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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157650	A. BUILDING 00 B. WING	08/08/2019

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

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Facility ID: 012829 Provider #: 157650 Medicaid #: 20108670 Visit dates: 7/31/19 - 8/8/19 Active Patients: 30 Discharged Patients: 20 (past 12 months) Skilled Unduplicated Patients: 23 (past 12 months) Home Health Aide Only Patients: 27 (past 12 months) At this Emergency Preparedness survey, Noble Home Health Care was found to be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E 0000		
G 0000 Bldg. 00	This visit was a Federal Recertification and State Licensure survey with 2 Complaints. This survey was partial extended on 8/6/19. Complaint #: IN00274374: Complaint was	G 0000		

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

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	substantiated. Federal deficiencies related to the complaint were cited. Complaint #: IN00288996 - Complaint was substantiated. Federal deficiencies related to the complaint were cited. Facility ID: 012829 Provider #: 157650 Medicaid #: 20108670 Visit dates: 7/31/19 - 8/8/19 Active Patients: 30 Discharged Patients: 20 (past 12 months) Skilled Unduplicated Patients: 23 (past 12 months) Home Health Aide Only Patients: 27 (past 12 months) This deficiency report reflects State Findings cited in accordance with 410 IAC 17.			
G 0574 Bldg. 00	Based on record review and interview, the agency failed to ensure the plan of care was individualized and specific to the patients' needs for 8 of 10 records reviewed (#1, #2, #4, #5, #6, #7, #8, #10). The findings include: 1. The undated agency policy titled "Physician Orders / Plan of Care" stated, "The physician sets	G 0574	G 574 – Based on the Surveyor’s concerns, we have changed the verbiage for how we write patients’ frequency and duration on all patient’s plan of care. While we felt each patient’s plan of care was specific and individualized, corrective action has already been taken. A physician’s order has been generated to remove the	08/27/2019

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	up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, items of drugs and equipment to be provided by the agency ... All orders on the CMS 485 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 is specific to the patient and that additional orders for services are present in the clinical record." 2. A review of clinical record #1 evidenced the frequency and duration of visits on the Home Health Certification and Plan of Care dated 6/10/19 - 8/8/19 was written as follows: "Home Health Aide [HHA] requesting to provide up to 6 hours per day, 7 days a week for 26 weeks." This left open the possibility that the agency could provide minimal or no hours any day during the certification period's schedule. 3. A review of clinical record #2 evidenced the frequency and duration of visits on the Home Health Certification and Plan of Care dated 7/19/19 - 9/16/19 was written as follows: "HHA requesting to provide up to 9 hours per day, 5 days a week for 26 weeks." This left open the possibility that the agency could provide minimal or no hours any day during the certification period's schedule. 4. A review of clinical record #4 evidenced the frequency and duration of visits on the Home Health Certification and Plan of Care dated 7/28/19 - 9/25/19 was written as follows: "SN request to provide up to three hours per visit every other day for 26 weeks to perform bowel program every other day for up to 3 hours ... HHA request to provide up to 8 hours per day 7 days a week for 26 weeks." This left open the possibility that the		term “up to” from all active patient’s plan of cares that contain the term “up to,” with the exception of Respite Care. All plans of care dated and/or generated on or after 08/27/2019 will use the new format (i.e. without the term “up to”). All skilled staff and office personnel have been in-serviced on the new verbiage to be used on all active patients’ plan of cares. To prevent from reoccurring, quarterly patient chart audits will be completed to verify the proper verbiage on frequency and duration for all active patients. Director of Nursing will be responsible for monitoring the corrective actions to ensure that this deficiency will not reoccur.	

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	agency could provide minimal or no hours any day during the certification period's schedule. 5. A review of clinical record #5 evidenced the frequency and duration of visits on the Home Health Certification and Plan of Care dated 6/22/19 - 8/20/19 was written as follows: "SN requesting to provide up to 3 - two hour visits per week for 26 weeks for wound care ... HHA requesting to provide up to 5 hours per day, 7 days a week for 26 weeks." This left open the possibility that the agency could provide minimal or no hours any day during the certification period's schedule. 6. A review of clinical record #6 evidenced the frequency and duration of visits on the Home Health Certification and Plan of Care dated 1/27/19 - 3/27/19 was written as follows: "HHA twice a day HHA requesting up to 8 units per day, 7 days a week for 26 weeks ... SN to provide comprehensive assessments. SN to provide comprehensive assessments." This left open the possibility that the agency could provide minimal or no hours any day during the certification period's schedule. 7. A review of clinical record #7 evidenced the frequency and duration of visits on the Home Health Certification and Plan of Care dated 5/3/19 - 7/1/19 was written as follows: "SN requesting up to 7 - one hour visits per week for 6 weeks; followed by up to 3 - 1 hour visits per week for 20 weeks for wound care ... HHA requesting to provide up to 8 hours per day, 7 days a week for 26 weeks." This left open the possibility that the agency could provide minimal or no hours any day during the certification period's schedule. 8. A review of clinical record #8 evidenced the frequency and duration of visits on the Home			

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	Health Certification and Plan of Care dated 4/23/19 - 6/21/19 was written as follows: " Home health aide request to provide up to 8 hours per day, 7 days a week for 26 weeks ... SN to provide comprehensive assessments." This left open the possibility that the agency could provide minimal or no hours any day during the certification period's schedule. 9. A review of clinical record #10 evidenced the frequency and duration of visits on the Home Health Certification and Plan of Care dated 6/13/19 - 8/11/19 was written as follows: " Home health aide requesting to provide up to 8 hours per day, up to 7 days a week for 26 weeks ... SN to provide comprehensive assessments." This left open the possibility that the agency could provide minimal or no hours any day during the certification period's schedule. 10. During an interview on 8/6/19 at 4:05 PM, the administrator and the director of nursing indicated a concern with the frequency which stated the hours could be 'up to' instead of specifically stated for an individualized plan of care. 410 IAC 17-13-1(a)(1)(D)(i-xiii)			
G 0682 Bldg. 00	Based on observation, record review, and interview, the home health agency failed to ensure all employees practiced standard/universal precautions in 1 of 1 home visit observation with a Registered Nurse (Patient #3, Employee A, Registered Nurse (RN).	G 0682	G 682 – All staff have been in-serviced on 08/28/2019 on all standard / universal precautions, infection prevention, and clean bag technique. All new employees hired on or after 08/29/2019 will be in-serviced on all standard / universal precautions and infection	08/28/2019

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	The findings included: The undated agency policy titled "To provide care, that is totally free of germs or microorganisms ... Procedure: Prior to use: 1. Inspect all packaging ... when opening the item, take extreme care to make sure the inside does not touch anything on the outside. 4. Do not touch any sterile item with your hands. Always wear sterile gloves before touching sterile items. 5. Place sterile items only on a sterile surface ... to change a sterile dressing, wear one pair of gloves to remove the soiled dressing, and then remove the soiled gloves ... " The undated agency policy titled "Central line dressing / Cap Change" stated, "Dressing and needleless connector change for CVC / PICC ... 1. Gather supplies ... Explain procedure; ask patient to turn head away from site or allow patient to wear mask 3. Hand hygiene 4. Don Sterile gloves 5. Remove old dressing 6. Dispose of old gloves 7. Hand hygiene 8. Don mask 9. Open supplies ..." During an observation on 8/5/19 at 3:15 PM, Employee A was observed to complete a skilled nurse visit with patient #3. Employee A was observed to change the PICC line dressing on the patient's left arm. During this procedure, Employee A was observed to place her nursing bag on a clean field. After performing hand hygiene, Employee A was observed to put on sterile gloves. The sterile field was placed on the clean field. The nurse placed supplies out onto the sterile field by placing gloved hands into a plastic sleeve and pulling out the supplies. She also was observed to touch her nursing bag on the bottom side of the bag. She then gently removed the PICC line dressing from the patient's		prevention and clean bag technique. In-services on standard / universal precautions, infection prevention, and bag technique are part of the agency's annual continuation of education. To prevent from reoccurring, quarterly chart audits of employees' files will be completed to verify all staff in-service on standard / universal precautions, infection prevention, and bag technique forms are documented accordingly. Director of Nursing will be responsible for monitoring this corrective action to ensure this deficiency will not reoccur.	

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	left arm. During an interview on 8/6/19 at 10:30 AM, Employee A indicated no awareness of an infection control concern at the home visit when the PICC line dressing change occurred. 410 IAC 17-12-1(m)			
G 0706 Bldg. 00	Based on record review and interview, the agency failed to ensure the Registered Nurse consistently and accurately reassessed the patient's needs for 1 of 3 closed records reviewed (#7). The findings included: The undated agency policy titled "Registered Nurse" stated, "Registered Nurse [RN]. Skilled nursing services shall be provided by a registered nurse in accordance with the plan of treatment. These services shall include the following ... Be responsible for the ill, injured or infirm and the maintenance of health and prevention of illness of others as well as a. Regularly re - evaluates the patients nursing needs ... " The undated agency policy titled "Wound Care Management" stated, "Documentation of wounds must include type of wound, measurements including length, depth and width, description of the wound bed, surrounding area, undermining, staging, color, odor, and estimated amount of drainage." A review of the skilled nursing visit note dated 6/19/19 completed by Employee D, RN, failed to	G 0706	G 706 – All skilled staff have been in-serviced on 08/26/2019 on proper skin assessment documentation. All newly employed skilled staff hired on or after 08/27/2019 will be in-serviced on proper documentation of skin assessments. This documentation is to include type of wound, measurements, including width, depth, and length of wound bed, surrounding area, undermining, staging, color, odor, and estimated amount of drainage. To prevent from reoccurring, quarterly patient chart audits will be completed to verify wound assessments are documented accordingly. Director of Nursing will be responsible for monitoring this corrective action to ensure this deficiency will not reoccur.	08/26/2019

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	evidence a complete skin assessment of the right heel. The note stated, "SN [skilled nurse] assessed patient's BLE [bilateral lower extremities]. Upon inspecting right foot, SN noted large amount of dead skin sloughed off patient's heel at this time, boggy to touch. SN found possible DTI [deep tissue injury] or ulcer to right heel." There was no assessment of the size, color, drainage, undermining, or inflammation of this area. The patient was transported to the emergency room for assessment of this wound. During an interview on 8/7/19 at 4:05 PM, the director of nursing and Employee D, Registered Nurse, indicated the area on the foot was not looking good and was not described completely. 410 IAC 17-12-2(g)			
G 0768 Bldg. 00	Based on record review and interview, the home health agency failed to ensure the home health aide successfully completed a competency evaluation program for 14 of 14 home health aide files reviewed (Employees # G, J - V) for these employees who cared for patients dependent on hoyer lift for transferring (#4, #5, #6, #8). The findings included: 1 The undated agency policy titled "Competency Evaluation" stated, "Newly hired and experienced field staff must demonstrate competency within the job description that applies to that staff member, prior to be permitted direct contact with patients. This may be established through several methods, such as demonstration of skills by the	G 0768	G 768 – While all field staff have completed the competency required, we realized the agency failed to ensure all field staff competency were documented properly. To correct this deficiency for all new Home Health Aides hired on or after 08/24/2019 the agency will use a modified Home Health Aide competency form to specifically include Hoyer Lift Transfers amongst a few other additions. All field staff have been in-serviced by 08/23/2019 on Hoyer use and it will be documented accordingly. To prevent from reoccurring, quarterly chart audits of	08/23/2019

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	employee to the supervisor as long as the supervisor has at least equal credentials ... Procedure ... the following competencies must be evaluated while the aide is performing the tasks with a patient or pseudo - patient ... safe transfer techniques and ambulation." 2. A review of personnel files evidenced home health aides were missing competency evaluations with the hoyer lift. These aides had cared for patients as noted below and were transferring these patients via the hoyer lift. A. A review of the file of Employee G, HHA, with a hire date of 1/10/17 and first patient contact date of 1/22/17, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #6 evidenced Employee V transferred patient #6 on 11/3/18. B. A review of the file of Employee J, HHA, with a hire date of 12/26/13 and first patient contact date of 1/1/14, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #5 evidenced Employee J transferred patient #5 on 5/4/19, 5/18/19, 5/19/19, 5/20/19, 5/22/19, 6/3/19, 6/10/19, 7/4/19, 7/11/19, 7/22/19, and 7/30/19. A review of clinical record #6 evidenced Employee V transferred patient #6 on 3/12/19. C. A review of the file of Employee K, HHA, with a hire date of 2/7/17 and first patient contact date of 2/10/17, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #6 evidenced		employees' files will be completed to verify HHAs' competency forms are documented accordingly. Director of Nursing will be responsible for monitoring this corrective action to ensure this deficiency will not reoccur.	

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	Employee K transferred patient #6 on 3/1/19. D. A review of the file of Employee L, HHA, with a hire date of 9/16/17 and first patient contact date of 9/19/17, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #6 evidenced Employee L transferred patient #6 on 2/23/19. E. A review of the file of Employee M, HHA, with a hire date of 11/12/18 and first patient contact date of 11/23/18, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #6 evidenced Employee M transferred patient #6 on 2/23/19. F. A review of the file of Employee N, HHA, with a hire date of 12/11/18 and first patient contact date of 12/18/18, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #6 evidenced Employee N transferred patient #6 on 11/1/18. G. A review of the file of Employee O, HHA, with a hire date of 3/4/19 and first patient contact date of 3/6/19, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #8 evidenced Employee O transferred patient #8 on 3/6/19. A review of clinical record #8 evidenced Employee L transferred patient #8 on 3/15/19. H. A review of the file of Employee P, HHA, with a hire date of 10/13/17 and first patient contact date of 11/10/17, failed to evidence a skills			

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validation for competency with hoyer lift.

A review of clinical record #5 evidenced Employee P transferred this patient on 4/23/19, 4/24/19, 4/25/19, 4/26/19, 4/27/19, 4/28/19, 4/29/19, 4/30/19, 5/1/19, 5/2/19, 5/3/19, 5/5/19, 5/6/19, 5/7/19, 5/8/19, 5/10/19, 5/17/19, 5/18/19, 5/19/19, 5/21/19, 6/3/19, 6/12/19, 7/6/19, 7/17/19, 7/25/19, 7/30/19, and 8/7/19.

A review of clinical record #6 evidenced Employee P transferred patient #6 on 3/4/19.

I. A review of the file of Employee Q, HHA, with a hire date of 4/30/19 and first patient contact date of 5/4/19, failed to evidence a skills validation for competency with hoyer lift.

A review of clinical record #8 evidenced Employee Q transferred patient #8 on 5/15/19.

J. A review of the file of Employee R, HHA, with a hire date of 4/16/12 and first patient contact date of 5/21/12, failed to evidence a skills validation for competency with hoyer lift.

A review of clinical record #4 evidenced Employee R transferred this patient on 7/28/19.

K. A review of the file of Employee S, HHA, with a hire date of 6/8/16 and 6/28/16, failed to evidence a skills validation for competency with hoyer lift.

A review of clinical record #5 evidenced Employee S transferred patient #5 on 5/9/19, 5/11/19, 5/20/19, 6/11/19, and 7/5/19.

A review of clinical record #6 evidenced Employee S transferred patient #6 on 2/23/19.

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	L. A review of the file of Employee T, HHA, with a hire date of 9/30/14 and first patient contact date of 10/6/14, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #4 evidenced Employee T transferred this patient on 7/30/19. M. A review of the file of Employee U, HHA, with a hire date of 2/19/19 and first patient contact date of 2/20/19, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #6 evidenced Employee U transferred patient #6 on 3/9/19, 3/12/19. N. A review of the file of Employee V, HHA, with a hire date of 6/25/18 and first patient contact date of 7/15/18, failed to evidence a skills validation for competency with hoyer lift. A review of clinical record #5 evidenced Employee V transferred this patient on 8/3/19. A review of clinical record #6 evidenced Employee V transferred patient #6 on 11/1/18. 3. During an interview on 8/6/19 at 3:40 PM, the director of nursing indicated the hoyer lift / range of motion / safe transfer techniques inservice dated 6/29/18 was used for a competency evaluation for the home health aides and home health aides were not competencied on the competency evaluation documents found in the employee files. 410 IAC 17-14-1(l)(A) 410 IAC 7-14-1(m)			

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G 0798 Bldg. 00	Based on observation, record review and interview, the Registered Nurse failed to ensure the HHA (home health aide) care plan was individualized and failed to identify safety precautions necessary for safe care for 1 of 1 identified patient receiving incenter hemodialysis (#2). The findings include: The undated agency policy titled "Home Health Aide" stated, "Written instructions for home care, including specific exercises are prepared by a registered nurse. Aide instructions are written in relation to the patient's plan of care and within the duties allowed to be permitted by a nurse aide. Written assignments and instructions are reviewed every 60 days and more frequently if changes in the patient's status and needs occur." During an observation on 8/2/19 at 7:30 AM, patient #2 was observed to have a right upper arm fistula used for hemodialysis. A review of the aide care plan dated 7/19/19 - 9/16/19 failed to evidence home health aides were given safety precautions to not take blood pressure in the patient's right arm. During an interview on 8/6/19 at 4:30 PM, Employee D, Registered Nurse, indicated the aide care plan lacked safety precautions that no blood pressures should be taken on the patient's right arm due to the location and presence of a right upper arm AV Fistula used for in center hemodialysis.	G 0798	G 798 – Based on the Surveyor's concerns, corrective action has already been taken. All aide care plans have been revised by skilled nurses to be more individualized and include any and all safety precautions. Changes to aide care plans were reviewed and discussed with each patient/patient representative and/or caregiver; each patient/patient representative and/or caregiver verbalized an understanding and agreement. All aide care plans dated and/or generated on or after 08/26/2019 will be reviewed by two clinicians for patient specifics. All skilled staff who create aide care plans have been in-serviced on the importance of individualized care plans to include any and all safety precautions. A review of all aide care plans was completed on 08/26/2019. To prevent from reoccurring, quarterly patient chart audits will be completed to verify aide care plans are individualized and include any and all safety precautions. Director of Nursing will be responsible for monitoring the corrective actions to ensure that this deficiency will not reoccur.	08/26/2019

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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157650	A. BUILDING 00 B. WING	08/08/2019

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

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	410 IAC 17-13-2(a)			