POC h been submitted to the physicia reflect the correct number of hours. Pt #9 was discharged and assisted with transferring serv to another agency. Pt #10 - An addendum was submitted to physician to refle correct hours of service. Pt. #3 - The Plan of Care for h been signed and entered in chet en signed and entered in chet en	itted ours itted ours nas an to ices ct as nart. vided isit e plan are n II es ent ices d	04/16/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		157650	B. WING 03/04/2021			2021	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
NODIEL	IOME LIEALTH OA	DELLO			STH STREET SUITE D		
NOBLE HOME HEALTH CARE LLC				HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	a subject subtitled "	Care Planning" stated,			patient's physician.		
	"Policy: 1. It is the	policy of this Agency to					
	1	zed, planned, appropriate care,					
	1 ~	vices based on the patient's			To prevent this deficiency from	ı	
		h the input of the patient for			recurring, the clinical manager		
	_	eving positive outcomes"			daily communicate any change		
					to the frequency, interventions		
	3. Clinical record r	eview on 3/4/2021, for patient			goals to the professional staff		
		1/2019, failed to evidence a			will review and recertify the wr		
		en established and signed by			plan of care at least once per		
		an for certification period			episode and as warranted by t	he	
	2/16/2020 - 4/15/2020.				patient's condition. Completion		
					date 04-16-2021		
	During an interview on 3/4/2021, at 11:23 AM, the						
	_	dicated the lack of the patient's					
	_	oversight. They further					
	1 ~	known if a plan of care had					
		sician for a signature.					
	1 3	5					
	4. Clinical record re	eview on 3/4/2021, for patient					
		/2017, primary diagnosis of					
		enced a document titled					
		ification and Plan of Care" for					
		1/14/2021 - 3/14/2021. This					
		ea subtitled "Orders and					
		stated, "Home health aide					
		le up to 2 hrs [hours] per day,					
		6 weeks Frequency and/or					
		creased if/when an available					
	1	, willing, and able to assist "					
		,					
	Record review evid	enced this patient received					
		day, 3 days a week since					
	_	d review failed to evidence					
		ne health services written in					
	their plan of care.	no nearth 501 v1005 written in					
	men plan of care.						
	During an interview on 3/4/2021, at 11:32 AM, the						
		dicated the reason this patient					
	_	nours as ordered on the plan					
	and not receive the r	loans as ordered on the plan					

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	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	#7. It is their prefere furnish care on beha	erson D, caregiver for patient ence to only utilize HHA D to alf of the agency.			
	#9, start of care 10/2 encephalopathy (dis function), evidences Health Certification certification period	30/2019, primary diagnosis of sease which alters brain d a document titled "Home and Plan of Care" for 6/26/2020 - 8/24/2020. This			
	Treatments" which requesting to provid 7 days a week for 2 failed to evidence the	ea subtitled "Orders and stated, "Home health aide de up to 10 hours a day, up to 6 weeks " Record review he plan of care was eet the patient's needs.			
	#10, start of care 2/2 progressive mutifoc of the white matter document titled "Ho Plan of Care" for ce 2/14/2021. This document Treatment of Care and Care a	eview on 3/4/2021, for patient 26/2019, primary diagnosis of cal leukoenchalopathy (disease of the brain), evidenced a come Health Certification and ertification period 12/17/2020 - cument had an area subtitled nents" which stated, "Home			
	days a week Fre	ng to provide 4 hours a day, 7 equency and/or duration may en an available caregiver is d able to assist "			
	care for 6 hours a da 12/17/2020. Record	enced this patient received ay, 7 days a week since d review failed to evidence the lividualized to meet the			
	clinical manager in	on 3/4/2021, at 1:07 PM, the dicated the duration stated on s an oversight, and should er day.			

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIEF		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	#3, start of care 2/1 1/12/2021 to 3/2/20 chronic obstructive that causes long-ter evidenced an agenc Health Certification of care was not sign On 3/4/2021 at 12:0	eview on 3/2/2021 for patient 7/2020, certification period 21, primary diagnosis of pulmonary disease [a disease m breathing problems], y document titled, "Home and Plan of Care". This plan led by the physician.  12 p.m., the clinical manager was lings and offered no additional			
	#4, start of care 9/1 12/28/2021 to 2/25/ blindness and cereb agency document ti Certification and PI had a subcategory t Treatments", which change inner cannu within a tracheostor SN [skilled nurse] t tolerated and off at	an of Care". This plan of care itled, "Orders and stated," SN [skilled nurse] to la [the inner tube that fits my tube] daily in the a.m o place rolled towel in hands as HS [bedtime] SN to apply ght] hand splints daily as			
	clinical manager inc and placing rolled t	y on 3/4/2021 at 12:20 p.m., the dicated applying hand splints owels in hands should be narrative section of the			
	agency documents (Shift Assessment", nursing visit notes be notes with the follow	ew evidenced a group of itled, "Nursing Flow Sheet identified as the skilled by the clinical manager. The wing dates failed to evidence ts and placing rolled towels in			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI 03/04	LETED
	ROVIDER OR SUPPLIER		2449 45	ADDRESS, CITY, STATE, ZIP CO STH STREET SUITE D AND, IN 46322	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR hands: 12/28/2021,	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 12/29/2021, 12/30/2021, 1/3/2021, 1/4/2021, 1/5/2021,	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	1/6/2021, 1/7/2021, 1/14/2021, 1/15/2021, 1/18/2021, 1/19/2021, 1/22/2021, 1/23/2021/26/2021, 1/27/2021, 1/30/2021, 2/7/2021, 2/11/2021, 2/15/2021, 2/18/202, 2/15/2021, 2/18/202	1/9/2021, 1/10/2021, 1/13/2021, 21, 1/16/2021, 1/17/2021, 21, 1/20/2021, 1/21/2021, 21, 1/20/2021, 1/21/2021, 21, 1/24/2021, 1/25/2021, 21, 1/28/2021, 1/29/2021, 21, 2/1/2021, 2/4/2021, 2/5/2021, 2/8/2021, 2/9/2021, 2/10/2021, 21, 2/13/2021, 2/14/2021, 21, 2/19/2021, 2/20/2021, 21, 2/19/2021, 2/20/2021, 21, 2/13/2021, 2/24/2021 and				
	following dates failinner cannula of the 12/28/2021, 12/29/2 1/2/2021, 1/3/2021, 1/7/2021, 1/15/2021, 1/16/202 1/19/2021, 1/23/2021, 1/24/202 1/27/2021, 1/28/202 1/31/2021, 2/12/2021, 2/13/2021, 2/13/202 2/18/2021, 2/19/202	d nursing notes on the ed to evidence changing the tracheostomy tube: 2021, 12/30/2021, 1/1/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/10/2021, 1/13/2021, 1/14/2021, 21, 1/17/2021, 1/18/2021, 21, 1/21/2021, 1/22/2021, 21, 1/25/2021, 1/26/2021, 21, 1/29/2021, 1/30/2021, 2, 2/4/2021, 2/5/2021, 2/6/2021, 2/9/2021, 2/10/2021, 2/11/2021, 21, 2/14/2021, 2/15/2021, 21, 2/20/2021, 2/21/2021, 21, 2/24/2021 and 2/25/2021.				
	stated, " Notify greater than (>) or l than (>) 110 or less greater than (>) 24 c [blood pressure] gre (<) 90. Diastolic B.	physician of: Temperature ess than (<) 97. Pulse greater than (<) 60. Respirations or less than (<) 12. Systolic BP eater than (>) 160 or less than P greater than (>) 90 or less s order failed to indicate how were to be taken.				

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  157650		A. BUILDING B. WING	00	COMPLETED 03/04/2021	
	ROVIDER OR SUPPLIER		2449	r address, city, state, zip cod 45TH STREET SUITE D LAND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	clinical manager inc checked on patient # Review of the skille 1/9/2021, 1/10/2021 2/20/2021, 2/21/202 each signed by emp	on 3/4/2021 at 12:08 p.m., the licated vital signs should be #4 every 4 hours at minimum.  d nursing notes dated , 1/24/2021, 2/6/2021, 2/7/2021, 21, 2/24/2021, and 2/25/2021, loyee E, RN [registered nurse], my patient blood pressures.			
G 0574  Bldg. 00	The individualized the following: (i) All pertinent dia (ii) The patient's monognitive status; (iii) The types of seequipment require (iv) The frequency made; (v) Prognosis; (vi) Rehabilitation (vii) Functional lim (viii) Activities perrous (ix) Nutritional require (ix) Nutritional require (ix) All medications (ix) Safety measurinjury; (xii) A description emergency depart re-admission, and to address the uncondition (ix) Patient and catraining to facilitate (ix) Patient-specifieducation; measure in the following individual in the following in t	ervices, supplies, and d; and duration of visits to be  potential; itations; mitted; uirements; eand treatments; es to protect against  of the patient's risk for ment visits and hospital all necessary interventions derlying risk factors. aregiver education and			

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  157650		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/04/2021		
	PROVIDER OR SUPPLIER			2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	directives; and (xvi) Any additional physician or allow to include.  Based on observation	elated to any advanced al items the HHA or red practitioner may choose on, record review, and	G 0	574	G574 - Pt.#1 Medication profil	le	04/16/2021
	individualized plan safety measures, mo out of 8 active patie	cy failed to ensure the of care included all services, edications and treatments in 6 ent records out of a total ds reviewed (#1, #2, #3, #4, #8,			has been updated to indicate treatment and medication purpose, as well as location for application of ointments. Pt.#2 A letter of coordination been sent for signature to the agency providing skilled nursi services. An addendum has be	nas ng een	
	agency policy titled 6.016.1, which state developed in according physician's orders, Name of the patient	on 3/2/2021 evidenced an I "Care Planning", Number ed, " The plan of care, dance with the referring may include, but not limited to: t Medications: dose / safety measures"			submitted to physician to incluall safety precautions. Pt.#3. Medication profile has bupdated to include the route of administration of medication. Addendum has been submitted physician to include all safety precautions. Pt.#4 Medication profile has bupdated to indicate PRN use a	peen If An d to een	
	#1, start of care 12/ 1/18/2021 to 3/18/2 quadriplegia [paraly evidenced a docum Certification and Pl	review on 3/2/2021 for patient 26/2013, certification period 2021, primary diagnosis of yesis from the neck down], ent titled, "Home Health an of Care". This plan of care obysician on 3/2/2021.			location of application of creat or ointments. An addendum has been submitted to physician to update orders, treatment and frequency of vital signs. Pt.#10 An addendum has been submitted to physician to update all PRN medications.	ms nas o	
	"Medications" which Maximum Strength thin layer to affected This order failed to of the as needed medialso stated, " Pr	d a subcategory titled, ch stated, " Desitin External 40% thin layer Apply d area PRN [as needed]". evidence an indication for use edication. This subcategory omethazine VC / Codeine Oral 5 - 5 - 10 mg [milligram] / 5 mL			All active medical charts were reviewed and updated as nee to include care coordination or other agencies providing serv Safety measures have been a to home health aide care plan The administrator in-serviced	ded f ices. idded	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		157650	B. W	ING		03/04/	/2021
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP COD		
NODIE		DELLO		1			
NOBLE F	HOME HEALTH CA	RE LLC		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	[milliliter], 5 mL tid	d [three times a day] prn [as			nursing staff on documenting		
	needed] (SN [skille	ed nurse] to administer PRN)"			medications and treatments to	)	
	This order failed to	evidence an indication for use			include name of medication,		
	of the as needed me	edication. This subcategory			purpose, frequency and route	and	
	also stated, " Ba	citracin External [a topical			location for application of		
	antibiotic] 500 unit	/ gm [gram] 1 apply to affected			ointments and creams.		
	area as needed (SN	to administer PRN)" This			To prevent this deficiency fron	n	
	order failed to evide	ence an indication for use as			recurring, the clinical manager	will	
	well as a location for	or application. This			be responsible for reviewing a	II	
	subcategory also sta	ated, " Santyl External [an			clinical records once per episo	ode	
	ointment to help he	al wounds] 250 unit / gm 1ml			and as warranted for safety		
	daily PRN (SN to administer PRN)" This order				measures, medications and		
	failed to evidence an indication for use as well as				treatments and that coordinati	on	
	a location for applic	eation.			of care is on plan of care.		
					Completion Date 4-16-2021		
	During an interview	on 3/4/2021 at 10:50 a.m., the					
		dicated any medication ordered					
	"as needed" should	have an indication for use					
	and all orders for al	l topical medications should					
	include location for	application.					
	The subcategory of	"Medications" in the plan of					
		Naproxen Sodium Oral [an					
		medication] 220 mg [milligram] 1					
		blet every 6-8 hours as needed					
	* /	ninister PRN) Klonopin Oral					
	* `	edication] 1 mg 1 tab (s) daily					
	_	PRN) Trintellix [an					
		al 10 mg 1 tab (s) daily (SN to					
		Gabapentin Oral [a					
	· · · · · · · · · · · · · · · · · · ·	treat seizures or nerve pain					
		cap po [by mouth] nightly. (SN					
		) Cholecalciferol [vitamin					
		nicrograms] (1000 UT) 1 cap (s)					
	1 caps po [by moutl	h] 2 x day (2000 units po daily).					
	(SN to Administer I	PRN) Pantoprazole Sodium					
	[a medication used to help control stomach acid]						
	Oral 40 mg 1 tab (s)	) by mouth 2 x day (SN to					
		Baclofen [a muscle relaxant]					
		) 40 mg 4 times a day (SN to					
		- • •	1				İ

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	ENT OF DEFICIENCIES  N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIED		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	mg 1 suppository(i (SN to Administer medication used to appetite] Oral 2.5 n day (SN to Adminimedication for commouth daily (SN to orders failed to cleat to take the medicat of administering by needed.	Dulcolax Rectal [a laxative] 10 es) Rectally every other day PRN) Dronabinol [a treat nausea or lack of ng 1 cap (s) by mouth 2 times a ster PRN) Senna [a stipation] Oral 2 tab (s) by administer PRN)" These arly indicate if the patient was ion as needed, or if only the act or the skilled nurse was as			
	manager stated abo plan of care, "That The clinical manag	ut the medication orders in the needs to be more specific". er indicated the agency failed of care included complete, clear			
	at 9:30 a.m., the pa PEG tube [a feedin stomach through th [a tube inserted to o	visit for patient #2 on 2/26/2021 tient was observed to have a g tube directly inserted to the e abdomen], a Foley catheter drain the bladder], and a num-assisted closure][a device d healing].			
	employee C, HHA skilled nursing serv	v on 2/26/2021 at 9:59 a.m., [home health aide], indicated rice from entity A managed the theter, and Wound VAC.			
	start of care 8/13/20 12/11/2020 to 2/8/2 Multiple Sclerosis, document titled, "F	new on 3/2/2021 for patient #2, 2020, certification period 2021, primary diagnosis of evidenced an agency Iome Health Certification and s plan of care was signed by the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/04/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAG	physician on 2/27/2 subcategory titled, This subcategory far Foley catheter, and care failed to mentifer from entity A.  On 3/4/2021 at 11:: informed of the fine documentation.  Review of the plan subcategory titled, subcategory stated, Oral 5 mg [milligrar mouth two times day fever reducer and by (s) Take one tablet of care had another Measures". This subleding Precaution During an interview clinical manager in should be included taking blood thinner.  4. Clinical record in #3, start of care 2/1 1/12/2021 to 3/2/20 chronic obstructive that causes long-ter evidenced an agence Health Certification of care had a subcate which stated, " inhaled medication Inhalation 200 mcg	2021. The plan of care had a "Orders and Treatments". stiled to include the PEG tube, Wound VAC. The plan of oned skilled nursing service  12 a.m., the clinical manager was dings and offered no further  of care evidenced a "Medications". This "Apixaban [a blood thinner] mm] 1 tab (s) Take one tablet by stily Aspirin [a pain and lood thinner] Oral 81 mg 1 tab by mouth daily" The plan subcategory titled, "Safety abcategory failed to evidence ins.  or on 3/4/2021 at 11:00 a.m., the dicated Bleeding Precautions in the plan of care for a patient					DATE
	_	erol [an inhaled medication for					

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	ENT OF DEFICIENCIES  N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 03/04/	ETED
	PROVIDER OR SUPPLIEF		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	[milligrams per mill lungs every 4 hrs P. HFA [an inhaled m problems] Inhalatio every 4 hours." The subcategory titled, indicated the patienthat turns liquid me inhaled]. The inhal care failed to indicate or nebulizer. The offailed to evidence a When informed of the 11:48 a.m., the clin where we'd need to The subcategory of "Medications" also thinner] Oral 2.5 m tablet by mouth twith had another subcated Measures". This subleding Precaution During an interview clinical manager in should be included taking blood thinner  5. Clinical record r #4, start of care 9/1 12/28/2021 to 2/25/blindness and cerebagency document tit Certification and Pl had a subcategory t stated, " Robitu	the plan of care titled stated, " Eliquis [a blood g [milligram] 1 tab(s) Take one ce a day" The plan of care egory titled, "Safety abcategory failed to evidence ins.  V on 3/4/2021 at 11:00 a.m., the dicated Bleeding Precautions in the plan of care for a patient				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE COMPL <b>03/04</b> /	ETED
	PROVIDER OR SUPPLIER		2449	T ADDRESS, CITY, STATE, ZIP COD 45TH STREET SUITE D ILAND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION needed] Dulcolax [a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	laxative] Rectal 10 daily PRN Fleet mg/30 mL 30 mL 1	mg 1 Suppository(ies) Rectally t Bisacodyl [a laxative] Rectal 10 l bottle Rectally daily PRN" failed to evidence an				
	"Medications" also to coat apply topica Triamcinolone Acetopical steroid crear PRN A & D Zir cream for skin irrita peri area PRN"	the plan of care titled stated, " Desitin External lly to peri area PRN tonide External 0.1% QS [a m] apply topically to peri area are Oxide External QS [a topical ation] apply topically to affected These medications failed to ion for as needed use.				
	"Medications" also External [a topical a topically to affected Hydrocortisone Ace External 2.5% QS a Ketoconazole Aceto 2% QS apply topica medications failed t	etate [a topical steroid cream]  apply topically PRN  bonide [a topical anti-fungal]				
	clinical manager in application should be medications ordered	or on 3/4/2021 at 12:05 p.m., the dicated the location for the listed for all topical d When informed of the li manager stated, "It's				
	which stated, " I Temperature greate	'Orders and Treatments",				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	r í	JILDING	nstruction 00	(X3) DATE : COMPL 03/04/	ETED
	PROVIDER OR SUPPLIEF			2449 45	ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Respirations greater Systolic BP [blood or less than (<) 90. 90 or less than (<) 60 indicate how frequent taken.  During an interview clinical manager in checked on patient: When informed of twas silent. 6. Clinifor patient #8, start diagnosis of hemiple one side of the body document titled "He Plan of Care" for cell 1/29/2021. This do "Medications" which Oral 300 MG [millimouth daily PRN [a [stool softener] Ora [by mouth] BID [tw. Record review faile PRN medications.  7. Clinical record relations.  7. Clinical record relations.  7. Clinical record relations of the whith evidenced an agence Health Certification period document had an arwhich stated " Medication period document had an	r than (>) 24 or less than (<) 12. pressure] greater than (>) 160 Diastolic BP greater than (>) 50" This order failed to ently vital signs were to be  on 3/4/2021 at 12:08 p.m., the dicated vital signs should be #4 every 4 hours at minimum. Sindings, the clinical manager fical record review on 3/4/2021, of care 6/10/2019, primary egia (paralysis or weakness on and and pritification period 12/1/2020 - cument had an area subtitled with stated " Xanax [sedative] grams] 1 cap(s) [capsules] by the sneeded] Docusate Sodium 1 100 MG 1 Tab(s) [tablets] PO for times a day] PRN "  d to evidence indications for all eview on 3/4/2021, for patient 26/2019, primary diagnosis of cal leukoencephalopathy enatter of the brain), y document titled "Home and Plan of Care" for 12/17/2020 - 2/14/2021. This ea subtitled "Medications" iralax [laxative] Oral 17 GM I packet daily PRN Tylenol fever reducer] Oral 325 MG 2 [16 Hours PRN " Record dence indications for all PRN					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 03/04/2021	
	ROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 45TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
G 0590 Bldg. 00	administrator and clear the indications for a listed on the plan of stated, "Okay."  17-13-1(a)(1)(D)(ii) 17-13-1(a)(1)(D)(ix) 484.60(c)(1) Promptly alert releated the HHA must prophysician(s) or allochanges in the part that suggest that cachieved and/or the altered. Based on record reversible for over a subject titled "Num" Purpose: To ensure patient care are provisted to a gency the agency's director of nursing, responsible for over of patient care 2. services that work unagency and provide	evant physician of changes omptly alert the relevant owed practitioner(s) to any tient's condition or needs outcomes are not being nat the plan of care should eiew and interview, the agency want changes in the patient's comptly alerted to the clinical records reviewed. (#7, e:  e:  exp policy, number 6.020.1, with rese Supervision" stated, e that all daily operations and reded in a professional state regulatory guidelines director of nursing, alternate and/or case manager are seeing the clinical operations  The DON will oversee all nder the licensure of the in services on an ongoing cy compliance to state and	G 0590	G590- Pt.#1 The patient's physician of notified of the deviation from the plan of care and this was documented in the clinical recept.#9 The patient is no longer active. Pt.#5 The patient is no longer active. Pt.#3 The plan of care has been submitted to the correct primar physician for signature and received.  All active medical charts have been reviewed to verify correct primary care physician The deficiency will be prevent from recurring by promptly alled the primary care physician to	en ry

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER HOME HEALTH CARE LLC	2449 45	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	2. An undated agency policy, number 6.016.1, with a subject titled "Care Planning" stated, "14. Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care. Changes will be written, timed /dated, and signed by the qualified clinician and physician making the changes 18. If person to person contact was not completed or if awaiting a return response, all Contacts and interactions shall be documented. The agency shall have a written policy regarding how the agency will intervene if the attending care provider cannot be contacted or does not respond timely"  3. Clinical record review on 3/4/2021, for patient #7, start of care 4/5/2017, primary diagnosis of cerebral palsy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 11/15/2020 - 1/13/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide up to 2 hrs [hours] per day, 7 days a week for 26 weeks Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist"  Record review evidenced an agency document titled "Missed Visit Form (HHA Visit)" which was digitally signed by HHA H, on 11/24/2020. This document stated "Reason: Other (Specify) Comments: [left blank] MD [doctor of medicine] Notified: No "Record review failed to evidence the patient's physician was notified of the deviation from the plan of care.  During an interview on 3/4/2021, at 11:40 AM, the clinical manager indicated notification to the physician of the missed visit was not documented in the clinical record.		changes in the patient's condiincluding a requested deviation made by the patient/caregiver the patient's scheduled hours. The primary physician will be notified and an order obtained amend plan of care. Clinical Manager will promptly update of care and patient profile.  The Clinical manager will be responsible to review all plan cares and communicate any changes or updates to the frequency, interventions and go to the professional staff and we review and recertify the writter plan of care at least once per episode and as warranted. The will be added as a component the quality improvement progrom Completion Date 4-16-2021	n to to  to plan  of  coals ill n is of

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  157650		A. BUILDING B. WING	00	COMPLET: 03/04/20	ED	
	PROVIDER OR SUPPLIER		2449 45	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE C	(X5) COMPLETION DATE
	#9, start of care 10% encephalopathy (disfunction), evidenced Health Certification certification period document had an ar Treatments" which requesting to provid 7 days a week for 2 duration may be decaregiver is present.  Record review evid. "Missed Visit Form dates: 8/5/2020, and stated "Reason: C [left blank] MD I review failed to evid was notified of the color buring an interview clinical manager ind physician of the mis in the clinical record patient #5 with start period 12/29/2021 to f legal blindness, ed document titled, "M 11/3/2020, signed b stated," MD [m During an interview clinical manager ind missed visits were rethe agency, not missed to the color of the color of the garden with the clinical record rec	eview on 3/4/2021, for patient 30/2019, primary diagnosis of sease which alters brain d a document titled "Home and Plan of Care" for 6/26/2020 - 8/24/2020. This ea subtitled "Orders and stated, "Home health aide de up to 10 hours a day, up to 6 weeks Frequency and/or creased if/when an available willing, and able to assist "  enced agency documents titled (HHA Visit)" for the following 18/12/2020. These documents other (Specify) Comments: Notified: No "Record dence the patient's physician deviation from the plan of care.  From 3/4/2021, at 12:43 PM, the dicated notification to the seed visit was not documented d. 5. Clinical record review for of care 8/31/2020, certification to 1/29/2021, primary diagnosis evidenced an agency tissed Visit Form" dated by employee N. This note edical doctor] Notified: No"  From 3/4/2021 at 11:50 a.m., the dicated only skilled nurse eported to the physician by seed home health aide visits.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 157650		r í	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 03/04/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NOBLE H	IOME HEALTH CAI	RE LLC			AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	chronic obstructive that causes long-tern evidenced an agency Visit Form", dated I K, HHA [home heal Reason: Cancellatidoctor] Notified: Y [person E, MD]"  Clinical record revied document titled, "He Plan of Care", dated clinical manager. T subcategory titled, "Primary Physician  During an interview clinical manager incomprimary physician of the primary physician of the physician of the primary physician of the physician of the primary physician of the physician of	Clinical Data" which stated,					
G 0592 Bldg. 00	484.60(c)(2) Revised plan of care A revised plan of conformation from the comprehensive as information concertoward the measure identified by the H of care. Based on record revisited to ensure the splan of care to reflec	are must reflect current ne patient's updated sessment, and contain rning the patient's progress rable outcomes and goals HA and patient in the plan iew and interview, the agency supervising nurse revised the current frequencies that of 10 clinical records reviewed.	G 0:	592	G592 - pt.#7 notified physician, receiv order to amend plan of care pe the caregiver's request. pt#10 Plan of Care has been amended to reflect the nursing	er	04/16/2021

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	
		157650	B. W	ING		03/04	/2021
NAME OF P	PROVIDER OR SUPPLIEI	· R	-		ADDRESS, CITY, STATE, ZIP COD	-	
					STH STREET SUITE D		
NOBLE F	HOME HEALTH CA	RE LLC		HIGHLAND, IN 46322			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The findings include	le:			needs of the patient.		
	1 Δn undated agen	acy policy number 4.004.1, with			All active medical charts were		
	_	'Physician Orders/Plan of			reviewed and the plan of care		
	•	ose: To ensure that each			revised to reflect the current h		
	patient's care is under the direction of a physician Policy: the physician establishes and reviews a plan of treatment for the patient. The plan is				status and nursing needs of the		
					patient.		
					'		
	updated and maintained as part of the agency's				To prevent this deficiency from	m	
	clinical record Procedure: 1. the physician sets				recurring, The agency's		
	up a plan of care, which includes the diagnosis,				professional staff will review t	he	
		be accomplished, an order for			clinical records on a continuo	us	
	· ·	m of drugs and equipment to			basis to ensure each plan of	care	
	be provided by the agency. 2. All orders on the				is specific to the patient.		
		pecific to the client condition in					
		ysician and appropriate			The Clinical manager will ens		
	-	vill review and recertify the			the supervising nurse revised	the	
	-	e at least once per episode and			plan of care to reflect the	<b>-</b>	
		e patient's condition 9. The			frequencies that are provided		
		al staff will review the clinical uous basis to ensure each			will be added as a componen		
		the patient and that additional			the quality improvement prog	ram.	
	_	are present in the clinical			Completion Date 4-16-2021		
	record "	are present in the eninear					
	2. Clinical record re	eview on 3/4/2021, for patient					
	#7, start of care 4/5	/2017, primary diagnosis of					
	cerebral palsy, evid	lenced a document titled					
	"Home Health Cert	ification and Plan of Care" for					
	_	1/14/2021 - 3/14/2021. This					
		rea subtitled "Orders and					
		stated, "Home health aide					
		de up to 2 hrs [hours] per day,					
	-	26 weeks Frequency and/or					
		creased if/when an available					
	caregiver is present, willing, and able to assist "  Record review evidenced this patient received						
		r day, 3 days a week since					
	-	d review failed to evidence the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CO A. BUILDING B. WING	instruction 00	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER  HOME HEALTH CARE LLC	2449 45	ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  plan of care was revised as needed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 3/4/2021, at 11:32 AM, the clinical manager indicated the reason this patient did not receive the hours as ordered on the plan of care, is due to Person D, caregiver for patient #7. It is their preference to only utilize HHA D to furnish care on behalf of the agency.  3. Clinical record review on 3/4/2021, for patient #10, start of care 2/26/2019, primary diagnosis of progressive mutifocal leukoenchalopathy (disease of the white matter of the brain), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 12/17/2020 - 2/14/2021. This document had an area subtitled "Orders and Treatments" which stated, "Home health aide requesting to provide 4 hours a day, 7 days a week Frequency and/or duration may be decreased if/when an available caregiver is present, willing, and able to assist "  Record review evidenced this patient received care for 6 hours a day, 7 days a week since 12/17/2020. Record review failed to evidence the plan of care was revised as needed.  During an interview on 3/4/2021, at 1:07 PM, the clinical manager indicated the duration stated on the plan of care was an oversight, and should written as 6 hours per day.			
0.0500	17-14-1(a)(1(C)			
G 0598 Bldg. 00	484.60(c)(3)(ii) Discharge plans communication (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		157650	B. W	ING		03/04	/2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			5TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC			AND, IN 46322		
(X4) ID	Г	STATEMENT OF DEFICIENCIE	1	ID	T		(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110		A plan of care, and the					BITTE
		care practitioner or other					
	health care profes	The state of the s					
	1	oviding care and services to					
		ischarge from the HHA (if					
	any).	,					
	,		G 0	598	G598 – Based on surveyor's		04/16/2021
	Based on record rev	view and interview, the home			concerns of the agency's failu	re to	
		l to ensure discharge plans			ensure discharge plans were		
		d to the patient and patient's			communicated to the patient a	and	
		discharged patients, in a total			the patient's physician. This		
	sample of 8 clinical	records reviewed. (#6, #9)			deficiency cannot be corrected		
					inactive patients, however, EN		
	The findings include	e:			was updated to document the		
					verbal notification given to pat	ient's	
	_	cy policy number 4.003.2, with			physician of discharge.		
	· ·	Client Records" stated, " z.					
		with the agency's documented			The deficiency will be prevent	ed	
		the client's physician and			from recurring by adhering to	_	
		needed that also includes: s provided; the course of care			Policy 3.001.1 which states th	е	
		ason for discharge or transfer;			agency will advise you		
		son receiving transfer report,			(patient/physician) of changes including the termination of	,	
		port; the transfer of orders and			services orally and in writing a	ne.	
	_	tus of the patient at time of			soon as possible, but no later		
	discharge "	tus of the patient at time of			15 calendar days from the dat		
	disenarge				the agency becomes aware of		
	2. An undated agend	cy policy number 3.001.1, with			change. In addition, such	. •	
	a subject subtitled "				communication will be		
	· ·	Rights" stated, "The agency			documented in EMR. At such	time	
		changes, including the			patient is notified, the physicia		
		ces orally and in writing as			will also be notified.		
		at no later than fifteen (15)					
	calendar days from	the date that the agency			The clinical manager is		
	becomes aware of a	change. If an agency is			responsible to ensure the		
	changing /deleting /	adding services or			deficiencies have been correc	ted	
	implementing a sch	eduled rate increase to all			and that compliance is		
	patients, the agency	shall provide a written notice			maintained.		
		tomer at least 30 days before					
	implementation "	•					

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ľ		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	A. BU	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURV         A. BUILDING       00       COMPLETEI         B. WING       03/04/202			LETED
	PROVIDER OR SUPPLIER			2449 45	ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		ATE	(X5) COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	#6, start of care 6/2 patient was notified date on 3/16/2020.  During an interview clinical manager increceive a discharge was difficult to get a patient indicated wawarmer" and did not to the patient's home.  4. Clinical record row #9, start of care 10/2 Person F, patient #9 by the administrator 7/29/2020. This lett physician, [Person G situation and will be services are transfer measure of good with date 30 days from the which will be Augustaled to evidence the notified of the discharge patient was patient which will an interview clinical manager increase.	eview on 3/4/2021, for patient 30/2019, evidenced a letter to 0's caregiver, which was signed and clinical manager on the stated "[Patient #7]'s G] has been made aware of the eupdated when [his/her] and discharged As a dill, we will set your discharge the date of our conversation ast 24, 2020 "Record review the patient's physician was					
G 0606	484.60(d)(3)						
<b>D</b>	Integrate all servic						
Bldg. 00	provided directly of assure the identifications that could be	, whether services are or under arrangement, to cation of patient needs and affect patient safety and eness and the coordination					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. WI	B. WING 03/04/202			/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	R			5TH STREET SUITE D		
NOBLE I	HOME HEALTH CA	RELIC			AND, IN 46322		
	1	. 12 220			1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of care provided b		~ ^				0.4/4.6/2004
	Based on observation, record review, interview,		G 0	606	G606 -		04/16/2021
	the home health agency failed ensure				Pt#2 – updated plan of care to	)	
		e provided by all disciplines			include the skilled nursing		
		patients in 1 of 3 clinical			services the patient receives.	The	
		f patients receiving services			current case conference and		
		ies out of a total sample of 10			60-day summary dated		
	clinical records reviewed. (#2)				04-06-2021 has evidence that	tne	
	The findings include:				patient has a Peg tube, foley		
					catheter and wound vac. The	_	
	1. Record review on 3/2/2021 evidenced an				summary includes the service		
					shared with the skilled nursing		
	agency policy titled, "Coordination of Client Care", number 3.009.1, which stated, "Purpose:				service.		
		taff and agencies providing			All active medical records hav	•	
		are engaged in effective			been reviewed to ensure	E	
		ng, and coordination of care			coordination of care with other		
		. Ensure that documentation			disciplines in the home.		
		cal record shows coordination			disciplines in the nome.		
	_	All service providers			All plan of cares will be update	h	
		of a client, including			as appropriate, to include all	, u,	
		are professionals or another			agencies providing services.		
		gaged in an effective			Patients have been advised to	1	
		ng, and coordination of care			notify agency if/when additional		
		. All such coordination of care			services are provided by other		
		in the client record. Each			agencies.		
		sed upon admission as to			~		
		gencies providing services to			The administrative staff will re	view	
		linical record will contain			the plan of cares quarterly for		
	appropriate docume	entation to support steps taken			coordination of care amongst		
	in the process of cli	ent care coordination			different disciplines/entities that		
	including contracted	d health care professionals			provided care to agency patie	nts.	
		The clinical record establishes			Completion Date 4-16-2021		
	that effective interc	hange, reporting, and					
		ent care does occur through					
	message documents	s, communication forms,					
	and/or case confere	nces"					
		visit for patient #2 on 2/26/2021					
	at 9:30 a.m., the pat	tient was observed to have a					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/04/	ETED
	ROVIDER OR SUPPLIER			2449 45	DDRESS, CITY, STATE, ZIP COD TH STREET SUITE D ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	stomach through the	g tube directly inserted to the e abdomen], a Foley catheter rain the bladder], and a um-assisted closure][a device d healing].					
	employee C, HHA   skilled nursing serv	y on 2/26/2021 at 9:59 a.m., [home health aide], indicated ice from entity A managed the theter, and Wound VAC.					
	start of care 8/13/20 12/11/2020 to 2/8/2 Multiple Sclerosis, document titled, "H Plan of Care". This physician on 2/27/2 subcategory titled, '	ew on 3/2/2021 for patient #2, 020, certification period 021, primary diagnosis of evidenced an agency ome Health Certification and plan of care was signed by the 021. The plan of care had a 'Orders and Treatments'.					
	Foley catheter, and	iled to include the PEG tube, Wound VAC. The plan of oned skilled nursing service					
	document titled, "C Summary", dated 2/ manager. This sum "Team Conference person B, M.D., (m manager, RN [regis employee C, HHA, summary failed to e tube, Foley catheter summary failed to e entity A. The summ Physician [check-n to coordinate care w	•					
	Review of the electr	ronic medical record for patient					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. W	NG _		03/04/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	1			5TH STREET SUITE D		
NOBLE F	HOME HEALTH CA	RE LLC		HIGHLAND, IN 46322			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	#2 on 3/2/2021 faile						
	communication not	•					
	During an interview on 3/4/2021 at 11:12 a.m., the clinical manager indicated care was coordinated						
	_	x with the other agencies					
	-	en informed of findings, the					
		dicated the agency did not					
		nunication. The agency failed					
	to evidence any coo	ordination of care with entity A					
	for patient #2.	•					
	-						
	17-12-2(g)						
0.0014	404.007.3743						
G 0614	484.60(e)(1)						
DI-1 00	Visit schedule						
Bldg. 00		luding frequency of visits					
		l and personnel acting on					
	behalf of the HHA	. view and interview, the agency		(1.4	G614 -		05/01/2021
		ents were provided a written	G 0	614		- 4	05/01/2021
	_	3 of 3 home visits out of a			Patient #2, monthly schedule	וכ	
		atient records reviewed (#2,			services was mailed on	lov	
		attent records reviewed (#2,			04/28/2021 for the month of M	-	
	#3, #7).				Patient #3, monthly schedule v	was	
	The findings includ	2.			mailed on 04/28/2021 for the		
	The initialities include	С.			month of May.	W00	
	1 Record review o	n 3/2/2021 evidenced an			Patient #7, monthly schedule wailed on 04/28/2021 for the	was	
	agency policy titled				month of May.		
		Rights", number 3.001.1, which			Thoriti of May.		
		ncy must inform a patient			Frequency of visits were revie	wed	
		sentative orally and in writing			and all active patients have	weu,	
	• •	7. The nature and frequency			received a schedule of service	s for	
	_	livered Patient Rights			the month of May 2021.	5 101	
		d how each service will be			and monar of May 2021.		
	provided"				All active patients will receive	bv	
	1				mail, the monthly schedule of	- 1	
	2. During a home visit for patient #2 on 2/26/2021			services. To prevent this			
		o evidence a written schedule			deficiency from recurring this		
	of visits from the ag				practice will continue on a mor	nthly	
	·	•	1		l '	,	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. W	NG		03/04/	2021
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDENCE NAME CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
G 0616	at 12:00 p.m. failed of visits from the ag  During an interview administrator indica ensure patients rece visits from the agen patient #7 on 2/26/2 written schedule of	to evidence a written schedule gency.  You on 3/3/2021 at 3:55 p.m., the sted the agency failed to ived a written schedule of cy.4. During a home visit for 2021, failed to evidence a visits from the agency.			The scheduler is responsible to ensure the patients are provide written schedule of visits from agency. This will be added as component of the quality improvement program. Complet Date 5-01-2021	ed a the a	
G 0616	484.60(e)(2) Patient medication	n schedule/instructions					
Bldg. 00	Patient medication schedule/instructions Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation and interview, the agency failed to ensure patients were provided a current written patient medication list in 3 of 3 home visits conducted (#2, #3, #7).  The findings include:  1. During a home visit for patient #2 on 2/26/2021 at 9:55 a.m., failed to evidence a current patient medication list provided by the agency.  During an interview on 2/26/2021 at 11:08, person C, caregiver to patient #2, indicated the agency did not provide her a current patient medication		G 0616 - Patient #2, a current written medication list will be provided on 05/14/2021. Patient #3, a current written medication list will be provided on 05/14/2021. Patient #7, a current written medication list will be provided on 05/14/2021. Reviewed all active patients' current written medication list. All patients will receive a copy on 05/14/2021.		on on All	05/15/2021	
	at 12:00 p.m., failed medication list prov	risit for patient #3 on 3/1/2021 It to evidence a current patient rided by the agency.			The deficiency will be prevented from recurring by providing a current written medication list at the beginning of each episode following a resumption of care anytime a change in medication	at and	

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

PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/04/2021	
	PROVIDER OR SUPPLIE		<u> </u>	2449 45	ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D AND, IN 46322			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  NOY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION	
TAG	clinical manager in part of the patient's of the findings, the 3. During an home	dicated a medication list was home folder. When informed clinical manager stated, "OK". visit for patient #7 on evidence a current medication y the agency.		TAG	reported.  The Clinical Manager will be responsible for providing a cur written medication list to patienthe start of each episode and any medication changes. This be added as a component of the quality improvement program. Completion Date 5-15-2021	nt at with will	DATE	
G 0768 Bldg. 00	services on beha individual has suc competency evaluation.  (1) The competer each of the subjeted of this section. Sunder paragraphs (xi) of this section observing an aide	uation						
	remaining subject through written exemination, or a health aide with a pseudo-patient as (2) A home health evaluation progra organization, exemparagraph (f) of the	t areas may be evaluated camination, oral fter observation of a home patient, or with a spart of a simulation.  In aide competency m may be offered by any ept as specified in his section.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  157650	A. BU B. W	JILDING ING	00	COMPL 03/04	
		107000	D. W	_		03/04/	12021
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC	HIGHLAND, IN 46322				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	as appropriate.	other skilled professionals, view and interview, the agency	G 0	768	G768 - Employee H - This		04/16/2021
		h home health aide (HHA)			deficiency has been corrected	l by	
		etency evaluation prior to			properly documenting and filir	-	
	_	ealth services for 1 of 4 HHA's,			employee file, the competency	-	
	in a total sample of (employee H)	8 personnel records reviewed.			that was completed prior to the	е	
	(employee n)				home health aide furnishing services.		
	The findings includ	le:					
	1 Am ym datad a cam	ear maliar mumban 2 000 1 with			100% of active employee reco		
		cy policy, number 2.009.1, with			were reviewed to ensure that completed competency evaluations.		
	a subject subtitled "Competency Evaluations" stated, "Purpose: To assess competency of all field staff Policy: Newly hired and experienced				was done prior to furnishing h		
					health services.	01110	
	field staff must den	nonstrate competency within					
		that applies to that staff			To prevent the deficiency from	ı	
	_	e permitted direct contact with			recurring, quarterly chart audi		
	-	may be used to assess			employees' files will be compl		
	-	ls checklist may also be used in			to verify HHAs' competency for	orms	
		esting Procedure: 1. All field ated for competency with			are documented accordingly.		
		description prior to receiving			A quarterly review of employe	e	
		s and prior to performing new			files by the Administrator will	J	
		tests are one method of			ensure this deficiency will not		
	_	e used in coordination with			recur. This will be added as a		
		5 Competency will be			component of the quality		
	•	allowing the aid to work in			improvement program.		
		of competency will be kept in sonnel file The minimum			Completion Date 04-16-2021		
		ed for each job will be					
		npetency test given. This will					
		he employee personnel file "					
		review on 3/3/2021, for HHA H					
	_	atient contact date of 4/9/2021.					
		ed to evidence HHA H					
	completed a compe patient contact.	etency evaluation prior to					
	patient contact.		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		157650	B. WI	NG		03/04/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				STH STREET SUITE D		
NOBLE H	IOME HEALTH CAI	RE LLC			AND, IN 46322		
(X4) ID	CLIMMA DAY	OTA TEMENT OF DEFICIENCIE	1	ID	•		(7/5)
PREFIX		STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ſΈ	DATE
		on 3/3/2021, at 3:44 PM, the					
	clinical manager inc						
	_	the competency exam was not					
	in HHA H's personnel file.  17-14-1(l)(A)						
C 0700	404.007.3763						
G 0798	484.80(g)(1)	assignments and duties					
Bldg. 00		assignments and duties nealth aide assignments					
Diag. 00	and duties.	lealth alue assignments					
		s are assigned to a specific					
		ered nurse or other					
		professional, with written					
		ctions for a home health					
	-	hat registered nurse or					
		skilled professional (that is,					
	physical therapist,	speech-language					
	pathologist, or occ	upational therapist).					
		iew and interview, the agency	G 0'	798	G798 - Based on surveyor's		04/16/2021
		registered nurse provided a			concerns of the agency's failur	e to	
		for the home health aide			ensure the registered nurse		
		total sample of 10 clinical			provided a complete care plan	for	
	records reviewed (#	2, #3, #6).			the home health aide. The		
	TEL C' 1' ' 1 1				deficiency has been corrected	•	
	The findings include	2:			providing an updated/complete		
	1 Decord review or	n 3/2/2021 evidenced an			care plan for the Home Health		
		, "Registered Nurse", number			Aide to include but not limited	lO .	
		d, " The RN [registered			safety measures, bleeding precautions, instructions for th	_	
		me health aide assignments,			aide not to use the Peg tube,		
	-	ructions for the aide, and			aspiration precautions, to use		
	supervise the aide in				extra caution when bathing an	v	
					patient with wound	,	
	2. Clinical record re	view on 3/2/2021 for patient #2,			dressing(s)/wound vac, to use		
	start of care 8/13/20	20, certification period			extra precaution when turning		
	12/11/2020 to 2/8/2021, primary diagnosis of				moving and to use proper		
	-	evidenced an agency			positioning with any patients w	/ho	
		ome Health Certification and			have these devices or take		
	Plan of Care", signe	d by the physician on			anti-coagulant medication.		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157650	B. W	ING		03/04/	/2021
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			5TH STREET SUITE D		
NORIEL	HOME HEALTH CA	RELIC			AND, IN 46322		
NOBLE		NL LLO		THIGHT	111D, III 40022		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	an of care evidenced a			Changes to aide care plans w		
		"Medications". This			reviewed and discussed with e		
		"Apixaban [a blood thinner]			patient/ caregiver; each patien	nt/	
		m] 1 tab (s) Take one tablet by			caregiver verbalized an		
		ily Aspirin [a pain and			understanding and in agreeme		
		lood thinner] Oral 81 mg 1 tab			All aide care plans dated and/		
	(s) Take one tablet	by mouth daily"			generated on or after 04/16/20		
			1		will be reviewed by two clinicia		
	Clinical record review evidenced an agency		1		for patient specifics. All skilled		
	document titled, "Aide Care Plan", dated				staff who create aide care plar	ns	
		ned by the clinical manager.			have been in-serviced on the		
	This care plan failed to evidence Bleeding				importance of individualized ca		
	Precautions.				plans to include any and all sa	-	
					precautions. A review of all aid	de	
	_	y on 3/4/2021 at 11:00 a.m., the			care plans was completed by		
	I -	dicated Bleeding Precautions			04/16/2021.		
		in the Aide Care Plan for a					
	patient taking blood	thinners.			The deficiency will be prevented		
	5				from recurring by including the	ese	
	1	t for patient #2 on 2/26/2021 at			safety measures on all home		
	·	nt was observed to have a PEG			health aide care plans as		
		e directly inserted to the			appropriate to patient condition	n.	
	1	e abdomen], and a Wound			Additionally, quarterly patient	4-	
	_	sted closure][a device used to			chart audits will be completed	το	
	assist wound healin	gj.			verify aide care plans are		
	Daviery of the Aide	Care Plan failed to evidence			individualized and include any	and	
		ated to the PEG tube and			all safety precautions that are		
	Wound VAC.	ated to the LEG tube and			appropriate.		
	Wound VAC.				The clinical manager is		
	During an interview	v on 3/4/2021 at 11:05 a.m., the			responsible to ensure that		
	~	dicated the Aide Care Plan for a			compliance is maintained.		
	_	tube and a Wound VAC			Compliance is maintained.		
	1 ~	ruction for the aide not to use					
		llow aspiration precautions, to					
		hen turning or moving the					
		positioning with these					
		al manager indicated she failed					
		tructions in the Aide Care					
	Plan.	a detions in the rude Care					
i e	1 1411.		1				1

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY TPLETED 14/2021
	PROVIDER OR SUPPLIER		2449 45	ADDRESS, CITY, STATE, ZIP 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	#3, start of care 2/1 1/12/2021 to 3/2/20 chronic obstructive that causes long-ter evidenced an agenc Health Certification of care had a subcat which stated, " 1 2.5 mg [milligram] mouth twice a day  Clinical record revi document titled, "A and signed by the c failed to evidence E  During an interview clinical manager in should be included patient taking blood  Review of the plan subcategory titled " stated, "Risk Factor falls - or any fall wi months)" The pl subcategory titled, ' stated, "Keep Pathw Change Support Ambulation Saf living] Fall Prec  Review of the Aide fall prevention or sa informed of the fine the clinical manage further documentation	ew evidenced an agency ide Care Plan", dated 1/2/2021 linical manager. This care plan bleeding Precautions.  on 3/4/2021 at 11:00 a.m., the dicated Bleeding Precautions in the Aide Care Plan for a lithinners.  of care evidenced a Patient Risk Profile", which s: History of falls (2 or more than injury - in the past 12 an of care also contained a l'Safety Measures", which way Clear Slow Position During Transfer and lety in ADLs [activities of daily sautions"  Care Plan failed to evidence aftery precautions. When lings on 3/4/2021 at 11:55 a.m., r stated, "OK", and offered no				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/04/2021	
	PROVIDER OR SUPPLIER		2449	T ADDRESS, CITY, STATE, ZIP COD 45TH STREET SUITE D ILAND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	home health aide ca by the supervising r 2/16/2020 - 4/15/20 During an interview clinical manager ind home health aide ca which was probably admitted during the change.	1/2019, failed to evidence a re plan had been established nurse for certification period 20.  7 on 3/4/2021, at 11:23 AM, the dicated the lack of the patient's re plan was an oversight due to the patient being agency's administrative				
G 0814 Bldg. 00	If home health aid patient who is not care, physical or of speech-language registered nurse in to the location who care no less frequivorder to observe a he or she is perfor Based on record revisited to ensure and (HHA) supervision 60 days for 2 of 10 days for	riew and interview, the agency on-site home health aide was conducted at least every clinical records reviewed. (#7,	G 0814	G814 – Pt.#7 – The completed home health aide supervisory visits to documented in the EMR. Pt.#5 – The completed home health aide supervisory visits to documented in the EMR.  All active patient medical recowere reviewed to ensure an or home health aide supervision was conducted at least every days for non-skilled care.  The deficiency will be prevented.	were rds nsite visit 30	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. WI	NG		03/04/	
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					STH STREET SUITE D		
NOBLE HOME HEALTH CARE LLC			HIGHLA	AND, IN 46322			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	every 30 days by a	RN [registered nurse] for			from recurring by ensuring tha	t	
	non-skilled care "				supervisory visits are conducte		
					and properly documented in th	ne	
	2. Clinical record re	eview on 3/4/2021, for patient			patient's EMR every 30 days f		
		/2017, primary diagnosis of			non-skilled car.		
		enced a document titled					
		ification and Plan of Care" for			The administrative staff will re	view	
	certification period 1/14/2021 - 3/14/2021. This				all supervisory visits quarterly		
	•	ea subtitled "Orders and			ensure 100% compliance is		
		stated, "Home health aide			maintained. Completion date		
		le up to 2 hrs [hours] per day,			04-16-2021		
		6 weeks " Record review			0.10202.		
		IHA supervisory visits were					
		ed, dating back to 11/15/2020.					
		,					
	During an interview	on 3/4/2021, at 11:41 AM, the					
	_	dicated the HHA supervisory					
	_	e documented clinical					
		ecord review for patient #5 with					
		220, certification period					
		2021, primary diagnosis of legal					
		d an agency document titled,					
		ification and Plan of Care".					
		d a subcategory titled,					
		nents" which stated, "					
		requesting to provide 6 (up to					
		lays a week; based on patient					
	·	ays a week, based on patient					
	need/request"						
	Paviany of nations #	5's electronic medical record					
	_	3/31/2020) to discharge					
	·	to evidence any home health					
	aide supervisory vis						
	arue supervisory vis	nis compicieu.					
	During an interview	on 3/4/2021 at 12:25 n.m. the					
	During an interview on 3/4/2021 at 12:25 p.m., the clinical manager indicated home health aide						
	_	nould have been done every					
	30 days for patient						
	30 days for patient ?	<i>⊤</i> J.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER		2449	T ADDRESS, CITY, STATE, ZIP COD 45TH STREET SUITE D LAND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
G 0818  Bldg. 00	that aides furnish manner, including following elements (i) Following the prompletion of task health aide by the appropriate skilled (ii) Maintaining an process with the pany), caregivers, a (iii) Demonstrating tasks; (iv) Complying with control policies and (v) Reporting chard condition; and (vi) Honoring paties.  Based on observation interview, the agency health aide (HHA) if assigned in 4 of 10 of #8, #10, #5)  The findings included 1. An undated agency a subject titled "Horocedure: the horrocedure: the horrocedure: the horrocedure: the horrocedure and received as registered nurse sup State law 2. Hom home health aide is	supervision must ensure care in a safe and effective but not limited to, the second care for a sassigned to a home registered nurse or other professional; open communication catient, representative (if and family; prompetency with assigned the infection prevention and deprocedures; and the patient's cent rights.  Son, record review and care plan as clinical records reviewed. (#7,	G 0818	G818 – This deficiency has be corrected by reviewing with some the importance of following expensive individualized care plan. Pt.# 7 the primary aide was verbally counseled on documentation of temperature last bowel movement and the importance of following each individualized care plan. Pt.#8 the primary aide was verbally counseled on documenting and the importation of following each individualized care plan. Pt.#10 the primary aide was verbally counseled on documenting and the importation of following each individualized care plan.	etaff ach ee and ee ance ed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
		157650	B. W	ING		03/04/	2021
				CTREET A	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
NODIE	IOME LIEALTH OA	DE LLO			STH STREET SUITE D		
NOBLE F	HOME HEALTH CA	RE LLG		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	instructions for hon	ne care, including specific			Pt.#5 the primary aide was		
		red by a registered nurse or			verbally counseled on		
		riate. Aide instructions are			documenting and the importar	nce	
		o the patient's plan of care and			of following each individualized		
		lowed to be permitted by a			care plan.	-	
	nurse aide "				odro pidri.		
					All active patient medical reco	rds	
	2. Clinical record re	eview on 3/4/2021, for patient			were reviewed to ensure that t		
		/2017, primary diagnosis of			home health aide followed the		
	· ·	enced documents titled "Home			individualized care plan.		
		and Plan of Care" for			individualized care plan.		
		s 11/15/2020 - 1/13/2021, and			This deficiency will be prevent	ad	
	1	21. These documents had an			from recurring by timely case	eu	
		ers and Treatments" which				view	
					management and repetitive re		
		h aide duties may include but			of such elements to include, b	uı	
		personal hygiene care, bathing,			not limited to, prescribed		
		ositioning, assistance with			exercises, elimination, linen		
	_	incontinent care, checking			change, last bowel movement	and	
	integumentary [skir	i] status, and light			temperature.		
	housekeeping "						
					The Administrator will be		
		enced agency documents titled			responsible by timely case		
		or the periods 11/15/2020 -			managing. to ensure the care		
		4/2021 - 3/14/2021. These			plans are followed accurately.	Α	
		Elimination Record bowel			quarterly chart review will be		
	1	sit Additional Comment			performed to ensure 100%		
		are to check temperature per			compliance. Completion Date	е	
	visit during Covid-	19 pandemic and report if not			04/16/2021		
	WNL [within norm	al limits] "					
		ne agency documents titled					
		to evidence the patient's					
	temperature was do	cumented on the following					
	dates: 12/9/2020, 12	2/11/2020, 12/14/2020,					
	12/16/2020, 12/18/2	2020, 12/21/2020, 12/23/2020,					
	12/25/2020, 12/28/2	2020, 12/30/2020, 1/1/2021,					
	1/18/2021, 1/20/2021, 1/22/2021, 1/25/2021,						
	1/27/2021, 1/29/2021, 2/1/2021, 2/3/2021, 2/5/2021,						
		1, 2/11/2021, 2/17/2021,					
	· ·	21, 2/24/2021, 2/26/2021, and					
		, -/- // 2021, 2/20/2021, and					

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 $3UVY11 \qquad {\tt Facility \, ID:} \quad 012829$ 

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	OF CORRECTION				COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER		2449 45	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR 3/1/2021.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	"HHA Visit" failed bowel movement w following dates: 11 11/25/2020, 11/30/2 12/21/2020, 12/23/2 12/30/2020, 11/202 1/22/2021, 1/25/202 2/1/2021, 2/3/2021, 2/11/2021, 2/17/202 2/24/2021, 2/26/202 During an interview clinical manager and of the dates and task HHA Visit notes. To "Okay."  3. Clinical record re #8, start of care 6/10 hemiplegia [weaknest the body], evidence Health Certification certification period document had an arteratments" which is duties may include thygiene care, bathin transfers, turning/powound prevention, so stomy [colostomy, abdominal wall to be colon] care, checkin medication assistant preparations, and liger Record review evidence with the solution of the colon of the colo	e agency documents titled to evidence the patient's last as documented on the /23/2020, 11/24/2020, 2020, 12/6/2020, 12/18/2020, 2020, 12/25/2020, 12/28/2020, 21, 1/18/2021, 1/20/2021, 21, 1/27/2021, 1/29/2021, 2/5/2021, 2/8/2021, 2/10/2021, 21, 2/19/2021, 2/22/2021, 21, and 3/1/2021.  For on 3/4/2021, at 11:37 AM, the diadministrator were informed as that not documented on the clinical manager replied, eview on 3/4/2021, for patient 0/2019, primary diagnosis of ess or paralysis on one side of diadicument titled "Home and Plan of Care" for 12/1/2020 - 1/292021. This eas subtitled "Orders and estated, "Home health aide out are not limited to: personal estated			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	1/29/2021. This doc Catheter Care per per visit Activity visit Turn or Pos Change Linen soiled Light House Bed per visit I Areas per visit per visit assist "  Record review of the "HHA Visit" failed colostomy was emp following dates: 12/12/10/2020, 12/13/2 12/25/2020, 12/28/2  Record review of the "HHA Visit" failed was made on the for 12/4/2021, 12/5/202 12/12/2021, 12/15/2 12/18/2020, 12/19/2 12/12/2020, 12/23/2 12/25/2020, 12/23/2 12/25/2020, 12/26/2 1/1/2021, 1/12	rument stated "Elimination r visit Empty Ostomy Bag r visit Empty Ostomy Bag r Assist in Transfer per sition per visit Household Wednesday visit and when sekeeping per visit Make Personal Care Check Pressure Oral Hygiene Denture Care  se agency documents titled to evidence the patient's stied and documented on the /5/2020, 12/6/2020, 12/9/2020, 2020, 12/17/2020, 12/30/2020, 2020, 12/30/2020, and 1/5/2021.  se agency documents titled to evidence the patient's bed sllowing dates: 12/3/2021, 20, 12/6/2020, 12/17/2021, 20, 12/10/2020, 12/11/2021, 20, 12/10/2020, 12/11/2021, 2020, 12/23/2020, 12/21/2020, 2020, 12/23/2020, 12/24/2020, 2020, 12/27/2020, 12/29/2020, 1/3/2021, 1/4/2021, 1/5/2021, 1/8/2021, 1/9/2021, 1/10/2021, 21, 1/14/2021, 1/16/2021, 21, 1/26/2021, 1/21/2021, 21, 1/26/2021, 1/21/2021, 21, 1/26/2021, 1/27/2021, and  se agency documents titled to evidence the patient are on the following dates: 2020, 12/22/2020, 12/27/2020, 2020, 12/22/2020, 12/27/2020,			
			1	I	1

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	re survey ipleted 04/2021
	PROVIDER OR SUPPLIER		2449 45	ADDRESS, CITY, STATE, ZIP 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR "HHA Visit" failed were changed on th	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION to evidence the patient's linens e following Wednesdays: 2020, 1/6/2021, 1/13/2021, and	ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	1/20/2021.  Record review of ar "HHA Visit" from 1 signed by HHA L. 2 evidence denture ca was performed.  Record review of ar "HHA Visit" from 1 signed by HHA L. 2 evidence light hous transfers, and turns/  During an interview administrator and cl	n agency document titled (2/22/2020, which was digitally) This document failed to re and pressure ulcer check (1/21/2021, which was digitally) This document failed to to the document failed to ekeeping, assist with the reposition was performed.  To on 3/4/2021, at 11:46 AM, the dinical manager were informed as that were not documented				
	"Thank you" in resp 4. Clinical record r #10, start of care 2/2 progressive mutifoc of the white matter document titled "Ho Plan of Care" for ce 2/14/2021. This doc "Orders and Treatm health aide duties m to: personal hygien assisting with ambut transfers, turning/po wound prevention,	eview on 3/4/2021, for patient 26/2019, primary diagnosis of cal leukoenchalopathy (disease of the brain), evidenced a some Health Certification and criffication period 12/17/2020 - cument had an area subtitled cents" which stated, "Home cay include but are not limited to e care, bathing/showering, lation, assisting with continent care, checking s, medication assistance and				

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	of correction identification number 157650	A. BUILDING B. WING	00	COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER	2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Record review evidenced an agency document titled "Aide Care Plan" for the period 12/17/2020 - 2/14/2014, which stated "Additional Comment Home health aides are to check temperature per visit during Covid-19 pandemic and report if not WNL "  Record review of the agency documents titled "HHA Visit" failed to evidence the patient's temperature was documented on the following dates: 12/17/2020, 12/19/2020, 12/21/2020, 12/22/2020, 12/25/2020, 12/26/2020, 12/28/2020, 12/30/2020, 12/31/2020, 1/2/2021, 1/3/2021,			
	12/30/2020, 12/31/2020, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/7/2021, 1/8/2021, 1/9/2021, 1/10/2021, 1/11/2021, 1/12/2021, 1/13/2021, 1/14/2021, 1/15/2021, 1/16/2021, 1/17/2021, 1/18/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/22/2021, 1/23/2021, 1/24/2021, 1/25/2021, 1/26/2021, 1/27/2021, 1/28/2021, 1/29/2021, 1/30/2021, 1/31/2021, 2/1/2021, 2/2/2021, 2/3/2021, 2/4/2021, 2/5/2021, 2/6/2021, 2/7/2021, 2/8/2021, 2/9/2021, 2/10/2021, 2/11/2021, 2/12/2021, 2/13/2021, and 2/14/2021.			
	On 3/4/2021, at 1:06 PM, the administrator and clinical manager were notified of dates the patient's temperature was not evidenced in the clinical record. 5. Clinical record review for patient #5 with start of care 8/31/2020, certification period 12/29/2021 to 1/29/2021, primary diagnosis of legal blindness, evidenced an agency document titled, "Aide Care Plan", dated 12/29/2020 and signed by the clinical manager. This document had a subcategory titled "Additional Comment", which stated, " Home Health Aide to assist patient with reminders to complete prescribed neck exercises patients temperature should be taken before starting care during Covid-19 pandemic"			

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	OF CORRECTION	IDENTIFICATION NUMBER  157650	r í	UILDING	00	COMPL 03/04/	ETED
	PROVIDER OR SUPPLIER			2449 45	.DDRESS, CITY, STATE, ZIP COD TH STREET SUITE D ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	aide] Visit". Review the following dates reminders to comple 12/29/2020, 12/30/2 1/10/2021, 1/11/202 1/18/2021, and 1/28  Review of the HHA dates failed to evide 12/29/2020, 12/30/2 1/11/2021, 1/14/202 1/25/2021.  During an interview clinical manager ince temperature should HHA visit note.  Review of the HHA 1/15/2021, 1/25/202 employee M, HHA, of any assigned task findings, the clinical from 1/28/2021 and note".	visit notes from the following ence a patient temperature: 2020, 12/31/2020, 1/4/2021, 21, 1/18/2021, 1/19/2021, v on 3/4/2021 at 12:26 p.m., the					
G 1024 Bldg. 00	and appropriately timed. Authenticat signature and a tit secured computer	e legible, clear, complete, authenticated, dated, and ion must include a le (occupation), or a entry by a unique nary author who has					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. W	NG		03/04/	/2021
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
NODIE	IOME LIEALTH OA	DELLO			5TH STREET SUITE D		
NORLE F	HOME HEALTH CA	RE LLC		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on record rev	view and interview, the agency	G 1	024	G1024 -		04/16/2021
	failed to ensure all	clinical record entries were			Pt.#1, The skilled nurse visits	are	
	legible, clear, comp	lete, and appropriately			documented in the EMR.		
	authenticated in 5 out of 10 total patient records				Pt.#2, the administrative staff	was	
	reviewed (#1, #2, #,	-			educated on proper document		
	·				for missed visits.		
	The findings includ	e:			Pt.#3, the administrative staff	was	
					educated on proper document	ation	
	Record review o	n 3/2/2021 evidenced an			for missed visits.		
	agency policy titled	, "Timeliness and Accuracy of			Pt.#7, the administrative staff	was	
	Entries in the Clinic	cal Record", number 4.003.1.			educated on proper document	ation	
	This policy stated, '	Purpose: To ensure that a			for missed visits.		
	current and accurate	e clinical record exists for each			Pt.#9, the administrative staff	was	
	patient and to ensur	e documents are filed in the			educated on proper document	ation	
	client's records in a	timely manner. Policy: Each			for missed visits.		
	entry into the client	record must be current,			The administrator in-serviced	staff	
	accurate, signed, le	gible, and dated with the date			to ensure all clinical record en	tries	
	of entry by the indi-	vidual making the entry.			were legible, clear, complete,	and	
	Documents must be	filed into the client record			appropriately authenticated.		
	timely and according	g to regulations and					
	retrievable during o	perating hours. Procedure: 1.			The deficiency will be prevented	ed	
	Complete clinical p	rogress notes on the date			from recurring by timely case		
	service is rendered.	Progress notes are to be			management ensuring all clinic	cal	
	recorded in Kinnser	/WellSky Software [electronic			record entries are documented	d	
	medical record] no	later than 14 days from the			within 14 days of completed vi	sit	
	completion of the v	isit"			for accuracy and appropriaten	ess	
					of documentation.		
	<ol><li>Clinical record r</li></ol>	eview on 3/2/2021 of the					
	electronic medical i	record for patient #1, start of			The Administrator will be		
		rtification period 1/18/2021 to			responsible for timely case		
		diagnosis of quadriplegia			managing to ensure all clinical		
	[paralysis from the	neck down], evidenced a			record entries are documented	k	
	calendar of visits.	This calendar indicated the			within 14 days of completed vi	sit.	
		on the following dates were			Completion Date 04/16/2021		
	1 -	1/2021, 2/2/2021, 2/4/2021,					
	2/6/2021, 2/8/2021,	2/10/2021, 2/12/2021 and					
	2/14/2021.						
	_	on 2/25/2021 at 11:54 a.m., the					
	clinical manager in	dicated staff had 48 hours to					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	r í	JILDING	instruction 00	(X3) DATE ( COMPL 03/04/	ETED
	PROVIDER OR SUPPLIER			2449 45	ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	enter documentation  During an interview clinical manager in were made on 1/31/2/6/2021, 2/8/2021 2/14/2021, but the indocumentation.  Clinical record revi documents titled, "I LVN [licensed voca Visit". The visit not 1/31/2021, 2/2/202 2/16/2021, and 2/20 LPN, contained a d Worksheet". The a worksheet stated, "coccyx [tailbone] at to indicate what oir Clinical record revi document titled, "H Plan of Care", signs 3/2/2021. This plantitled, "Medications Maximum Strength thin layer to affecte Bacitracin External 500 unit / gm [granneeded (SN to adm [an ointment to help 1ml daily PRN (SN During an interview when informed of to manager stated aboo "we don't know whomanager indicated in the state of the	a LSC IDENTIFYING INFORMATION In following a patient visit.  In following a patient visits  I		TAG			DATE
		J F M					ļ

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MUI A. BUII B. WIN	LDING	nstruction <u>00</u>	(X3) DATE : COMPL 03/04/	ETED
	PROVIDER OR SUPPLIEF			2449 45	DDRESS, CITY, STATE, ZIP COD TH STREET SUITE D ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	#2, start of care 8/1 12/11/2020 to 2/8/2 Multiple Sclerosis, documents titled, "I visit form dated 12/ C, HHA [home hea Other (Specify) Co The note failed to e was missed. When clinical manager sta inappropriate". Mis 1/16/2021 and 1/30 Cancellation of Car  During an interview clinical manager in should include a rea missed. When info clinical manager in "Cancellation of Ca canceled the care an  4. Clinical record r #3, start of care 2/1 1/12/2021 to 3/2/20 chronic obstructive that causes long-ter evidenced an agenc Visit Form", dated K, HHA [home hea Reason: Cancellat doctor] Notified: Y [person E, MD]"	review on 3/2/2021 for patient 3/2020, certification period 2021, primary diagnosis of evidenced a group of agency Missed Visit Form". A missed 31/2020, signed by employee Ith aide], stated, " Reason: omments: Approved day off" vidence a reason why the visit informed of the findings, the ated, "That's totally seed visit notes dated /2021 both stated, " Reason: e"  It wo on 3/4/2021 at 11:10 a.m., the dicated all missed visit notes ason for why the visit was rmed of the findings, the dicated the statement, are", failed to indicate who and for what reason.  Review on 3/2/2021 for patient 7/2020, certification period (21, primary diagnosis of pulmonary disease [a disease m breathing problems], y document titled, "Missed 1/26/2021, signed by employee Ith aide]. This form stated, " ion of Care MD [medical res, by Phone. Physician:					
	document titled, "H	fome Health Certification and d 12/28/2020 and signed by the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3UVY11 Facility ID: 012829

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	 ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 03/04/	ETED
	PROVIDER OR SUPPLIER		2449 45	DDRESS, CITY, STATE, ZIP COD TH STREET SUITE D ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	clinical manager. T subcategory titled, ' "Primary Physician	his document had a 'Clinical Data" which stated,	mo			BAIL
	clinical manager inc primary physician of manager stated, "Th	dicated person E was not the f patient #2. The clinical ney [the HHA's] shouldn't be It shouldn't even say that."				
	manager indicated t Care", failed to ind	he findings, the clinical he statement, "Cancellation of icate who canceled the care . 5. Clinical record review on				
	primary diagnosis of document titled "Ho Plan of Care" for ce	t #7, start of care 4/5/2017, f cerebral palsy, evidenced a ome Health Certification and ortification period 11/15/2020 - cument had an area subtitled				
	health aide requesti [hours] per day, 7 d Frequency and/or d	ents" which stated, "Home ng to provide up to 2 hrs ays a week for 26 weeks uration may be decreased a caregiver is present, willing,				
	and able to assist  Record review evid					
	digitally signed by l document stated "T Reason: Other (Spo blank] MD [docto Supervisor Notified	HHA H, on 11/24/2020. This raveled to Patient: No ecify) Comments: [left or of medicine] Notified: No : Yes, by Fax" Record				
	patients care or an i	dence who canceled the ndication why.				
	#9, start of care 10/2 encephalopathy (disfunction), evidence	30/2019, primary diagnosis of sease which alters brain d a document titled "Home and Plan of Care" for				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $3UVY11 \qquad {\tt Facility \, ID:} \quad 012829$ 

If continuation sheet

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

PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157650	A. BU B. WI		00	COMPLETED 03/04/2021	
		107 000			A DDDEGG CITY OT ATE TID COD	00/01/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D		
NOBLE F	IOME HEALTH CAI	RE LLC	HIGHLAND, IN 46322				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAU		6/26/2020 - 8/24/2020. This		TAG			DATE
	_	ea subtitled "Orders and					
	Treatments" which	stated, "Home health aide					
		le up to 10 hours a day, up to					
	_	6 weeks Frequency and/or					
	_	creased if/when an available					
	caregiver is present,	, willing, and able to assist "					
	Record review evide	enced agency documents					
		t Form (HHA Visit)" digitally					
	signed by HHA O, f	from the following dates:					
		and 8/12/2020. These					
		Fraveled to Patient: No					
	Reason: Cancellation of Care Comments: [left blank] MD Notified: No Supervisor Notified:						
	_	view failed to evidence who					
		s care or an indication why.					
	17-15-1(a)(7)						
N 0000							
Bldg. 00							
		nplaint survey with 3 rvey visit took place 2/25/2021	N 00	000			
	Complaints:						
		antiated with related findings					
		antiated with related findings					
	IN00320943 - subst	antiated with related findings					
	Facility ID: 012829						
N 0447	410 IAC 17-12-1(c	2)(4)					
	Home health agen	псу					
Bldg. 00	administration/mai	•					
		(4) The administrator, who					
	may also be the st	upervising physician or					

State Form Event ID: 3UVY11 Facility ID: 012829 If continuation sheet Page 55 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/04/2021	
	PROVIDER OR SUPPLIE			2449 45	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE PROPERTY OF THE PRO		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	registered nurse reshall do the follow (4) Ensure the acmaterials and acting Based on observation interview, the administrative, the findings included 1. Record review of agency policy titled 1.020.1, which state information, if known members of the pull documents must act and its services offer 2. Review of the agray 3/4/2021 evidences and its services offer 2. Review of the agray and its following: Skill Physical Therapy (1) Therapy"  3. Review of the widentified by the clipublic website, state OFFERED Physical Therapy Speech Therapy	couracy of public information wities.  on, record review, and mistrator failed to ensure information for the home health dee:  on 3/2/2021 evidenced an dee; " The following with shall be disclosed to olic Services Offered All curately represent the agency ered."  gency's admission packet on deed a document titled, "Admission ated, " Our services include led Nursing Home Health Aide Occupational Therapy Speech erebsite www.noble4care.com, mical manager as the agency's ed, " THERAPY SERVICES and Therapy Occupational therapy"  where on 2/25/2021 at 11:45 a.m., or indicated the agency ed nursing and home health erapies.  4:22 p.m., when informed of the	N 0	447	br="">N-0447 - Agency's New Admission Packet has been updated. PT ST OT have beer removed from admission packmaterials. WebsitePT ST Of have been removed from Website. Office hours have been reflect hours of operation as Monday – Fri 10am to 5pm. The hours of operation has be corrected on the agency's fror door to reflect 10am to 5pm. All current patients will receive updated Admission Criteria document that reflects the services offered and hours of operation  Public information materials a activities will be a component review at the agency's annual evaluation.  The Administrator will be responsible to ensure this deficiency will not recur. Completion date 04-16-2021  ="" p=""> = "" p="">	n cet DT Deen ts to Deen nt e an	04/16/2021
	findings, the clinicato be updated".	al manager stated, "That needs			="" p=""> ="" p="">		

State Form Event ID: 3UVY11 Facility ID: 012829 If continuation sheet Page 56 of 64

		l í	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157650	A. BUILDING B. WING	00	COMPLETED 03/04/2021
		137030	_ <del></del>		00/04/2021
NAME OF I	PROVIDER OR SUPPLIE	R		r address, city, state, zip cod 45TH STREET SUITE D	
NOBLE I	HOME HEALTH CA	ARE LLC		LAND, IN 46322	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SIATE CONTINUE TO T
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	="" p="">	DATE
	6 Record review	evidenced an agency policy		="" b="">	
		peration", number 1.005.1,		="" p="">	
	1	The office will be open to the		="" p="">	
		:00 am till 5:00 pm Monday		="" p="">	
	through Friday."			="" p="">	
				="" p="">	
	7. On 2/25/2021 a	t 11:30 a.m., a sign was observed		="" p="">	
	outside of the agen	cy's front door which stated, "		="" p="">	
	Office Hours 8:	30 a.m 5:00 p.m"		="" p="">	
				="" b="">	
		view on 2/25/2021 at 11:45 a.m.,			
the clinical manager indicated the office hours					
	were 10:00 a.m. to 5:00 p.m.				
	9. On 3/3/2021 at	3:30 p.m., when informed of the			
	findings, the clinic	al manager indicated the hours			
	listed on the sign w	vere incorrect.			
N 0458	410 IAC 17-12-1(	(f)			
	Home health age	• •			
Bldg. 00	administration/ma	anagement			
	Rule 12 Sec. 1(f)	Personnel practices for			
		be supported by written			
		loyees caring for patients in			
		subject to Indiana licensure,			
		egistration required to			
		ective service. Personnel			
		yees who deliver home			
		hall be kept current and umentation of orientation to			
	the job, including				
		b description.			
	(2) Qualification				
	` '	nited criminal history			
	pursuant to IC 16				
	·	rrent license, certification,			
	or registration.	,			
	_	rmance evaluations.			
			N 0458	N0458- Based on surveyor's	04/16/2021

State Form Event ID: 3UVY11 Facility ID: 012829 If continuation sheet Page 57 of 64

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

PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  157650			ILDING	00	COMPLETED 03/04/2021	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NOBLE H	OME HEALTH CA	RE LLC			AND, IN 46322		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION	1	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	Based on record rev	view and interview, the			findings, and the nature of the		
		to ensure all personnel files			deficiency being in the past, w		
	-	include documentation of job			could not correct the deficiency	y of	
	_	al history check, current			a criminal background check		
		evaluations in 3 of 8 personnel			being performed prior to the ho	ome	
	records reviewed. (	employee A, D, G)			health's first patient contact.  However, the balance of the		
	The findings includ	۵٠			surveyor's concern have been		
	The imanige menua	<del></del>			addressed; Administrator,		
	1. An undated agen	cy policy, number 2.002.1, with			Supervising Nurse, LPN, and I	НА	
		sonnel Records" stated,			employee records now have the		
	"Purpose: To ensu	are a standard method for			required job description, crimir		
	maintaining employ	vee records Policy: A			history check, current license a	and	
	separate file for eac	h employee will be maintained.			annual performance evaluation	ns.	
		re confidential. They are					
	_	tion by federal and state			To prevent deficiency from		
		Following are the			recurring, prior to patient conta		
	-	the management of personnel			all employees will have a signe		
		al personnel records Each			job description, criminal history		
		a minimum, copies of items			check and current license in the		
		ing page [document listed on hire Items with			employee file. All new hire fold	iers	
		reviewed periodically prior to			will be checked by Clinical  Manager prior to patient conta	ct	
		to an employee. If an item is			for accuracy and completion o		
		reviewed before the patients			required documents. Annual	ı alı	
		employee A separate			performance reviews will be		
	_	ecord for each employee with			immediately placed in employe	ee	
	sensitive data shall	include, but not be limited to:			files.		
		inal History and related					
	documents "				Administrator will maintain		
					compliance by auditing 20% of	f	
	2. An undated, ager	•			active employee files		
		" stated, "Personnel Records			quarterly. Completion date		
		following: k. Job description license cc. Verification of			04-16-2021		
	bb. Professional Professional license						
		Criminal History Results "					
	Evaluations II. C	Anninai History Results					
		cy policy, number 2.013.1, with formance Evaluation" stated,					
			1				

State Form Event ID: 3UVY11 Facility ID: 012829 If continuation sheet Page 58 of 64

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

PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		157650	B. W	ING		03/04/	/2021
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					STH STREET SUITE D		
NOBLE I	HOME HEALTH CA	RE LLC		HIGHLA	AND, IN 46322		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	"Purpose: To pro evaluation of an em	ovide for annual in periodic					
		nance Policy: The written					
	performance of each employee shall be performed						
	on at least an annual basis, by a qualified staff						
	member Procedure: 1. Evaluations are						
	performed by the person(s) who supervise the						
	employee and shou	ld be signed by the person					
		luation 6. An evaluation is					
	_	d of the first year of					
		nnually 11. A copy of the					
		by the employee is placed in					
	the personnel file	"					
	4 Personnel record	review on 3/3/2021, for					
		ministrator, evidenced a start					
		Record review failed to					
		the required job description,					
	-	id check, and an annual					
	performance evalua	ation.					
	During an interview	v on 3/3/2021, at 3:50 PM, the					
	_	ated they could not find their					
		ation, but remembered it had					
	been completed in a						
	   • p	2/2/2021 6 1					
		review on 3/3/2021, for home					
		D, evidenced a first patient 6/19. Record review evidenced					
		round check was conducted on					
	_	review failed to evidence a					
		d check was completed prior to					
	HHA D's first patie						
	( D 1	2/2/2021					
		review on 3/3/2021, for					
		urse (LPN) G, evidenced a first					
	_	of 4/9/2019. Record review ent printed from the in.gov					
		"Licence Information					
	•	2020 " Record review failed to					
	ZAPHAGGH. 10/31/2	1020 III Teecora review funed to					

State Form Event ID: 3UVY11 Facility ID: 012829 If continuation sheet Page 59 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. WI	NG		03/04/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				STH STREET SUITE D		
NOBLE F	IOME HEALTH CAI	RELIC			AND, IN 46322		
HOBELT				1110112	140, 14 10022		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ation of LPN G's current					
	license information.						
	O:: 2/2/2021 -+ 2.4	1 DM 4b - docinistant and					
		1 PM, the administrator and					
	clinical manager offered no explanation for the missing items in HHA D and LPN G's personnel						
	file.	IA D and LFN G's personner					
	me.						
N 0460	410 IAC 17-12-1(g	3)					
	Home health agen						
Bldg. 00	administration/mai	-					
		As follows, personnel					
		ervising nurse, appointed					
		(d) of this rule, shall:					
	(1) Be kept currer	• •					
	(2) Include a copy	of the following:					
	(A) Limited crimir	nal history pursuant to IC					
	16-27-2.						
	(B) Nursing licens	se.					
	(C) Annual perfor	rmance evaluations.					
	(D) Documentation	on of orientation to the job.					
		uations required by this					
		e performed every nine (9)					
	to fifteen (15) mon	ths of active employment.					
			N 0	460	br="">N0460 – Based on		04/16/2021
		riew and interview, the			surveyor's concerns regarding		
		to ensure the personnel file for			Supervising Nurse's annual		
		se was kept current to include			performance reviews, both cur		
	an annual performan	nce evaluation. (employee B)			and past performance evaluati	ons	
	TTI (" 1' ' 1 1				are in employee files.		
	The findings include	e:			br="">This deficiency will be		
	1 An undated again	cy policy, number 2.002.1, with			prevented by immediately filing		
	_	sonnel Records" stated,			Annual Performance Reviews	III	
	-	are a standard method for			employee file. br="">Administrator will mainta	vin	
	-	ree records Policy: A			compliance by auditing 20% of		
		h employee will be maintained.			active employee files quarterly		
	-	re confidential. They are			br="">		
		tion by federal and state			="" span="">		
	-	Following are the			="" p="">		
		I showing are the	1		P= *		

State Form Event ID: 3UVY11 Facility ID: 012829 If continuation sheet Page 60 of 64

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUIL	A. BUILDING 00		COMPLETED	
157650		157650	B. WING 03/04			2021	
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			TH STREET SUITE D		
NOBLE HOME HEALTH CARE LLC					ND, IN 46322		
NODLE HOWE HEALTH CARE LLC			<u>, L'</u>	🔾	, 10022		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	-	the management of personnel			="" span="">		
		al personnel records Each			="" spanpast="" annual=""		
		a minimum, copies of items			performance="" reviews=""		
		ing page [document listed			have="" been="" filed="" in=""		
		oon hire Items with			the="" employee="" charts. <=		
	-	reviewed periodically prior to	1		span="">		
	~ ~ .	to an employee. If an item is			="" p="">		
	-	reviewed before the patients			="" p="">		
	are assigned to that	employee "			="" p="">		
	2 4 1 . 1	4			="" p="">		
	2. An undated, ager	-			="" p="">		
		" stated, "Personnel Records			="" p="">		
		following: ee. Performance			="" p="">		
	Evaluations "				="" spanpast="" annual=""		
	2 Am um datad agam	over a discrepance of 2 012 1 with			performance="" reviews=""		
		cy policy, number 2.013.1, with formance Evaluation" stated,			have="" been="" filed="" in=""		
	-	ovide for annual in periodic			the="" employee="" charts.<=" p="">		
	evaluation of an em				p- > ="" span="">		
		ance Policy: The written			="" p="">		
		h employee shall be performed			="" span="">		
	-	l basis, by a qualified staff			="" p="">		
					="" p="">		
	member Procedure: 1. Evaluations are performed by the person(s) who supervise the				="" span="">		
		ld be signed by the person			="" p="">		
		uation 6. An evaluation is			="" span="">		
	completed at the end of the first year of employment and annually 11. A copy of the evaluation signed by the employee is placed in				="" p="">		
					="" p="">		
			1		="" p="">		
	the personnel file				="" p="">		
	_		1		="" p="">		
	4. Personnel record	review on 3/3/2021, for			="" p="">		
		nical manager, evidenced a			="" p="">		
		118. Record review failed to			-		
	evidence document	ation of an annual	1				
	performance evalua	tion for the clinical manager					
	for 2020.						
	During an interview on 3/3/2021, at 3:50 PM, the						
	administrator indica	ated the performance					

State Form Event ID: 3UVY11 Facility ID: 012829 If continuation sheet Page 61 of 64

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
157650		B. WING			03/04/2021			
			STREET ADDRESS, CITY, STATE, ZIP COD					
NAME OF P	ROVIDER OR SUPPLIER				TH STREET SUITE D			
NOBLE HOME HEALTH CARE LLC				HIGHLAND, IN 46322				
(V4) ID	1		1	ID	·		(75)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
		ducted in April 2020, but was						
		The clinical manager added						
		performance evaluation is						
	probably at home.							
N 0490	410 IAC 17-12-2(k							
	Q A and performa	•						
Bldg. 00	` '	A home health agency						
		good faith, to attempt to						
	•	uring the five (5) day period						
		ection (i) of this rule. If the						
	_	cy cannot provide such						
	•	at period, its continuing						
		e the services must be						
	documented.		1,,,	400	NO 400 P. C. A. WOLL		0.4/1.6/2021	
		riew and interview, the agency	N 0	490	N0490 Patient #9 has been	1	04/16/2021	
		ne health services were nith, and documented during			discharged from this agency a	na		
		_			assisted with transferring to	iida		
	the last 15 calendar day period prior to discharge in 1 of 3 discharged patients, in a total sample of 8 clinical records reviewed. (#9)  The findings include:				another agency that could provide the needed hours of service.			
					The administrative staff will			
					document missed visits, rather			
					than the home health aide. Th			
	1. An undated agend	cy policy number 3.001.1, with			agency's policy regarding			
	a subject subtitled "Client Conduct, Responsibility and Rights" stated, "The agency will advise you of changes, including the termination of services orally and in writing as				documenting missed visits has	5		
					been updated.			
					·			
					To prevent a lapse of service p	orior		
	soon as possible, bu	t no later than fifteen (15)			to 15-day calendar period prior	r to		
	calendar days from	the date that the agency			discharge. An LPN/RN will be			
	becomes aware of a	change. If an agency is			assigned to perform the duties	of a		
	changing /deleting /	adding services or			home health aide if a home he	alth		
		eduled rate increase to all			aide is not available. The			
		shall provide a written notice			physician will be consulted re			
		tomer at least 30 days before			inability to provide services. Th	ne		
	implementation "				patient and caregiver will be			
					notified by registered mail whe			
	2. Clinical record review on 3/4/2021, for pa				the agency is unable to provid	е		
	#9, start of care 10/3	30/2019, primary diagnosis of			services as needed.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
157650		B. WING 03/04/2021				/2021		
l				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					5TH STREET SUITE D			
NOBLE HOME HEALTH CARE LLC			HIGHLAND, IN 46322					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		sease which alters brain						
		d a document titled "Home		The Administrator will be				
		and Plan of Care" for			responsible for notifying if patients			
	_	6/26/2020 - 8/24/2020. This				ring services within a 15-day dar period prior to discharge sure that this deficiency does ecur. Completion date		
		ea subtitled "Orders and			1			
		stated, "Home health aide			-			
		le up to 10 hours a day, up to			• · · · · · · · · · · · · · · · · · · ·			
	7 days a week for 2	6 weeks "			4/16/2021.			
	Record review evic	lenced a letter to Person F,			="" b=""> ="" b="">			
		er, which was signed by the			="" p="">			
	-	linical manager on 7/29/2020.			="" p="">			
		Patient #7]'s physician,			="" p="">			
	[Person G] has been made aware of the situation				="" p="">			
	and will be updated when [his/her] services are				="" p="">			
	transferred and discharged For clarification,				="" span			
	since I know there v	was some confusion on your			="" b="">			
	part, federal guidelines state an agency is required				="" span<="" p="">			
	to give a 48 hour no	otice before discharging from			="" span<="" p="">			
	services and Indiana	a regulations state a 15 day			="" span<="" p="">			
	notice is required.	As a measure of good will, we			="" span<="" p=""> ="" span="	"">		
	will set your discha	rge date 30 days from the date			="" spanall="" future=""			
	of our conversation which will be August 24, 2020 "  Record review evidenced an agency document				discharges="" will="" follow=""			
					policy="" #3.001.1.<="" p="">			
					="" span="">			
					="" p="">			
	titled, "Missed Visit Form (HHA Visit)" from				br="">			
	8/12/2020, and digitally signed by HHA O. This				="" p="">		1	
	document stated "Traveled to Patient: No				="" p="">			
	Reason: Cancellation of Care Comments: [left			="" p="">				
	blank] MD Notified: No Supervisor Notified:			="" p="">				
	No " Record review failed to evidence an		="" spanall="" future=""					
	attempt was made to provide services on this			discharges="" will="" follow=""				
	date.				policy="" #3.001.1.<="" p="">			
	D1	dan midama hamada 191			="" span="">		1	
	Record review failed to evidence home health				="" p="">			
		pted for 5 of the last 15			="" p="">			
	calendar days prior to discharge, which include				="" span="">			
the following dates: 8/9/2020, 8/15/2020, 8/17/2020,				="" p="">				
8/18/2020, and 8/21/2020.					="" p="">			

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

PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/04/2021			
NAME OF PROVIDER OR SUPPLIER  NOBLE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	During an interview on 3/4/2021, at 12:39 PM, the clinical manager explained the agency had a hard time staffing the patient's home, due to the parameters given by Person F. The clinical manager indicated, based on the clinical record, it would appear the agency was not attempting to provide services during the 15 day calendar period prior to discharge.  During an interview on 3/4/2021, at 3:53 PM, the clinical manager indicated the agency was unaware they had the ability to use a licensed practical nurse (LPN), or a registered nurse (RN), in the place of a home health aide, to ensure the patient's needs were met.				="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">			

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