STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157650	A. BUILDING B. WING	04/30/2025

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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: 4/22/2025 □ 4/25/2025 and 4/28/2025 □ 4/30/2025 Unduplicated Skilled Admissions for the last 12 Months: 15 At this Emergency Preparedness survey, Noble Home Health Care, LLC, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. A1	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a home health provider.	G0000		

Survey Date: 4/22/2025 □ 4/25/2025 and 4/28/2025 □ 4/30/2025

Unduplicated Skilled Admissions for the last 12 Months: 15

During this Federal Recertification Survey, Noble Home Health Care LLC was found to be out of compliance with Condition of Participation at 42 CFR 484.105 Organization and administration of services.

Based on the Condition-level deficiencies during the April 30, 2025 survey, Noble Home Health Care LLC was subject to an extended survey on April 22, 2025, pursuant to section 1891(c)(2)(D) of the Social Security Act. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning April 30, 2025 and continuing through April 29, 2027.

This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.

Abbreviations used in report: POC □ Plan of Care, CM □ Clinical Manager, SOC - Start of Care, HHA - Home Health Aide, RN - Registered Nurse, LPN - Licensed Practical Nurse, SN -

	Skilled Nurse. QR: A1 5/06/2025			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: (1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment included the physical status of the patient in 1 of 1 active clinical record review with a gastrostomy (GT, a feeding tube) (Patient #1) and in 1 of 1 active clinical record reviewed with a wound (Patient #5). The findings include: 1. During an observation of care on 04/23/2025, at 11:05 AM, Patient #1 was observed with a tube inserted into the abdomen connected to a bag containing a liquid. A clinical record review evidenced a comprehensive assessment [CA] for recertification, dated 04/11/2025 completed by RN 1, which indicated Patient had a GT for enteral nutrition	G0528	1. Patient #1 Assessment of the feeding tube, including size, site assessment and type of device has been added to nursing documentation. The documentation of oxygen delivery and flow and frequency has been added to nursing documentation. Patient #5 Agencies providing wound care or dialysis have been notified for orders regarding the dressings their agency has applied. 2. The comprehensive assessment of all current patients will be reviewed to ensure the accuracy reflecting the patient's status at SOC, Recertification or current visits. 3. Professional staff will do QA of SN notes as submitted to ensure the accuracy of the assessment. Documentation education will be assigned to designated nursing staff to ensure accuracy of their notes. 4. Every OASIS will have a QA	2025-05-30

	(provided via a feeding tube directly into the stomach) and indicated Patient received oxygen at 2 liters per minute (the rate of oxygen administration. The CA failed to include the size of the feeding tube and the appearance of the stoma (opening of the skin for the tube) and surrounding skin and failed to include the method of oxygen delivery and frequency. On 04/25/2025, at 4:25 PM, RN 1 indicated the GT was a Mickey button (type of feeding tube) and the size was 14 French (unit of measure for feeding tube) and 2.0 centimeters in length with a balloon to hold it in place filled with 3 milliliters of air. RN 1 indicated the Patient received oxygen as needed via nasal cannula (a tube inserted into the nostrils) to maintain oxygen saturation levels. On 04/30/2025, at 1:41 PM, the Alternate CM indicated the assessment of the feeding tube size and the appearance of the stoma and surrounding skin was not included in the comprehensive assessment and indicated the comprehensive assessment did not include the frequency and method of oxygen delivery. 2. A clinical record review for Patient #5 evidenced a comprehensive		review prior to being exported to ensure 100% compliance. 5. This will be completed by 05/30/2025.	

assessment for the SOC dated 03/24/2025 completed by the Alternate CM which indicated the Patient had a dressing covering the left heel due to a wound for which Entity 5 provided wound treatment. The comprehensive assessment failed to include an assessment of the wound. The clinical record failed to evidence an order that indicated the wound dressing was not to be removed and failed to evidence any assessment of the wound provided by Entity 5. The assessment indicated Patient received dialysis (a medical treatment that filters the blood) and had a central venous catheter (an thin tube going into a large vein) at the right subclavian (a vein under the upper chest) and failed to include the assessment of the site to include if a dressing was present.

On 04/30/2025, at 2:03 PM, the Alternate CM indicated she did not assess the wound to the left foot due to Patient #5 had a dressing in place covering the wound that was applied by Entity 5 and she did not want to remove the dressing. She indicated she did not have an assessment of the wound from Entity 5 and did not include an assessment of the central venous catheter to include a dressing was present over the site.

410 IAC 17-14-1(a)(1)(B)

G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure the comprehensive assessment included a medication review of the drug interactions in 1 of 2 active clinical records reviewed with a SOC in 2025. (Patient #4) The findings include: A clinical record review for Patient #4 evidenced a document titled Medication Interactions dated 04/30/2025 which indicated a potential drug interaction between Nayzilam (to treat seizures) and Xcopri (to treat seizures). The POC for the initial certification period 03/31/2025-05/29/2025 indicated the Patient s medications included Nayzilam and Xcopri. The comprehensive assessment for the SOC dated 03/31/2025 failed to evidence the assessment of the potential drug interaction between Nayzilam and Xcopri.	G0536	1. Patient #4 The medication record has been corrected to reflect the physician notification for duplicate therapy or interactions. 2. All clients' medications have been reviewed to identify significant drug interactions, duplicative drug therapy, and or non-compliance with drug therapy. 3. Skilled nurses have been in-serviced on identifying potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Going forward, nursing staff will use Drugs.com to scan meds for potential drug interactions. 4. Medication profiles will be reviewed every 60 days for accuracy regarding drug duplications, drug interactions and patient's compliance with drug therapy. 5. This will be completed by 05/30/2025	2025-05-30

	On 04/30/2025, at 12:49 PM, the Alternate CM indicated the comprehensive assessment did not include the drug interaction between Nayzilam and Xcopri. 410 IAC 17-14-1(a)(1)(B)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the assessment of the caregiver □s willingness, ability, and capability to provide care in 3 of 3 active clinical records reviewed with a caregiver. (Patient #1, 4, 5) The findings include: 1. A clinical record review for Patient #1 evidenced a comprehensive assessment for recertification dated 04/11/2025 which indicated the Patient was wheelchair bound and dependent on others for personal care and activities of daily living, feeding, and medication administration. The comprehensive assessment failed to	G0538	1. Patient #1 The next comprehensive assessment has been corrected to indicate the caregiver and their ability, availability and willingness to care for the patient in the absence of home health services. Patient #4 The next comprehensive assessment has been corrected to indicate the caregiver and their ability, availability and willingness to care for the patient in the absence of home health services. Patient #5 The next comprehensive assessment has been corrected to indicate the caregiver and their ability, availability and willingness to care for the patient in the absence of home health services 2. All clients with a caregiver in the absence of home health, have been reviewed and corrections to the OASIS	2025-05-30

	identify who the caregiver was and the willingness, ability, and availability of the caregiver in the absence of the home health services. On 04/30/2025, at 1:41 PM, the CM indicated the assessment of the caregiver was not included in the comprehensive assessment. 2. A clinical record review for Patient #4 evidenced a comprehensive assessment for the SOC dated 03/31/2025 which indicated the Patient required seizure precautions and was dependent for personal care and activities of daily living, feeding, and medication administration. The comprehensive assessment failed to identify the willingness and ability of the caregiver in the absence of the home health services. On 04/30/2025, at 1:27 PM, the CM indicated the comprehensive assessment did not include the ability and willingness of the caregiver to provide care. 3. A clinical record review for Patient #5 evidenced a comprehensive assessment for the SOC dated 03/24/2025, which indicated the Patient had a wound and lived with a caregiver, and the assessment failed to include the assessment of the caregiver.		made to reflect the caregiver and their ability, availability and willingness to care for the patient. 3. Skilled nurses have been in-serviced to ensure the patient's primary caregiver or other available supports including their ability, availability and willingness to care for the patient are documented in the SOC and Oasis. 4. Every Oasis will have a QA review prior to being exported to ensure 100% compliance. 5. This will be completed by 05/30/2025	

	On 04/30/2025, at 2:00 PM, the Alternate CM indicated the comprehensive assessment did not include an assessment of the caregiver. 4. On 04/30/2025, at 1:45 PM, the Alternate CM indicated there was not a space for the assessment of the caregiver on the recertification comprehensive assessment form.			
G0562	Discharge Planning 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. Based on record review and interview, the agency failed to provide a 15-day discharge notice before the date of discharge in 1 of 1 closed clinical records reviewed due to goals met. (Patient #7) The findings include: A policy updated 04/23/2025 titled □Discharge/Transfer from Service indicated the agency would notify the patient no later than 15 days before	G0562	1 1. Patient #7 – Patient is discharged, At time of discharge patient/Family unavailable to discuss discharge 2 All 2025 discharged patients (6) charts have been reviewed for appropriate time of notice relevant to time of discharge. Discharge log audit created 3 All discharged patients will receive a 15 day notice, when applicable and a communication note in the EMR. 4 100% of all discharged patients will be reviewed quarterly for proper documentation and this process will be added to the QAPI program for review by the quality team.	2025-05-30

	the date on which the discharge would take place and would document the notice of discharge in the clinical record. A clinical record review for Patient #7 evidenced the Patient was discharged on 01/21/2025 and evidenced a letter addressed to the Patient dated 01/14/2025 which indicated the Patient would be discharged from the agency effective 01/21/2025 which was less than 15 days. On 04/30/2025, beginning at 1:05 PM, the Administrator indicated there was no additional documentation to indicate the agency provided discharge notice prior to 01/14/2025. 410 IAC 17-12-2(i)		5 This will be completed by May 30, 2025	
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to evidence medical information regarding patients course of treatment and outcome was sent to the attending physician in 2 of 2 closed	G0564	1 Patient #6 - patient has been discharged prior to survey. Patient #7 -patient has been discharged prior to survey. 2 All current pending discharged patients (2) have been reviewed to ensure they have a discharge summary that includes all information pertinent to the patient's current course of illness and treatment, post-discharge goals of care and treatment and will be sent to the receiving facility or healthcare practitioner.	2025-05-30

	clinical records reviewed. (Patient #6 and 7) The findings include: 1. A policy, updated 04/23/2025, titled Discharge/Transfer from Service, indicated the agency would send a discharge summary to the attending physician, within 2 business days of discharge. 2. The clinical record for Patient #6 evidenced the Patient was discharged from the agency on 04/10/2025 and failed to evidence a discharge summary was sent to the physician. 3. A clinical record review for Patient #7 evidenced the Patient was discharged from the agency on 01/21/2025 and failed to evidence a discharge summary was sent to the physician. 4. On 04/30/2025, at 12:40 PM, the Administrator indicated the agency did not complete nor send a discharge summary to the physicians. 410 IAC 17-13-2(a)(b)(9)		3 Professional staff have been educated to ensure that discharge summaries are to be sent within 2 days of discharge to primary provider 4 100% of discharged patients will be reviewed to ensure the discharge summary was sent. 5 This will be completed by May 30, 2025	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that	G0572	1 Patient #5 –Patient currently receiving hha services as ordered in the POC 2 All patients have been reviewed to ensure each patient receives home	2025-05-30

	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 provide services as directed in the POC in 1 of 2 active clinical records reviewed with a SOC in 2025. (Patient #5) The findings include: A clinical record review for Patient #5 evidenced a POC for the initial certification period 03/24/2025-05/22/2025 which indicated the agency was to provide HHA services 2-3 hours per day 5 days a week for 9 weeks. The clinical record failed to evidence the agency provided HHA services until 4/17/2025. On 04/30/2025, at 2:45 PM, the CM indicated the authorization for HHA services was received on 04/10/2025, and the agency was trying to figure out the HHA schedule. 410 IAC 17-13-1(a)		health services written in their plan of care and the plan of care is individualized. 3 Professional staff have been educated to promptly document a communication note and if needed an order to the primary provider for any delays in care due to miscommunication, lack of authorization or scheduling conflicts that the patient might incur. 4 All patient care plans are reviewed by the case manager to ensure it has been followed and implemented timely. This will be included in quality meeting quarterly 5 This will be completed by May 30, 2025	

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 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.	G0574	1 Patient #1 – the plan of care was amended to remove wound care instructions and goals, add the size of the GT, jugular port and O2 administration Patient #2 – The plan of care was amended to include the attendant care and medication indicators Patient #3- The plan of care was amended to be individualized to include the homemaker services that she receives Patient #5 The plan of care was amended to include the frequency of wound care to the left foot and the renal diet and 32-ounce fluid restriction. 2. All patients plan of care have been reviewed to ensure plan of care contained all medications, and type and frequency of services, 3 Professional staff will be educated to ensure the plan of care contains all medications and type and frequency of services received 4. All patient records will be reviewed every 60 days by professional staff to ensure the care plan has been updated to include all services the patient is receiving 5 This will be completed by May 30,	2025-05-30

	Based on observation, record review, and interview, the agency failed to ensure the plan of care was individualized to include the patient-specific interventions and goals in 4 of 5 active clinical records reviewed. (Patient #1, 2, 3, 5) The findings include: 1. A clinical record review evidenced a comprehensive assessment for recertification dated 04/11/2025 completed by RN 1 indicated the Patient had no wounds, had a gastrostomy (GT, feeding tube) for enteral nutrition (provided via a feeding tube directly into the stomach), and received oxygen at 2 liters per minute (the rate of oxygen administration). The comprehensive assessment indicated the Patient had a right jugular (neck) port for intravenous (through the vein) access. The POC for the recertification period 04/14/2025-06/12/2025 which indicated the goals included wounds would decrease in size by 75% and indicated the SN interventions included to discontinue wound care when wounds have healed, surgical wounds to remain open to air, change the GT every 90 days, flush the central line (a thin tube inserted into a large vein) with normal saline (solution) and jugular port. The POC failed to include the size of the GT and the		2025	

	administration of oxygen to include the frequency and mode of delivery. On 04/25/2025, at 4:25 PM, RN 1 indicated the GT was a Mickey button (type of feeding tube) and the size was 14 French (unit of measure for feeding tube) and 2.0 centimeters in length with a balloon to hold it in place filled with 3 milliliters of air. RN 1 indicated the Patient received oxygen as needed via nasal cannula (a tube inserted into the nostrils) to maintain oxygen saturation levels and indicated the Patient did not have any wounds or open areas and indicated the Patient only had a jugular port. On 04/30/2025, at 1:47 PM, the CM indicated the GT size and the oxygen administration intervention were not included in the POC and indicated the Patient did not have both a central venous line and a jugular port. The CM indicated the interventions and goals related to wounds should have been removed from the POC since the Patient did not have any wounds. 2. During an observation of care at the home of Patient #2 on 04/24/2025, at 10:30 AM, Person 1 was observed in the home.			

On 04/24/2025, at 10:30 AM, Person 1 indicated she provided attendant care through Entity 2 for the Patient 2 times a week for 5 hours each day.

On 04/28/2025, at 1:37 PM, Person 3 at Entity 2 indicated Entity 2 provided the Patient attendant care 2 days a week for 5 hour a day.

A clinical record review evidenced a POC for recertification period 03/06/2025-05/04/2025 which failed to include the services provided by Entity 2. The POC indicated medications Trazadone (antidepressant) and Sertraline (antidepressant) to be taken as needed and failed to provide an indication for use.

On 04/30/2025, at 1:29 PM, the Alternate CM indicated Trazadone was to be taken as needed for sleep and was unsure why the Sertraline was to be taken as needed when it is supposed to be taken daily.

On 04/30/2025, beginning at 1:29 PM, the CM indicated there were no indications for use on the POC for Trazadone and Sertraline and the attendant care services from Entity 2 were not included in the POC.

3. A clinical record review for Patient #3 evidenced a comprehensive assessment for recertification dated 04/24/2025 which indicated the Patient

received homemaker services through Entity 4.

The POC for recertification period 04/28/2025-06/26/2025 which failed to include the homemaker services provided from Entity 4.

On 04/30/2025, at 2:22 PM, the CM indicated the services provided by Entity 4 were not included on the POC.

4. A clinical record review for Patient #5 evidenced a comprehensive assessment for the SOC dated 03/24/2025 completed by the Alternate CM which indicated the Patient had a dressing covering the left heel due to a wound for which Entity 5 provided wound treatment. The assessment indicated the Patient received dialysis (a medical treatment that filters the blood).

On 04/30/2025, at 12:36 PM, Person 8 indicated the Patient received dialysis at Entity 6 and was ordered a renal diet and a 32 ounce fluid restriction daily.

The POC for the initial certification period 03/24/2025-05/22/2025 failed to include the wound care and frequency of wound care to the left heel, failed to include the renal diet and 32 ounce fluid restriction

On 04/30/2025, beginning at 1:56 PM, the CM indicated the renal diet, fluid

	restriction, and wound care were not included in the POC.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and interview, the agency failed to ensure skin treatment was provided only as ordered by the physician in 1 of 1 observation with a LPN. (Patient #3) The findings include: A clinical record review for Patient #3 evidenced POC for recertification periods 02/27/2025- 04/27/2025 and 04/28/2025- 07/28/2025 indicated the SN was to provide pressure ulcer (wounds from pressure to the skin) prevention care to the right buttock to include cleansing the wound with normal saline (wound cleanser), applying skin preparation (a skin conditioner), and bordered gauze. During an observation of care at Patient □s home, on 04/29/2025 at 12:00 PM, LPN 1 was observed applying a substance from a package labeled □alginate (a wound dressing used to absorb drainage) and a	G0580	1. Pt. #3 The plan of care has been updated to only include treatments and services provided by the agency staff as ordered by the physician. The physician order is attached to the patient's EMR. 2. Agency will review all patient's plan of care to ensure all services and treatments were administered as ordered by a physician. 3. Skilled nurses will be in-serviced to ensure that all services and treatments are administered only as ordered by the physician. 4. All patients' plans of care are reviewed by professional staff to ensure the plan of care has been followed. 5. This will be completed by 05/30/2025	2025-05-30

	bordered foam dressing to the right buttock area. The SN visit notes completed by LPN 1 and dated 03/04/2025, 03/11/2025, 03/18/2025, 03/25/2025, 04/01/2025, 04/10/2025, 04/15/2025, and 04/22/2025 indicated LPN 1 applied silver alginate and foam dressing. The clinical record failed to evidence a physician order for the alginate and foam dressing. On 04/29/2025, beginning at 12:04 PM, LPN 1 indicated she applied the alginate every time, because it helped with the healing process. On 04/30/2025, at 2:18 PM, the Alternate CM indicated she could not find the order for the alginate and foam dressing. The Alternate CM indicated the list of supplies documented on a physician order was not an order for the use of the alginate and foam dressing. 410 IAC 17-13-1(a)			
G0584	Verbal orders 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies.	G0584	1 Patient #4 –Since survey exit,verbal order for SOC has been received back with physician signature and is included in the patient's EMR	2025-05-30

	(4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review and interview, the agency failed to ensure verbal orders were written and send to the physician for signature in 1 of 2 active clinical records reviewed with a SOC in 2025. (Patient #4) The findings include: A policy titled Physician Orders/Plan of Care updated 04/23/2025 indicated the agency would ensure verbal orders would put into writing, signed and dated by the person receiving the order, and be signed by the physician. A clinical record review for Patient #4 evidenced an initial assessment dated 03/28/2025 completed by the CM which indicated the verbal SOC order was received from the physician. The clinical record failed to evidence the CM sent the verbal order to the physician to be signed. On 04/30/2025, at 1:25 PM, the CM indicated the verbal order was not sent to the physician for signature and just documented on the initial assessment.		2 Reviewed all patients' records for verbal orders to ensure they have been signed by the provider. 3 Professional staff will be educated to ensure that all services and treatments are administered only as ordered by physician and all verbal orders are signed and in the EMR 4 Upon submission, every plan of care is reviewed by clinical manager to ensure accuracy of plan of care. The clinical manager will be responsible for the ongoing monitoring until 100% compliance 5 This will be completed by May 30, 2025	

	410 IAC 17-14-1(a)(H)			
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 observation, record review, and interview, the agency failed to coordinate care with all entities/disciplines providing care to the patient in 3 of 3 active clinical records reviewed with services provided by another agency. (Patient #2, 3, 5) The findings include: 1. During an observation of care at the home of Patient #2 on 04/24/2025, at 10:30 AM, Person 1 was observed in the home. On 04/24/2025, at 10:30 AM, Person 1 indicated she provided attendant care through Entity 2 for the Patient 2 times a week for 5 hours each day. On 04/28/2025, at 1:37 PM, Person 3 at Entity 2 indicated Entity 2 provided the Patient attendant care 2 days a week for 5 hour a day and indicated there had been no care coordination with the agency. A clinical record review failed to	G0606	1. Patient #2. Coordination of care with the attendant care company was completed and the POC was amended to reflect this Patient #3 Complete assessments are to be performed each SOC and Recertification. Coordination of care completed with the homemaker company and POC was amended to reflect this Patient #5- Coordination of care with the dialysis, wound care, physical therapy and homemaker companies was completed and the POC was amended to reflect these services. 2. All patients plan of care have been reviewed to include Care coordination with all other entities in the home and the plan of cares updated, as needed. 3. Skilled nurses will be in-serviced to ensure that any change in services, treatments or patient condition is reported to case manager immediately . A care coordination will be completed at each recertification	2025-05-30

	evidence care coordination with Entity 2. On 04/30/2025, at 1:33 PM, the CM indicated there was no care coordination with Entity 2. 2. During an observation of care on 04/29/2025, at 11:47 AM, Patient #3 yelled □ouch when LPN 1 touched both lower legs/ankles. A clinical record review evidenced a comprehensive assessment for recertification dated 04/23/2025 completed by the Alternate CM which indicated the Patient had no pain and received homemaker services through Entity 4. The clinical record failed to evidence care coordination with Entity 4. SN visit notes completed by LPN 1 dated 04/01/2025, 04/10/2025, 04/15/2025, and 04/22/2025 indicated the Patient had no pain. The clinical record failed to evidence LPN 1 reported the new onset of pain to the RN case manager. On 04/30/2025, at 2:22 PM, the CM indicated there was no care coordination with Entity 4.		4. 100% patients will have a care coordination completed at each recertification and reviewed by the clinical manager to ensure accuracy. 5. This will be completed by 05/30/2025.	

	On 04/30/2025, at 2:25 PM, the Alternate CM/RN case manager indicated she was unaware of the new onset of pain. 3. A clinical record review for Patient #5 evidenced a POC for the initial certification period 03/24/2025-05/22/2025 which indicated the Patient received wound treatment from Entity 5 for a wound to the left heel, received dialysis (a medical treatment to filter the blood) from Entity 6 three days a week, and received PT services from Entity 7 one time per week. The clinical record failed to evidence care coordination with Entities 5, 6 and 7. On 04/30/2025, beginning at 1:56 PM, the CM indicated there was no care coordination with Entities 5, 6, and 7. 410 IAC 17-12-2(g) and 410 IAC 17-12-2(h)			
G0646	Program activities 484.65(c) (1) The HHA's performance improvement activities must (i) Focus on high risk, high volume, or problem-prone areas; (ii) Consider incidence, prevalence, and severity of problems in those areas; and	G0646	1 Agency is updating the quality indicator data including measures derived from OASIS. 2 All patients will be included in the quality program. Data will be utilized to monitor the effectiveness and safety of services, quality of care, and identify opportunities for improvement for all hospitalizations	2025-05-30

	(iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the agency failed to ensure the Quality Assurance and Performance Improvement (QAPI) program included performance improvement activities for high risk and high frequency areas. The findings include: A review of the hospitalization log for 2025 indicated 6 hospitalizations with an average census of 25. The QAPI program failed to evidence performance improvement activities to address the hospitalizations. On 04/30/2025, at 2:48 PM, the CM indicated the agency had not implemented any performance improvement activities to address the patient hospitalizations.		3 Update QAPI program to measure the effectiveness and safety of services and implement performance improvements activities to address patient hospitalizations 4 The frequency and detail of the data collection will be approved by the HHA's governing body quarterly. 5 This update will be completed by May 30 , 2025	
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties.	G0798	1. Patient #5 The Oasis and the Aide Plan of care have been updated. 2. All patients plan of care have been reviewed to ensure the plan of care contained nutritional status and the diet prescribed for the patient. 3. Documentation education will be assigned to designated staff to ensure	2025-05-30

	Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the RN appropriately assigned the HHA to care for the Patient in 1 of 1 active clinical record reviewed with dialysis (medical treatment to filter the blood). (Patient #5) The findings include: A clinical record review for Patient #5 evidenced a comprehensive assessment for the SOC dated 03/24/2025 completed by the Alternate CM which indicated the Patient received dialysis (a medical treatment that filters the blood). On 04/30/2025, at 12:36 PM, Person 8 indicated the Patient received dialysis at Entity 6 and was ordered a renal diet and a 32 ounce fluid restriction daily. The HHA Care Plan dated 03/24/2025 and signed by the Alternate CM failed to include the renal diet and fluid restriction in the directions to the HHA. On 04/30/2025, at 2:09 PM, the Alternate CM indicated she had not yet informed the HHA of the Patient □s fluid restriction and renal diet.		accuracy of their assessments and documentation. 5. This will be completed by 05/30/2025.	

	410 IAC 17-14-1(m)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the agency failed to ensure the HHA provided care as directed in the care plan in 1 of 2 active clinical records reviewed with HHA services. (Patient #5) The findings include:	G0800	1 Patient #5-Aide care plan was updated and reviewed with the aide providing the care to ensure the aide understands that each service needs to be performed and documented correctly 2 All patients will be included in the QAPI program to ensure accuracy and completion of documentation as per care plan 3 Aides inserviced on the importance of providing care as indicated on the care plan and to document accurately on each hha visit note 4 Clinical manager is responsible for ongoing monitoring to ensure this deficiency does not recur 5 This will be complete by May 30, 2025	2025-05-30

	A clinical record review for Patient #5 evidenced a HHA Care Plan dated 03/24/2025 which indicated the HHA was to obtain the temperature, pulse, respiration rate, and blood pressure, assist the Patient with a bath, provide foot care, and record the last bowel movement at every visit. The HHA visit note dated 04/17/2025 failed to evidence the HHA provided a bath, foot care, recorded the last bowel movement, and obtained the temperature, pulse, respiration rate, and blood pressure as directed in the care plan. On 04/30/2025, at 2:12 PM, the Alternate CM indicated the HHA did not provide the services per the care plan.			
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.	G0940	1 Agency has accepted a patient for skilled services using their Medicare benefits. 2 Review of agency's current patient roster insurance status to ensure there is not a need for skilled services under the patients' Medicare benefit 3 Agency will retain referrals that are for skilled services using Medicare and document on a referral log reason of acceptance or denial for services. 4 Agency's Governing body will	2025-05-30

	Based on record review and interview the Governing Body and Administrator failed to ensure the Medicare Provider met the Condition of Participation for Organization and Administration of Services when they failed to provide skilled services to individuals, eligible to receive skilled home health services under their Medicare benefit (See G 942) for 1 of 1 Medicare provider.		ensure that the improvements are sustained by reviewing referral log quarterly to ensure correct acceptance or denial of Medicare referrals. 5 Referral log and review will be completed by May 30, 2025 and reviewed at governing body meeting.	
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the governing body failed to ensure the administrator adhered to the agencies Medicare agreement to accept and provide services to Medicare eligible beneficiaries and the declination to provide skilled services to Medicare beneficiaries, for 1 of 1 agency. Findings include: During the Entrance Conference, conducted on 04/22/2025, beginning	G0942	1 Agency has accepted a patient for skilled services using their Medicare benefits 2 The governing body has reviewed the agency's current patient roster insurance status to ensure there is not a need for skilled services under the patients' Medicare benefit 3 Agency will retain referrals that are for skilled services using Medicare and document on a referral log reason of acceptance or denial for services. 4 Agency's Governing body will ensure that the improvements are sustained by reviewing referral log quarterly to ensure correct acceptance or denial of Medicare referrals. 5 Referral log and review will be completed by May 30, 2025 and reviewed at governing body meeting.	2025-05-30

	at 10:40 AM, the Administrator reported the agency was certified by Medicare, but the agency did not have any Medicare patients on their current census and had not for at least five years. Review of the active patient roster failed to evidence the agency provided services for Medicare patients. Review of the Governing Body Meeting Minutes from 2023, 2024, and 2025 failed to evidence any discussion regarding the failure to accept and provide services to Medicare patients. On 04/22/2025, at 2:20 PM, the Administrator indicated the agency had not provided services for any Medicare patients since she was hired on 12/19/2019. The Administrator indicated the agency did not have SN staff that wanted to provide the intermittent Medicare visits. The administrator relayed any referrals received for Medicare services were referred to another home health agency.			
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care	G1022	1. Patient #6 - patient has been discharged prior to survey. Patient #7 -patient has been discharged prior to survey. 2. All current pending	2025-05-30

	and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to ensure the discharge summary was sent to the physician within 2 business days in 2 of 2 closed clinical records reviewed. (Patient #6 and 7) 1. The revised policy, dated 04/23/2025 and titled □Discharge/Transfer from Service indicated the agency would send the physician a discharge summary within 2 business days of discharge. 2. The clinical record for Patient #6 evidenced Patient was discharged from the agency on 04/10/2025; the record failed to evidence a discharge summary was sent to the physician. 3. The clinical record for Patient #7 evidenced Patient was discharged on 01/21/2025; the record failed to evidence a discharge summary was sent to the physician. 4. On 04/30/2025, at 12:40 PM, the Administrator indicated the agency did send a discharge summary to the		discharged patients (2) have been reviewed to ensure they have a discharge summary that includes all information pertinent to the patient's current course of illness and treatment, post-discharge goals of care and treatment and will be sent to the receiving facility or healthcare practitioner. 3. Administrative staff have been educated to ensure that discharge summaries are to be sent within 2 days of discharge to primary provider 4. All discharged patients will be reviewed to ensure the discharge summary was sent 5. This will be completed by May 30, 2025	

	physician of Patient 6 nor Patient #7. 410 IAC 17-13-2(a)(9)			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure documentation was completed timely and accurately in 3 of 5 active clinical records reviewed. (Patient #2, 3, 5) The findings include: 1. A policy titled Timeliness and Accuracy of Entries in the Clinical Record updated 04/23/2025 indicated staff was to complete clinical progress notes on the date service was rendered. 2. The clinical record for Patient #2 evidenced HHA visit notes completed by HHA 1 dated 04/22/2025, 04/23/2025, and 04/25/2025 which indicated HHA 1 made a visit in the morning and in the evening on each day and provided the Patient a shower both in the morning and in the	G1024	1. Patient #2 The AIDE plan of care was corrected to indicate which ADLs and IADLs are to be completed in the AM shift and the PM shift Patient #3 Physician office was notified with update of patient's medications. Patient #5 Staff has been notified to complete all notes according to policy. 2. Professional staff will do a QA review of all care plans and notes to ensure the care plans are followed and documented accurately 3. All staff will be in-serviced to ensure that any change in services, treatments, medication or patient condition is reported to case manager immediately . The patient's physician will then be notified of changes with the patient.. 4. The clinical manager will be responsible to review all patients medication lists, plans of care and documentation to ensure accuracy documentation and to ensure this	2025-05-30

	evening. On 04/28/2025, at 2:01 PM, the Patient indicated they only take a shower in the morning and not in the evening. On 04/29/2025, at 1:52 PM, HHA 1 indicated she does not give the Patient a shower in the evenings but documented she did, because sometimes the Patient spills food and she helps clean him up. On 04/30/2025, at 1:38 PM, the CM indicated the agency had been working with the HHAs to not leave a blank on the visit note and documented a shower since there was only 1 care plan for both morning and evening visits which indicated the HHA was to assist with a shower. 3. A clinical record review for Patient #3 evidenced a POC for recertification period 02/27/2025-04/27/2025 which indicated the Patient □s medication included escitalopram (antidepressant) to be taken daily. On 04/29/2025, at 11:35 AM, the Patient indicated to LPN 1 they had not taken escitalopram all month because the prescription ran out. SN visit notes completed by LPN 1 and dated 04/01/2025, 04/10/2025, 04/15/2025, and 04/22/2025 indicated LPN 1 documented the Patient		deficiency does not recur 5. This will be completed by 05/30/2025.	

	demonstrated medication compliance, there were no medication changes, and took escitalopram for depression. The clinical record failed to evidence LPN 1 documented the Patient □s inability to take escitalopram as ordered. On 04/29/2025, at 12:18 PM, LPN 1 indicated she did not document the Patient did not have the escitalopram, because the physician was aware. On 04/30/2025, at 2:24 pm, the CM indicated LPN 1 should not have documented there were no changes with medication and the Patient demonstrated medication compliance. 4. A clinical record review for Patient #5 evidenced a POC for the initial certification period 03/24/2025-05/22/2025 which indicated the agency was to provide HHA services 2-3 hours per day 5 days a week for 9 weeks. The clinical record failed to evidence the agency provided HHA services after 4/17/2025. On 04/30/2025, at 2:45 PM, the CM indicated the HHA did provide services on 04/19/2025, 04/22/2025, 04/23/2025, 04/24/2025, and 04/25/2025 but had not yet documented the visits. 410 IAC 17-15-1(b)			

N0000	Initial Comments This visit was for a State Re-Licensure survey of a home health provider. Survey Dates: 4/22/2025 □ 4/25/2025 and 4/28/2025 □ 4/30/2025 Unduplicated Skilled Admissions for the last 12 Months: 15	N0000		

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
Paula Rousis	Administrator	5/23/2025 7:13:34 PM