STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K130	A. BUILDING B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAL AT HOME LLC	1335 SADLIER CIRCLE EAST DRIVE, INDIANAPOLIS, IN, 46239

(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 Department of Health in accordance with 42 CFR 484.102. Survey Dates: 06/05/24, 06/06/24, 06/07/24, and 06/10/24. Active Census: 149 At this Emergency Preparedness survey, Heal at Home, LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers 42 CFR 484.102. QR completed by Area 3 on 6-12-2024.	E0000	No response required	

G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider in conjunction with one (1) complaint, conducted by the Indiana Department of Health. Survey Dates: 06-05-2024, 06-06-2024, 06-07-2024, and 6-10-2024 Complaint: # 107373 with related and unrelated deficiencies cited. 12-month unduplicated census: 154 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR completed by Area 3 on 6-12-2024.	G0000	No response required	
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.	G0536	**Staffwill be re-educated on medication reconciliation that occurs at time ofadmission, when any medications are changed, after inpatient stays, atrecertification and at discharge.** Educationwill be done, and a learning module will be completed by all RNs and LPNs. The policy3-709 –	2024-07-10

	Based on record review and interview the agency failed to ensure a review of all current medications was conducted to identify any potential adverse effects, drug reactions, including ineffective drug therapy, side effects, duplicate therapy, and/or noncompliance with medication regimen, in 1 of 8 active clinical records reviewed. (Patient #2) Findings include: 1. Review of an undated agency document titled '3-700 MEDICATION PROFILE' indicated, "... PURPOSE To provide a complete list of ALL medications the client is taking ... identify discrepancies between client profile and the physician and/or agency ... The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation of medication ..." Review of an undated agency document titled '3-709 MEDICATION RECONCILIATION' indicated, "POLICY Heal at Home will reconcile all medications taken by the client		Medication Reconciliation has been sent to the nursing team for review. Staffwill be educated to inquire about all prescribed and non-prescribed medicationsto include vitamins and herbals. With eachvisit, staff should review each medication on the medication list to verifythey are still taking the medication and if any additional medication changeshave been made. Staffwill be instructed to notify and document that the provider was notified ifthere are any medication issues discovered.DON/ADON/QARN will review each OASIS and POC/Change Order and compare medications on thereferral information to what is on the patient's MAR. If there are anydiscrepancies, follow-up will be done by DON/ADON with the Case Manager and thefield staff. This may include contacting the patient or the MD/NP/PAOffice to complete an accurate medication reconciliation. This review will correct the deficiency for100% of patients. Item will become aQAPI monitor for compliance and trending. Responsiblefor the above are the DON, ADON, and Administrator.	

	during admission to home care, at recertification, after inpatient facility stays, at time of discharge, and whenever needed ... Medications will be reviewed with the client on each home visit to determine if other prescriptions or non-prescription drugs are being taken ..." 2. Review of the clinical record for Patient #2 evidence a Plan of Care with a start of care date of 11-12-2021 for the certification period of 04-30-2024 through 06-28-2024, was completed and signed by Registered Nurse (RN) 1 on 04-25-2024, and contained diagnoses which included, but were not to limited to: unspecified chronic respiratory disease (disease of the airways and other structures of the lung), tracheostomy (surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing) status, gastrostomy (surgical procedure used to insert a tube, often referred to as a "G-tube", through the abdomen and into the stomach used to provide a route for tube feeding, and/or to vent the stomach for air or		This wasimplemented on June 25, 2024. Nursingeducation is due b July 10, 2024. There will be ongoing tracking and monitoringthrough the QAPI process quarterly	

	drainage) status, and contained a medication list, which included but was not limited to the following: Advair (medication which treats two of the main causes of asthma symptoms: airway constriction and airway inflammation, to help prevent symptoms in the first place) twice daily, Flonase (used to relieve seasonal and year-round allergic and non-allergic nasal symptoms: stuffy/runny nose, itching, and sneezing) daily, Sodium Chloride 3% inhalation solution (treats conditions that cause thick mucus in the lungs, works by thinning and loosening mucus, making it easier to clear from the lungs, may also be used to help deliver other medications to the lungs) four times daily, Supplemental water 30 mls over 30 mins 5 x day an hour after feeding infuses 10 am – 1 pm- 4 pm- 7 pm – 10 pm, Triamcinolone 0.1% topical cream (works by activating natural substances in the skin to reduce swelling, redness, and itching) apply twice daily to tissue around the g-tube. 3. On 06-06-2024 at 11:00 AM during a home visit interview for Patient #2, License Practical			

	Nurse (LPN) 1, who was also a primary caregiver, was shown the most recent Plan of Care dated 04-25-2024 and completed by Registered Nurse (RN) 1. LPN 1 was queried as to each medication and the corresponding directions for each medication on the list. LPN 1 indicated the only medication the patient currently was taking was Advair, Flonase was not 'daily', was only used seasonally, Sodium Chloride was only used when given with Albuterol (used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease) PRN (as needed), Supplemental water was no longer being given, 'I give Pedialyte 10 AM and 2 PM', and indicated further the Triamcinolone cream was no longer being used, but a clear barrier cream was used instead. 4. On 06-06-2024 at 2:30 PM, in a telephone interview, LPN 1, who was also a primary caregiver for Patient #2, indicated Flonase had never been given as 'Daily'. Indicated 'Supplemental Water' had been			

	replaced and indicated Pedialyte was given instead 'for the last six months, or the 1st of the year'. Indicated was not using the Triamcinolone Cream which had been prescribed by a Nurse Practitioner and then was subsequently discontinued by the doctor and the family was then instructed to use a barrier cream instead, they had been using Critic-Aid Clear AF, and indicated they were able to purchase this cream from Amazon and had been using this for years. When queried as to how the Registered Nurse (RN) reviews medications for Patient #2 during the recertification visits, LPN 1 indicated the RN 'just asks questions', 'just asks me questions'. When queried about whether Sodium chloride was still being given, LPN 1 indicated it was only used when given with Albuterol. And further indicated the Albuterol had not been needed or administered since approximately January of 2023 and was aware Albuterol was not currently on the list. Reiterated Advair was only needed in AM and PM, and was the only medication the patient was currently taking.			

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview the agency failed to ensure ketone call orders were included on the plan of care in 1 of 6 active record reviews. (Patient #3) Findings include: A review of a policy dated 12/2017 titled 'PLAN OF CARE 3-580' revealed, "... The Plan of Care shall be completed in full to include: ... diagnostic tests ... treatments, and procedures ..." A review of the Clinical Record for Patient #3 revealed a Plan of Care dated 05/03/2024 and signed by Registered Nurse (RN) 3 for the certification	G0572	**No range on point of care tests** **Staff will be educated that all point-of-care testingperformed should include who is to perform and what actions should be takenwith the results of the test. Theseitems will be included on the plan of care.** **The policy2-310 – Laboratory Testing has been sent to the nursing team for review.** **DON/ADON/Q RN will review each case involving point of caretesting and verify that it includes who is to perform the tests and the actionsthat should be taken with the results.** **Item will become a QAPI monitor.** **Responsiblefor the above are the DON, ADON, and Administrator.** **This wasimplemented on June 25, 2024. Nursingeducation is due by July 10th, 2024. There will be ongoing tracking and monitoringthrough the QAPI process quarterly. This will be ongoing tracking and monitoringthrough the QAPI process**	2024-07-10

	07/06/2024 evidenced Ketostix (tell you whether you have no ketones [a type of chemical that your liver produces when it breaks down fats. Your body uses ketones for energy] present or if you have trace, small, moderate, or large ketones present) 1 strip daily and as needed to check ketone level, urine. An LPN visit note dated 05/24/2024 and signed by LPN 2 indicated Person A, a family member was going to test ketones that evening. The Plan of Care failed to identify who is to check ketone levels and what levels need to be reported to the physician. On 06/06/2024 at 7:50 AM RN 4 indicated they check ketone levels every morning, that the physician likes for Patient #3 to be in the range of moderate to high with their ketones, and they would notify the physician if it was out of the ordinary.			

	On 06/06/2024 at 12:33 PM, RN 3, the case manager for Patient #3 indicated there should be a range and when to notify the physician and the case manager with the Ketostix order. On 06/10/2024 at 11:31 the Director of Nursing indicated there needed clarification on the Ketostix order, needed to know who was to perform the test, needed to know ranges, and when to notify the physician. 410 IAC 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview the agency failed to ensure the clinical staff notified the attending physician with a medication error in 1 of 6 active records reviewed. (Patient #3) Findings include:	G0590	**Staff will be re-educated on the policy and verification ofreview will be done.** **The policies2-300 – Incident Reporting, 3-381 Complaint/Grievance Policy and 3-720Medication Administration Error have been sent to the nursing team for review.** **DON/ADON will review any medication errors and relay theirfindings to the Administrator for review.** **The staff member involved with the surveyor citation has beencounseled. Discussion was held with thenurses caring for the patient regarding proper care and labeling of feedings asneeded. This was completed during the survey.** **Item will become a QAPI monitor.** **Responsiblefor the above are the DON, ADON, and Administrator**	2024-07-10

	1. A review of an undated policy titled 'MEDICATION ADMINISTRATION ERROR' revealed, "... The client's physician is notified of medication errors ... a complete narrative description is documented by the responsible staff member and reviewed by the supervisor ... Appropriate action for follow-up with personnel is instituted ... the incident, actions taken, and client response will be documented in the clinical record ...". 2. A record review of Patient #3 revealed a Plan of Care dated 05/03/2024 and signed by Registered Nurse (RN) 3 for the certification period of 05/08/2024 through 07/06/2024 which evidenced diagnoses but not limited to Epileptic spasms (a sudden flexion, extension or mixed flexion-extension of proximal and truncal muscles, lasting 1-2 seconds), Patient #3 was to receive Enteral (the administration of food or drug into the human gastrointestinal tract) feedings through a gastrostomy tube (this is surgically placed to deliver		**This wasimplemented on June 25, 2024. Nursingeducation is due by July 10th, 2024. This will be ongoing tracking and monitoringthrough the QAPI process**	

	through a flexible tube that goes directly into your stomach) and was to receive Ketogenic Enteral feedings 685 milliliters Ketocal 4:1 (formulated, beneficial supplement to ketogenic diets, high-fat, low-carb diet helps seizure control) plus 420 ml water (total daily volume 1105) 230 milliliters 1 feed at 9 PM via gastrostomy via pump at 285-380 milliliters per hour as tolerated, and 685 milliliters Ketocal 4:1 plus 420 ml waster (total daily volume 1105) 220 milliliters give 4 feeds at 9 AM, 12 PM, 3 PM, and 6 PM via gastrostomy (G-tube) via pump at 285-380 milliliter per hour as tolerated. A visit note dated 05/24/2024 for Patient #3, signed by LPN 2 evidenced a Ketogenic formula 220 milliliters was administered via the pump through the G-tube from 12:05 PM to 12:46 PM and 2:58 PM to 3:51 PM and indicated the patient had tolerated both feedings well. The record failed to evidence physician notifications from 05/24/2024 through 06/03/2024.			

	3. During a phone interview on 06/07/2024 at 1:08 PM with Person A, the family member of Patient #3 indicated on 05/24/2024 when preparing for the tube feeding at 6 PM, they noticed the color was different in the bag than what it should have been. Person A called LPN 2 and asked about the feedings LPN 2 had given. Person A and LPN 2 decided LPN 2 must have grabbed the wrong feeding to give to Patient #3. Person A indicated they did notify Person D, the attending physician of the wrong tube feedings and Patient #3 had 7 seizures on 05/25/2024, was better on 05/26/24, and was back at baseline on 05/27/2024 which is 1-2 seizures per day. During a phone interview on 06/07/2024 at 1:37 PM LPN 2 indicated they did receive a call on 05/24/2024 in the evening from Person A, and it was thought LPN 2 had given the wrong formula to the patient, LPN 2 indicated there were 2 different types of formula in the cabinet and they must have grabbed the wrong one. LPN 2 indicated they should have notified the Registered Nurse			

	called the physician as well. On 06/10/2024 at 9:16 AM, the Director of Nursing indicated with medication errors there would be immediate education for all staff, education with the family to label shelves as needed, discipline staff if appropriate, file a medication error report, and contact the physician. This writer attempted to phone Person D the attending physician for Patient #3, on 06/07/2024 at 3 PM, left a voice message, and on 06/10/2024 at 8:46 AM with no return calls. 410 IAC 17-13-1(a)			
G0612	Written instructions to patient include: 484.60(e) Standard: Written information to the patient. The HHA must provide the patient and caregiver with a copy of written instructions outlining: Based on record review and interview, the agency failed to ensure patients received written instructions for their plan of care, medications, and schedules in 3 of 4 home visits.	G0612	**Upon completion of the Plan of Care and at eachrecertification, the Plan of Care, Medication list and calendar schedule willbe mailed to the patient's home. Aletter will be included instructing the patient/family to place these items inthe agency folder that is in their home. They will be instructed to remove and discard older versions.** **All staff will be re-educated on the agency**	2024-06-21

	(Patients 2, 3, and 4) Findings include: 1. A review of a policy dated 12/2017 titled 'HOME CARE BILL OF RIGHTS 3-380' revealed, "... Rights of the patient ... 4. ... b. The care to be furnished, including disciplines and frequency of visits ...". 2. On 06/06/2024 at 7:45 AM, the review of Patient #3's home folder failed to evidence their Plan of Care, a Medication list, and schedule. When queried RN 4 indicated that Person A, a family member probably had placed those items somewhere. 3. On 06/06/2024 at 3:20, the review of Patient #4 home folder failed to evidence their Plan of Care, Medication list, and schedule. 4. During an interview on 06/06/2024 at 3:20 RN 5, a family member to Patient #4 indicated there not a Plan of Care, Medication list or schedule, and couldn't recall if there had ever been one. 5. During an interview on 0607/2024 at 1:08 PM, Person A indicated they do not have a		**folder and toreview if the documents are present.** **Education will be done with the HHA's on the folder and tonotify the case manager if the documents are not present. A "Task" will be added to the care plan forthem to acknowledge presence of folder in the home. If they are not able to locate the folder,they will notify the scheduling team or the Case Manager for follow up. HHA notes will be reviewed through the QAprocess to verify compliance and to address any issues. Tasks will be added to all new SOC's andRecertifications starting June 20, 2024, and will be added to all care plans byAugust 30, 2024.** **The nursing team will be educated to educate the family atstart of care and with any subsequent visits. They will verify that the agency folder is available, and that Plan ofCare and Medication List is available.** **Education will be done to the staff to educate the family onthe importance of placing these documents in the agency folder and having themavailable as needed by the home healthcare staff or EMS.** **The agency folder contains the Home Care Bill of Rights,Emergency Preparedness, Transfer/Discharge policy, ISDH Advance Directiveinformation, home safety and information on how to contact the agency or ISDHfor grievances and complaints.** **Office procedures were developed for support staff to mailout the documents timely.** **Item will become a QAPI monitor for compliance and tracking. There will be ongoing tracking and monitoring through the QAPIprocess quarterly** **Responsiblefor the above are the DON, ADON, Scheduling Manager, and Administrator.** **This wasimplemented on June 21, 2024.**	

	Plan of Care or a Medication list from the Agency. 6. During an interview on 06/06/2024 at 12:40 RN 3, a Registered Nurse Case Manager indicated they were unaware they were to put a Plan of Care or a Medication list in the patient's home folders. 7. During an interview on 06/07/2024 at 12:10 the Administrator indicated they had not realized the Plan of Care, Medication Lists, and schedules were not being placed in the patient's homes. 8. On 06-06-2024 at 2:00 PM during a home visit with Patient #2, LPN 1 who is also a caregiver for the patient, offered two agency folders for review, neither contained a Plan of Care. When queried as to whether the agency ensured an updated Plan of Care gets placed in the folder, the nurse indicated, ''No". Person E, a family member and caregiver of Patient #2 was shown a copy of the Plan of Care, and was then queried as to whether they had their own copy of the patient's Plan of Care elsewhere, or had ever received a Plan of Care			

	from the agency which contained the frequency of services, treatments, and medication list, Person E indicated had 'never' received such documents from the agency. 9. On 06-06-2024 at 4:03 PM the Director of Nursing indicated knowing the Plan of Care 'should go back out to the patient'.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on record review, observation, and interview the agency failed to ensure staff utilized appropriate infection control, personnel protective equipment, and hand hygiene practices while providing care in 1 of 4 home visits observed. (Home Health Aide (HHA) 1)	G0682	**Infectioncontrol will be reinforced with all staff.** **HomeHealth Aides will complete the online module for Infection Control as part oftheir annual requirements.** **The homehealth aide that was observed by the surveyor will be re-educated by the NurseEducator for infection control and the skills assessment completed for thatsection. She will also be provided with waterproofcovering to wear on her feet during the time she is assisting the patient inthe shower.** **Staffwill be instructed to notify the office staff if they need any supplies in thehome, to include hand sanitizer, gloves or any additional or specific PPE.** **Nursingwill be instructed to observe and instruct on infection control during theirrecertification and supervisory visits when the HHA is present.** **Item willbecome a QAPI monitor for compliance and tracking for annual and ongoingeducation.** **Responsiblefor the above are the DON, ADON, and Administrator.**	2024-07-10

	Findings include: 1. Review of an agency document 'EFFECTIVE: 1/31/18' titled 'PERSONAL PROTECTIVE EQUIPMENT (PPE) - REFERENCE #5017' stated, "PROCEDURE: The appropriate PPE shall be worn when: ... Whenever there is danger of contamination from blood, body fluids (including secretions and excretions except sweat), or other potentially infectious materials ... All PPE shall be removed prior to leaving a work area ... Protective clothing (gowns and aprons) shall be worn according to isolation guidelines, policy or necessity ... shoe covers shall be worn as needed ..." Review of an agency document 'EFFECTIVE: 1/31/18' titled 'HAND HYGIENE - CDC GUIDELINES - REFERENCE #5011' stated, "PURPOSE: To provide guidelines for effective hand hygiene in order to prevent the transmission of bacteria, germs, and infections ... All staff shall use hand-hygiene techniques, as set forth in the following procedure ... When hands are soiled ...		**This wasimplemented on June 25, 2024. Home HealthEducation is due by July 10th, 2024. There will be ongoing tracking and monitoringthrough the QAPI process quarterly**	

	... After coming in contact with patient's intact skin ... i.e. ... lifting/moving the patient ... After contact with medical equipment/supplies in patient areas ... Always after removing gloves ... " 2. On 06-07-2024 at 8:30 AM during a home visit for Patient #8, Home Health Aide (HHA) 1 was observed wearing a knee-length skirt and flip-flops. Entering the roll-in shower, HHA 1 with gloves donned, proceeded to assist the patient who was seated in a rolling shower chair, to complete their shower. During the shower the aide utilized a detachable shower head to rinse the patient's hair and body, the aide's exposed feet were also inadvertently sprayed with water. After the shower, the aide dried off the patient with a bath towel, then transported the patient to their bedroom area and assisted with transferring from the chair to the bed, covered the patient for comfort and privacy, and allowed the patient to rest before dressing. The aide returned to the roll-in shower and proceeded to rinse and ring out a sponge used during the			

shower. The aide then doffed their gloves, washed their hands with soap and water, dried their hands with disposable paper towels, and shut off the faucet with paper towel. A bath towel used during the shower remained on the floor, using their sandaled feet to scoot the towel around on the floor, the aide attempted to 'mop' up any water droplets that remained on the floor after transporting the patient from the shower to the bed. When this was completed the aide slipped out of their flip-flops and stepped onto the towel itself and dried off their feet. The aide put on a different pair of white, lacy-appearing, closed-toed shoes, then returned to pick up the flip-flops and carried them to another area of the room. The aide then proceeded to the patient's bedside, donned a new pair of gloves and began assisting the patient with applying lotion to their body. Hand Hygiene was not performed during changes in tasks. Hand hygiene was not performed after handling the flip flops with bare hands, and not before donning gloves to apply lotion to the patient's body.

N0000	Initial Comments This visit was for a State Re-Licensure Survey of a Home Health Provider. Survey dates: 06/05, 06/06, 06/07, and 06/10/24. 12-Month Unduplicated Skilled Admissions; 31. QR completed by Area 3 on 6-12-2024.	N0000	No response required	

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
Joseph Hollis	RN, Administrator	6/25/2024 4:08:55 PM