STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K064	B. WI	NG		11/27/	2017
					_		-
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
A T 1 1 0 N 4 F		NEO 11 O			82ND ST STE 216		
AT HOME	E HEALTH SERVIC	ESTLC		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
G 0000							
Bldg. 00							
			G 0	000			
	This was a Feder	ral follow up recertification					
		an ionow up receitification					
	survey						
	Survey Dates: N	November 20 and 21, 2017					
	Facility Number	· 012383					
	Medicaid Number: 201005950A						
	Census: 55						
	C1 0						
	Sample: 9						
G 0144	494 14(a)						
G 0144	484.14(g)	OF PATIENT SERVICES					
Bldg. 00		or Patient Services  I or minutes of case					
Blug. 00	conferences estab						
		ting, and coordination of					
	patient care does	occui.	$\int_{G} 0$	1 1 1	G 144		12/27/2017
			100	144	5177		12/2//201/
		review and interview, the			The Director of Nursing will		
	agency failed to	ensure case conference			in-service all nursing staff on the		
	documents inclu	ded detailed information of			need to document details of		
		cy of services being			effective interchange, reporting and	l	
					coordination of patients with other		
		group home and who to			health care providers/caregivers.		
	report issues / co	oncerns to within the group			The details will be included in the		
	home in 1 out of	1 record reviewed of a			case conference and shall indicate		
	natient who resid	led in a group home in a			frequency of visits, care provided,		
	F ##10110 10010	w 5			what to report and who to report		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		15K064	B. W	ING	_	11/27/2017
NAMEGE	DD OTABLE OF GLASS ASS			STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIEF				82ND ST STE 216	
AT HOM	E HEALTH SERVIC	ES LLC		INDIAN	APOLIS, IN 46250	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LISC IDENTIFYING INFORMATION		TAG		DATE
	sample of 9. (#6	o)			involved in caring for the patient. The in-service was provided on	
					December 19, 2017.	
	Findings include:				·	
					The Director of Nursing will ensure	
	1. The clinical r	ecord for patient #6, SOC			all nursing new hires are oriented to	
		iewed and contained a plan			document details of effective	
	1	•			interchange, reporting and coordination of patients with other	
		ertification period of			health care providers/caregivers	
	9/27/17 to 11/25	/17.			and what the details will include to	
					begin December 27, 2017.	
	A. Review	of the recertification				
	assessment dated	d 9/26/17, the patient			The Director of Nursing with	
	resided in a grou	-			Governing Body approval has	
	resided in a grou	p nome.			initiated Quality Assurance	
					Performance Improvement (QAPI) Activities regarding case	
		of an agency document titled			conference/care coordination. The	
	"Case Conference	ce / Coordination of Care"			Performance Improvement (PI)	
	dated 9/22/17 an	d 10/20/17, the notes			Committee will use the agency's	
	indicated "Care	coordination performed with			QAPI process to evaluate	
		ler" but failed to include the			opportunities for improvement,	
					planning, monitoring, and	
	_	nformation that was			re-evaluation of the activities. Included in the PI activities will be	
	1	as the type and frequency of			collection of data to measure	
	services being p	rovided by the group home			success or need for revisions to PI	
	and who to report	rt issues / concerns to			activities. 10% of all clinical	
	within the group	home.			records will be audited to ensure	
					case conferences/care coordination	
	C Daviers	of an aganay document titled			was conducted and documented to	
		of an agency document titled			demonstrate effective exchange, reporting and coordination of	
		and Coordination of			patient care until 100% compliance	
	Shared Home Ca	are Patients" dated 9/5/17			is consistently maintained each	
	and 9/6/17, faile	d to include documentation			quarter. The PI activity was	
	of the patient res	iding in a group home, the			reviewed and re-evaluated on	
	_	I frequency of services being			December 14, 2017	
	1				The Divertor of Name in 1911	
	1 ^	group home and who to oncerns to within the group			The Director of Nursing will be responsible for monitoring that the	
		recommend to resitles in the compassion			i responsible for infollitoring fildt file	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K064		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/27/2017		
	ROVIDER OR SUPPLIER		6525 E	ADDRESS, CITY, STATE, ZIP COD E 82ND ST STE 216 NAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	home.			this deficiency is corrected and will not reoccur	
	Director of Clini 12:25 PM. The Services indicate information in the Coordination of was not aware the the group home	ings was reviewed with the cal Services on 11/21/17 at Director of Clinical ed she thought the re Case Conference / Care were sufficient and rere were no information of in the Communication and Shared Home Care Patients		Completion Date: December 27, 2017	
G 0158 Bldg. 00	SUPER Care follows a writestablished and podoctor of medicine. Based on record agency failed to Practical Nurse for regards to chang tube feeds and wactive records re (#6 and 12)  Findings included  1. The clinical residual and residual	eriodically reviewed by a e, osteopathy, or podiatric review and interview, the ensure the Licensed followed the plan of care in ing urostomy wafer, gastric rater flushes in 2 out of 6 viewed in a sample of 9.	G 0158	G158  The Director of Nursing will in-service all staff on the need to review the current plan of care for each patient prior to providing care. The in-service will include the importance of following the plan of care with documentation to demonstrate care provided, any equipment, supplies used, specialized tubes or wafers, medications administered with dose/route/time, and the patient/caregiver's response to the	f
	·	iewed and contained a plan ertification period of		care provided. Any deviations to the plan of care will be reported to the	

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Event ID:

NZKC12 Facility ID: 012383

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLET	
		15K064	B. W	ING	_	11/27/2	017
NAME OF F	DOMNED OF CLIPPLIED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	•			82ND ST STE 216		
AT HOMI	E HEALTH SERVIC	ES LLC		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		/17, with orders for skilled			Director of Nursing and patient's physician with documentation		
		val and reapply an urostomy			regarding any new orders from the		
	wafer weekly.				physician. The in-service was		
					provided on December 19, 2017.		
	A. Review	of the skilled nursing visit			The Director of Nursing met with		
	notes daated 11/	1, 11/3, 11/8, 11/13,			staff privately who failed to		
	11/15 and 11/17.	the visit notes failed to			document care according to plan of		
		urostomy wafer had been			care for educational purposes and		
	changed.				to ensure competency when caring		
	changea.				for patients with urostomy wafers, peg tubes, gastrostomy tubes,		
	D. Th. C. 1	to a second to a decide at			cleaning, feeding and flushing		
		ings was reviewed with the			techniques, procedures for fecal		
		cal Nursing on 11/21/17 at			impaction removal by December 27	',	
	1:40 PM. At 1:5	1 PM, the Director of			2017		
	Clinical Nursing	indicated she had spoken			The Director of Nursing will ensure		
	with the primary	nurse and the primary nurse			all new hires are oriented to the		
	indicated she had	d documented the change of			importance of following the plan of		
	the wafer on the	Friday visits. After review			care and all verbal orders and to		
		it notes / dates in conjuction			document details of care provided,		
	_	r with the Director of			supplies and equipment and the patient/caregivers response to		
		s, the primary nurse did not			treatment. The training will begin		
		•			December 27, 2017.		
	provide services	to the patient on Fridays.					
		10			The Director of Nursing with		
		ecord for patient #12, SOC			Governing Body approval has initiated Quality Assurance		
		iewed. The clinical record			Performance Improvement (QAPI)		
	included a plan of	of care for the certification			Activities regarding following the		
	period of 9/26/17	7 to 11/24/17, with orders			plan of care. The Performance		
	for skilled nursir	ng to clean peg tube with			Improvement (PI) Committee will use the agency's QAPI process to		
		daily and as needed,			evaluate opportunities for care		
		nistration with 30 ml			provided to patient's that follow the	e	
		ater before and after			patient's Plan of Care. Included in		
					the PI activities will be collection of		
		nistration, and 300 ml of			data to measure success or need for revisions to PI activities. 10% of all	r	
	jevity formula th	rough peg tube over 3			clinical records will be audited to		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K064	B. WI	NG		11/27/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			82ND ST STE 216		
AT HOMI	E HEALTH SERVIC	CES LLC		INDIAN	APOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	ensure all staff are following the		DATE
	•	day. The order indicated			patient's plan of care until 100%		
	_	140 ml an hour through			compliance is consistently		
	1	eral pump and skilled			maintained each quarter. The PI		
		regiver may adjust feeding			activity was reviewed and re-evaluated on December 14, 2017	,	
	amount to 600 m	nl over an 8 hour shift and			re-evaluated on December 14, 2017		
	300 ml during a	4 hour shift when the patient			The Director of Nursing will be		
	attends school or	r MD appt [appointment].			responsible for monitoring that the		
					corrective actions to ensure that		
	A. The Med	lication section of the plan			this deficiency is corrected and will not reoccur		
		the patient would receive			nocreocedi		
		s overnight via pump every			Completion Date: December 27,		
	night.	s overnight via pamp every			2017		
	mgnt.						
	B Askilled	I nursing visit note dated					
		:00 to 7:00 PM, indicated					
		·					
		stinal assessment that 500 ml					
		and 30 ml of "flushing." The					
		ative note indicated " 2					
	1 ^ -	via infinity pump, PEG "					
		o indicated whether the peg					
	tube was cleaned	d. The skilled nurse failed					
	to follow the pla	n of care in regards to					
	cleansing of peg	tube, peg tube feedings,					
	and whether med	dications had been given as					
		family / caregiver had given					
	the medications.						
	C A skilled	I nursing visit note dated					
		:17 to 7:17 PM, indicated					
		·					
	_	stinal assessment that no					
		vas provided but "hydration					
	300 mls / 100 m	ls / hr [hour]" was provided.					

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Event ID:

NZKC12 Facility ID: 012383

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		15K064	B. WI	NG		11/27/	2017
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The skilled nurse	e narrative note indicated "					
	hydration com	menced at 4:10 PM. 300					
	mls / 100 mls / h	our no medication due at					
	this time. hydrat	tion still in progress "					
	The skilled nurse	e failed to follow the plan of					
	care.						
	D. The find	ing was reviewed with the					
	Director of Clini	cal Services on 11/21/17 at					
	3:00 PM. The D	rirector of Clinical Services					
	indicated there w	vas not an order for water					
	infusion on the p	lan of care and the skilled					
	-	follow the plan of care.					
		The second secon					
G 0180 Bldg. 00	NURSE The licensed pract	LICENSED PRACTICAL tical nurse prepares clinical					
	and progress note	S.	G 0	180	G180		12/27/2017
	Rased on record	review, the Licensed		100			12/2//201/
		ailed to ensure skilled			The Director of Nursing will		
		es included documentation of			in-service all licensed practical nursing staff regarding standards of		
	-	vided and amount of fleets			care with documentation with		
	•	n 2 out of 6 active records			clinical and progress notes. The		
		mple of 9. (#6 and 11)			in-service will include the importance of following the plan of		
	icvicwed iii a sai	inpic of 9. (#6 and 11)			care and physician orders with		
	Findings include	:			documentation to demonstrate care provided, any equipment, supplies used, specialized tubes or wafers,	<b>?</b>	
	1. The clinical re	ecord for patient #6, SOC			medications administered with		
		iewed and contained a plan			amount/dose/route/time; and administration of fleets enemas and		
		ertification period of			the amount of fluid administered; and the patient/caregiver's		

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Event ID:

NZKC12 Facility ID: 012383

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	
		15K064	B. W	ING	_	11/27/2	2017
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			82ND ST STE 216		
AT HOM	E HEALTH SERVIC	CES LLC		INDIAN	APOLIS, IN 46250	_	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9/27/17 to 11/25	/17, with orders for skilled			response to the care provided. Any	'	
	nursing to perform a bowel program which			deviations to the plan of care will be reported to the Director of			
	consist of admin	istration of a fleets enema,			Nursing and patient's physician		
	digital stimulation	on and manual extraction of			with documentation regarding any		
	_	nt resides in a group home.			new orders from the physician. The	9	
	stooi. The patien	in resides in a group nome.			in-service was provided on		
					December 19, 2017		
		of the skilled nursing visit			The Director of Neuralina meat with		
	notes dated 11/1	0 and 11/17/17, the notes			The Director of Nursing met with staff privately who failed to		
	indicated the box	wel program was performed			document care according to plan of		
	but the failed to	be specific with the amount			care for educational purposes and		
		that was instilled and how			to ensure competency when caring		
					for patients with urostomy wafers,		
	•	ated the procedure. The			peg tubes, gastrostomy tubes,		
	note also failed t	to include documentation of			cleaning, feeding and flushing		
	coordination of s	services with the group			techniques, procedures for fecal impaction removal by December 27	,	
	home clinician.				2017	'	
					2017		
	B Review (	of the skilled nursing visit			The Director of Nursing will ensure		
		•			all new hires are oriented to the		
	•	11/3, 11/8, 11/10, 11/13,			importance of following the plan of		
		/17, the notes indicated the			care and all verbal orders and to		
	bowel program v	was performed but failed to			document details of care provided, supplies and equipment and the		
	be specific with	the amount of fleets enema			patient/caregivers response to		
	that was instilled	l. The note also failed to			treatment. The training will begin		
		ntation of coordination of			December 27, 2017.		
		e group home clinician.					
	services with the	group nome emmeran.			The Director of Nursing with		
					Governing Body approval has		
		ings were reviewed with the			initiated Quality Assurance Performance Improvement (QAPI)		
	Director of Clini	ical Nursing on 11/21/17 at			Activities regarding documentation		
	11:40 PM. The	Director of Clinical Nursing			of all nursing staff but special		
		ne lack of information and			attention to the license practical		
	_	aformation / documentation			nurse's documentation of care and		
		normation / documentation			progress notes that follows the plan	۱	
	to provide.				of care and specifically documents		
					according to medication administration standards of care.		
l			1		auministration standards of care.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K064			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/27/2017	
	PROVIDER OR SUPPLIER		6525 E	ADDRESS, CITY, STATE, ZIP COD 82ND ST STE 216 APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	6/29/15, was revincluded a plan of period of 10/16/2 for skilled nursing.  A. A skilled 10/29/17 and 11/2 medications were document what reduced before the finding Director of Clinical 1:30 PM. The Director of clinical acknowledged the control of	ecord for patient #11, SOC iewed. The clinical record of care for the certification 17 to 12/14/17, with orders ag to administer medications.  I nursing visit notes dated 79/17, indicated e given but failed to medications were provided.  Ings were reviewed with the cal Nursing on 11/21/17 at pirector of Clinical Nursing are lack of information and formation / documentation		The Performance Improvement (PI) Committee will use the agency's QAPI process to evaluate opportunities for care provided to patient's that follow the patient's Plan of Care. Included in the PI activities will be collection of data to measure success or need for revisions to PI activities. 10% of all clinical records will be audited to ensure all staff are following the patient's plan of care until 100% compliance is consistently maintained each quarter. The PI activity was reviewed and re-evaluated on December 14, 2017 The Director of Nursing will be responsible for monitoring that the corrective actions to ensure that this deficiency is corrected and will not reoccur  Completion Date: December 27, 2017	,	
N 0000						
Bldg. 00	This was a State survey	follow up relicensure	N 0000			
	Survey Dates: N Facility Number	November 20 and 21, 2017 : 012383				
	Medicaid Number	er: 201005950A				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K064		A. BU	A. BUILDING <u>00</u> COM			survey .eted /2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
N 0522	Census: 55 Sample: 9 410 IAC 17-13-1(a	•					
Bldg. 00	written medical pla periodically review dentist, chiropract podiatrist, as follow	ws:	N 0	522	N522		12/27/2017
	agency failed to Practical Nurse for regards to change tube feeds and wactive records re (#6 and 12)  Findings include  1. The clinical re 1/30/17, was reverse for the ce 9/27/17 to 11/25	review and interview, the ensure the Licensed followed the plan of care in ing urostomy wafer, gastric vater flushes in 2 out of 6 viewed in a sample of 9.  ecord for patient #6, SOC riewed and contained a plan ertification period of /17, with orders for skilled oval and reapply an urostomy			The Director of Nursing will in-service all staff on the need to review the current plan of care for each patient prior to providing care. The in-service will include the importance of following the plan of care with documentation to demonstrate care provided, any equipment, supplies used, specialized tubes or wafers, and the patient/caregiver's response to the care provided. Any deviations to th plan of care will be reported to the Director of Nursing and patient's physician with documentation regarding any new orders from the physician. The in-service was provided on December 19, 2017		
	wafer weekly.  A. Review onotes daated 11/11/15 and 11/17	of the skilled nursing visit 1, 11/3, 11/8, 11/13, , the visit notes failed to urostomy wafer had been			The Director of Nursing met with staff privately who failed to document care according to plan of care for educational purposes and to ensure competency when caring for patients with urostomy wafers, peg tubes, gastrostomy tubes, cleaning, feeding and flushing		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K064	B. WI	NG		11/27/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			6525 E	82ND ST STE 216		
AT HOMI	E HEALTH SERVIC	ES LLC		INDIAN.	APOLIS, IN 46250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	changed.				techniques, procedures for fecal impaction removal by December 27,		
	B. The findings was reviewed with the				2017	'	
	Director of Clini	cal Nursing on 11/21/17 at			The Director of Nursing will ensure		
	1:40 PM. At 1:5	1 PM, the Director of			all new hires are oriented to the		
		indicated she had spoken			importance of following the plan of		
	_	nurse and the primary nurse			care and all verbal orders and to document details of care provided,		
		• •			supplies and equipment and the		
		d documented the change of			patient/caregivers response to		
		Friday visits. After review			treatment. The training will begin		
	•	it notes / dates in conjuction			December 27, 2017.		
	with the calendar	r with the Director of			The Director of Nursing with		
	Clinical Services	s, the primary nurse did not			Governing Body approval has		
	provide services	to the patient on Fridays.			initiated Quality Assurance		
	•	•			Performance Improvement (QAPI)		
	2 The clinical re	ecord for patient #12, SOC			Activities regarding following the		
		iewed. The clinical record			plan of care. The Performance Improvement (PI) Committee will		
					use the agency's QAPI process to		
	•	of care for the certification			evaluate opportunities for care		
	*	7 to 11/24/17, with orders			provided to patient's that follow the	:	
		ng to clean peg tube with			patient's Plan of Care. Included in		
	soapy and water	daily and as needed,			the PI activities will be collection of data to measure success or need for		
	medication admi	nistration with 30 ml			revisions to PI activities. 10% of all		
	[milliliters] of w	ater before and after			clinical records will be audited to		
	medication admi	nistration, and 300 ml of			ensure all staff are following the		
		rough peg tube over 3			patient's plan of care until 100%		
		day. The order indicated			compliance is consistently maintained each quarter. The PI		
	•	•			activity was reviewed and		
	_	140 ml an hour through			re-evaluated on December 14, 2017		
		eral pump and skilled					
	_	regiver may adjust feeding			The Director of Nursing will be		
		al over an 8 hour shift and			responsible for monitoring that the corrective actions to ensure that		
	300 ml during a	4 hour shift when the patient			this deficiency is corrected and will		
	attends school or	MD appt [appointment].			not reoccur		
			ı		Completion Date: December 27		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K064		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>		SURVEY LETED 1/2017	
	PROVIDER OR SUPPLIER E HEALTH SERVIC		6525 E	ADDRESS, CITY, STATE, ZIP COD 8 82ND ST STE 216 NAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	of care indicated Jevity 1.5, 4 can night.	lication section of the plan I the patient would receive s overnight via pump every		2017		
	10/22/17 from 1 in the gastrointe of tube feeding a skilled visit narr PM pt hydration The note failed tube was cleaned	In nursing visit note dated :00 to 7:00 PM, indicated stinal assessment that 500 ml and 30 ml of "flushing." The ative note indicated " 2 via infinity pump, PEG " to indicated whether the peg d. The skilled nurse failed in of care in regards to				
	cleansing of peg	tube, peg tube feedings, dications had been given as family / caregiver had given				
	10/30/17 from 3 in the gastrointe enteral feeding v 300 mls / 100 m The skilled nurs hydration con mls / 100 mls / 1 this time. hydra The skilled nurs care.	In nursing visit note dated :17 to 7:17 PM, indicated stinal assessment that no was provided but "hydration ls / hr [hour]" was provided. e narrative note indicated "nmenced at 4:10 PM. 300 nour no medication due at tion still in progress " e failed to follow the plan of				
	D. The find	ing was reviewed with the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K064		(X2) MULTIPLE C A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 11/27/2017		
	ROVIDER OR SUPPLIER E HEALTH SERVIC		6525 E	ADDRESS, CITY, STATE, ZIP COD E 82ND ST STE 216 NAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Director of Clini 3:00 PM. The D indicated there w infusion on the p nurses failed to f 410 IAC 17-14-1(a Scope of Services Rule 14 Sec. 1(a) services are limite purposes of practi setting, the registe following: (F) Coordinate se  Based on record agency failed to documents inclu- type and frequen provided by the a report issues / co home in 1 out of	cal Services on 11/21/17 at prector of Clinical Services was not an order for water plan of care and the skilled collow the plan of care.  (a)(1)(F)  (1)(F) Except where does not the home health pred nurse shall do the rvices.  The eview and interview, the ensure case conference ded detailed information of cy of services being group home and who to encerns to within the group of 1 record reviewed of a ded in a group home in a services.		N545  The Director of Nursing will in-service all nursing staff on the need to document details of effective interchange, reporting and coordination of patients with other health care providers/caregivers. The details will be included in the case conference and shall indicate frequency of visits, care provided, what to report and who to report concerns or issues for all providers involved in caring for the patient. The in-service was provided on December 19, 2017.	12/27/2017
	1/30/17, was rev	ecord for patient #6, SOC iewed and contained a plan ertification period of /17.		The Director of Nursing will ensure all nursing new hires are oriented t document details of effective interchange, reporting and coordination of patients with other health care providers/caregivers	0
		of the recertification 19/26/17, the patient		and what the details will include to begin December 27, 2017.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K064		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/27/2017			
NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
1.70	B. Review of "Case Conference dated 9/22/17 are indicated "Care group home lead specifics of the indiscussed, such a services being pland who to reposit within the group of the patient respecific type and provided by the report issues / conformation of Clinical Coordination of was not aware the group home.	of an agency document titled ce / Coordination of Care" ad 10/20/17, the notes coordination performed with der" but failed to include the information that was as the type and frequency of rovided by the group home rt issues / concerns to			The Director of Nursing with Governing Body approval has initiated Quality Assurance Performance Improvement (QAPI) Activities regarding case conference/care coordination. The Performance Improvement (PI) Committee will use the agency's QAPI process to evaluate opportunities for improvement, planning, monitoring, and re-evaluation of the activities. Included in the PI activities will be collection of data to measure success or need for revisions to PI activities. 10% of all clinical records will be audited to ensure case conferences/care coordination was conducted and documented to demonstrate effective exchange, reporting and coordination of patient care until 100% compliance is consistently maintained each quarter. The PI activity was reviewed and re-evaluated on December 14, 2017  The Director of Nursing will be responsible for monitoring that the corrective actions to ensure that this deficiency is corrected and will not reoccur  Completion Date: December 27, 2017			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER  15K064	B. WING			11/27/2017	
		101004	D. W1			11/2//	2017
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 82ND ST STE 216		
AT HOME HEALTH SERVICES LLC				APOLIS, IN 46250			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENC IT		DATE
	documents.					ļ	
N 0554	410 IAC 17-14-1(a	a)(2)(B)					
	Scope of Services						
Bldg. 00	•	(2) (B) For purposes of					
	-	ne health setting, the					
	licensed practical	nurse shall do the					
	following:	al natas					
	(B) Prepare clinic	ai notes.	N 0:	554	N554		12/27/2017
	Daned an manual	maniana dha Liannaa d	110.	) J <del>-</del>			12/2//2017
		review, the Licensed			The Director of Nursing will		
		failed to ensure skilled			in-service all licensed practical		
	_	es included documentation of			nursing staff regarding standards of care with documentation with		
	•	vided and amount of fleets			clinical and progress notes. The		
	enema instilled i	n 2 out of 6 active records			in-service will include the		
	reviewed in a san	mple of 9. (#6 and 11)			importance of following the plan of		
					care and physician orders with	_	
	Findings include	:			documentation to demonstrate care provided, any equipment, supplies	2	
					used, specialized tubes or wafers,		
	1. The clinical r	ecord for patient #6, SOC			medications administered with		
		iewed and contained a plan			amount/dose/route/time; and administration of fleets enemas and	ı	
	•	ertification period of			the amount of fluid administered;	,	
		/17, with orders for skilled			and the patient/caregiver's		
		m a bowel program which			response to the care provided. Any		
	• .				deviations to the plan of care will		
		istration of a fleets enema,			be reported to the Director of Nursing and patient's physician		
	_	on and manual extraction of			with documentation regarding any		
	stool.				new orders from the physician. The	!	
					in-service was provided on		
	A. Review	of the skilled nursing visit			December 19, 2017		
	notes dated 11/1	0 and 11/17/17, the notes			The Director of Nursing met with		
	indicated the box	wel program was performed			staff privately who failed to		
	but the failed to	be specific with the amount			document care according to plan of		
		hat was instilled and how			care for educational purposes and to ensure competency when caring		
	the patient tolera	ted the procedure.			for patients with urostomy wafers,		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
15K0		15K064	B. WING			11/27/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					82ND ST STE 216		
AT HOME HEALTH SERVICES LLC					APOLIS, IN 46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					peg tubes, gastrostomy tubes,		
	B. Review	of the skilled nursing visit			cleaning, feeding and flushing techniques, procedures for fecal		
	notes dted 11/1,	11/3, 11/8, 11/10, 11/13,			impaction removal by December 27,		
	11/15 and 11/17	/17, the notes indicated the			2017		
		was performed but failed to					
		the amount of fleets enema			The Director of Nursing will ensure		
	-				all new hires are oriented to the		
	that was instilled	1.			importance of following the plan of care and all verbal orders and to		
					document details of care provided,		
	C. The find	ings were reviewed with the			medication administered, supplies		
	Director of Clini	ical Nursing on 11/21/17 at			and equipment and the		
	11:40 PM. The Director of Clinical Nursing				patient/caregivers response to		
	acknowledged the lack of information and				treatment. The training will begin		
	had no further information / documentation				December 27, 2017		
					The Director of Nursing with		
	to provide.				Governing Body approval has		
					initiated Quality Assurance		
	2. The clinical r	record for patient #11, SOC			Performance Improvement (QAPI)		
	6/29/15, was rev	riewed. The clinical record			Activities regarding documentation		
	included a plan	of care for the certification			of all nursing staff but special attention to the license practical		
	period of 10/16/	17 to 12/14/17, with orders			nurse's documentation of care and		
	*	ng to administer medications.			progress notes that follows the plan		
	101 Sitting Harsin	is to dammister incurrents.			of care and specifically documents		
	A A a1-i11	d nursing visit notes deted			according to medication		
		d nursing visit notes dated			administration standards of care. The Performance Improvement (PI)		
	10/29/17 and 11	· ·			Committee will use the agency's		
	medications wer	re given but failed to			QAPI process to evaluate		
	document what i	medications were provided.			opportunities for care provided to		
					patient's that follow the patient's		
	B. The findings were reviewed with the Director of Clinical Nursing on 11/21/17 at 1:30 PM. The Director of Clinical Nursing				Plan of Care. Included in the Pl		
					activities will be collection of data to measure success or need for		
					revisions to PI activities. 10% of all		
		•			clinical records will be audited to		
	•	ne lack of information and			ensure all staff are following the		
	had no further in	formation / documentation			patient's plan of care until 100%		
	to provide.						
	had no further information / documentation to provide.				patient's plan of care until 100% compliance is consistently maintained each quarter. The Pl		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K064		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/27/2017			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
N 0563 Bldg. 00	listed in subsectio (2) review the pla severity of the pat but at least every.  Based on record Nurse failed to c assessment of the upon recertificat reviewed of patie diabetes in a sam.  Findings include  1. The clinical reviewed of the control	The appropriate therapist in (b) of this rule shall: in of care as often as the ient's condition requires, two (2) months;  review, the Registered onduct an adequate e patients type 2 diabetes ion in 1 out of 1 records ents being recertified with higher of 9. (#6)	N 0563	activity was reviewed and re-evaluated on December 14, 201  The Director of Nursing will be responsible for monitoring that the corrective actions to ensure that this deficiency is corrected and will not reoccur  Completion Date: December 27, 2017  N563  The Director of Nursing will in-service all staff on the need to review the current plan of care for each patient prior to providing care as the patient's condition changes, and at least every two (2) months. The in-service will include the importance of following the plan of care with documentation specific to the patient's medical needs that demonstrates the RN follows standards of care when conducting assessments related to the patient's known disease process. The in-service will cover specific expectations regarding assessment with diabetics and the integumentary skin assessment including foot care assessment and ranges of blood sugar. The	12/27/2017  12/27/2017		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		15K064	B. WING		11/27/2017		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					82ND ST STE 216		
AT HOME HEALTH SERVICES LLC			10025 E 02ND ST STE 210 INDIANAPOLIS, IN 46250				
				II (IDI) (I (I	711 0210, 117 10200		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	A. Review of the comprehensive				in-service will cover the importance		
	recertification as	ssessment dated 9/26/17, the			of patient specific medical needs;		
	Endocrine assess	sment indicated the patient's			any equipment, supplies used, specialized tubes or wafers, and the patient/caregiver's response to the		
		taken on 9/25/17 at 10:30					
	I -	lt of 96. No other			care provided. Any deviations to the	e	
					plan of care will be reported to the		
		uch as diabetic foot exam or			Director of Nursing and patient's		
	patient blood sug	gar ranges since last RN			physician with documentation		
	assessment, were	e provided within the			regarding any new orders from the physician. The in-service was		
	Endocrine assess	sment section.			provided on December 19, 2017.		
					p		
	D Davion	of the Professional services			The Director of Nursing met with		
					staff privately who failed to		
		ne 9/26/17 comprehensive			document the comprehensive		
	recertification as	ssessment, the note indicated			assessment that met the patient's		
	for skilled nursii	ng or care giver to perform			individual medical needs for		
	glucose monitor	ing daily and as needed, to			educational purposes and to ensure		
	notify the physician for blood sugars <60 or				competency when caring for diabetic patients by December 27,		
	1	tiali for blood sugars <00 or		2017			
	>300.						
					The Director of Nursing will ensure		
	C. Review	of the Integumentary (skin)			all new registered nurse hires are		
	assessment with	in the 9/26/17			oriented to the importance of		
		recertification assessment,			completing the comprehensive		
	_	·			assessment of all systems		
	ine section failed	d to include a diabetic foot			especially those where a diagnosis		
	assessment.				specifically has standards of care established for assessment and		
					documentation. The training will		
	D. The find	ings were reviewed with the			begin December 27, 2017.		
		ical Nursing on 11/21/17 at			•		
		· ·			The Director of Nursing with		
	1:40 PM. The Director of Clinical Services acknowledged the findings and had no further documentation or information to				Governing Body approval has		
					initiated Quality Assurance		
					Performance Improvement (QAPI)		
	provide.				Activities regarding the registered nurse comprehensive assessment of	£ .	
	_				all systems follows standards of	ı	
					practice. The Performance		
					Improvement (PI) Committee will		

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

PRINTED: 01/26/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K064	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/27/2017			
NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA* DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
					use the agency's QAPI process to evaluate opportunities for care provided to patient's that follow the patient's Plan of Care. Included in the PI activities will be collection of data to measure success or need for revisions to PI activities. 10% of all clinical records will be audited to ensure all staff are following the patient's plan of care until 100% compliance is consistently maintained each quarter. The PI activity was reviewed and re-evaluated on December 14, 2017  The Director of Nursing will be responsible for monitoring that the corrective actions to ensure that this deficiency is corrected and will not reoccur  Completion Date: December 27, 2017			

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