	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/11/2021	
	ROVIDER OR SUPPLIER			2449 45	ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0000	REGULTION ON	ESC IDENTIFICATION ORGANIZATION		mo			DITTE
Bldg. 00	of a complaint surve 2/25/2021-3/4/2021		G 0	000			
	This deficiency repo in accordance with	ort reflects State Findings cited 410 IAC 17.					
	Health Care LLC ha and 1 new condition standard deficiencie standard deficiencie federal standard def Based on the Condit the March 4, 2021 s 1891(a)(D)(iii) of the to be precluded from training and/ or com- for the two years be due to being found of Conditions of Partice	adition visit, Noble Home as 1 condition recited (484.60) a cited (484.45); 8 federal as were corrected, 10 federal as were recited; and 7 new federal citencies were cited. Attion-level deficiences cited at urvey and pursuant to Section as Act, your agency continues an operating home health aide appetency evaluation program ginning 3/4/2021 - 3/3/2023, but of compliance with cipation 484.60 Care Planning, are and Quality of Care.					
	Quality Review Cor	mpleted on 6/29/21 by Area 3					

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. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER		2	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	PR	ID EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0370 Bldg. 00		ipation: HHAs must rt all OASIS data collected					
	Based on record rev health agency failed transmitted each con the CMS/ State syst service being provide assessment OASIS transmitted and valice system (see tag G37 affected all Medical any skilled services. The cumulative effection the home health a provision of quality environment for the	with G 0370 G370 Reporting OASIS 1. Administrator/Clinical Manager reviewed the standard or inputting OASIS data for each skilled nursing rovided (See tag G372); completed SIS data was successfully validated by a CMS approved G378). These deficient practices dicaid patient who are receiving G 0370 G370 Reporting OASIS 1. Administrator/Clinical Manager reviewed the standard or inputting OASIS data for each skilled nursing and submitting forms. Downloaded and activated program regarding inputting service being provided. Oasis will be inputted into program and submitted. The AA has been		ated will data ning rd a for	08/27/2021		
G 0372 Bldg. 00	electronically trans	esmitting OASIS A must encode and smit each completed nt to the CMS system,					

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STATEMEN	NT 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		06/11/	/2021
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			5TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC			AND, IN 46322		
	T		1		· 		(V.f.)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
IAU		R LSC IDENTIFYING INFORMATION eneficiary with respect to	+	IAU			DATE
	which information is required to be transmitted (as determined by the Secretary),						
		completing the assessment					
	of the beneficiary.	· · · · · ·					
	i in it is a strong any.		G 0	372	G372 Encoding and		08/27/2021
	Based on record rev	view and interview, the home		. , .	transmitting OASIS		00,2,,2021
		I to ensure they electronically			Administrator/Clinical		
		mpleted OASIS assessment to			Manager reviewed the standa	rd	
		tem for each skilled nursing			regarding inputting OASIS dat		
	service being provi	ded for 2 of 2 clinical records			admissions, re-certifications,		
	reviewed of patient	s receiving a skilled nursing			resumptions, hospitalizations	and	
	service which has the	he potential to affect all clinical			discharges. Pt.#3 has a		
	records within the h	nome health agency. (#3, #4)			completed OASIS recertification	on	
					and will be electronically		
	The findings includ	e:			transmitted to the CMS/State		
					system. Pt.#4 has a complete		
	_	ency policy, number 6.019.1,			OASIS recertification and this		
		ive Assessment of Patients			be electronically transmitted to		
		. Purpose: To achieve			CMS/State system. An Oasis		
	_	ement in the quality of care			submission log will be maintai		
	-	on patient outcomes and			by the administrative assistan		
	_	itical information is routinely			and reviewed by the Administ	rator	
		th timely assessments			monthly.		
		t's initial and changing needs.			2. Completion Date		
	Policy: A compreh	ensive assessment automes and Assessment			08-27-2021.		
		ASIS) utilizing the most current			3. An electronic log will be	٦	
	`	rill be performed on qualified			used to indicate the completed Oasis that needs to be	u	
		Care; Within 48 hours			transmitted.		
	_	table referral; When the			4. Oasis submission will be	ž	
		warrants due to major decline			performed monthly and the	•	
	-	ent, but not less frequently			administrative assistant will		
		nonth; At discharge;"			maintain log.		
]	, 6,					
	2. The undated age	ency policy, number 4.008.1,					
		Fransmission of OASIS					
	-	" Purpose: To ensure					
		data entry of all Outcomes					
	-	Formation Set (OASIS) patient					

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 06/11/2021	
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
NOBLE H	HOME HEALTH CA	RE LLC		5TH STREET SUITE D 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	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	7: OASIS information collected			
		mption of care follow-up,			
	_	fer to an inpatient facility will			
		and locked into the computer			
		n calendar days from the date			
		ompleted. The OASIS			
		sent electronically to the State			
		data in the clinical record.			
		The authorized Agency COASIS information into the			
	_	comprehensive assessment is			
	_	eted by the RN [registered			
	_	te rehabilitation professional.			
	8. The OASIS is	-			
		nitted with accurate, complete,			
	-	OASIS data that accurately			
		s status at the time of the			
	_	pplicable patients to the State			
		S OASIS contractor at least			
		t that meets CMS electronic			
	data and edit specif	ications. 9. Designated			
	employees that tran	smit to the State will secure			
	each "OASIS initial	I feed back report" and			
		These reports are to be filed			
		on documentation. The			
		nsure that follow-up on			
	· ·	rs are performed and			
		essary 10. In the event			
		unable to submit OASIS data			
		, the Administrator will			
	-	cess and confidentiality of			
	-	while transferring information			
		of an alternate computer. 11.			
	the State agency or	pleted OASIS assessment to			
	contractor"	uic Civio UASIS			
	3 A raviany of man	survey information provided			
		artment of Health, stated there			
	-	available for this agency.			
	was no Oasis uala	avanable for this agency.			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	4. The clinical record and contained a plat period of 5/2/21 to nursing 1 hour were assessment, educatic compliance. 5. The clinical record and contained a plat period of 5/9/21 to nursing (no frequer comprehensive asset). During an intervithe surveyor asked. The clinical supervithis because they or and not Medicare. assistant) then indicated Medicaid. 7. During an intervithe clinical supervitit may be something record might automost the administrator and a printed email and correspondence record Health Consumer A Providers and Systewhich measures the receiving home hear	ord of patient #3 was reviewed in of care for the certification 6/30/21, with orders for skilled kly for comprehensive fon, and medication ord of patient #4 was reviewed in of care for the certification 7/7/21, with orders for skilled acy or duration) for essment and education. Friew on 06/11/2021 at 11:00 a.m. for an OASIS submission log. isor indicated they do not do anly have Medicaid patients Employee H (administrative exated they did not submit friew on 06/11/2021 at 11:14 a.m., sor then indicated she thought g that their electronic medical natically send. Friew on 06/11/2021 at 11:20 a.m., and clinical supervisor provided emails on their computer of eived from (HHCAHPS) Home assessment of Healthcare ems (HHCAHPS is a program as experiences of people alth care from	TAG	DEFICIENCY)	DATE
	administrator and c they thought this w confirmation of OA				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ′	ULTIPLE CO JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
AND FLAIN	of connection	157650	B. WI			06/11/2021
	PROVIDER OR SUPPLIER		_	2449 45	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D 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	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	was submitted from this home health agency. This deficient practice affected all Medicaid patients receiving skilled services by this home health agency.					
G 0382	484.45(c)(2)					
	. , , ,	ng compliant software				
Bldg. 00						
		oftware that complies with				
		nation Processing Standard				
(FIPS 140-2, issued May 25, 2001) from the HHA or the HHA contractor to the CMS collection site.						
	Conceilor site.		G 0	382	G382 Transmit data using	08/27/2021
	Based on record rev	view and interview, the home	00	302	compliant software	00/2//2021
		I to ensure an approved			An approved system to	
		o transmit OASIS data to the			transmit Oasis to the CMS	
	CMS [Center for M	edicare / Medicaid Services]			system will be downloaded an	ıd
	system for all agence	ey beneficiaries.			activated. Two employees wil	il be
	The findings includ	e:			designated on how to review a transmit Oasis data. 2. Completion Date	and
		policy, number 4.008.1, titled			08-27-2021.	
	I -	nission of OASIS Information"			3. The clinical manager wil	
		Administrator must designate			responsible for providing oasis	3
		that will possess the Agency			data to the administrative	
		nowledge of how to			assistant. The administrative	
		nit OASIS data to the State at The OASIS information must be			assistant or Administrator will	
	-	nitted with accurate, complete,			transmit to CMS. 4. The Clinical Manager wi	ll he
	1	OASIS data that accurately			responsible for reviewing the	11 50
		status at the time of the			program data. The EMR will	
	-	pplicable patients to the State			electronically track and monitor	or
		OASIS contractor at least			Oasis submissions monthly.	
	monthly in a format	that meets CMS electronic			<u> </u>	
	-	ications 10. In the event				
		mable to submit OASIS data				
		, the Administrator will				
	_	cess and confidentiality of				
	patent information v	while transferring information				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/11/2021	
	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 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)	TE	(X5) COMPLETION DATE
		of an alternate computer. 11. pleted OASIS assessment to the CMS OASIS					
	the Indiana Departr	rvey information provided by ment of Health, stated there a available for this agency.					
	surveyor asked for The clinical superv this because they of and not Medicare.	ov on 06/11/2021 at 11:00 a.m. the an OASIS submission log. isor indicated they do not do nly have Medicaid patients Employee H (administrative cated they did not submit					
	the clinical supervis	or on 06/11/2021 at 11:14 a.m., sor then indicated she thought g that their electronic medical natically send.					
	the administrator ar a printed email and correspondence rec Health Consumer A Providers and Syste which measures the receiving home hea Medicare-certified	home health agencies). The linical supervisor indicated as evidence of the					
	software that comp Information Proces health agency or wi	o be any evidence they had a lies with the Federal sing Standard from the home ith the home health agency MS collection site. This					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLE B. WING 06/11/2			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 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
	_	fected all Medicaid patients vices by this home health					
G 0530	484.55(c)(2)	and care preferences					
Bldg. 00	The patient's strer preferences, inclube used to demon progress toward a identified by the proutcomes identified	ngths, goals, and care ding information that may strate the patient's chievement of the goals atient and the measurable d by the HHA;					
	health agency failed were identified in cothe patients received reviewed. (#2) The findings include 1. The undated age titled "Care Plannin the policy of this Agindividualized, plan treatment, and/or se needs and goals wit the purpose of achie Care planning is perservices are approprinceds and problems process will include Identification of pat to resolve the patier Procedure: 4. The developed during an on-going assessment Measurable and ind Actions to be taken 9. The care planning the patier procedure in the patier procedu	ncy policy, number 6.016.1, g" stated " Policy: 1. It is gency to provide ned, appropriate care, rvice based on the patient's h the input of the patient for eving positive outcomes. 2. rformed to ensure that care and riate to each patient specific . 3. The care planning the following: b. ient's goals and interventions tt's problems and/or needs The Plan of Care will be and based on the initial and	G 0	530	G530 Strengths, goals, and care preferences 1. Patient #2 has been discharged. All active patient plans of care will be reviewed accuracy of services with achievable goals to be provide POCs that included incorrect skilled nursing orders will be amended to include achievable goals and sent to physician for signature. 2. completion dates 8/27/20 3. The nursing staff will be in-serviced on developing plan cares to reflect patient's health needs and achievable goals the can be adequately met. 4. To prevent this deficience from recurring, the Clinical Manager will be responsible for reviewing the POCs every 60 for accuracy prior to submission the physician for signature.	ed. 221. of nat y or days	08/27/2021

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		157650	B. WI	NG		06/11/	2021
NAME OF D	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					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	•	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
	•	l implemented to meet					
	individualized patie	ent problems and goals"					
	Clinical record r	eview for patient #2, start of					
	care 10/01/2018, certification period 03/19/2021 -						
		y diagnosis of chronic					
		ary disease, evidenced an					
	agency document ti						
	Certification and Pl	an of Care" dated and signed					
	by the clinical mana	ager on 03/19/2021. This plan					
	of care had an area	subtitled "Goals and					
	Outcomes" which stated "Patient to be pain free.						
	Patient to achieve a pain relief rating of 0-2 by						
	medication and/or nonpharmacologic pain relief						
		kin integrity will remain intact					
		Patient will be free from signs					
		espiratory distress during the					
	_	ll be free from cardiac					
	_	ng the certification period.					
		from signs and symptoms of					
		the episode. Patient will					
		gram sodium] Heart Healthy ring the episode. Patient's					
	ADL [activities of o						
	_	ties of daily living] needs will					
	_	nce of home health aide.					
		free of adverse medication					
		e episode Discharge plans;					
		ge plans: When reliable					
	_	willing and able to manage all					
	_	care" This patient only					
	seen a skilled nurse						
		very certification period and					
		ces from a home health aide.					
	These goals and out	tcomes would not be					
	attainable with a pa	tient documented with					
	episodes of forgetfu	ilness and having instructions					
	once every certifica	tion period from a skilled					
	nurse.						

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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 SUR COMPLETE 06/11/202			ETED		
	PROVIDER OR SUPPLIER		<u> </u>	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE	
G 0536 Bldg. 00	During an interview the clinical manager visited the patient at assessment and then in the 60 days. The clinical manager hor plan of care goals w visit per episode, in stated "I see what you will be a seen as the content of the clinical manager hor plan of care goals w visit per episode, in stated "I see what you will be a seen as the content of the content of the clinical manager hor plan of care goals when the clinical manager has a seen as the clinical manager has	on 06/11/2021 at 12:14 p.m., indicated a skilled nurse only the comprehensive would see if goals were met surveyor they queried the w could the patient achieve the ith only one skilled nursing which the clinical manager ou're saying."					DATE
	including ineffective side effects, significate drug the with drug therapy. Based on record revelealth agency failed patients were preserved serious medication in the primary care physical sides.	effects and drug reactions, re drug therapy, significant ficant drug interactions, rapy, and noncompliance fiew and interview, the home for to ensure all medications the fibed were reconciled and interactions were reported to expect to expect the fiber of the fiber	G 0	536	G536 Review of all current medications 1. Patient #2 has been discharged. 2. completion date 8/27/202 3. All active charts will be reviewed to ensure all medicat prescribed are reconciled and serious medication interactions	tions	08/27/2021
	1. The undated ager titled "Medication A" 11. To prevent adverse drug reaction medication profile f drug reactions listed severe are reported prior to administration other types of adversuch as consuming a	ncy policy, number 4.009.2, administration Record" stated and reduce the likelihood of ons, this agency checks the for interaction risks. Drug to a spotentially moderate or to the prescribing physician on. Patients are educated on se interactions possibilities, alcohol while taking certain d and medication interactions.			will be reported to PCP. 4. To prevent this deficience from recurring, the Clinical Manager will be responsible for reviewing the comprehensive assessment every 60 days to ensure the medication reconciliation is complete and action taken, if needed.	y	

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLI A. BUILDING B. WING	e construction G <u>00</u>	COM	TE SURVEY SPLETED 1/2021
	F PROVIDER OR SUPPLIEI HOME HEALTH CA		2449	EET ADDRESS, CITY, STATE, ZIP CO 9 45TH STREET SUITE D GHLAND, IN 46322	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE AF	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	2. The undated age titled "Medication of the responsibility of to record all medical currently taking on basis. Documentat admission, the medifrequency. Procedurall drug therapy a prossible effectivency potential interaction toxic effects, unusure reactions, duplicate the need for laborate drug allergies, and drug recalls and protection to the physician. 4. A patient/provider with and current medical receiving agency we current medication. 3. Clinical record of care 10/01/2018, co. 05/17/2021, primal obstructive pulmon agency document to the Record" dated and on 05/17/2021. The subtitled "Current of Duloxetine HCL[hydepression and anx Cap (s) PO [by modisintegrating table (s) PO 1 Tablet Q [Nausea Antiemetic Oral 50 MG 1 Tab	ency policy, number 4.009.1, Profile" stated " Policy: It is f the admitting therapist/nurse ations that the patient is a routine or PRN [as needed] ion will include upon dication, route, amount and ure: 3. Nursing staff check ratient may be taking to identify ress, ineffectiveness, actual or rus, side effects, desired effects, ral/unexpected effects, allergic redrug therapy, non-adherence, rory monitoring of drug levels, contraindicated medication and rest time of discharge the fill be provided with a complete tion profile. Upon transfer the rill receive a complete and profile (whenever, possible)" review for patient #2, start of retification period 03/19/2021 - rury diagnosis of chronic ary disease, evidenced an rited "Patient Medication signed by the clinical manager ris document had an area Medications" which stated " rydrogen chloride] [for riety] Oral 30 MG [milligram] 1 ruth] Daily Zofran ODT [oral rt] [for nausea] Oral 8 MG 1 Tab revery]8 PRN [as needed] For s traMADol HCl [for pain] (s) PO Q4 Hours PRN d" This document also				

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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 06/11/2021	
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DBE COMPLETION
		cian was not contacted and			
	Duloxetine and Zof medication interaction serotonin syndrome result in coma or de evidence in the clin physician was notif medication interaction. Record review evid Duloxetine and Tra medication interaction serotonin syndrome result in coma or de evidence in the clin physician was notif medication interaction. During an interview the clinical manage [electronic medical interactions and if it don't take any action. Clinical record revidocument titled "Disigned by the clinic stated "Discharge S Patient wears a nitrobut states she really and denies chest particular record revinitroglycerin patch medication reconcil	enced the combination of madol can cause a serious from by increasing the risk of a, in which severe cases can eath. There failed to be ical record the primary care fied of this possible severe from. You on 06/11/2021 at 12:00 p.m., or indicated "Kinnser" record] will tell you about the doesn't flag it at high risk I			
	During an interview	on 00/11/2021 at !2:02 p.m.,		1	

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STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	PROVIDER OR SUPPLIEI		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION r indicated she didn't update	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
G 0546 Bldg. 00	The last 5 days of with the start-of-ca (i) Beneficiary ele (ii) Significant cha (iii) Discharge and during the 60-day Based on record rehealth agency failed assessment was con accordance with the Declaration Waiver 1 of 4 clinical record. The findings include According to the C Declaration Blanke the waiver indicate completion requires assessment was ext. Clinical record revious/13/2020, primar sclerosis, failed to design and the control of the control of the completion of the completion of the completion requires assessment was ext.	ery 60 days unless: fevery 60 days beginning fare date, unless there is a- cted transfer; finge in condition; or for return to the same HHA for episode. In the consure a comprehensive for home health agencies, in for reviewed. (#1) In the consument of the comprehensive for home health agencies for home health agencies, in for reviewed. (#1) In the comprehensive for patient #1, start of care for diagnosis of multiple for diagnosis of multiple for diagnosis of the certification for the certification for the certification	G 0546	G546 Timely comprehensive assessments 1. Pt. #1 comprehensive assessment is completed with physician's signature and filed patient's EMR for cert period 4-10-21 to 6-08-21. 2. completion date 8/27/2023. All active records will be reviewed to ensure a comprehensive assessment is completed timely. 4. To prevent this deficience from recurring, the Clinical Manager will be responsible for reviewing the comprehensive assessment to ensure it is completed within 30 days.	in 21. y
	During an interview	v on 06/09/2021 at 2:40 p.m., the ated she was still working on			

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the patient's 4/9/2021 recertification

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		IDENTIFICATION NUMBER 157650	A. BUILDING B. WING	00	COMPLETED 06/11/2021
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR COmprehensive asses stated she performed recertification was replan of care] was remanager stated she adocument, but was be buring an interview the clinical manager working on it." (in r	not done and in turn the 485 ot complete. The clinical was working on this	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
G 0570 Bldg. 00	Condition of partic coordination of ser Patients are accept reasonable expect meet the patient's rehabilitative, and place of residence receive an individual including any revisindividualized plant care and services patient-specific net comprehensive as identification of the and the measurab anticipates will occimplementing and care. The individualso specify the patient and train furnished in according standards of practi	social needs in his or her . Each patient must palized written plan of care, sions or additions. The of care must specify the necessary to meet the eds as identified in the sessment, including e responsible discipline(s), le outcomes that the HHA cur as a result of coordinating the plan of alized plan of care must attent and caregiver ning. Services must be dance with accepted	G 0570	G570 Care planning, coordination, quality of care 1. Patient #2 has been	08/27/2021

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		157650	B. W	TNG	_	06/11/2021	
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DROLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	K			TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC		HIGHLA	AND, IN 46322		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO			X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		LETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		DA	TE
		ome according to the plan of ; a plan of care was established			discharged. Pt.#4 a corrected		
	`	d followed (see tag G572); the			POC has been sent to the		
		a followed (see tag G572); the led all required elements (see			physician that does not include		
	_	s were only administered as			skilled nursing services that w not ordered.	ere	
	- '	-			2. completion date 8/27/20	21	
	ordered by a physician (see tag G580); the plan of care was reviewed by the physician a minimum of				3. The Nursing staff will be	۷۱.	
	every 60 days (see tag G588); the primary care				in-serviced on developing pati	ents'	
	physician was informed of changes to services in				plan of care to reflect patient's		
	the plan of care (see tag G590); coordination of				health needs that can be		
	care with outside healthcare entities which				adequately met.		
	provided services to the agency patients (see tag				4. To prevent this deficience	y	
	G606); and an updated medication schedule was				from recurring, the Clinical		
		patients (see tag G616).			Manager will be responsible for	or	
					reviewing the POC after admis		
		ect of these problems resulted			every 60 days for accuracy pr	or to	
		agency's inability to ensure			submission to the physician fo	r	
		health care in a safe			signature.		
		Condition of Participation 42					
		planning, coordination of					
	services, and quality	y of care.					
	A standard citation	was also cited					
	21 Standard Citation	was also cited.					
	Based on record rev	view and interview, the home					
		d to ensure the patients needs					
	were met in their ho	ome according to the plan of					
	care 2 of 4 clinical i	records reviewed. (#2, #4)					
	Findings include:						
	1. The undated age	ncy policy, number 6.016.1,					
	_	g" stated " Policy: 1. It is					
	the policy of this A	gency to provide					
	individualized, plan	nned, appropriate care,					
	treatment, and/or se	rvice based on the patient's					
	_	h the input of the patient for					
		eving positive outcomes. 2.					
	Care planning is per	rformed to ensure that care and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. W	ING		06/11/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC			AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY 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
		riate to each patient specific					
	_	s. 3. The care planning					
	process will include the following: b.						
	_	tient's goals and interventions					
	to resolve the patient's problems and/or needs. c.						
	Implementation of the planned care or services by appropriate clinicians and/or the patient/family. d.						
	Monitoring the patient's response to the care						
	provided and/or the outcome of the care provided						
	will be ongoing 8. The RN [registered nurse]						
		prehensive assessment in the					
	formation of a care plan Procedure: 4. The						
	Plan of Care will be developed during and based						
	on the initial and on-going assessments,						
	including: a. Identification of appropriate patient						
	_	eds 7. All qualified					
	1 ~	ved in the patient's care, either					
	directly or indirectl	y, will contribute to the Plan of					
	Care, including con	sideration of the patient's					
	problems, needs, co	ondition and wishes and the					
	patient's ability to r	espond to care services 10.					
		based upon the physician's					
	_	asses the equipment, supplies,					
		vices required to meet the					
		12. The frequency of the					
		of Care is based on changes in					
	•	status, needs and the					
		ors affecting care. The					
		nal/Clinical Manager/Case					
		ist is responsible for revising					
		updating the Plan every 60					
		is determined to be needed					
		ne patient will be prioritized in e level of services to be					
	provided"	LICYCI OI SCIVICCS IO UC					
		review for patient #2, start of					
	care 10/01/2018, ce	ertification period 03/19/2021 -					
		primary diagnosis of chronic					
	obstructive pulmon	ary disease, evidenced an					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 06/11/2021			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 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)	TE	(X5) COMPLETION DATE
IAU	agency document to Certification and Pl signed by the clinic This plan of care has Treatments" which old female who live caregiver. Patient I in the past six mont re-hospitalization. decline in health an help. Patient suffer Patient at risk for falls. Patient complying with me SN [skilled nurse] to assessments SN pain medication be achieve better pain on nonpharmacologincluding relaxation stretching, position SN to instruct patient pressure ulcer form to instruct the Patien cardiac dysfunction SN to instruct patient on signs and calling 911. SN to signs/symptoms of report to MD [mediurinalysis and urine test as needed for signs ludge pain, foul ourine and fever. SN			IAG			DATE

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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 06/11/2021	
	ROVIDER 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	with or without min resulting in serious	et agency to report any fall or injury and to call 911 for fall injury or causing severe pain to instruct patient on fall			
	skilled nursing visit assessment to provi the patient and care of care. The skilled patient's needs.	other than the comprehensive de the education needed for giver as indicated in the plan nurse failed to meet the			
	primary diagnosis: l disease of the brain problems with vision sensation or balance evidenced an agence	wiew on 6/11/21 for patient #4, Multiple Sclerosis (Disabling and spinal cord causing n, arm or leg movement, e), start of care 11/21/18, y document titled "Home and Plan of Care," for			
	certification period the clinical supervis SN [skilled nurse] t medication before p instruct patient on n	5/9/21 - 7/7/21, and signed by sor. This document stated " o instruct patient to take pain pain becomes severe SN to conpharmacological			
	alleviate pain] pain instruct patient/care prevent skin breakd formation SN to	lo not use medications to relief measures SN to giver on measures to help own and pressure ulcer instruct the patient/caregiver			
	breath] SN to in measures to detect a instruct the patient/c could be signs of a	ribute to SOB [shortness of struct patient/caregiver on and alleviate edema SN to caregiver the symptoms that heart attack SN to instruct er on signs/symptoms of UTI			
	[urinary tract infect Patient/Caregiver of SN to instruct th agency to report any	ion] SN to instruct n a well balanced regular diet e Patient/Caregiver to contact y fall SN to instruct the fall precautions" This			

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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 SURVEY COMPLETED 06/11/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D	
NOBLE H	HOME 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
G 0572 Bldg. 00	requesting to provid week (Monday thru days a week (Saturd Respite HHA [home additional care/time Clinical record revies killed nursing visit assessment to provid the patient and caregof care. The skilled patient's needs. 4. During an intervithe clinical supervis nursing services that every certification proposed by the patient and the house of the patient and the house of the patient are well as the patient must services that are well and for the patient must services that are well and for the patient must service that are well and for the patient must service that are well and for the patient must service that are well and for the patient must service that are well and for the patient must service that are well and for the patient of the patie	other than the comprehensive de the education needed for giver as indicated in the plan nurse failed to meet the liew on 6/11/21 at 12:16 p.m., or stated she does the skilled t are stated in the plan of care period and stated she usually thave been since the last time tome.	G 0572	G572 Plan of care 1. Patient #1 cert period 4/10-21 – 6/08/21 has a completed and signed plan of	08/27/2021

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i î		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		157650	B. WING		06/11/2021
NAME OF I			STREI	ET ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIER		2449	45TH STREET SUITE D	
NOBLE H	HOME HEALTH CA	RE LLC	HIGH	HLAND, IN 46322	
(X4) ID	SUMMARY	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 APPROPRI	
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	ly by the primary care		care. Patient #2 cert period	
		clinical records reviewed. (#1,		3/19/21 to 5/17/21 an addend	
	#2)			to the POC was completed a	na
	The findings includ	۹۰		returned with signature. 2. completion date 8/27/20	124
	The initings includ	С.		3. All active patients' med	
	1. The undated agency policy, number 6.016.1,			records will be reviewed and	l l
	_	g" stated " Purpose: To		have a current plan of care si	
		process to the clinicians for		by the physician. All missed	_
		and revising patient care or		documentation will be comple	
		etly or through a written		and the physician will be notif	l l
		1. It is the policy of this		4. To prevent this deficien	
	-	individualized, planned,		from recurring, the profession	•
	appropriate care, tre	eatment, and/or service based		staff will be responsible for	
	on the patient's need	ds and goals with the input of		updating the POC every 60 d	ays
	the patient for the p	urpose of achieving positive		which include notifying the	
	outcomes. 2. Care	planning is performed to		physician of missed visits.	
		services are appropriate to			
		e needs and problems. 3. The			
		ss will include the following:			
		are based on the patient's			
		a. b. Identification of patient's			
	_	ons to resolve the patient's			
	_	eds. c. Implementation of the			
	_	vices by appropriate clinicians			
	-	amily. d. Monitoring the			
		the care provided and/or the provided will be ongoing			
		g process will be documented			
	_	Treatment Procedure: 4.			
		ill be developed during and			
		and on-going assessments,			
		ification of appropriate patient			
	_	eds. b. Measurable and			
	*	s. c. Specific services to be			
		ns to be taken to meet the			
	-	pe, frequency and duration of			
		6. The admitting SN [skilled			
		therapist] will initiate the			
		e at the start of care, and the			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTII A. BUILDII B. WING		nstruction 00	(X3) DATE : COMPL 06/11/	ETED
	PROVIDER OR SUPPLIEF		24	49 45	DDRESS, CITY, STATE, ZIP COD TH STREET SUITE D ND, IN 46322		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREF	ΊΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	plan will e updated	at least eery sixty (60) days or nary of care will be sent every	TA	G			DATE
	60 days thereafter or more often as needed 9. The care planning decisions will be reflected in						
	the specific services	s provided and the designated					
	individualized patie	ent problems and goals. 10.					
	orders and encompa	based upon the physician's asses the equipment, supplies,					
	patient's needs"	vices required to meet the					
	titled "Physician Or	ency policy, number 4.004.1, rders/ Plan of Care" stated " e that each patient's care is					
	physician establishe	of the physician. Policy: The es and reviews a plan of					
	-	tient. The plan is updated and rt of the Agency's clinical					
		1. The physician sets up a includes the diagnosis,					
		be accomplished, an order for of drugs and equipment to be					
		ency. 2. All orders on the pecific to the client condition					
	and needs 7. T	the physician and appropriate rill review and recertify the					
	written plan of care	at least once per episode and patient's condition 10.					
	The Agency provid	es written and oral reports to					
	treatment and appro	ding the patient's plan of opriateness of the continuation					
	reports to the physic	cy provides written and oral cian regarding the patient's					
	more frequent if the	very 60 days. Reports may be ere is an emergency, a need to e or a need to terminate					
	services 12. If	the Agency does not receive a					
		orders within thirty (30) days r is sent to the physician for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET B. WING 06/11/20			ETED		
	ROVIDER 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)	TE	(X5) COMPLETION DATE
	signature, the Agency contacts the physician's office to obtain the signed document or resends the order(s) to be signed. All follow-up contacts to obtain signed orders are documented."						
	care 08/13/2020, ce 06/08/2021, and pri	review for patient #1, start of critification period 04/10/2021 - critification period of multiple widence any plan of care for riod.					
	on the patient's rece 04/10/2021 - 06/08. done the visit, but t so in turn the 485/p	v on 06/09/2021 at 2:40 p.m., the indicated she was still working ertification for episode /2021. She indicated she had he recertification was not done lan of care was not complete. vas working on this, but was					
	care 10/01/2018, c 05/17/2021, and pri obstructive pulmon agency document to Certification and Pl signed by the clinic failed to have a phy document had a sec Treatments" which requesting to provide	an of Care" dated and digitally ral manager on 03/19/2021, but visician's signature. This ration titled "Orders and stated " Home Health Aide de 6 hours a day up to 5 days SN to provide					
	[home health aide] 4/20/21, 4/21/21/21, 4/21/21/21/21, 4/21/21/21, 4/21/21/21/21/21/21/21/21/21/21/21/21/21/	v documents titled "HHA Visit" dated 4/16/21, 4/19/21, /22/21, and 4/23/21, failed to provided services 6 hours a he plan of care.					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		157650	B. W			06/11		
	ROVIDER OR SUPPLIER		•	2449 45	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN 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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	on 6/11/21 at 12:25 p.m., the						
		licated she didn't see						
	communication or anything documented for the reason the home health aide missed hours.							
	410 IAC 17-13-1(a)							
G 0574	484.60(a)(2)(i-xvi)						'	
		include the following						
Bldg. 00		plan of care must include						
	the following:							
	(i) All pertinent dia	_						
		nental, psychosocial, and						
	cognitive status;	ervices, supplies, and						
	. ,							
	equipment require	a; and duration of visits to be						
	made;	and duration of visits to be						
	(v) Prognosis;							
	(vi) Rehabilitation	notential:						
	(vii) Functional lim	•						
	(viii) Activities perr							
	(ix) Nutritional req							
	(x) All medications							
	, ,	es to protect against						
	injury;	. 3						
		of the patient's risk for						
		ment visits and hospital						
		all necessary interventions						
	to address the und	derlying risk factors.						
	(xiii) Patient and c	aregiver education and						
	training to facilitate	e timely discharge;						
	(xiv) Patient-speci	fic interventions and						
	education; measu	rable outcomes and goals						
	_	HA and the patient;						
	, ,	lated to any advanced						
	directives; and							
	, , ,	al items the HHA or						
		ed practitioner may choose						
	to include.						İ	

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i f		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		157650	B. W	ING		06/11/2021	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				5TH STREET SUITE D		
NODIEL	JOME HEVITH CV	BELLC			AND, IN 46322		
NOBLE F	HOME HEALTH CA	RE LLC		HIGHL	AND, IN 40322		
(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	COMPLET	ΓΙΟN
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
			G 0	574	G574 Plan of care must inclu	de 08/27/2	2021
	Based on record rev	view and interview the home			1. Pt.#3 the POC has been		
	health agency failed	l to ensure the individualized			amended to include the location	n to	
	plan of care included all the location to apply				apply the topical medications.		
	topical medications and failed to include				Pt.#4 POC has been amended	l to	
	implanted devices in	n 3 of 4 clinical records			include the location to apply th	e	
	reviewed. (#2, #3, #	#4)			topical medications. A discha	ge	
					summary addendum page wa	s	
	The findings include:				added to Pt.#2 discharge char	t	
					which states the patient has a		
	1. Review of the agency policy revised 6/10/21				pacemaker.		
	titled "Client Records," stated " To establish				2. completion date 8/27/20	21.	
	and maintain a client record system to assure that				All active patients' POC		
	the care and services provided to each client are				and medication profiles were		
		urately documented, readily			reviewed to ensure the patient	s	
		ematically organized to			conditions and needs are		
	-	iance and retrieval of			individualized and include all t	ne	
	-	on processing of data related to			locations to apply the topical		
		e client record will include but			medications and any implante	b	
		of the following information:			devices.		
	Care plan that in	cludes medications"			4. The clinical manager is		
					responsible for reviewing on		
	_	ency policy revised 6/10/21			admission and every 60 days	all	
		ders/Plan of Care," stated "			POCs and medication for the		
	-	ent's care is under the			accuracy of all medications, ro		
		sician The physician			and location and documentation	on of	
		ews a plan of treatment for the			any implantable devices.		
		updated and is maintained as					
		s clinical record The					
		plan of care, which includes					
	the diagnosis, progr	-					
	-	rder for each service, item of					
		nt to be provided by the					
		ers on the CMS 485 [Plan of					
		ic to the client condition and					
	needs"						
	2 01: 1	(10/01 6					
		eview on 6/10/21 for patient #3,					
		Chronic obstructive pulmonary					
	disease (long-term i	inflammatory lung disease that			1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		157650	B. W	ING		06/11/	/2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC			AND, IN 46322		
	Г		1	1	,		OVE)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION irflow from the lungs,	+	TAG	DEFICIENCY.		DATE
		ty breathing), start of care					
	11/3/20, evidenced an agency document titled "Home Health Certification and Plan of Care," for						
		5/2/21 - 6/30/21, and signed by					
	_	ysician and clinical supervisor.					
		ed " Proctozone-HC					
		treat minor pain, itching,					
	-	mfort] External 2.5% thin layer					
	1 -	ice a day" This document					
		here to apply the medication.					
		11 3					
	During an interview on 6/11/21 at 12:44 p.m., the						
	_	ndicated the plan of care does					
	_	ply the medication, but she is					
	now adding to the p	olan of care to apply the					
	medication to the ex	xternal rectum area.					
	4. Clinical record re	eview on 6/11/21 for patient #4,					
	primary diagnosis: 1	Multiple Sclerosis (Disabling					
	disease of the brain	and spinal cord causing					
	problems with visio	on, arm or leg movement,					
		e), start of care 11/21/18,					
		y document titled "Home					
		and Plan of Care," for					
	•	5/9/21 - 7/7/21, and signed by					
	·	sor. This document stated "					
	_	tion used as a moisturizer to					
		y, rough, scaly, itchy skin and					
		ns] Protective External 1-10ml					
		hin coat to affected area and					
		prevent skin breakdown"					
		ed to include where the					
		ocated to apply the medication.					
		eview for patient #2, start of					
		rtification period 03/19/21 -					
		liagnosis of chronic obstructive					
	1 *	evidenced an agency					
		ome Health Certification and					
		and digitally signed by the					
	ciinicai manager on	03/19/2021. This document					

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, ´		ì	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157650		A. BUILDING 00 COMPLETED B. WING 06/11/2021			
		137 030				00/11/	2021
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
NOBLE H	HOME HEALTH CA	RE LLC		HIGHLAND, IN 46322			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION nything about the patient's	1	AG	DEFICIENC!)		DATE
	implanted pacemaker.						
	document titled "Di digitally signed by t 05/20/2021. This d "Discharge Summa stated " Patient ht 05/04/2015)"	ew evidenced an agency scharge Summary" dated and the clinical manager on ocument had an area subtitled ry Addendum Page" which as a pacemaker (inserted on 06/11/2021 at 12:10 p.m., sor indicated it was an o(1)(D)(xiii)					
G 0580 Bldg. 00	484.60(b)(1) Only as ordered b Drugs, services, a administered only or allowed practitio	nd treatments are as ordered by a physician					
	health agency failed received prior to all administered by the records reviewed. (The findings included The undated agency "Physician Orders/" Purpose: To ensure under the direction of physician established treatment for the paphysician sets up a physician sets up	e: y policy, number 4.004.1, titled Plan of Care" stated " that each patient's care is of the physician. Policy: The es and reviews a plan of tient Procedure: 1. The plan of care, which includes	G 0580	0	G580 Physician Order 1. Pt.#2 has been discharg The POC was submitted to physician and returned signed 2. completion date 8/27/20: 3. All active patient charts to be reviewed to determine if the POC has been returned with a physician signature. The plan care and other physician order requiring a physician's signatur will be filed in the patients EMI within 7 days of receipt in office second request for physician orders will be requested for physician orders not received within 14 days. 4. To prevent this deficience	I. 21. will e a of rs of rs R e.e. A	08/27/2021

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	PROVIDER OR SUPPLIEF		2449 4	ADDRESS, CITY, STATE, ZIP COD 15TH STREET SUITE D LAND, 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
	drugs and equipmen Agency 5. Cop other orders requiris should be filed in the of receipt in office, appropriate profess; recertify the written episode and as warn condition 12. It a signed physician's of the date the order signature, the Agen office to obtain the the order(s) to be sit to obtain signed order (condition). Clinical record revi 10/01/2018, certification and Pl signed by the clinical document indicated provide services 6 leaves for 26 weeks, provide comprehen nurse was to instruct medication and non instruct patient on pand skin breakdown cardiac dysfunction instruct patient on leadema, instruct patient on diet, instruction of the diet.	at to be provided by the pies of the plan of care and ing a physician's signature are client record within 7 days 7. The physician and it plan of care at least once per ranted by the patient's are to the physician for expectation of the physician for expectation of the physician's signed document or resends gened. All follow-up contacts ders are documented" The way for patient #2, start of care attion period 03/19/2021 - y diagnosis of chronic ary disease, evidenced an tiled "Home Health an of Care" dated and digitally all manager on 03/19/2021. This the home health aide was to hours a day up to 5 days a the skilled nurse was to sive assessments, the skilled at the patient of pain pharmacologic pain relief, prevention of pressure ulcers and relieve complications, now to detect and alleviate ent on signs and symptoms of a patient to recognize and relieve complications, now to detect and alleviate ent on signs and symptoms of a patient or signs and a patient or contacts.		from recurring, the administratistaff will be responsible for logging, monitoring and tracking physician orders.	tive
		instruct patient of fall ocument failed to evidence the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULT A. BUILD B. WING		STRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021		
	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	PRE	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	(X5) COMPLETION
G 0590 Bldg. 00	patient's primary can to the administration and services. The cevidence that a verb prescribing physicial. During an interview the clinical managers sent off to the physicand the agency did to was signed by the physicand that suggest that centre that suggest that cachieved and/or the be altered.			AG	DEFICIENCY		DATE
	health agency failed physician to any chat that suggest that out achieved and/or that altered in 1 of 4 clin. The findings include 1. Review of the age titled "Care Planning information includir status, types of services, goals and interesting the discipline, prognosing functional limitation."	It to promptly alert the relevant anges in the patient's needs tecomes are not being t the plan of care should be nical records reviewed. (#4)	G 0590	f 1 2 3 in r t t t	G590 Promptly alert relevant obysician of changes 1. Pt.#4 has a signed addendum physician order to hervices when the patient and amily member preferred home health aide is not available. 2. completion date 8/27/2023. The professional staff will anserviced on ensuring the relevant physician is notified with POC needs to be altered, othere are significant changes to the patient's needs and of any missed visits. An electronic logwill be used to track and monit frequency of home visits.	nold 21 I be then or o	08/27/2021

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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 06/11/2021	
	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)	TE	(X5) COMPLETION DATE	
me	treatments, and inst will be developed of and on-going assess Clinicians will info any changes that su of Care"	ructions The Plan of Care luring and based on the initial sments, including rm the patient's physician of ggest a need to alter the Plan		Mo	4. To prevent this deficience from recurring, the Clinical Manager will be responsible for weekly logging and monitoring home visit frequency.	or	BAIL	
	titled "Physician Or To ensure that each direction of the phy establishes and revi patient. The plan is part of the Agency! Agency's profession clinical records to of of treatment and ap continuation of care written and oral rep the patient's plan of	reders/Plan of Care," stated " patient's care is under the rsician The physician lews a plan of treatment for the supdated and is maintained as sclinical record The hal staff continuously reviews letermine adequacy of the plan propriateness of the e The Agency provides borts to the physician regarding c treatment and the continuation of care"						
	primary diagnosis: disease of the brain problems with visic sensation or balance evidenced an agence Health Certification period the clinical supervision Home Health Aideday, 5 days a week hours a day, 2 days Sunday) for 9 week aide] will be used in requested"	eview on 6/11/21 for patient #4, Multiple Sclerosis (Disabling and spinal cord causing on, arm or leg movement, e), start of care 11/21/18, by document titled "Home in and Plan of Care," for 5/9/21 - 7/7/21, and signed by sor. This document stated " requesting to provide 6 hours a (Monday thru Friday) and 4 a week (Saturday and its. Respite HHA [home health of additional care/time is						
		idenced agency documents Form (HHA [home health						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING 00 B. WING		COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER		STREET A 2449 48 HIGHLA		
(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
	5/24/21, and 5/29/2: administrator. Thes Patient/Caregiver do patient/caregiver on unavailable at this ti assist patient MI Notified No' to evidence the ager the caregiver's conti 5/15/21 - 5/29/21. During an interview administrator indica patient #4 did not we employee C, home I passing away from 6 family needed the he could not accept have despite the agency of administrator indical could to honor the falso indicated they of the missed visits. 41- IAC 17-13-1(a)(6)	e documents stated " eclines services today; ly want a specific aide who is ime. Patient family able to D [Doctor of Medicine] ' Clinical record review failed acy notified the physician of nual refusal of services from on 6/11/21 at 1:06 p.m., the ted the family member of ant anybody else besides nealth aide due to her brother COVID. She indicated the elp, but the family member ving anyone else there, offering another aide. The ted they did the best they amily member's refusal. She did not notify the MD for all of			
G 0606 Bldg. 00	provided directly o assure the identific factors that could a	whether services are r under arrangement, to cation of patient needs and affect patient safety and eness and the coordination			
	Based on record rev health agency failed care with outside en	iew and interview, the home to ensure coordination of tities which provided to agency patients, in 2 of 4	G 0606	G606 Integrate all services 1. Pt.#2 has been discharg Pt.#1 a letter of care coordinat will be submitted to entity D. A amended plan of care has bee submitted to the physician for	tion An

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		157650	B. W	ING		06/11/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t .			TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC			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	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					signature with Entity D name,		
	The findings includ	e:			frequency and services provide		
	1 The 1-4-1				2. completion date 8/27/202		
		ency policy, number 3.009.1,			3. All active patients will be		
	titled "Coordination of Client Care" stated " Purpose: To ensure that all staff and agencies				contacted to determine if they		
	providing services to a client are engaged in				receiving services from addition entities. The professional staf		
	effective interchange, reporting, and coordination				be in-serviced on asking patie		
	of care regarding the client. Ensure that				on admission and during the		
	documentation in the patient's clinical record				duration of care regarding any		
	shows coordination of services. Policy: All				entity providing care.		
	service providers involved in the care of a client,				4. To prevent this deficienc	y	
	including contracted health care professionals or				from recurring, the administrat	ive	
	another Agency, wi	ll be engaged in an effective			staff will be responsible for		
	interchange, reporti	ng, and coordination of care			including a letter of care		
		. All such coordination of care			coordination in all admission		
		in the clinical record. Each			packets to identify other entitie		
		sed upon admission as to			providing service in the home.		
		gencies providing services to					
		edure: 1. Upon admission, the					
	_	will identify any agencies					
	-	ng care 4. The clinical					
		appropriate documentation to					
		in the process of client care ing contracted health care					
	professionals provide	~					
	professionals provid	ding care					
	2 Clinical record r	eview for patient #2, start of					
		ertification period 03/19/2021 -					
		y diagnosis of chronic					
		ary disease, evidenced an					
	•	tled "Discharge Summary"					
		the clinical manager on					
	05/20/2021. This document had an area subtitled						
	"Discharge Summary Addendum Page" which stated " Patient states she continues to receive						
	services from [name	e of home health agency] for					
		iving PT [physical therapy]					
	from Entity B"						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, 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	
TAG		ewith Entity B.	TAG	DEFICIENCY)	DATE
	the clinical manage they (Entity B) prov and that she had 5 v	or on 06/11/2021 at 12:05 p.m., r indicated the patient reported vided physical therapy services visits of PT. Employee H stant) indicated she just asked provided and when.			
	care 08/13/2020, ce 06/08/2021, primar sclerosis, evidenced "Missed Visit For (I dated and digitally s	eview for patient #1, start of rtification period 04/10/2021 - y diagnosis of multiple I an agency document titled HHA [home health aide] Visit), signed by the administrator is document indicated the lized.			
	_	on 06/09/2021 at 2:00 p.m., r indicated the patient was ty C.			
	the clinical manage health agency] prov "home care". Then	on 06/09/2021 at 3:00 p.m., r indicated Entity D [home rided the patient with her the clinical manager indicated my coordination of care with			
	410 IAC 17-12-2 (h	1)			
G 0616	484.60(e)(2) Patient medication	n schedule/instructions			
Bldg. 00	Patient medicatior including: medicat frequency and whadministered by H	n schedule/instructions, tion name, dosage and ich medications will be IHA personnel and on behalf of the HHA.			
			G 0616	G616 Patient medication	08/27/2021

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLI	ETED
		157650	B. W	ING		06/11/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			TH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC			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)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		on, record review, and			schedule/instructions		
		health agency failed to			1. Pt.#4 has received a cop	by of	
	provide to the patient medication				the medication profile.		
		ns, including: medication			2. completion date 8/27/20	21	
	_	frequency and which			3. The deficiency will be		
		administered by the home			prevented from recurring by		
		onnel in 1 of 1 clinical records			providing a current written	_	
	reviewed. (#4)				medication list at the beginnin	g of	
	TE1 (* 1' ' ' '				each episode, following a		
	The findings includ	e:			resumption of care, and anytir		
	D · Cd	1. 1. (40/04)			change in medication is report		
	Review of the agency policy revised 6/10/21 titled				4. The Clinical Manager wi		
	"Medication Profile," stated " To list and notify physician of medications that the patient is				responsible for providing a cui	rrent	
		-			written medication profile to		
		a PRN [as needed] basis			patients at the start of each		
		the Agency, the admitting RN			episode of care if there have b	peen	
		or therapist is provided in the			any medication changes.		
	_	sheet on which to record the					
	1 ' '	he patient is taking on a is. The medication profile must					
		following All current					
		te prescribed or taken Name					
		Pose Frequency Drug					
		ate discontinued Drug					
		s The medication profile					
	_	east every 60 days or more					
	_	Il new medications will be					
		ation profile and checked for					
		the case manager"					
	During a home visit	t on 6/10/21 at 9:10 a.m. for					
	_	diagnosis: Multiple Sclerosis					
		of the brain and spinal cord					
		vith vision, arm or leg					
	movement, sensation or balance), start of care						
		y member of patient #4 provided					
		et. The admission packet was					
		a medication profile with the					
		5/19. The agency failed to					
		vas provided with the most					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		r í	a. building <u>00</u>			(x3) date survey completed 06/11/2021	
	ROVIDER OR SUPPLIER		2	2449 457	DDRESS, CITY, STATE, ZIP COD I'H STREET SUITE D ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
G 0798 Bldg. 00	During an interview clinical supervisor i patient #4 is very primedication list up to need to provide a cupatient and family a informed that the aguipated medication or as often as needed 484.80(g)(1) Home health aided Standard: Home health aided patient by a registra appropriate skilled patient care instruited prepared by the other appropriate sphysical therapist, pathologist, or occurrence of delegating care provided through patients receiving the home health aide as records reviewed with the findings including the findings including the supervision of th	on 6/10/21 at 4:40 p.m., the indicated the family member of coactive about keeping the odate. She asked if they still arrent medication list to the and the clinical supervisor was gency still needs to provide an profile at least every 60 days d. assignments and duties health aide assignments is are assigned to a specific ered nurse or other a professional, with written ctions for a home health that registered nurse or skilled professional (that is, speech-language cupational therapist). Ariew and interview, the home at to ensure an aide care plan registered nurse for the ang nursing directed patient gh the home health agency for ome health aide services for all signments, in 2 of 4 clinical with a home health aide. (#1,	G 0798		G798 Home Health aide assignments and duties 1. Patient #1 the nurse has completed the Aide Care Plan Patient #4 the nurse has completed the Aide Care Plan active patients Aide Care Plan were reviewed for completion the Registered Nurse. 2. Completion Date 8/27/20 3. The nursing staff will be in-serviced on establishing a written home health aide Care Plan on admission and updatir the Aide Care Plan every 60 d at the time of recertification and	. All s by 021 ng ays	08/27/2021

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	ľ	JILDING	onstruction 00	(X3) DATE : COMPL 06/11/	ETED
	PROVIDER OR SUPPLIEI			2449 45	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)	ATE	(X5) COMPLETION DATE
	are clearly stated. Skilled nursing servegistered nurse in treatment. These se following: Procedulation home health aide as instructions for the the home" 2. Review of the againstruction for the the home Health aide as instructions for the the home Health that all home health clearly stated Thursing, Alternate Case manager are restructions for home exercises, are prepart therapist as approprimental that all home health clearly stated" 3. Review of the againstruction in relation the duties all nurse aide" 3. Review of the againstruction in the duties and accurate patient and to ensure client's records in a into the client records in a into the client records in a contract the client records in the client records in a contract the client rec	stered Nurse responsibilities Policy: Registered Nurse (RN). vices shall be provided by a accordance with the plan of ervices shall include the are: 4. The RN will make ssignments, prepare written aide, and supervise the aide in gency policy revised 6/10/21 h Aide," stated " To ensure h aide visits responsibilities are he agencies Director of Director of Nursing, and/or esponsible for Written he care, including specific hard by a registered nurse or riate. Aide instructions are of the patients plan of care and lowed to be permitted by a gency policy revised 6/10/21 hnd Accuracy of Entries in the tated " To ensure that a he clinical record exists for each he documents are filed in the timely manner Each entry had must be current, accurate, he dated with the date of the hual making the entry. he filed into the client record had to regulations and hyperating hours" review for patient #1 on p.m., evidenced the home health medical record system heatronic medical record system heatronic medical record system			whenever there is a change in patient's physical status. 4. To ensure this deficient does not recur, the Clinical Manager will be responsible freviewing all Aide Care Plans admission and every 60 days as needed, to ensure that it is completed by the registered nurse, current, accurate, sign and dated by the registered not determined by the registered nurse.	y or on or ed,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BU	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING <u>00</u> B. WING			X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIEF		•	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 R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
G 0800 Bldg. 00	listed patient #1's no 06/08/2021, and ser service calendar was stated "Aide Care Passigned to the clinic of 04/10/2021 and it document was "not During an interview clinical manager in we just carry over for During an interview the clinical manage only needed to be schad not signed it, it the agency's electron 484.80(g)(2) Services provided A home health aid are: (i) Ordered by the practitioner; (ii) Included in the (iii) Permitted to be law; and (iv) Consistent with training. Based on record revealth agency failed aides followed the atthe registered nurse reviewed with home. The findings included in the undated age titled "Home Health"	ame, episode of 04/10/2021 - rvice calendar. Below the s a list of tasks. Entry #1 rlan" which indicated it was ical manager, had a target date indicated the status of the started". on 06/09/2021 at 2:52 p.m., the dicated I know how it looks, but from the last aide care plan. on 06/11/2021 at 11:20 a.m., ir indicated the aide care plan igned by her, but since she showed up as not signed on inic medical record. 17-13-2(a) by HH aide le provides services that physician or allowed plan of care; e performed under state the the home health aide riew and interview, the home it to ensure the home health aide care plan established by , in 2 of 4 clinical records e health aides. (#1, #2) e: ncy policy, number 6.021.1, in Aide" stated " Policy: The	G 08		G800 Services provided by Haide 1. Pt.#2 was discharged. A was counseled for not following the aide care plan. Pt.#1 Aide counseled on following the aide care plan. 2. Completion date 08/27/2 3. All active charts will be reviewed to ensure the aide care.	ide g was le :021	08/27/2021
1	agencies Director o	f Nursing, Alternate Director			plans are being followed. The		

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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 06/11/2021	
	ROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
	SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR OF Nursing, and/or of for assigning and or visits. Procedure: Thave the following services that are ordinated plan of care, only the plan of care and received from the registered under State law home care, includin prepared by a registanger appropriate. Aide in relation to the patient duties allowed to be care 10/01/2018, ce 05/17/2021, primare obstructive pulmons agency document than digitally signed 03/19/2021. This districtive pulmons agency document than digitally signed 03/19/2021. This districtive pulmons agency document than digitally signed 03/19/2021. This districtive pulmons agency document than digitally signed 03/19/2021. This districtive pulmons agency document care (with movement, assist in turn or position the Thursdays and when housekeeping, make patient preference), (per patient preference), (per patient preference), (per patient preference), provide partial bath preference), shampoo in provide skin care, p				e ager visits e
	Clinical record review	ew evidenced agency			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPI A. BUILDIN B. WING		nstruction <u>00</u>	(X3) DATE COMPL 06/11 /	ETED	
	PROVIDER OR SUPPLIED		244	9 45	DDRESS, CITY, STATE, ZIP COD TH STREET SUITE D ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	dated 04/16/2021, 0 which failed to evic completed: assist t pericare, shampoo, hygiene denture ca: During an interview the clinical manage saying. We need to	HHA [home health aide] Visit" 04/22/2021 and 05/13/2021, dence the following tasks were o dress, comb hair, foot care, back rub/massage, oral re, partial bath and tub. v on 06/11/2021 at 12:31 p.m., er stated "I see what you're o coach them to put something					
	Clinical record revidocuments titled "I 04/23/2021, 05/05/05/12/2021, which tasks were complet dress, comb hair, for	be blank aide task areas) ew evidenced agency HAA Visit" dated 04/20/21, 2021, 05/06/2021, 05/11/2021, and failed to evidence the following ed: change linen, assist to bot care, pericare, shampoo, oral hygiene denture care, o.					
	1	ov on 06/11/2021 at 12:33 p.m., or indicated sometimes the to sleep.					
	document titled "H which failed to evid completed: assist t pericare, shampoo,	iew evidenced an agency HA Visit" dated 04/21/2021, dence the following tasks were o dress, bomb hair, foot care, back rub/massage, oral re, check pressure areas, partial					
	care 08/13/2020, co 06/08/2021, primar sclerosis, evidence "Aide Care Plan" d the clinical manage	review for patient #1, start of crification period 04/10/2021 - y diagnosis of multiple d an agency document titled ated and digitally signed by cr on 04/10/2021. This aide care nome health aide was to					

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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	COM	ie survey ipleted 11/2021	
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP 5TH STREET SUITE D AND, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	care, record bowel in range of motion, tun (Monday, Wednesd light housekeeping, back rub massage (pressure areas, come complete bath (per preference), oral hy bath/sponge (per pashampoo hair (per pand to practice university). Clinical record revidocument titled "HI This home health ain ail care, partial bat patient as directed of the clinical manage have wanted to be be clinical record revidocument titled "HI This home health air ange of motion, bat bath, comb hair and directed on the aide directed on the aide or not. During an interview the clinical manage wasn't done and indivouldn't know if it aide or not.	iew evidenced an agency HA Visit" dated 05/08/2021. de visit note failed to evidence the or tub was provided to the on the aide care plan. or on 06/11/2021 at 11:29 a.m., or indicated the patient may not bothered. ew evidenced an agency HA Visit" dated 05/15/2021. de visit note failed to evidence ck rub/massage, tub, complete I foot care was provided as				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	them (home health a not done. Clinical record revidence and titled "HI This home health air	ew evidenced an agency HA Visit" dated 05/17/2021. de visit note failed to evidence nged as directed on the aide	TAG	DEI CHACT	DATE
G 0818 Bldg. 00	that aides furnish manner, including following elements (i) Following the p completion of task health aide by the appropriate skilled (ii) Maintaining an process with the pany), caregivers, a (iii) Demonstrating tasks; (iv) Complying wit control policies an	supervision must ensure care in a safe and effective , but not limited to, the s: atient's plan of care for s assigned to a home registered nurse or other I professional; open communication eatient, representative (if and family; a competency with assigned the infection prevention and			
	(vi) Honoring paties 5. Clinical record reare 10/01/2018, ce 05/17/2021, primare obstructive pulmons documents titled "Heated 04/16/2021, 04/21/2021, 04/21/2021, 05/06/2021, 05/11/2 which failed to evide	ent rights. eview for patient #2, start of rtification period 03/19/2021 - y diagnosis of chronic ary disease, contained agency (HA [home health aide] Visit" 4/19/2021, 04/20/2021, 2021, 04/23/2021, 05/05/2021, 2021, 05/12/2021 and 05/13/2021, dence the aide care plan registered nurse was followed.	G 0818	G818 HH aide supervision elements 1. Pt.#3 aide visit document 5/7, 5/28, 5/24 by Employee E failed to evidence following the POC. The supervisory visit 6/2 clinical manager incorrectly documented. Both the aide and clinical manager have been counseled. Pt. #4 aide visits o 5/11, 5/13, 5/16, 5/18, 5/19, 5/2	a 3 by d

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157650	B. W	ING _		06/11/	/2021
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	t			5TH STREET SUITE D		
NORLE F	HOME HEALTH CA	RELIC			AND, IN 46322		
	IOWE HEALTH OA			11131127	110, 111 10022		
(X4) ID		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					5/26, 5/27 5/30, 6/1, 6/3, 6/6, 0	•	
		also failed to evidence that			6/9, 6/10 Aide failed to follow		
		sits were made on 04/26/2021,			of care and the aide superviso	•	
		2021, 04/29/2021, 04/30/2021,			visit on 6/7/21 failed to ensure		
		2021, 05/07/2021, 05/10/2021 and			the aide followed the aide plar		
		ome health aide failed to follow			Both aide and supervising nur		
	the plan of care.				have been verbally counseled		
	The eliminature 1	failed to evidence the home			Pt.#2 has been discharged bu		
		ours of home health aide			noted that in multiple occurrer	ices	
		ours of nome nearth ande I on the plan of care, for the			the aide care plan was not		
		-			followed. The aide supervisor	У	
	dates of 04/16/2021, 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021 and 04/23/2021. The home				visit on 5/17 was incorrectly documented as it did not indic	oto	
	health aide failed to follow the plan of care.				the aide not following the Aide		
	nearm and raned to	Tonow the plan of care.			Care Plan.	·	
	A review of an age	ncy document titled "Aide			Pt.#1 aide visits 5/8, 5/15 and		
		dated and digitally signed by			5/17 aide failed to follow aide	care	
		r on 05/17/2021. This			plan and supervisory visit on 6		
	_	Reports for duty as assigned			incorrectly document the aide	,,,,	
		lows client plan of care as			followed the POC. Both the a	ide	
	1 -	tory Documents			and clinical supervisor were		
	appropriately: Satis	-			verbally counseled.		
		•			Completion date		
	During an interview	on 06/11/2021 at 12:25 p.m.,			08/27/2021		
	the clinical manage	r stated she didn't see any			3. Timely case manageme	nt of	
	communication or o	locumented reason for the			aide's care plan documentatio	n	
	home health aide m	issed hours.			will be done to ensure aide is		
					following the aide care plan.		
	During an interview	on 06/11/2021 at 12:31 p.m.,			4. The Clinical Manager wi	ll be	
	the clinical manage	r stated "We need to coach			responsible for weekly reviewi	ng	
	them to put in some	thing." (in reference to blank			all home health aides and		
	areas on the home h	nealth aide visit notes)			professional documentation no	otes	
					to ensure that this deficiency of	does	
		on 06/11/2021 at 12:39 p.m.,			not recur.		
	_	concerns with the supervisory					
		al manager stated "I see what					
	you're saying."						
		eview for patient #1, start of	1				
	care 08/13/2020, ce	rtification period 04/10/2021 -					

i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		157650	B. WING		06/11/2021
NAME OF P	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP O	COD
				45TH STREET SUITE D	
NOBLE F	HOME HEALTH CA	RE LLC	HIGH	HLAND, IN 46322	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COL	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE CONTINUE TION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
		y diagnosis of multiple ntained agency documents			
		health aide] visit dated			
	_	2021, and 05/17/2021, the home			
		tes failed to evidence the aide			
	care plan was follow	wed.			
	_	ncy document titled "Aide			
		dated and digitally signed by r on 06/08/2021. This			
	_	Follows client plan of care as			
		nt" This supervision element			
	failed to be correct.				
	Based on record res	view and interview the home			
		to ensure that aides			
		safe and effective manner,			
		imited to: following the			
	_	re for completion of tasks			
	assigned to a home	health aide by the registered			
	nurse in 4 of 4 clini	cal records reviewed. (#1, #2,			
	#3, #4)				
	The findings includ	۰.			
	The imanige metud	~.			
	1. Review of the ag	ency policy revised 6/10/21			
		n Aide," stated " To ensure			
		aide visits responsibilities are			
	1	he home health aide shall have			
		nsibilities Provide services			
		the physician in the plan of			
		vices written in the plan of s written instructions from the			
		s written instructions from the pervisor as permitted under			
	State law"	servisor as permined under			
	Saic law				
	2. Review of the ag	ency policy revised 6/10/21			

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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	COM	TE SURVEY TPLETED 11/2021	
	PROVIDER OR SUPPLIEF		2449 4	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	titled "Nurse Super that all daily operat provided in a profes state regulatory guinurse will oversee that the patient of takes place on a consupervising nurse ware aware of conditional timely manner ensure that the patient being followed through the staff communication" 3. Clinical record reprimary diagnosis: disease (long-terming causes obstructed a resulting in difficultificational supervisor. Change Linen From Record bowel move that the patient of the properties of the provided in the properties of the provided in the provided in the provided in the properties of the provided in the prov	vision," stated " To ensure ions and patient care are ssional standard that meets delines The supervising hat patient communication	TAG	DEFICIENCY		DATE

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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	COM	ie survey ipleted 11/2021	
	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	titled "Aide Superv signed by the clinic stated " Follows " Excellent" Tailed to ensure the plan by changing the recording the last be During an interview administrator staate and 5/28/21 were need to be documented. During an interview clinical supervisor seed to be documented. During an interview clinical supervisor seed to be documented to be doc	idenced agency documents health aide] Visit," dated '16/21, 5/18/21, 5/19/21, 5/23/21, '30/21, 6/1/21, 6/3/21, 6/6/21, 6/10/21. Clinical record review he patient received either a blete bath on the				

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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	OOSTRUCTION OO	(x3) date survey completed 06/11/2021				
	PROVIDER OR SUPPLIER		2449 4	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 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			
	titled "Aide Supervisigned by the admirstated " Follows Excellent" Tfailed to ensure the plan by providing ebath every visit.	denced an agency document isory Visit," dated 6/7/21 and histrator. This document client plan of care as instructed the home health aide supervisor aide followed the aide care ither a partial bath or complete						
	clinical supervisors that the baths were the patient has mult exhausted and decli	or on 6/11/21 at 1:03 p.m., the stated she is noting the days not completed. She indicated iple sclerosis and may be ning the baths since the baths from him, but this was not						
G 1024	484.110(b) Authentication							
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						
	Based on record rev health agency failed	riew and interview the home I to ensure all entries were nticated in 3 of 4 clinical	G 1024	G1024 Authentication 1. Pt.#3 The home health a home visit dated 6-4-21 has be authenticated with the home health aide's signature. Pt.#2 The Patient Communica	een			
	titled "Home Health that all home health clearly stated Tl	e: ency policy revised 6/10/21 n Aide," stated " To ensure aide visits responsibilities are ne home health aide shall have nsibilities Completing		document dated 4-26-2021 has been authenticated with the Administrator's credentials. Pt.#1 The home health aide vis notes dated 04/19, 4/20, 4/21, 4/22, 4/26, 4/27 4/28, 5/3, 5/4, 5/5, 5/6, 5/10, 5/11, 5/12, 5/13	sits			

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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 SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD ISTH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR appropriate records 2. Review of the ag titled "Clinical Record and maintain a clier the care and service completely and acce accessible and syste facilitate the compli information All patient's clinical record legibly written in in recording person with and surname and tit 3. Clinical record re primary diagnosis: disease (long-term in causes obstructed air resulting in difficult 11/3/20, evidenced titled "HHA [Home 6/4/21. This docum health aide signed tit the visit. During an interview clinical supervisor in says that it is compliant say digitally sig 4. Clinical record care 10/01/2020, co 05/17/2021, evidence "Patient Communic digitally signed by the	ency policy revised 6/10/21 ords," stated " To establish at record system to assure that is provided to each client are curately documented, readily ematically organized to fance and retrieval of notes and reports in the ord shall be typewritten or in the fith his full name or first initial le" Eview on 6/10/21 for patient #3, Chronic obstructive pulmonary inflammatory lung disease that firstow from the lungs, by breathing), start of care an unsigned agency document Health Aide] Visit," dated ent failed to evidence the home the document after completing	HIGHL ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) 5/14, 5/16, 5/17, 5/18, 5/20, 5 and 6/8, 2021. All have been authenticated with the home health aide's credentials. The home health aide home visit dated 05/19/2021 has been authenticated with the home health aide's signature and credentials. The home health documentation note dated 05/11/2021 with an incorrect on 05/12/2021 has been correand authenticated. 2. Completion Date 08-27-3. All active patient's home health aide home visit notes a professional clinical notes will reviewed for signature, date, credentials. All electronic staff notes of active employees we reviewed and include the employees' credentials, dates and signatures. The home he aides and professional staff win-serviced on ensuring documentation notes are legiclear, complete, and appropria authenticated and dated which includes computer entry signatures. 4. The Clinical Manager we responsible for weekly reviewed all home health aides and professional documentation recurs.	aide entry ected -2021 e and I be and ff ere s, ealth vill be ble, iately ch will be ving
		eview for patient #1, start of rtification period 04/10/2021 -			

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIE		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION	
	06/08/2021, primare evidenced agency of health aide] Visit" 04/21/2021, 04/22/04/28/2021, 04/28/05/05/2021, 05/06/05/12/2021, 05/18/06/08/2021. These failed to evidence to credentials. Clinical record revidence to document titled "H. This document fail aide's signature and During an interview the administrator in noticed that the hot didn't show up on a Clinical record revidence to the didn't show up on a Clinical record revidence that the hot didn't show up on a clinical record revidence that the hot didn	ry diagnosis multiple sclerosis, documents titled "HHA [home dated 04/19/2021, 04/20/2021, 2021, 04/26/2021, 04/27/2021, 2021, 05/03/2021, 05/04/2021, 2021, 05/10/2021, 05/11/2021, 2021, 05/14/2021, 05/16/2021, 2021, 05/20/2021, 05/24/2021 and shome health aide visit notes the home health aide visit notes the home health aide's he home health aide's dated to evidence the home health dicredentials. What on 06/11/2021 at 11:26 a.m., andicated she never actually me health aide credentials agency documents. It we evidenced an agency HA Visit" dated 05/11/2021. It ide visit note indicated the movement was 05/12/2021, isit. This note failed to be a vinidicated the date had to be a				
N 0000						
Bldg. 00	This visit was for a	follow-up visit of a State	N 0000	n/a		

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li di		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		157650	B. WI	NG		06/11/	2021
	ROVIDER OR SUPPLIER		<u> </u>	2449 45	ADDRESS, CITY, STATE, ZIP COD		
NOBLE F	IOME HEALTH CAI	RE LLC		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	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
	complaint survey th 2/25/2021 - 3/4/202	at was conducted on 1.					
	Survey Dates: 6/9/2	021, 6/10/2021, and 6/11/2021					
	Facility ID: 012828						
		te deficiencies were corrected, were recited, and 1 new state i.					
	Quality Review Cor	mpleted on 6/29/21 by Area 3					
N 0447	410 IAC 17-12-1(c	3)(4)					
	Home health agen						
Bldg. 00	administration/mai	nagement					
	Rule 12 Sec. 1(c)	(4) The administrator, who					
	may also be the su	upervising physician or					
	registered nurse re	equired by subsection (d),					
	shall do the follow	_					
	` '	curacy of public information					
	materials and activ	vities.					
			N 0	447	N0447		07/20/2021
		riew and interview the			1. Patient #4 has received the		
		home health agency failed to			corrected introduction letter wi		
	-	of public information			the Agency's hours of operation	n.	
	materials in 1 of 4 c	linical records reviewed. (#4)			2. All current patients have		
	The findings include	e:			received a corrected introducti letter with the correct hours of operation. A signature page		
	1. Review of the age	ency policy revised 6/10/21			signed by each patient confirm	ning	
	·	ve Control," stated " To			receipt of the corrected	J	
	define the composit				introduction letter has been pla	aced	
	-	ne Agency's key components			in the patient chart.		
		or shall be responsible for			3. To ensure the accuracy of		
	implementing and s	upervising the administrative			public information, the agency	's	
		cy and administratively			Admission packet which conta		
	supervise the provis	ion of all services. At a			the hours of operation, has be	en	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	l í	JILDING	nstruction 00	(X3) DATE COMPL 06/11 /	ETED
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC		HIGHLA	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)	TE	(X5) COMPLETION DATE
	accuracy of public is activities Operation Monday through Fr 2. During a home vipatient #4, primary (Disabling disease of causing problems with movement, sensation 11/21/18, the family the admission packed observed to include indicated the hours 5:00 p.m. Monday the administrator failed operation in the administrator indicated 10 through Friday. During an interview administrator indicated indi	isis on 6/10/21 at 9:14 a.m. for diagnosis: Multiple Sclerosis of the brain and spinal cord with vision, arm or leg on or balance), start of care y member of patient #4 provided et. The admission packet was a welcome letter that of operation were 8:30 a.m. to chrough Friday. The to ensure the hours of mission packet given to the 1:00 a.m. until 5:00 p.m. Monday			corrected. The admission pack will be reviewed before admiss to ensure the accuracy of publinformation. 4. The Clinical Manager will be responsible for reviewing all admission documents before patients are admitted for servicensure this deficiency will not recur. Completion date 07-20-	sion ic e ce to	
N 0458	410 IAC 17-12-1(f						
Bldg. 00	employees shall be policies. All employees indiana shall be so certification, or recognition to the respective of employ health services shall be policies.	nagement Personnel practices for the supported by written to by es caring for patients in tubject to Indiana licensure, tigistration required to totive service. Personnel tees who deliver home thall be kept current and mentation of orientation to the following: to description.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2021		
	PROVIDER OR SUPPLIEF		2449	ET ADDRESS, CITY, STATE, ZIP COD 45TH STREET SUITE D HLAND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
	pursuant to IC 16- (4) A copy of cur or registration. (5) Annual performage of employees who of the agency failed of employees who of the agency failed of employees who of the agency failed of the findings included and the following partial of the agency failed and the agency failed an	rent license, certification, mance evaluations. view and interview the home It to ensure personnel records deliver home health services and include a receipt of job opy of the current license in 3 ed. (employee C, F, I) e: ency policy revised 6/10/21 coords," stated " To ensure a r maintaining employee ate file for each employee will each file shall contain, at a f items listed on the following in hire Items with expiration lically prior to assigning a yee. If an item is required, it effore patients are assigned to versonnel Records include at Job description c" review on 6/10/21 for health aide, evidenced a start I an expired home health aide view evidenced a document gov website that stated " in Expiration: 2/21/23" ical supervisor on 6/10/21 at eview failed to evidence mployee C current license	N 0458	N458 1. Employee C current licer been filed in their personner record. Employee F current license and signed and dat description has been filed in personnel record. Employee I signed and date description has been filed in personnel record. 2. 100% of active employee records have been reviewer ensure that the current licer and signed and dated job descriptions are in their per record. The administrative assistant been in-serviced on maintal tracking, and logging employersonnel records. 3. A Personnel Log has been developed in order to track employees required person documents. 4. The Administrative Assis will be responsible for montreviewing the Personnel log verify all licenses are current that all active employees has signed and dated job description Date 07-20-202	el t ed job en their ed job en their es' ed to ense es esonnel ent has eining, byees' en and log enel estant ethly eg to ent and eave a eiption

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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 SURVEY COMPLETED 06/11/2021
	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 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
	administrator indica employee C was in sometimes it is in the put it in the personnal. Personnel record employee F, home leader of 8/7/20, and license. Record reversely printed from the in. License Information received by the adm p.m. Record review	the died the current license for the green book. She indicated he green book and they do not hel folder. review on 6/10/21 for health aide, evidenced a start an expired home health aide riew evidenced a document gov website that stated " h Expiration: 7/6/23" hinistrator on 6/10/21 at 1:20 v failed to evidence mployee F current license			
	A record review on job description for taide. Record review and dated job describe administrator in During an interview administrator walked different location w	6/10/21 evidenced an agency the position of home health w failed to evidence a signed iption by both employee F and the personnel record. You on 6/10/21 at 1:19 p.m., the ed off to get the license from a then the current license was			
	binder in another ro actually a green bin During an interview	cated it was in the green from. She indicated it was not der but a blue binder. From 6/10/21 at 1:22 p.m., the sted the job description was oyee F.			
	employee I, home h date of 12/2/20 and the position of hom failed to evidence a	review on 6/10/21 for health aide, evidenced a start an agency job description for e health aide. Record review signed and dated job employee I and administrator ord.			

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		IDENTIFICATION NUMBER 157650	 JILDING	00	COMPL 06/11/	ETED
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP COD		
NOBLE H	HOME HEALTH CAI	RE LLC		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
	administrator indica	on 6/10/21 at 1:16 p.m., the sted there was not a signed job ersonnel file for employee I.				
N 0464	410 IAC 17-12-1(i))				
DI4= 00	Home health agen	-				
Bldg. 00	administration/mar	nagement The home health agency				
	, ,	ill employees, staff				
		s providing care on behalf of				
	the agency, and contractors having direct					
	patient contact are evaluated for tuberculosis and documentation as follows:					
	, ,	th a negative history of				
		legative test result must vo-step tuberculin skin test				
	using the Mantoux	· · · · · · · · · · · · · · · · · · ·				
	-	say unless the individual				
		n that a tuberculin skin test				
	has been applied a	at any time during the				
	previous twelve (1	2) months and the result				
	was negative.					
	` '	ep of a two-step tuberculin				
	_	Mantoux method must be				
		(1) to three (3) weeks after				
	the first tuberculin	skin test was				
	administered. (3) Any person wi	th:				
	(A) a documented					
	(i) history of tuber					
	(ii) previously posi					
	tuberculosis; or					
	· ·	reatment for tuberculosis;				
	or					
		results to the tuberculin				
	skin test;					
		chest rediograph to				
	exclude a diagnos					
	(4) Aπer baseline	testing, tuberculosis				

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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	<u>00</u> COMPLETED		ETED
		157650	B. W	NG		06/11/	/2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			5TH STREET SUITE D		
NORI E I	HOME HEALTH CA	RELIC			AND, IN 46322		
NODEL	TOWL TILALITI CA	TE EEG		HIGHLA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	screening must:						
	(A) be completed annually; and						
	(B) include, at a r	ninimum, a tuberculin skin					
	test using the Mar	ntoux method or a					
	quantiferon-TB as	say unless the individual					
	was subject to sub						
	. ,	aving a positive finding on a					
	tuberculosis evalu	lation may not:					
	1 ' '	ome health agency; or					
	(B) provide direct patient contact;						
	unless approved by a physician to work.						
	(6) The home health agency must maintain						
	documentation of tuberculosis evaluations						
	showing that any						
	1 ' '	e home health agency; or					
	(B) having direct	₹`					
	_	e finding on a tuberculosis					
		n the previous twelve (12)					
	months.						
			N 0	N 0464 N464			08/27/2021
		view and interview the home			1. Employee-I –has completed	la	
		d to ensure all employees, staff			Baseline Individual TB Risk		
	_	ons providing care on behalf of			Assessment and has received		
		aluated for tuberculosis in 1 of			Step 1 of 2-step TB test and		
	5 records reviewed.	(employee I)			results will be placed in		
	TE1 (* 1' · · · · ·				employee's file.		
	The findings includ	e:			2. 100% of active employee fil		
	Daview of the	ov. moliov. movine d 6/10/01 4:41-4			will be reviewed to ensure prior		
	_	cy policy revised 6/10/21 titled			patient contact, a Baseline 2-s	tep	
		Assessments," stated " To			TB Test was completed, if		
	1	th Assessments for employees			indicated.		
		perculosis screening which			100% of active employees have		
	shall be administered to all new employees who				completed a Baseline Individu		
		contact and annually thereafter			TB Risk Assessment. A signed	a .	
		agency must maintain			copy was placed in the		
		aberculosis evaluations			employees' file.		
		erson working for the home			3. All new employees will be		
		ving direct patient contact has			required to have a Baseline 2-	•	
	_	ing on a tuberculosis			TB skin test prior to direct patie	ent	
	examination within	the previous twelve (12)			contact, if indicated. Current		

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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	COMPL	ETED
		157650	B. W	NG		06/11/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				5TH STREET SUITE D		
NOBLE F	HOME HEALTH CAI	RE LLC			AND, IN 46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	months "				employees will have an annua	I TB	
					screening.		
	Personnel record re-	view on 6/10/21 for employee I,			4. To prevent this deficiency fr	om	
	home health aide, ev	videnced a start date of 12/2/20			recurring, the administrative st	aff	
	and first patient con	tact on 12/4/20. Record			will be responsible for monthly		
	review failed to evid	dence the agency conducted a			reviewing employees Medical		
	tuberculosis nationa	l standard evaluation for			Personnel record to ensure the	Э	
	employee I.				annual TB assessment and an	ınual	
					personnel requirements are		
	_	on 6/11/21 at 12:30 p.m., the			completed timely.		
administrator and clinical manager indicated they had no nationally recognized program to screen				Completion Date 08-27-2021			
	for tuberculosis.						
N 0486	410 IAC 17-12-2(h	n)					
	Q A and performa	•					
Bldg. 00	-	The home health agency					
	shall coordinate its	s services with other health					
	or social service p	roviders serving the patient.					
			N 0	486	N486		08/27/2021
		riew and interview, the home			1. Patient #1 A letter of		
		to ensure coordination of			coordination will be submitted	to	
		itities which provided			the entity providing additional		
		to agency patients, in 2 of 4			services for the patient. An		
	clinical records revi	ewed. (#1, #2)			addendum to the Plan of Care including the name of the entit		
	The findings include	٠.			and services being provided w	•	
	The imanigs merca	c.			submitted to the physician for	III DC	
	1. The undated age	ncy policy, number 3.009.1,			signature. Patient #2 has beer	1	
	_	of Client Care" stated "			discharged.		
		that all staff and agencies			All active patients will be		
	•	o a client are engaged in			contacted to identify if they are)	
		e, reporting, and coordination			receiving services from additio		
		e client. Ensure that			outside entities. If determined,		
	documentation in th	e patient's clinical record			Coordination of Care will be		
		of services. Policy: All			documented and filed in patier	nt's	
	service providers in	volved in the care of a client,			EMR.		
		d health care professionals or			3. The Professional staff will be	е	
		ll be engaged in an effective			in-serviced on identifying upon		
	interchange, reporting	ng, and coordination of care			patient's admission all entities		

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	PLAN OF CORRECTION IDENTIFICATION NUMBER 157650 A. BUILDING 00 B. WING		COMPLETED 06/11/2021		
	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 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
	will be documented client will be assess identify any other as the client Proce SN [skilled nurse] winvolved in providir record will contain a support steps taken coordination including professionals provided as the coordination of care 10/01/2018, ce. 05/17/2021, primary obstructive pulmonate agency document the dated and signed by 05/20/2021. This described as the coordination of care included as the coordination included as the coordination included as	eview for patient #2, start of rtification period 03/19/2021 - 7 diagnosis of chronic ary disease, evidenced an thed "Discharge Summary" the clinical manager on ocument had an area subtitled by Addendum Page" which ates she continues to receive to of home health agency] for aving PT [physical therapy] Ew failed to evidence any the with Entity B. From 06/11/2021 at 12:05 p.m., the indicated the patient reported by the physical therapy services is ists of PT. Employee H stant) indicated she just asked		providing services. A letter of coordination will be submitted the entity for signature and file the patient's medical record. T name of the entity and service provided will be documented of the Plan of Care. The entity with notified of any significant chand 4. To ensure this deficiency for recurring, the Clinical Manage be responsible for reviewing a admission packets to identify other entities providing service submitting a letter of coordinate and notifying the entity of any significant changes. Completion Date 08-27-2021	d in he s on II be ges om r will II

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER		2449	ET ADDRESS, CITY, STATE, ZIP COD 9 45TH STREET SUITE D HLAND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	
	on 05/27/2021. Thi patient was hospital During an interview the clinical manager hospitalized at Entit During an interview the clinical manager health agency] prov "home care". Then	on 06/09/2021 at 2:00 p.m., rindicated the patient was			
N 0520 Bldg. 00	for care on the base expectation that the can be adequately agency in the patients agency in the patients agency in the patients agency failed were met in their hed care 2 of 4 clinical numbers. The undated age titled "Care Planning the policy of this Agindividualized, plan treatment, and/or seneeds and goals with the purpose of achience agency agenc	Patients shall be accepted sis of a reasonable patient's health needs met by the home health ent's place of residence. The patient's health needs met by the home health ent's place of residence. The patients needs one according to the plan of records reviewed. (#2, #4) The policy, number 6.016.1, g" stated " Policy: 1. It is	N 0520	N 520 1. Patient #2 has been discharged. Patient #4 - A corrected Plar care will be sent to the physi that does not include skilled nursing services that were n ordered. 2. All active patients' plar cares will be reviewed for active of services to be provided. Identified incorrect Plans of will be amended and sent to physician for review and sign 3. The Nursing staff will in-serviced on developing paplan of care to reflect patient health needs that can be	cian ot n of curacy Care the nature. oe atients'

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING B. WING	00	COMPLETED 06/11/2021	
NAME O	F PROVIDER OR SUPPLIEF	\ !		ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D	
NOBLE	HOME HEALTH CA	RE LLC		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
	process will include Identification of parto resolve the patier Implementation of appropriate clinicia Monitoring the patier provided and/or the will be ongoing will perform a comport formation of a care Plan of Care will be on the initial and or including: a. Ident problems and/or ne professionals involved directly or indirectly Care, including comproblems, needs, compatient's ability to reach the Plan of Care is orders and encompadisciplines, and sere patient's needs review of the Plan of the patient's health environmental factor qualified profession Manager or Therap the Plan of Care or days if skilled care 16. The needs of the order to identify the provided" 2. Clinical record reare 10/01/2018, ce 05/17/2021, with a obstructive pulmon agency document times.	e the following: b. tient's goals and interventions nt's problems and/or needs. c. the planned care or services by ns and/or the patient/family. d. tent's response to the care outcome of the care provided 8. The RN [registered nurse] prehensive assessment in the plan Procedure: 4. The developed during and based n-going assessments, ification of appropriate patient teds 7. All qualified ored in the patient's care, either y, will contribute to the Plan of sideration of the patient's outdition and wishes and the tespond to care services 10. based upon the physician's assess the equipment, supplies, wices required to meet the 12. The frequency of the of Care is based on changes in status, needs and the tors affecting care. The hal/Clinical Manager/Case ist is responsible for revising updating the Plan every 60 is determined to be needed the patient will be prioritized in the level of services to be		adequately met. 4. To prevent this deficient from recurring, the Clinical Manager will be responsible for reviewing the Plans of care aff admission every 60 days for accuracy prior to submission to the physician for signature. Completion Date 08-27-2021	cy or ter

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PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	ROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ALSO IDENTIFYING DIFFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	
	signed by the clinic This plan of care ha Treatments" which old female who live caregiver. Patient h in the past six mont re-hospitalization. decline in health an help. Patient suffer Patient at risk fo risk for falls. Patien complying with me SN [skilled nurse] t assessments SN pain medication bef achieve better pain on nonpharmacolog including relaxation SN to instruct patien pressure ulcer form to instruct the Patien cardiac dysfunction SN to instruct patien alleviate edema. SN following symptom attack: chest discort arms, back, neck, ja breath, cold sweat,			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	calling 911. SN to signs/symptoms of report to MD [medi urinalysis and urine test as needed for si	instruct the Patient on UTI [urinary tract infection] to cal doctor]/SN. SN may obtain culture & sensitivity (C&S) gns/symptoms of UTI, to			
	urine and fever. SN [2 gram sodium] He the Patient to contact	dor, cloudy or blood-tinged I to instruct Patient on 2gNA+ eart Healthy diet. SN to instruct et agency to report any fall for injury and to call 911 for fall			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/11/2021	
NAME OF I	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP COD	-	
	HOME HEALTH CA				TH STREET SUITE D ND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROWING DE AN OF CORRECTION		(X5)
PREFIX	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
	_	injury or causing severe pain					
	or immobility. SN precautions."	to instruct patient on fall					
	Clinical record review failed to evidence any						
	skilled nursing visi	t other than the comprehensive					
	_	ide the education needed for					
	*	egiver as indicated in the plan					
	of care. The skilled nurse failed to meet the patient's needs. 3. Clinical record review on 6/11/21 for patient #4, primary diagnosis: Multiple Sclerosis (Disabling						
	disease of the brain and spinal cord causing						
	problems with vision, arm or leg movement,						
	sensation or balance), start of care 11/21/18,						
		ey document titled "Home					
	1	and Plan of Care," for					
		5/9/21 - 7/7/21, and signed by					
	the clinical supervis	sor. This document stated "					
		to instruct patient to take pain					
		pain becomes severe SN to					
	_	nonpharmacological					
	_	do not use medications to					
		relief measures SN to					
	•	egiver on measures to help					
		lown and pressure ulcer					
		o instruct the patient/caregiver ribute to SOB [shortness of					
		nstruct patient/caregiver on					
	_	and alleviate edema SN to					
		caregiver the symptoms that					
	_	heart attack SN to instruct					
	_	er on signs/symptoms of UTI					
		ion] SN to instruct					
		n a well balanced regular diet					
	_	ne Patient/Caregiver to contact					
		y fall SN to instruct the					
		n fall precautions" This					
		ed " Home Health Aide					
	requesting to provide 6 hours a day, 5 days a						

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PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 157650	A. BUILDING B. WING	00	COMPLETED 06/11/2021	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D		
NOBLE H	HOME 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)	(X5) COMPLETION DATE	
N 0522 Bldg. 00	week (Monday thru days a week (Saturd Respite HHA [home additional care/time Clinical record revies skilled nursing visit assessment to provie the patient and caregor of care. The skilled patient's needs. 4. During an intervithe clinical supervise nursing services that every certification properties in the home control of the patient Care Rule 13 Sec. 1(a) written medical play periodically review dentist, chiropracted podiatrist, as follows Based on record reviewed periodically reviewed was established, indireviewed periodical	Friday) and 4 hours a day, 2 ay and Sunday) for 9 weeks. It health aide] will be used if it is requested" Every failed to evidence any other than the comprehensive de the education needed for giver as indicated in the plan nurse failed to meet the Every failed to meet the last time of the care established and failed by the physician, for, optometrist or every failed to ensure the plan of care ividualized, followed and by by the primary care elinical records reviewed. (#1,	N 0522	N522 1. Patient #1 cert period 4/10-6/08/21 has a completed and signed plan of care. Patient #2 cert 3/19/21 to 5/17/21 has a completed and signed plan of filed in their discharged chart. 2. All active patients' medical records will be reviewed to ensure they have a current plan of cal	08/27/2021 21 – 2 care	
	titled "Care Plannin define a systematic	ncy policy, number 6.016.1, g" stated " Purpose: To process to the clinicians for and revising patient care or		signed by the physician. All missed visit documentation is completed and the physician had been notified.		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 157650		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/11/2021		
	F PROVIDER OR SUPPLIEI E HOME HEALTH CA		•	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)	TE	(X5) COMPLETION DATE
	services either direct agreement. Policy: Agency to provide appropriate care, the on the patient's need the patient for the productions. 2. Care ensure that care and each patient specific care planning procedure. Formulation of consideration of the patient's response to outcome of the care of the specific service actions planned and individualized paties of the Plan of Care is orders and encompared the specific service actions planned and individualized paties of the plan of Care is orders and encompared the specific service actions planned and individualized paties of the plan of Care is orders and encompared the specific service actions planned and individualized paties orders and encompared the specific service actions planned and individualized paties orders and encompared the specific service actions planned and individualized paties orders and encompared the specific service actions planned and individualized paties orders and encompared the specific service actions planned and individualized paties orders and encompared the specific service actions planned and individualized paties.	ctly or through a written 1. It is the policy of this individualized, planned, eatment, and/or service based ds and goals with the input of ourpose of achieving positive planning is performed to discrices are appropriate to coneeds and problems. 3. The eas will include the following: care based on the patient's inc. b. Identification of patient's items to resolve the patient's eads. c. Implementation of the vices by appropriate clinicians amily. d. Monitoring the context of the care provided and/or the exprovided will be ongoing in approcess will be documented of the developed during and and on-going assessments, iffication of appropriate patient eds. b. Measurable and s. c. Specific services to be ms to be taken to meet the type, frequency and duration of the eat the start of care, and the at least eery sixty (60) days or mary of care will be sent every or more often as needed 9. decisions will be reflected in services required to meet the eat the problems and goals. 10. based upon the physician's assess the equipment, supplies, vices required to meet the eat the start of care the supplies, vices required to meet the care problems and goals. 10.			3. All missed visit communicated documentation will be completed by professional staff and include notifying the physician. An electronic log for physician signatures was implemented to track and monitor outgoing an incoming physician signed ord. To prevent this deficiency for recurring, the professional states be responsible for updating the POC every 60 days. The administrative assistant will be responsible for submitting a second request for Plans of Contractive within 30 days and document the contact attempts. Completion Date 08-27-2021	ion ided ides o d ders. om ff will e	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 157650 B. WING	COMPLETED 06/11/2021
NAME OF PROVIDER OR SUPPLIER NOBLE HOME HEALTH CARE LLC STREET ADDRESS, CI 2449 45TH STRE HIGHLAND, IN 46	ET SUITE D
PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO	VIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY) OXIONAL (X5) COMPLETION DATE
2. The undated agency policy, number 4.004.1, titled "Physician Orders' Plan of Care" stated " Purpose: To ensure that each patient's care is under the direction of the physician. Policy: The physician establishes and reviews a plan of treatment for the patient. The plan is updated and is maintained as part of the Agency's clinical record. Procedure: 1. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item of drugs and equipment to be provided by the Agency. 2. All orders on the CMS 485 will be specific to the client condition and needs 7. The physician and appropriate professional staff will review and recertify the written plan of care at least once per episode and as warranted by the patient's condition 10. The Agency provides written and oral reports to the physician regarding the patient's plan of treatment and appropriateness of the continuation of care. The Agency provides written and oral reports to the physician regarding the patient's condition at least every 60 days. Reports may be more frequent if there is an emergency, a need to alter the plan of care or a need to terminate services 12. If the Agency does not receive a signed physician's orders within thirty (30) days of the date the order is sent to the physician's office to obtain the signed document or resends the order(s) to be signed. All follow-up contacts to obtain signed orders are documented." 3. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, and primary diagnosis of multiple sclerosis failed to evidence any plan of care for this certification period.	

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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			LETED				
	PROVIDER OR SUPPLIEF		2449 4	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 PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION UULD BE PROPRIATE	(X5) COMPLETION DATE			
	clinical supervisor in on the patient's rece 04/10/2021 - 06/08/done the visit, but it so in turn the 485/p She indicated she with behind. 4 Clinical record care 10/01/2018, co 05/17/2021, and pri obstructive pulmon agency document ti Certification and Pl signed by the clinic failed to have a phy document had a sec Treatments" which requesting to provid week for 26 weeks. comprehensive asset A review of agency [home health aide] 4/20/21, 4/21/21, 4/evidence the HHA day as ordered on the different communication or a communication or a second control of the clinical manager in communication or a second control of the clinical manager in communication or a communication	an of Care" dated and digitally al manager on 03/19/2021, but sician's signature. This tion titled "Orders and stated " Home Health Aide de 6 hours a day up to 5 days SN to provide essments" documents titled "HHA Visit" dated 4/16/21, 4/19/21, 2/2/21, and 4/23/21, failed to provided services 6 hours a							
N 0524	410 IAC 17-13-1(a	a)(1)							
Bldg. 00	Rule 13 Sec. 1(a) plan of care shall:	(1) As follows, the medical							

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STATEMENT OF DEFICIENCIES X1) F		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00		COMPLETED	
		157650	B. WING 06/11/2021				/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCE NEARLOS 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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
TAG	home health agen (B) Include all set skilled service is b (B) Cover all pert (C) Include the fo (i) Mental statu (ii) Types of ser required. (iii) Frequency a (iv) Prognosis. (v) Rehabilitatio (vi) Functional li (vii) Activities per (viii) Nutritional re (ix) Medications (x) Any safety against injury. (xi) Instructions referral. (xii) Therapy more treatment. (xiii) Any other ap Based on record rev health agency failed plan of care included topical medications implanted devices i reviewed. (#2, #3, # The findings included 1. Review of the ag titled "Client Record and maintain a client the care and serviced completely and acce accessible and syste facilitate the completely facilitate the completely	revices to be provided if a peing provided. inent diagnoses. allowing: as. revices and equipment and duration of visits. In potential. In mitations. In potential. In mitations. In and treatments. In and treatments. In measures to protect and treatments. In properties and treatments. In potential in the properties of the properties are all the location to apply and failed to include and of 4 clinical records (44)	N 0		N524 1. The POC has been amended Patient #3 to include the location apply topical medications. POC has been amended for Patient #4 to include the location apply topical medications. Adischarge summary addendur page was added to Patient #2 chart which states the patient an implanted device. 2. All active patients POCs we reviewed to ensure the patient conditions and needs are individualized and include all tocations to apply topical medications. 3. POC will be reviewed every	ion The ion A m has ere t's	08/27/2021	

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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		(X3) DATE SURVEY COMPLETED 06/11/2021		
		157650	B. WIN	·		06/11/	2021
	PROVIDER OR SUPPLIES			2449 45	DDRESS, CITY, STATE, ZIP COD TH STREET SUITE D		
NOBLE HOME HEALTH CARE LLC				HIGHLA	ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
IAG	a new client The not be limited to all Care plan that in 2. Review of the ag titled "Physician Or To ensure each patidirection of the phy establishes and revipatient. The plan is part of the Agency's physician sets up a the diagnosis, prograccomplished, an ordrugs and equipmer agency All orde Care] will be specifineeds" 3. Clinical record reprimary diagnosis: disease (long-term acauses obstructed a resulting in difficul 11/3/20, evidenced "Home Health Cert certification period the primary care phy This document state [medication used to swelling, and discontain the primary than the primary tha	eclient record will include but of the following information: cludes medications" ency policy revised 6/10/21 rders/Plan of Care," stated " ent's care is under the sician The physician ews a plan of treatment for the supdated and is maintained as a clinical record The plan of care, which includes nosis, goals to be refer for each service, item of an to be provided by the error on the CMS 485 [Plan of are to the client condition and eview on 6/10/21 for patient #3, Chronic obstructive pulmonary inflammatory lung disease that inflow from the lungs, ty breathing), start of care an agency document titled iffication and Plan of Care," for 5/2/21 - 6/30/21, and signed by ysician and clinical supervisor. ed " Proctozone-HC of treat minor pain, itching, mfort] External 2.5% thin layer ice a day" This document here to apply the medication, but she is olan of care to apply the		IAG	days for the accuracy of medication application and implanted devices. 4. The Clinical Manager is responsible for reviewing on admission and every 60 days POCs for accuracy of medications, route and locatic and documentation of implant devices. Completion Date 08-27-2021	all	DATE

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 157650		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	disease of the brain problems with visic sensation or balance evidenced an agence Health Certification period the clinical supervis Aloe Vesta [medicatreat and prevent drain minor skin irritation [milliliters] Apply to PRN [as needed] to This document failed affected area was lowed medication. 5. Clinicater of care 10/01/203/19/21 - 05/17/21 obstructive pulmon agency document to Certification and Plasigned by the clinicated by the clinicated patient's implantated "Didigitally signed by 05/20/2021. This document titled "Didigitally signed by 05/20/2021. This document the Discharge Summa stated" Patient he 05/04/2015)"	2018, certification period , primary diagnosis of chronic ary disease, evidenced an tled "Home Health an of Care" dated and digitally al manager on 03/19/2021.					
N 0527 Bldg. 00	410 IAC 17-13-1(a Patient Care Rule 13 Sec. 1.(a)	a)(2))(2) The health care					'

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/11/2021		
	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 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	shall promptly ale the medical comp to any changes th	of the home health agency rt the person responsible for onent of the patient's care at suggest a need to alter					
	health agency failed physician to any chat suggest that ou achieved and/or that altered in 1 of 4 clin. The findings included 1. Review of the aguittled "Care Plannir information including status, types of service visits, goals and interest discipline, prognosifunctional limitation activities, nutritional treatments, and instead will be developed deand on-going assessed Clinicians will info any changes that sure of Care" 2. Review of the aguittled "Physician On To ensure that each direction of the phy establishes and revipatient. The plan is part of the Agency's Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the Agency's profession clinical records to contact the sure of the sure of the Agency's profession clinical records to contact the sure of th	view, and interview the home d to promptly alert the relevant anges in the patient's needs tcomes are not being at the plan of care should be nical records reviewed. (#4)	N O	0527	N527 1. Patient #4 the primary physician has been notified th times the caregiver refused services. A signed order has been received to amend the POC. 2. All active patients' POCs wereviewed to ensure the releval physician is promptly alerted the changes in the patient's needs. 3. The Professional staff will inserviced on completing all mistoriated to completing all mistoriated to complete the physician and clinical managed be responsible for ensuring all missed visits are documented physicians are notified, plans care are amended and a communication note is entereinto the EMR. Completion Date 08-27-2021	peen ill be nt o n ssed udes nical pes r will l , of	08/27/2021

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING 00 B. WING			COMPLETED 06/11/2021			
	ROVIDER 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
	written and oral rep the patient's plan of	e The Agency provides orts to the physician regarding treatment and he continuation of care"						
	primary diagnosis: I disease of the brain problems with vision sensation or balance evidenced an agence. Health Certification period the clinical supervise. Home Health Aide aday, 5 days a week hours a day, 2 days Sunday) for 9 week aide] will be used if requested" A record review evititled "Missed Visit aide] Visit)," dated 5/24/21, and 5/29/2 administrator. These Patient/Caregiver depatient/caregiver on	eview on 6/11/21 for patient #4, Multiple Sclerosis (Disabling and spinal cord causing an, arm or leg movement, e), start of care 11/21/18, y document titled "Home and Plan of Care," for 5/9/21 - 7/7/21, and signed by sor. This document stated " requesting to provide 6 hours a (Monday thru Friday) and 4 a week (Saturday and s. Respite HHA [home health and fadditional care/time is form (HHA [home health form (HHA [home health form)]). The section of the section of the state of the section of th						
	assist patient M. Notified No to evidence the ager the caregiver's conti 5/15/21 - 5/29/21.	D [Doctor of Medicine] " Clinical record review failed ney notified the physician of inual refusal of services from						
	administrator indica patient #4 did not w employee C, home	y on 6/11/21 at 1:06 p.m., the atted the family member of vant anybody else besides health aide due to her brother COVID. She indicated the						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING 00 COMPLETED B. WING 06/11/2021			
	ROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD	
NOBLE F	HOME HEALTH CAI	RE LLC	HIGHL	AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
	could not accept have despite the agency of administrator indica could to honor the fa	elp, but the family member ving anyone else there, offering another aide. The ted they did the best they amily member's refusal. She did not notify the MD for all of			
N 0533	410 IAC 17-13-2				
DI 1 00	Nursing Plan of Ca				
Bldg. 00	must be developed the purpose of delepatient care provide agency for patients	A nursing plan of care d by a registered nurse for egating nursing directed led through the home health s receiving only home es in the absence of a			
	following: (1) A plan of care	an of care must contain the and appropriate patient			
	identifying informa (2) The name of the distribution (3) Services to be	he patient's physician.			
	(4) The frequency(5) Medications, d(6) Signed and dapersonnel providing	and duration of visits. liet, and activities. Ited clinical notes from all g services.			
	(7) Supervisory vi(8) Sixty (60) day(9) The discharge(10) The signature who developed the	summaries. note. of the registered nurse			
	Based on record rev health agency failed was developed by a purpose of delegating care provided through	iew and interview, the home to ensure an aide care plan registered nurse for the ag nursing directed patient gh the home health agency for ome health aide services for all	N 0533	N533 1. Patient #1 the nurse has completed and signed the Aide Care Plan. Patient #4 the nurs has completed and signed the Aide Care Plan. 2. All active patient Aide Care	е

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PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING 00 B. WING		COMPLETED 06/11/2021				
NAME OF P	PROVIDER OR SUPPLIER	- L	STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D					
NOBLE H	HOME HEALTH CA	RE LLC		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			
	home health aide as records reviewed w #4) The findings includ 1. The undated age titled "Registered N ensure that all Registered	signments, in 2 of 4 clinical vith a home health aide. (#1,		Plans will be reviewed for completion and signature. 3. The nursing staff will be in-serviced on establishing a written care plan on admission and updating the aide care platevery 60 days at the time of recertification. 4. To ensure this deficiency do not recur, the Clinical Manage be responsible for reviewing a Aide Care Plans on admission every 60 days or as needed, to	n nn pes r will II			
	treatment. These see following: Procedu home health aide as	ervices shall include the are: 4. The RN will make signments, prepare written aide, and supervise the aide in		ensure that it is current, accurs signed, and dated by the registered nurse. Completion Date 08-27-2021				
	titled "Home Health that all home health clearly stated Th Nursing, Alternate I Case manager are re- instructions for hom exercises, are prepa therapist as approprimentation to	gency policy revised 6/10/21 in Aide," stated " To ensure aide visits responsibilities are the agencies Director of Director of Nursing, and/or the esponsible for Written the care, including specific the red by a registered nurse or that aide instructions are to the patients plan of care and to owed to be permitted by a						
	titled "Timeliness a Clinical Record," st current and accurate patient and to ensur client's records in a into the client recor	ency policy revised 6/10/21 nd Accuracy of Entries in the ated " To ensure that a e clinical record exists for each e documents are filed in the timely manner Each entry d must be current, accurate, dated with the date of the						

State Form Event ID: 3UVY12 Facility ID: 012829 If continuation sheet Page 70 of 84

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 06/11/2021			
	ROVIDER 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
ing	entry by the individ Documents must be timely and accordin retrievable during of 4. Clinical record in 06/09/2021 at 2:18 jagency's electronic (Wellsky). This ele	ual making the entry. filed into the client record g to regulations and	1710		BAIL		
	06/08/2021, and ser service calendar wa stated "Aide Care P assigned to the clini	vice calendar. Below the s a list of tasks. Entry #1 lan" which indicated it was cal manager, had a target date ndicated the status of the					
	clinical manager inc	on 06/09/2021 at 2:52 p.m., the dicated I know how it looks, but rom the last aide care plan.					
	the clinical manager only needed to be si	on 06/11/2021 at 11:20 a.m., r indicated the aide care plan igned by her, but since she showed up as not signed on nic medical record.					
N 0541	410 IAC 17-14-1(a Scope of Services						
Bldg. 00	Rule 14 Sec. 1(a) services are limite purposes of practi setting, the register following:	(1)(B) Except where d to therapy only, for ce in the home health ered nurse shall do the valuate the patient's nursing					
	health agency failed	riew and interview, the home I to ensure all medications the ribed were reconciled and	N 0541	N541 1. Pt. #2 has been discharged #1 Recertification comprehens assessment is complete, sign	sive		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		157650	B. W	/ING		06/11/	2021
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				STH STREET SUITE D		
NOBLE	HOME HEALTH CA	PELLC					
INODLE	HOME HEALTH CA	NE LLU		niGnL/	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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	serious medication	interactions were reported to			by physician, and filed in patie	nt's	
	the primary care ph	ysician during the medication			EMR.		
	reconciliation and f	ailed to ensure the			2. All active charts will be revi	ewed	
	comprehensive asse	essment was completed timely			to ensure all medications		
	to meet the patient's	s nursing needs in 2 of 4			prescribed were reconciled an	ıd	
	clinical records revi	iewed. (#1, #2)			serious medication reactions v	were	
			1		reported to the primary care		
	The findings includ	e:			physician. All client records wi	ll be	
					reviewed to ensure the		
	1. The undated agency policy, number 4.009.2,				comprehensive assessment is		
	titled "Medication Administration Record" stated				completed in timely manner to)	
	" 11. To prevent and reduce the likelihood of				meet the patient's needs.		
	adverse drug reactions, this agency checks the				3. A medication reconciliation	will	
	medication profile for interaction risks. Drug to				be conducted during the		
	_	d as potentially moderate or			comprehensive assessment e	very	
	_	to the prescribing physician			60 days or if there are any		
	1 ~	ion. Patients are educated on			changes in the patient's condi	tion.	
		rse interactions possibilities,			4. To prevent this deficiency fr	rom	
	_	alcohol while taking certain			recurring, the Clinical Manage	r will	
	1	d and medication interactions.			be responsible for every 60 da	ays	
	Education will be d	ocumented on the visit note"			reviewing the comprehensive assessment to ensure the		
	2. The undated age	ncy policy, number 4.009.1,			medication reconciliation is		
		Profile" stated " Policy: It is			complete and action taken, if		
		f the admitting therapist/nurse			needed, and ensure that the		
		itions that the patient is			comprehensive assessments	are	
		a routine or PRN [as needed]			completed timely.		
	, , ,	on will include upon			Completion Date 08-27-2021		
		ication, route, amount and					
		re: 3. Nursing staff check					
	all drug therapy a p	atient may be taking to identify					
	possible effectivene	ess, ineffectiveness, actual or					
	potential interaction	ns, side effects, desired effects,					
	toxic effects, unusu	al/unexpected effects, allergic					
	reactions, duplicate	drug therapy, non-adherence,					
	the need for laborat	ory monitoring of drug levels,					
	drug allergies, and	contraindicated medication and					
	drug recalls and pro	omptly report any problems to	1				
	the physician. 4. A	at time of discharge the					
	patient/provider will be provided with a complete						

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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 06/11/2021
	ROVIDER 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	receiving agency wi	ion profile. Upon transfer the ill receive a complete and profile (whenever, possible)"			
	care 10/01/2018, ce 05/17/2021, prima obstructive pulmonagency document ti	rtification period 03/19/2021 - ry diagnosis of chronic ary disease, evidenced an tled "Patient Medication signed by the clinical manager			
	on 05/17/2021. Thi subtitled "Current M Duloxetine HCL[hy	s document had an area Medications" which stated " rdrogen chloride] [for ety] Oral 30 MG [milligram] 1			
	disintegrating tablet (s) PO 1 Tablet Q [o Nausea Antiemetics	ath] Daily Zofran ODT [oral c] [for nausea] Oral 8 MG 1 Tab every]8 PRN [as needed] For s traMADol HCl [for pain]			
	Analgesics - Opioid	(s) PO Q4 Hours PRN" This document also rian was not contacted and ctions.			
	Duloxetine and Zof medication interacti serotonin syndrome	enced the combination of ran can cause a serious on by increasing the risk of , in which severe cases can			
	evidence in the clin	ath. There failed to be ical record the primary care ied of this possible severe on.			
	Duloxetine and Trai medication interacti serotonin syndrome result in coma or de evidence in the clini	enced the combination of madol can cause a serious on by increasing the risk of , in which severe cases can ath. There failed to be ical record the primary care ied of this possible severe on.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING B. WING	00	COM	PLETED 1/2021	
	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	the clinical manager [electronic medical interactions and if it don't take any action Clinical record reviet document titled "Discharge Stated she really and denies chest paid Clinical record revinitroglycerin patch of medication reconcil During an interview the clinical manager the profile. 4. Clinical record record record record (1972) Care 08/13/2020, prisclerosis, failed to ecomprehensive asseption of 04/10/202 During an interview clinical manager stated she performed recertification was replan of care] was not manager stated she company the stated she care the sta	ew evidenced an agency scharge Summary" dated and all manager on 05/20/2021, ummary Addendum Page oglycerin patch for chest pain doesn't have chest pain at all in at time of assessment" ew failed to evidence a con the patient's plan of care or interest and occumentation. From 06/11/2021 at 12:02 p.m., reindicated she didn't update eview for patient #1, start of famary diagnosis of multiple evidence a recertification ssment for the certification 1 - 06/08/2021. From 06/09/2021 at 2:40 p.m., the ted she was still working on 11 recertification ssment. The clinical manager d the visit, but the not done and in turn the 485 ot complete. The clinical was working on this				

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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. WING 06/11/2021				
	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	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	the clinical manager	r stated "I'm sorry I'm still					
	working on it." (in r	regards to completion of the					
		essment conducted on					
	04/09/2021).						
N 0547	410 IAC 17-14-1(a						
	Scope of Services						
Bldg. 00		(1)(H) Except where					
		d to therapy only, for					
	purposes of practice in the home health						
	setting, the registered nurse shall do the						
	following:						
	(H) Accept and carry out physician,						
	chiropractor, podia						
	optometrist orders	(oral and written).					
			N 0	547	N547		08/27/2021
		view and interview, the home			1. Pt. #2 Discharged POC was	3	
		l to ensure verbal orders were			submitted to physician and		
	-	services and treatments being			returned signed.		
		agency in 1 of 4 clinical			2. All active patient charts will		
	records reviewed. (#2)			reviewed to determine comple		
	The findings includ				of the POC with signatures. The	те	
	The findings include	e:			plan of care and other orders requiring a physician's signatu	ıro	
	The undated agency	policy, number 4.004.1, titled			will be filed in the patients EM		
		Plan of Care" stated "			within 7 days of receipt in office		
		that each patient's care is			the Agency does not receive a		
	-	of the physician. Policy: The			signed physician orders within		
		es and reviews a plan of			thirty (30) days, the order is	!	
		tient Procedure: 1. The			resent.		
	•	plan of care, which includes			3. An electronic tracking log		
	the diagnosis, progn	-			system will be used to monitor	r	
		rder for each service, item of			and track all outstanding POC		
	_	nt to be provided by the			without signatures. All follow-u		
		pies of the plan of care and			contacts will be documented in	•	
		ng a physician's signature			patient's EMR.		
	-	ne client record within 7 days			4. To prevent this deficiency fr	om	
		7. The physician and			recurring the administrative sta		
	-	ional staff will review and			will be responsible for monthly		
		plan of care at least once per			monitoring and tracking physic		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157650	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	ROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 15TH 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	episode and as warr condition 12. I a signed physician's of the date the order signature, the Agen office to obtain the the order(s) to be signature, the Agen office to obtain signed order to obstructive pulmonagency document to Certification and Pl signed by the clinic document indicated provide services 6 leaves for 26 weeks, provide comprehens murse was to instruct medication and non instruct patient on pand skin breakdown cardiac dysfunction instruct patient on hedema, instruct patient on hedema, instruct patient on diet, instruct patient on diet, instruction of a urinally sis and urine patient on diet, instruction of services. The cevidence that a verbel of the administration and services. The cevidence that a verbel of the administration and services. The cevidence that a verbel of the administration and services. The cevidence that a verbel of the administration and services.	anted by the patient's If the Agency does not receive orders within thirty (30) days is sent to the physician for cy contacts the physician's signed document or resends gned. All follow-up contacts ters are documented" we for patient #2, start of care ation period 03/19/2021 - y diagnosis of chronic ary disease, evidenced an tled "Home Health an of Care" dated and digitally all manager on 03/19/2021. This the home health aide was to sours a day up to 5 days a the skilled nurse was to sive assessments, the skilled		orders. Completion Date 08-27-2021	
	During an interview	on 06/11/2021 at 12:20 p.m.,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUI	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 06/11/2021			LETED	
	PROVIDER OR SUPPLIER			2449 45	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	TE	(X5) COMPLETION
N 0606 Bldg. 00	the clinical manage sent off to the physicand the agency did was signed by the public to the physicand the agency did was signed by the public to the physicand the agency of Services Rule 14 Sec. 1(n) therapist in therapist in therapist in therapist in therapist in the initial visit to the make a supervisor (30) days, either wis present or abse assess relationship whether goals are. Based on record revibe health agency failed furnished care in a sincluiding, but not lipatient's plan of car assigned to a home nurse in 4 of 4 clinic #3, #4). The findings included 1. Review of the age titled "Home Health that all home health clearly stated The following responsible that are ordered by care, only those services and received as registered nurse support that are ordered by care and received as registered nurse support that are support to the physican support that are ordered by care and received as registered nurse support that are ordered by care and received as registered nurse support that are support that	A registered nurse, or y only cases, shall make he patient's residence and ry visit at least every thirty when the home health aide nt, to observe the care, to ps, and to determine being met. View and interview the home I to ensure that aides safe and effective manner, mited to: following the e for completion of tasks health aide by the registered cal records reviewed. (#1, #2, e: e: ency policy revised 6/10/21 in Aide," stated " To ensure aide visits responsibilities are ne home health aide shall have insibilities Provide services the physician in the plan of swritten in the plan of swritten instructions from the pervisor as permitted under	N 06	TAG	N606 1. Pt.#3-Aide has received ver counseling regarding not follow the Aide Plan of Care on 5/7, and 5/24, 2021. Pt.#4 Aide was counseled on not following the written care plan on 5/11, 5/16, 5/18, 5/19, 5/23, 5/26, 5/5/30, 6/1, 6/3, 6/6, 6/8, 6/9 and 6/10, 2021. The Clinical Super was counseled on failing to er that the Aide was following Aid Care Plan. Pt. #2 has been discharged. Aide was counsel for not following plan of care. Clinical Supervisor was couns on failing to ensure the aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan. Pt. The clinical supervisor was counseled on failing to ensure aide followed the aide care plan.	rbal wing 5/28, as e 3, //27, d rvisor asure de ed The eled t. #1	08/27/2021
		ency policy revised 6/10/21 vision," stated " To ensure			to ensure the aide care plans being followed as assigned by		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER		2449 4	ADDRESS, CITY, STATE, ZIP COD 5TH STREET SUITE D AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE
	provided in a profes state regulatory guid nurse will oversee to takes place on a consupervising nurse ware aware of condition a timely manner and ensure that the patients being followed through the staff communication and the	cons and patient care are assional standard that meets delines The supervising hat patient communication atinuous basis. The fill ensure that all disciplines on changes and evaluations in The supervising nurse will ent's POC [plan of care] is ugh chart audits, note reviews, and patient communication eview on 6/10/21 for patient #3, Chronic obstructive pulmonary inflammatory lung disease that irflow from the lungs, by breathing), start of care an agency document titled ated 5/2/21 and signed by the This document stated " ridays and when soiled ement Per visit" idenced agency documents health aide] Visit," dated and signed by employee E, These documents indicated the field on 5/7/21 and 5/28/21. ew failed to evidence the linen Friday as ordered in the Aide denced an agency document elast bowel movement. even failed to evidence the aide wel movement. even failed to evidence the aide wel movement as ordered in		Clinical Manager to ensure the aide follows the aide care plar 3. Nursing staff will be in-serv on frequency of Aides supervivisits, developing Aides Plan of Care and ensuring the Aide is following the Aide Plan of Car The Aides will be in-serviced of following the Aide Plan of Car and notifying the Clinical Manor Nursing Supervisor when the are missed home visits and withey are unable to complete a tasks listed on the Aide Plan of Care. 4. To prevent this deficiency frecurring, the Clinical Manage be responsible for weekly reviall aide documentation for completion of tasks and the A Supervisory documentation for timeliness of Aide Supervisory visits. Completion Date 08-27-2021	n. iced sory of e. on e ager nere hen re of rom er will ew of

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		A. BUILDING B. WING	00	COMPLETED 06/11/2021	
	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
	titled "Aide Supervisigned by the clinic stated " Follows on Excellent" Tailed to ensure the plan by changing the recording the last be During an interview administrator staate and 5/28/21 were not documented. During an interview clinical supervisor state and socument the bowe document the bowe document the bowe document the bowe disease of the brain problems with vision sensation or balance evidenced an agence Plan," dated 5/9/21 supervisor. This document has the partial bath or compusit with patient's publication of the partial bath or compusition of the partial bath or compusition of the partial bath or compusition of the partial bath or comparial bath or co	idenced agency documents health aide] Visit," dated [16/21, 5/18/21, 5/19/21, 5/23/21, 30/21, 6/1/21, 6/3/21, 6/6/21, 6/10/21. Clinical record review the patient received either a plete bath on the			

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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 SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIEI		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 APPROPRIATE OF T	(X5) COMPLETION DATE
	titled "Aide Superv signed by the admir stated " Follows Excellent"	isory Visit," dated 6/7/21 and nistrator. This document client plan of care as instructed The home health aide supervisor aide followed the aide care either a partial bath or complete			
	clinical supervisor that the baths were the patient has multexhausted and declarate a lot of energy documented.5. Cli #2, start of care 10/03/19/2021 - 05/17 chronic obstructive agency documents aide] Visit" dated 0/04/20/2021, 04/21/05/05/2021, 05/06/05/13/2021, which	v on 6/11/21 at 1:03 p.m., the stated she is noting the days not completed. She indicated tiple sclerosis and may be ining the baths since the baths from him, but this was not nical record review for patient 01/2018, certification period /2021, primary diagnosis of pulmonary disease, contained titled "HHA [home health 4/16/2021, 04/19/2021, 02021, 04/22/2021, 05/11/2021, 05/12/2021 and failed to evidence the aide care the registered nurse was			
	home health aide v. 04/27/2021, 04/28/ 05/03/2021, 05/04/ 05/14/2021. The hother plan of care.	also failed to evidence that isits were made on 04/26/2021, 2021, 04/29/2021, 04/30/2021, 2021, 05/07/2021, 05/10/2021 and ome health aide failed to follow			
	health provided 6 h services, as directed dates of 04/16/2021 04/21/2021, 04/22/	failed to evidence the home ours of home health aide d on the plan of care, for the 1, 04/19/2021, 04/20/2021, 2021 and 04/23/2021. The home of follow the plan of care.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		JILDING	instruction 00	(X3) DATE COMPL 06/11 /	ETED	
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD STH STREET SUITE D		
NOBLE H	HOME HEALTH CA	RE LLC		AND, IN 46322		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	· ·			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
PREFIX TAG	A review of an ager Supervisory Visit" the clinical manage document stated " Satisfactory Fol instructed: Satisfactory appropriately: Satisfactory instructed: Satisfactory appropriately: Satisfactory appropriately: Satisfactory and interview the clinical manage communication or communica	v on 06/11/2021 at 12:25 p.m., r stated she didn't see any documented reason for the aissed hours. v on 06/11/2021 at 12:31 p.m., r stated "We need to coach ething." (in reference to blank nealth aide visit notes) v on 06/11/2021 at 12:39 p.m., concerns with the supervisory eal manager stated "I see what review for patient #1, start of extification period 04/10/2021 - y diagnosis of multiple intained agency documents health aide] visit dated 2021, and 05/17/2021, the home tees failed to evidence the aide	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
		. Follows client plan of care as nt" This supervision element				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157650		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 06/11/2021			
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
N 0610	410 IAC 17-15-1(a Clinical Records				
Bldg. 00	Rule 15 Sec. 1. (a legible, clear, com authenticated and must include signa computer entry.)(7) All entries must be plete, and appropriately dated. Authentication atures or a secured	N 0610	N610	08/27/2021
	appropriately author records reviewed. (#			1. Pt.#3 The home health aide home visit dated 6-4-21 has b authenticated with the home health aide's signature. Pt.#2	een
	titled "Home Health that all home health clearly stated The following responsive appropriate records 2. Review of the aguittled "Clinical Record and maintain a clienthe care and service completely and accuracessible and systefacilitate the compliminformation All patient's clinical recording person with and surname and tit 3. Clinical record record record states and surname and tit and surname and surnam	ency policy revised 6/10/21 in Aide," stated " To ensure aide visits responsibilities are the home health aide shall have insibilities Completing" ency policy revised 6/10/21 ords," stated " To establish that record system to assure that as provided to each client are curately documented, readily ematically organized to fance and retrieval of motes and reports in the ord shall be typewritten or k, dated and signed by the th his full name or first initial		Patient Communication documented 4-26-2021 has been authenticated with the Administrator's credentials. Pto The home health aide visits not dated 04/19, 4/20, 4/21, 4/22, 4/26, 4/27 4/28, 5/3, 5/4, 5/5, 5/10, 5/11, 5/12, 5/13, 5/14, 5/5/17, 5/18, 5/20, 5/24, and 6/8 2021. All have been authentic with the home health aide's credentials. The home health home visit note dated 05/19/20 has been authenticated with the home health aide's signature acredentials. The home health documentation note dated 05/11/2021 with an incorrect on 05/12/2021 has been correland authenticated. 2. All active patient's home he aide home visit notes and professional clinical notes will reviewed for signature, date, a	z.#1 botes 5/6, 716, 3, ated aide 021 ne and aide entry ected ealth be
	disease (long-term i causes obstructed ai resulting in difficult	nflammatory lung disease that airflow from the lungs, by breathing), start of care an unsigned agency document		credentials. All electronic staff notes of active employees we reviewed and include the employees' credentials, dates	re

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	OF CORRECTION OF CORRECTION 157650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	PROVIDER OR SUPPLIER HOME HEALTH CARE LLC	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	titled "HHA [Home Health Aide] Visit," dated 6/4/21. This document failed to evidence the home health aide signed the document after completing the visit. During an interview on 6/11/21 at 12:55 p.m., the clinical supervisor indicated in the computer it says that it is completed but the document does not say digitally signed.4. Clinical record review for patient #2, start of care 10/01/2020, certification period 03/19/2021 - 05/17/2021, evidenced an agency document titled "Patient Communication" dated 04/26/2021 and digitally signed by the administrator. This document failed to have the administrator's credentials. 5. Clinical record review for patient #1, start of care 08/13/2020, certification period 04/10/2021 - 06/08/2021, primary diagnosis multiple sclerosis, evidenced agency documents titled "HHA [home health aide] Visit" dated 04/19/2021, 04/20/2021, 04/21/2021, 04/22/2021, 04/26/2021, 04/27/2021, 05/05/2021, 05/06/2021, 05/03/2021, 05/04/2021, 05/05/2021, 05/06/2021, 05/10/2021, 05/11/2021, 05/13/2021, 05/13/2021, 05/14/2021, 05/12/2021, 05/18/2021, 05/14/2021, 05/14/2021, 05/17/2021, 05/18/2021, 05/20/2021, 05/24/2021 and 06/08/2021. These home health aide visit notes failed to evidence the home health aide's credentials. Clinical record review evidenced an agency document titled "HHA Visit" dated 05/19/2021. This document failed to evidence the home health aide's credentials. During an interview on 06/11/2021 at 11:26 a.m., the administrator indicated she never actually noticed that the home health aide credentials didn't show up on agency documents.	IAG	and signatures. 3. The home health aides and professional staff will be in-serviced on ensuring documentation notes are legit clear, complete, and appropria authenticated and dated which includes computer entry signatures. 4. The Clinical Manager will be responsible for weekly review all home health aides and professional documentation in to ensure that this deficiency not recur. Completion Date 08-27-2021	ole, ately h e ing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE C AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 157650 B. WING		JILDING ING	00	(X3) DATE COMPL 06/11 /	ETED		
NAME OF PROVIDER OR SUPPLIER NOBLE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 2449 45TH STREET SUITE D HIGHLAND, IN 46322				
TAG REGULATION Clinical docume This hor patient's one day authenti During a	CH DEFICIEN ILATORY OR record revient titled "HI ne health ai last bowel after the vise. un interview cal manage	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ew evidenced an agency HA Visit" dated 05/11/2021. de visit note indicated the movement was 05/12/2021, sit. This note failed to be y on 06/11/2021 at 11:38 a.m., r indicated the date had to be a		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE

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