STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	201081670A	A. BUILDING B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE HOME HEALTH CARE LLC	2449 45TH STREET SUITE D, HIGHLAND, IN, 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a Post-Condition Revisit Survey. Facility ID: 012829 Survey Dates: 8/5/2022 - 8/11/2022	N0000		2022-08-31
G0000	INITIAL COMMENTS This visit was for a Post-Condition Revisit Survey. Facility ID: 012829 Survey Dates: 8/5/2022 - 8/11/2022 These deficiencies reflect State Findings cited in accordance with 410 IAC 17.	G0000		2022-08-31

E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider. Survey Dates: 8/5/2022 to 8/11/2022 At this Emergency Preparedness survey, Noble Home Health Care LLC was found to be in compliance with Conditions of Participation 42 CFR 484.102 Emergency Preparedness requirements for Medicare Participating Providers and Suppliers. QR Completed 8/22/2022 A4	E0000		2022-08-31
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on observation, record review, and interview, the agency failed to ensure the OASIS (outcome and assessment information set)(the patient-specific, standardized assessment used in Medicare home health care) accurately reflected patient s status at time of assessment in 2 of 3 records reviewed (#2, 3). The findings include: 1. Record review on 8/11/2022 evidenced an agency policy titled, Comprehensive	G0374	**G0374** **Pt.#2** OASIS recertassessment has been corrected to accurately reflect the ability of the patientto transfer. **Pt.#3 -** OASIS start of care assessment dated 7/5/22 has been corrected toanswer the questions of M2003 and M2010, M2020, M2030. Every start ofcare, recertification, and resumption, will have a quality review by theprofessional staff to ensure the oasis accurately reflects the patient statusat the time of	2022-08-31

	Assessment of Patients (OASIS) , updated 8/10/2022, which stated, Purpose: To achieve measurable improvement in the quality of care provided focusing on patient outcomes and assessing that all critical information is routinely incorporated through timely assessments identifying a patient s initial and changing needs. Policy: A comprehensive assessment incorporating the Outcomes and Assessment Information Set (OASIS) utilizing the most current approved version will be performed & The OASIS data collected must accurately reflect the patient s status at the time of the assessment &. 2. Clinical record review for patient #2 on 8/9/2022 evidenced an OASIS recertification assessment, dated 7/29/2022. The section titled Musculoskeletal indicated the patient could transfer independently to and from the toilet, move from bed to chair with minimal assistance, and walk with use of a cane. In the section titled, Coding: Safety and Quality of Performance , the following activities were Not attempted due to environmental limitations : Roll left and right, Sit to lying, Lying to sitting, Chair/bed transfer, Toilet transfer, Walk 50 feet with two turns, Walk 10 feet on uneven surfaces, and 1 step (curb). During an interview on 8/11/2022 at 11:00 AM, the administrator indicated the patient was able to transfer with minimal assistance and walk with a cane. When informed of the findings, the administrator stated, Those are wrong. That doesn t make sense . 3. Clinical record review for patient #3, on 8/9/2022 evidenced an OASIS Start of Care assessment, dated 7/5/2022. Review of the assessment evidenced questions M2003, M2010, M2020 and M2030 were not answered. During an interview on 8/11/2022 at 12:39 PM, the administrator indicated the OASIS start of care dated 7/5/2022 had just been submitted, and she didn t know why there wasn t an alert to complete the unanswered questions. The		assessment. In addition one-on-one skilled nurse review of theoasis assessments**.** The Administratoris responsible to QA review 100% of OASIS submissions.	

	administrator indicated all answers should be completed on the OASIS assessment by the nurse.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the plan of care was individualized and followed in 3 of 3 clinical records reviewed (Patients #1, 2, 3) The findings include: 1. Record review on 8/11/2022 evidenced an agency policy titled, Physician Orders / Plan of Care , updated 8/10/2022, which stated, Purpose: To ensure that each patient s care is under the direction of the physician & Procedure: & The physician sets up a plan of care & All orders & will be specific to the client condition and needs & The Agency s professional staff will review the clinical records on a continuous basis to ensure that each POC [plan of care] is specific to the patient &.	G0572	**G0572** **Pt.#1** Plan of Care hasbeen corrected to reflect that the medication boxes are filled by the facilitythe patient resides in. The skilled nurse visit notes have been corrected to reflectanticoagulant, seizure and fall precaution assessments. **Pt.#2** SN visit notes were corrected to includeseizure precaution assessments. **Pt.#3** SN visit notes were corrected to include anticoagulant and fallprecaution assessments. One-on-one skillednurse education re skilled nurse visit notes to include assessments of allsafety precautions as noted in the plan of cares. All skilled nurse visit notes and plan ofcares will be case managed as needed in plan of care. The ClinicalDirector will be responsible to QA review 100% of SN notes to ensure the planof care was followed. The administrator will be responsible to QA review 100% allplan of cares to ensure they	2022-08-31

	2. Record review evidenced an agency policy titled, Medication / Prescriptions Orders , updated 8/10/2022, which stated, & Medication orders or prescriptions are clear and accurate. Medication orders must be complete &. 3. Record review evidenced an agency policy titled, Care Planning , updated 8/10/2022, which stated, & It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and / or service based on the patient s needs and goals with the input of the patient for purpose of achieving positive outcomes &. 4. Clinical record review for patient #1 was performed on 8/8/2022. The plan of care for certification period 6/29/2022 to 8/27/2022 indicated the patient was on Anticoagulant [blood thinner] Precautions, Seizure Precautions and Fall Precautions. Review of skilled nurse visit notes dated 7/14/2022, 7/16/2022, 7/18/2022, 7/20/2022, 7/22/2022, and 7/24/2022 failed to evidence Anticoagulant, Seizure, and Fall Precautions. During an interview on 8/10/2022 at 4:34 PM, the administrator indicated safety precautions should be addressed at each visit and documented in the skilled nurse visit notes. Review of the plan of care evidenced a section titled, Orders and Treatments , which stated, & SN [skilled nurse] to & fill medication boxes as indicated &. During an interview on 8/10/2022 at 3:31 PM, RN (registered nurse) #1 indicated the patient lived in an Assisted Living Facility, who managed the patient s medications. RN #1 indicated she did not fill medication boxes for the patient because it was not needed.		appropriate care andtreatment based on the patient’s needs and goals.	

During an interview on 8/10/2022 at 3:31 PM, the administrator indicated filling medication boxes was not needed by the patient, and the plan of care was not individualized.

5. Clinical record review for patient #2 was performed on 8/9/2022. The plan of care for certification period 6/4/2022 to 8/2/2022 indicated the patient was on Seizure Precautions.

Review of all skilled nurse visit notes for the certification period failed to evidence Seizure Precautions.

6. Clinical record review for patient #3 was performed on 8/9/2022. The plan of care for certification period 7/5/2022 to 9/2/2022 indicated the patient was on Anticoagulant Precautions and Fall Precautions.

Review of all skilled nurse visit notes for the certification period failed to evidence Anticoagulant Precautions and Fall Precautions.

During an interview on 8/11/2022 at 12:41 PM, the administrator indicated safety precautions should be addressed at each visit and documented in the skilled nurse visit notes.

The plan of care for certification period 7/5/2022 to 9/2/2022 included the following skilled nurse duties: instruct the patient / caregiver to inspect the patient s feet daily, instruct the patient to wear clean, dry socks and change them every day. The plan of care indicated the patient was home alone 80% of the time, and family was not supportive.

	Review of the skilled nurse notes evidenced the patient was blind. Review of the Start of Care admission assessment evidenced the patient was unable to put on footwear. During an interview on 8/11/2022 at 12:35 PM, the administrator indicated patient #3 was unable to inspect their feet or change their socks. The administrator indicated the plan of care was not individualized to the patient. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for	G0574	**G0574** **Pt.#1** POC was correctedto reflect the patients current address. In addition the POC has been correctedto evidence indications for the use of senna, ibuprofen and Tylenol. **Pt.#3** POC was corrected to indicate no bloodpressure or veni puncture on the left arm and all medications include theindications for use. One-on-oneskilled nurse education regarding plan of cares will include completemedication orders, specific goals and accurate patient information. The ClinicalDirector will be responsible to QA review 100%	2022-08-31

	emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the plan of care included complete medication orders, patient-specific goals, and current patient information in 2 of 3 clinical records reviewed (#1, 3). The findings include: 1. Record review evidenced an agency policy titled, Care Planning , updated 8/10/2022, which stated, & It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and / or service based on the patient s needs and goals with the input of the patient for purpose of achieving positive outcomes &. 2. Record review evidenced an agency policy titled, Medication / Prescriptions Orders , updated 8/10/2022, which stated, & Medication orders or prescriptions are clear and accurate. Medication orders must be complete &. 3. Clinical record review for patient #1 was performed on 8/8/2022. The plan of care for certification period 6/29/2022 to 8/27/2022 had a subsection titled, Patient s Name and Address , which indicated the patient s address		of SN notes to ensure the planof care was followed. The Administrator will be responsible to QA review 100% ofall plan of cares to ensure they are individualized, planned, appropriate careand treatment based on the patient's needs and goals.	

	was [address]. During an interview on 8/10/2022 at 3:42 PM, the administrator indicated the address indicated for patient #1 was the address of the agency, not the patient s address. When queried, the administrator indicated the plan of care failed to evidence the patient s current address. Review of the plan of care evidenced a subsection titled, Medications , which indicated the patient was taking Senna, Ibuprofen, and Tylenol as needed. The plan of care failed to evidence indications for use of Senna, Ibuprofen, and Tylenol. 4. Clinical record review for patient #3 was performed on 8/9/2022. The plan of care for certification period 7/5/2022 to 9/2/2022 stated, & No blood pressure or venipuncture [drawing blood from a vein with a needle] in right arm & Review of the admission comprehensive assessment and all skilled nurse visit notes evidenced the patient had a dialysis graft in their left arm, and blood pressures were taken on the right arm. During an interview on 8/11/2022 at 12:11 PM, RN [registered nurse] #1 indicated patient #3 s dialysis graft was in their left arm, and she checked their blood pressure on the right arm. During an interview on 8/11/2022 at 12:11 PM, the administrator indicated the plan of care was incorrect. The administrator indicated she needed to correct the plan of care to say no blood pressure or venipuncture on the left arm. Review of the plan of care evidenced a			

	subsection titled, Medications , which indicated the patient was taking Promethazine (a medication used to treat allergies, motion sickness, nausea or pain) and Zolpidem (a medication used to treat insomnia) as needed. The plan of care failed to evidence indications for use of Promethazine and Zolpidem. 5. During an interview on 8/10/2022 at 3:16 PM, the administrator indicated all medications ordered as needed should include an indication for their use. 410 IAC 17-13-1(a)(1)(D)(ix)(xiii)			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review, and interview, the agency failed to coordinate services with other entities providing care in 2 of 2 records reviewed receiving care from outside entities (#1, 3). The findings include: 1. Record review on 8/11/2022 evidenced an agency policy titled, Coordination of Client Care , updated 8/10/2022, which stated, & All service providers involved in the care of a client & will be engaged in an effective interchange, reporting, and coordination of care regarding the client. All such coordination of care will be documented in the client record &.	G0606	**G0606** **Pt.#1** Episode of physical therapy has been completed. **Pt.#3** Patient has beendischarged. However, a verbalcommunication was documented regarding the patient's attendance at dialysis. A coordination ofcare document will be completed at the start of care and updated at eachrecertification. This document will be signed by patient or caregiver anduploaded to the patient's EMR. Theadministrative staff will be responsible to ensure the coordination of servicesis completed and includes other	2022-08-31

	2. During an interview on 8/8/2022 at 9:20 AM, HHA (home health aide) #1 indicated patient #1 had received physical therapy from home care agency #1 since the end of June 2022. During an interview on 8/8/2022 at 9:22 AM, patient #1 indicated they received physical therapy services from home care agency #1 from the end of June 2022 until the end of July 2022. Clinical record review on 8/8/2022 for patient #1, start of care 6/29/2022, certification period 6/29/2022 to 8/27/2022, failed to evidence coordination of care with home care agency #1. During an interview on 8/10/2022 at 3:48 PM, RN [registered nurse] #1, case manager for patient #1, indicated she did not know patient #1 had received physical therapy until told by the surveyor. 3. Clinical record review for patient #3, start of care 7/5/2022, was performed on 8/9/2022. The plan of care for certification period 7/5/2022 to 9/2/2022 indicated the patient attended dialysis 3 times a week at dialysis center #2. Clinical record review failed to evidence coordination of care with dialysis center #2. During an interview on 8/11/2022 at 12:02 PM, the administrator indicated care should be coordinated with other entities providing care for the patient. When queried, the administrator indicated the agency created a form for care coordination, but hadn t used it for this patient.		entities providing care.	

	410 IAC 17-12-2(h)			

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

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