STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAL AT HOME LLC	1335 SADLIER CIRCLE EAST DRIVE , INDIANAPOLIS, Indiana, 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
G0000	INITIAL COMMENTS This visit was for a Federal/State Complaint survey of a Home Health Provider. Survey Dates: 08-09-2024, 08-12-2024, 08-13-2024, and 08-14-2024 Complaint: IN00108886 Non-compliant, with related and unrelated findings 12-month Unduplicated Skilled Admission: 41 Survey was fully extended on 08-12-2024 and announced to the Administrator at 2:36 PM During this Federal/State Complaint Survey, Heal at Home, LLC. was found to be out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights, 484.58 Discharge Planning, 484.105 Organization and Administration of Services, as related to this complaint and 484.80 Home Health Aide Services, unrelated to this complaint. Based on the Condition-level deficiencies during the 08-14-2024 survey, your Home Health agency was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 08-12-2024. 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 programs for a period of two years beginning 08-14-2024 and continuing through 08-13-2026. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR completed by Area 3 on 8-21-2024.	G0000		
G0406	Condition of Participation: Patient rights. CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language	G0406		

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G0406	Continued from page 1 and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure patients or their representatives were notified and consented to any changes in the care and documentation of such changes in their clinical record (G434) and failed to ensure patients were discharged for cause (G452). The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the provision of protecting patient rights for the Condition of Participation of 42 CFR 484.50 which could result in the agency not providing quality health care for all 274 patients. .	G0406		
G0434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure patients or their representatives were notified and consented to any changes in the care and	G0434		

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G0434	Continued from page 2 documentation of such changes in 6 of 6 discharged clinical records. (Patients #1, 2, 3, 4, 5, and 6) Findings include: 1. A review of an agency's policy titled 'NOTICE OF RIGHTS 3-385' revealed, "... The HHA shall involve the patient's family in care ... and or service decisions ... permitted by the patient ... Documentation within the patient's medical record shall reflect that the patient and/or legal representative participates ... services provided ..." 2. A review of an agency's policy titled 'DISCHARGE/TRANSFER PROCESS 3-500' revealed, "... To avoid charges of "abandonment" at the time of discharge agency documentation will include the following: The appropriate notice was given prior to discharge ...and will be documented in the client record ... The client, family, and physician(s) participated in the decision to discharge client from the agency ..." 3. A review of the clinical record for Patient #1 evidenced the patient was discharged on 04/10/2024. The record failed to evidence documentation of notifying the patient or family of pending discharge. 4. A review of the clinical record for Patient #2 evidenced the patient was discharged on 04/02/2024. The record failed to evidence documentation of notifying the patient or family of pending discharge. 5. A review of the clinical record for Patient #3 evidenced the patient was discharged on 11/03/2023. The record failed to evidence documentation of notifying the patient or family of pending discharge. 6. A review of the clinical record for Patient #4 evidenced the patient was discharged on 03/29/2024. The record failed to evidence documentation of notifying the patient or family of pending discharge. 7. A review of the clinical record for Patient #5 evidenced the patient was discharged on 04/04/2024. The record failed to evidence documentation of notifying the patient or family of pending discharge. 8. A review of the clinical record for Patient #6 evidenced the patient was discharged on 03/26/2024. The record failed to evidence documentation of notifying the patient or family of pending discharge. 9. On 08/12/2024 at 9:14 AM during an interview, Person B, a family member of Patient #1, who was the Power of	G0434		

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G0434	Continued from page 3 Attorney (POA) indicated they hadn't heard from the agency about a discharge from the agency. 10. On 08-14-2024 at 12:07 PM in a telephone interview with Patient #2, when queried about discharging from Heal at Home, the patient indicated they had said 'yes' when the agency asked if the patient would be agreeable to transferring, and indicated was aware the agency had 'switched' them to a new agency [Entity Q]. Indicated it was all still the same staff providing care, 'don't know why the switch'. 11. On 08-09-2024 at 9:27 AM, in a telephone interview with Person P, caregiver and POA for Patient #5, indicated had been called by the agency regarding discharging the patient, could not recall who had called or when, but was upset by this news, and was told this was standard procedure. When Person P asked for a reason, was told 'insurance-wise, Medicaid'. Person P indicated, 'we did not ask for any change' and had queried the agency as to how Patient #5 had been 'picked', indicated was then told some patients needed to change over because 'something was closing'. 12. On 08/09/2024 at 3:14 PM, the acting Administrator indicated they thought all patients/family members had been notified and should had been documented in the patient's journal notes of the discharges from the agency, and agreed there was no communication in the clinical records of intent to discharge Patients 1, 2, 3, 4, 5, and 6. The Administrator further indicated a letter of intent to discharge should be mailed, preferably certified, and a copy of the letter uploaded to the patient's record. 13. On 08/12/2024 at 10:00 AM RN 3 indicated Person T, former Clinical Manager/Director of Nursing had made the calls to all the discharged patients and/or representatives. 14. On 08/12/2024 at 12:10 PM, Person T returned this surveyors' call, indicated they had spoken with Patients 1, 2, 3, 4, 5, and 6, families, and their representatives about the discharges and if they were agreeable. When queried if they contacted the POA for Patient #1, Person T indicated since Patient #1 lived at Entity U, a group home, they had spoken with Person V, the house manager about the discharge. When queried where the documentation of those conversations were located, they indicated they had not documented the conversations. 17-12-3(b)(2)(D)(i)(BB)	G0434		
G0452	Transfer and discharge	G0452		

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G0452	Continued from page 4 CFR(s): 484.50(d) Standard: Transfer and discharge. The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only transfer or discharge the patient from the HHA if: This STANDARD is NOT MET as evidenced by: Based on record review and interviews the agency failed to ensure 6 of 6 discharge patients were discharged for cause. (Patients #1, 2, 3, 4, 5, and 6) Findings include: 1. A review of an agency's undated policy titled 'DISCHARGE/TRANSFER PROCESS 3-500' revealed, "... The agency may only transfer or discharge the patient from the agency if: 1. The transfer or discharge is necessary for the patient's welfare ... 2, The Patient or payer will no longer pay for the services ... 3, The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the home health agency agree that the measurable outcomes and goals set forth in the plan of care have been achieved ... 4. The patient refuses services ... 5. The home health agency determines ... the patient's (or other persons in the patient's home) behavior is disruptive ... to the extent that deliver of care to the patient or the ability of the agency is seriously impaired ... 6. The patient dies or 7. The home health agency ceases to operate ...". 2. A review of the clinical record for Patient #1 evidenced the patient was discharged on 04/10/2024. The clinical record for Patient #1 evidenced a document titled 'Discharge Order' dated 04/10/2024 signed by RN 3 indicated it was a verbal order from Person A, the attending physician to discharge the patient from the agency. The record failed to evidence documentation of discharge for cause. 3. A review of the clinical record for Patient #2 evidenced the patient was discharged on 04/02/2024. The clinical record for Patient #1 evidenced a document titled 'Discharge Order' dated 04/02/2024 signed by RN 3, indicated the patient was to transfer to Entity Q, an affiliated start-up home health agency. The record failed to evidence documentation of discharge for cause.	G0452		

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G0452	Continued from page 5 4. A review of the clinical record for Patient #3 evidenced the patient was discharged on 03/21/2024. The clinical record for Patient #3 evidenced a document titled "Discharge Order' dated 03/21/2024 and signed by RN 3 indicated the patient was to transfer to Q, an affiliated start-up home health agency. The record failed to evidence documentation of discharge for cause. 5. A review of the clinical record for Patient #4 evidenced the patient was discharged on 03/29/2024. The clinical record for Patient #4 evidenced a document titled "Discharge Order' dated 03/29/2024 and signed by RN 3 indicated the patient was to transfer to Q, an affiliated start-up home health agency. The record failed to evidence documentation of discharge for cause. 6. A review of the clinical record for Patient #5 evidenced the patient was discharged on 04/04/2024. The clinical record for Patient #3 evidenced a document titled 'Discharge Order' dated 04/04/2024 and signed by RN 3, indicated was a verbal order from Doctor O, the ordering physician, to discharge the patient from the agency. The record failed to evidence documentation of discharge for cause. 7. A review of the clinical record for Patient #6 evidenced the patient was discharged on 03/26/2024. The clinical record for Patient #6 evidenced a document titled "Discharge Order' dated 03/26/2024 and signed by RN 3 read: "Per [Person D], the attending physician for Patient #6, discharge the patient from the agency. Family and new Home Health company to assume care." The record failed to evidence documentation of discharge for cause. 8. On 08/09/2024 at 5:34, Person V the house manager for Entity U indicated the home care agency notified them the Agency would discharge Patient #1 but didn't know why and were not given a 15- day notice of discharge letter. 9. On 08/12/2024 at 9:14 AM, Person B, a family member and Power of Attorney for Patient #1 indicated they were not aware of the discharge, they had not received a call from the agency. 10. On 08-09-2024 at 12:15 PM in a telephone interview Person L, a registered nurse with Doctor M, indicated they were unaware Patient #2 had been discharged from the agency, and after reviewing internal records, indicated there were no calls on record from the agency in regard to discharging Patient #2 from home health	G0452		

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G0452	Continued from page 6 services. 11. On 08-14-2024 at 12:07 PM in a telephone interview with Patient #2, when queried about discharging from Heal at Home, the patient indicated they had said 'yes' when the agency asked if the patient would be agreeable to transferring, and indicated was aware the agency had 'switched' them to a new agency [Entity Q]. Indicated it was all still the same staff providing care, 'don't know why the switch'. 12. On 08/09/2024 at 12:57 PM, Person W, an RN at Entity K indicated they received an order for Patient #4 to transfer to Entity Q on 03/21/2024, that the agency had not placed any phone calls to Entity K and further indicated they didn't know why the patient was transferring to the other agency. 13. On 08/12/2024 at 12:57 PM Person X the office manager at Entity F indicated there was no communication from the agency about transferring Patient #4 to another agency. 14. On 08-09-2024 at 9:27 AM, in a telephone interview with Person P, caregiver and POA for Patient #5, indicated had been called by the agency regarding discharging the patient, could not recall who had called or when, but was upset by this news, and was told this was standard procedure. When Person P asked for a reason, was told 'insurance-wise, Medicaid'. Person P indicated, 'we did not ask for any change' and had queried the agency as to how Patient #5 had been 'picked', indicated was then told some patients needed to change over because 'something was closing'. Indicated Patient #5 was currently on service with a new agency, Entity Q, and the patient continued to have the same aide, everything was the same, no changes. 15. On 08-12-2024 at 11:30 AM in a telephone interview with Person N of Doctor O's office, indicated they did not know who was currently providing Home Health care to Patient #5. Person N indicated "no verbal order was given". Person N indicated their office had not received a telephone call from the agency. and was unaware the patient had been discharged from the agency. 16. On 08-12-2024 at 11:25, Person Z, a family member of Patient #6 indicated the Agency had phoned about the discharge and was fine with the transfer to Entity R, as long as it didn't interfere with the care, but did not receive a 15-day notice of discharge letter. 17. On 08/12/2024 at 11:57 the acting Administrator	G0452		

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G0452	Continued from page 7 indicated they could not recall all reasons for discharge for cause but listed not able to staff, goals met, or death. The acting Administrator indicated discharging a patient to use for an affiliated start-up home health agency, is not a reason for discharge.	G0452		
G0560	Discharge Planning CFR(s): 484.58 Condition of Participation: Discharge planning. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure patients were appropriately discharged from Home Health services and failed to ensure the discharges were for cause (an accepted reason). The agency failed to follow their discharge planning process. (see G0562). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients were appropriately discharged from services which could result in the agency not providing quality health care for all 274 patients. *	G0560		
G0562	Discharge Planning CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure patients were discharged and/or transferred appropriately in 6 of 6 discharged records reviewed. (Patients #1, #2, #3, #4, #5, and #6)	G0562		

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G0562	Continued from page 8 Findings include: 1. Review of an agency policy updated 12/2017, titled 'Discharge/Transfer Process 3-500' indicated, "… Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client/family will participate in this process ... Client and their representatives (if any) are told in a timely manner (at a minimum, 15 days prior) of the need to plan for for discharge ... Clients and their representatives are informed of the reason for discharge … agency documentation will include the following: The appropriate notice was given prior to discharge (at a minimum, 15-days) and will be documented in the client record … evidence the decision was not made unilaterally … The client, family and physician(s) participated in the decision to discharge client from agency … Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file …" 2. Review of the closed clinical record for Patient #1 with a discharge date of 04/10/2024, failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 3. Review of the closed clinical record for Patient #2 with a discharge date of 04-02-2024, failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 4. Review of the closed clinical record for Patient #3 with a discharge date of 11/03/2023, failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 5. Review of the closed clinical record for Patient #4 with a discharge date of 03/29/2024, failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for	G0562		

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G0562	Continued from page 9 discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 6. Review of the closed clinical record for Patient #5 with a discharge date of 04-04-2024, failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient or Power of Attorney (POA, a person legally designated to make decisions or act on another's behalf) was aware of or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 7. Review of the closed clinical record for Patient #6 with a discharge date of 03/26/2024, failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 8. On 08-09-2024 at 3:39 PM, the Administrator indicated if it were the agency's decision to discharge a patient, the patient should be given a 15-day discharge notice, the agency should be notifying the MD and obtaining an order to discharge. 9. On 08-12-2024 10:15 AM, Registered Nurse (RN) 3, when queried as to how Discharges from the agency are performed, indicated discharge visits are not done in person, but are done over the phone, 'never been a physical visit'. Indicated the patient should also receive a 15-day notice and this would be documented in the clinical record. When queried further regarding the lack of documentation in the clinical records of Patient's #1,2,3,4,5 and 6, and why and how the patients had been discharged, indicated had been instructed by Corporate Person 1 to find current Heal at Home patients, who required few hours, were dually insured with both Medicare and Medicaid, and who would be agreeable to go to Entity Q. When queried as to who had directed this activity, indicated Corporate Person 1 had, and was likely instructed by Corporate Person 3, to obtain patients for Entity Q in this manner. Indicated Person T had been the one to call the patients in question about opening a new agency and if they would like to 'move over', indicated it was his/her understanding that the patients were given the option to accept or not.	G0562		

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G0562	Continued from page 10 10. On 08-12-2024 at 11:55 AM the Administrator indicated starting up another Home Health agency would not be a reason to discharge current patients from Heal at Home.	G0562		
G0574	Plan of care must include the following CFR(s): 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		

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G0574	Continued from page 11 This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure safety measures to protect against injury and necessary interventions to address the underlying risk factors were on the individualized plan of care for 1 of 4 active clinical records reviewed. (Patient #9) Findings include: 1. A review of an undated policy titled 'CARE PLANS 3-660' revealed, "... The Care Plan shall include ... A list of specific interventions with plans for implementation ...". 2. A review of the clinical record for Patient #9 revealed a document titled 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' with a start of care date of 07/12/2023 for the certification period of 07/06/2024 through 09/03/2024 signed by RN 1 on 07/01/2024. The Plan of Care for Patient #9 evidenced the following diagnoses but not limited to DiGeorge syndrome (DGS), 'also known as 22q11.2 deletion syndrome' (a congenital disorder) that can cause a range of lifelong problems but not limited to seizures. Patient #9 was to receive Skilled Nursing services 5 days a week for 7-8 hours per day. SN interventions were documented as but not limited to: Assess for signs/symptoms and frequency of seizure activity. Chart seizure activity in the nurse's notes/seizure record. Document seizure activity to include: date, time, length precipitating factors, description of seizure and behavior following seizure. 3. On 08/13/2024 at 11:04 AM, RN 1 indicated they weren't aware of recent seizure activity with Patient #9, when queried if Patient #9 was on seizure medications, RN 1 indicated Patient #9 was on seizure medications, and didn't realize seizure interventions should be on the plan of care. When queried if they knew what some of the interventions were they indicated they would lower them to the floor, turn on side, keep objects clear, and give rescue medications if indicated. 4. On 08/13/2024 at 12:06 the acting Administrator indicated seizure precautions should list what should be done in the event of a seizure on the Home Health Plan of Care. 410 IAC 17-13-1(a)(1)(B)	G0574		
G0584	Verbal orders CFR(s): 484.60(b)(3)(4)	G0584		

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G0584	Continued from page 12 (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. (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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure verbal orders were properly obtained for 1 of 6 discharged records reviewed. (Patient #5) Findings include: 1. Review of agency policy titled 'Physician Orders 3-635' indicated, "... Each telephone/verbal order shall be written down or entered into the computer and then read back to the individual delivering the order ... The staff member shall verify the order by reading back the order to the individual providing it to verify it was received properly. The following statement will appear on electronic verbal orders in [agency's electronic medical record system (EMR)] before the electronic signature: "By checking this box, you will be applying your digital signature indicating you have verified and read back the Change Order ..." 2. Review of the clinical record for Patient #5, start of care date of 08-25-2021 with a recertification period of 02-11-2024 to 04-10-2024, contained a 'Discharge Order' dated 04-04-2024 which stated, "VO(verbal order): per [Doctor O], discharge patient from agency." and was electronically signed by Registered Nurse (RN) 3 on 04-04-2024. 3. On 08-12-2024 10:15 AM, Registered Nurse (RN) 3, when queried as to the Verbal Order (VO) to discharge Patient #5 and the definition of a V.O., RN 3 indicated when a verbal order was received from a physician or their representative. When queried further as to how the order had been obtained for Patient #5, RN 3	G0584		

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G0584	Continued from page 13 indicated they had not called Doctor O for an order to discharge but had only written the order, which was then faxed to the provider. When queried as to what should have been done, RN 3 indicated should have called and discussed discharge with patient's provider and the order should have been written differently. 4. On 08-12-2024 at 11:30 AM in a telephone interview with Person N of Doctor O's office, indicated "no verbal order was given" to discharge Patient #5 from the agency. After reviewing internal records, indicated they had a Discharge Order in hand from Heal at Home dated 04-04-2024, which stated, "VO: Per [Doctor O], discharge patient from the agency". Person N indicated their office had received no telephone calls from the agency and was unaware the patient had been discharged from the agency, indicated a verbal order would have required 'they call me, and get the order', otherwise would not have been a verbal order. 410 IAC 17-14-1(a)(H)	G0584		
G0598	Discharge plans communication CFR(s): 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure revisions to patients discharge plans had an appropriate cause/reason and were communicated and agreed upon with the patient, caregiver and ordering provider in, 6 of 6 discharged clinical records reviewed. (Patients #1, #2, #3, #4, #5, and #6) Findings include: 1. Review of an agency policy titled 'Discharge/Transfer Process 3-500' indicated, "… Clients and their representatives are informed of the reason for discharge … agency documentation will include the following: The appropriate notice was given prior to discharge (at a minimum, 15-days) and will be documented in the client record … evidence the decision was not made unilaterally … The client, family and	G0598		

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G0598	Continued from page 14 physician(s) participated in the decision to discharge client from agency … Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file …" 2. Review of an agency policy titled 'Notice of Rights 3-385' indicated, "… [Entity Q] supports and maintains documentation of compliance with the following Patients Rights and Responsibilities … Right to receive written notice … in advance of reduction or termination of on-going care …" 3. Review of an agency policy titled 'Clinical Documentation 3-680' indicated, "… Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented …" Review of the closed clinical record for Patient #1 failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the POA was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 4. Review of the closed clinical record for Patient #2 failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 5. Review of the closed clinical record for Patient #3 failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 6. Review of the closed clinical record for Patient #4 failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 7. Review of the closed clinical record for Patient #5 failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence	G0598		

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G0598	Continued from page 15 documentation the patient or Power of Attorney (POA, a person legally designated to make decisions or act on another's behalf) was aware of, or in agreement with discharge and failed to evidence the discharge had been discussed with and verbal orders had been properly obtained from the ordering provider. 8. .Review of the closed clinical record for Patient #6 failed to evidence documentation a discharge was expected or planned, failed to evidence documentation of the need/reason for discharge, failed to evidence documentation the patient was aware or in agreement with discharge, and failed to evidence the discharge had been discussed with the ordering provider. 9. On 08/12/2024 at 9:14 AM during an interview, Person B, a family member of Patient #1, who was the Power of Attorney (POA) indicated they hadn't spoken with the agency about a discharge. 10. On 08/09/2024 at 12:57 PM, Person W, an RN at Entity K indicated they received an order for Patient #4 to transfer to Entity Q on 03/21/2024, that the agency had not placed any phone calls to Entity K and further indicated they didn't know why the patient was transferring to the other agency. 11. On 08/12/2024 at 12:10, Person T returned this surveyors' call, indicated they had spoken with Patients 1, 2, 3, 4, 5, and 6, families, and their representatives about the discharges and if they were agreeable. When queried if they contacted the POA for Patient #1, Person T indicated since Patient #1 lived at Entity U, a group home, they had spoken with Person V, the house manager about the discharge. When queried where the documentation of those conversations were located, they indicated they had not documented the conversations. 12. On 08-09-2024 at 3:39 PM, the Administrator indicated if it were the agency's decision to discharge a patient, the patient should be given a 15-day discharge notice, the agency should be notifying the MD and obtaining an order to discharge. 13. On 08-12-2024 at 11:55 AM the Administrator indicated starting up another Home Health agency would not be a reason to discharge current patients from Heal at Home.	G0598		
G0682	Infection Prevention CFR(s): 484.70(a)	G0682		

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G0682	Continued from page 16 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. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview the agency failed to ensure staff members followed appropriate infection control practices while providing hands-on care for patients in 2 of 3 home visits observed. (Home Health Aide (HHA) 10 and Licensed Practical Nurse (LPN) 1) Findings include: 1. A review of a policy titled 'HAND HYGIENE-CDC GUIDELINES REFERENCE #5011' dated 2/13/18 revised 12/27/22 revealed, "... Gloves shall be worn when contact with blood, bodily fluids, mucous membranes ... Change gloves and discard after each patient contact ... Change gloves when moving from a contaminated body site to a clean body site on the same patient Change gloves when handling contaminated/dirty items in the patient's home ... all staff shall use the hand-hygiene techniques ... antimicrobial soap and water or an alcohol- based rub ... before each patient encounter ...after coming in contact with patient's intact skin, i.e., take a patient's blood pressure, pulse, lifting/moving the patient, after working on a contaminated body site then moving to a clean body site ... after coming in contact with bodily fluids ... after contact with medical equipment/supplies .. always after removing gloves ... PROCEDURE ... wash hand thoroughly ... dry hands with clean paper towel, turn off faucets with used paper towel and discard ..." 2. Review of an agency policy revised 12-27-2022 titled 'STANDARD PRECAUTIONS #5010' indicated, "... Gloves: To be worn when touching ... bodily fluids, secretions, excretions, mucus membrane ... and other contaminated items, i.e., equipment. Gloves do NOT take the place of hand hygiene. Hand hygiene is to be performed prior to putting on and after removing gloves. Gloves should be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms ..." 3. On 08/13/2024 at 9 AM during a home visit to observe HHA 10 provide care to Patient #7, HHA 10 assisted Patient #7 to the bathroom, Patient #7 sat on toilet, HHA 10 assisted with undressing, assisted Patient #7	G0682		

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G0682	Continued from page 17 into the bathtub. HHA 10 doffed gloves and donned a clean pair of gloves. HHA 10 began rinsing Patient #7, washed and rinsed their hair, then washed and rinsed their entire body. HHA 10 went to the sink, doffed gloves, turned the water on, washed their hands, turned the water off with their right hand, and dried their hands on the towel hanging next to the sink, and donned a clean pair of gloves. Assisted Patient #7 out of the tub onto the toilet lid covered with a towel. Assisted with drying and dressing Patient #7, doffed and donned gloves, assisted Patient #7 with brushing their teeth. After Patient #7 was finished HHA 10 cleaned the toothbrush off, put toothbrush up, and changed gloves. Assisted with putting socks and shoes on. Home Health Aide 10 failed to perform hand hygiene between glove changes and failed to change gloves at appropriate intervals while providing care. 4. On 08-13-2024 at 11:05 AM, Licensed Practical Nurse (LPN) 1 was observed providing care to Patient #8. The patient required intermittent suctioning to remove secretions from the mouth due to an inability to clear mucus or saliva on their own related to an impaired ability to swallow. The patient was in the living room, sitting upright in a motorized wheelchair and was pleasantly conversant. When it became apparent oral secretions were accumulating and affecting the patient's ability to continue speaking clearly, LPN 1 offered to provide suctioning and the patient agreed it was a good time. The nurse proceeded to a back room where a portable suction machine was kept, returned with the machine, turned it on, and placed a Yankauer (an oral suctioning tool, typically a firm plastic suction tip with a large opening surrounded by a bulbous head, designed to allow effective suction without damaging surrounding tissue) in the patient's mouth to suction away the accumulated secretions, to the patient's satisfaction. The nurse then returned the machine to the backroom, then returned to the living room and sat down. Licensed Practical Nurse 1 failed to perform hand hygiene and gloves were not worn, before, during, or after the procedure. 5. On 08/14/2024 at 9:48 AM during an interview with HHA 10 when queried if they always use the cloth towel in Patient #7's bathroom, they indicated yes because there's no room for paper towels. When queried if they use alcohol hand sanitizer they indicated the office was too far to drive to get a small bottle of hand sanitizer. When queried if they were to use hand sanitizer or wash their hands between glove changes,	G0682		

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G0682	Continued from page 18 they indicated they don't usually perform hand hygiene between glove changes. 6. On 08-13-2024 at 11:59 AM after the home visit, the LPN 1 was queried as to the proper procedure for suctioning patients and the nurse indicated should wash or sanitize hands, indicated usually keeps sanitizer in her pocket but it was located in the bag on this day, apply gloves, get the catheter, allow patient to spit, take off cap, suction, replace cap, then dispose of gloves. 7. On 08-13-2024 at 2:50 PM during an interview with the acting Administrator, indicated they should always use hand hygiene between changing gloves, should never use the cloth towel in the home, and always use a paper towel to turn the water off. 8. On 08-13-2024 at 2:55 PM, while discussing the home visit for Patient #8 and the infection control breach observed, the acting Administrator indicated the LPN should have gloves on when suctioning, change tips, and perhaps have mask and eye protection on depending on the situation, should have hand sanitizer available, and should have gloves available. 410 IAC 17-12-1(m)	G0682		
G0750	Home health aide services CFR(s): 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure home health aide in-service hours were completed and documented (778); failed to ensure the Registered Nurse (RN) failed to identify seizure precautions on the aide care plan (798); and failed to ensure a home health aide followed a patient's plan of care to provide ordered hands-on personal care and failed to be aware the aide was performing unauthorized tasks (G0800). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care, thus	G0750		

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G0750	Continued from page 19 resulting in con-compliance with Condition of Participation CFR 484.80 Home Health Aide Services which could result with the Agency not providing quality health care for all 274 patients. Findings include; *	G0750		
G0778	Documentation of inservice training CFR(s): 484.80(d)(2) The HHA must maintain documentation that demonstrates the requirements of this standard have been met. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure in-service hours were completed and documented with 4 of 12 home health aide (HHA) employee records reviewed. (HHA 6, 7, 9, and 10) Findings include: 1. A review of an undated policy titled 'IN-SERVICE EDUCATION/STAFF DEVELOPMENT 4-320' revealed "In-service training or continuing education programs will be provided and documented for employees ... records on in-service education programs will be maintained and attendance will be documented ... Heal At Home will comply with in-service education requirements for home health aides ... The Home Health Aide must complete twelve (12) hours per year ..." 2. On 08/14/2024 a review of HHA 6 employee record failed to evidence in-service hours for the year of 2023. 3. On 08/14/2024 a review of HHA 7 employee record failed to evidence in-service hours for the year of 2023. 4. On 08/14/2024 a review of HHA 9 employee record failed to evidence in-service hours for the year of 2023. 5. On 08/14/2024 a review of HHA 10 employee record failed to evidence in-service hours for the year of 2023. 6. On 08/14/2024 at 3 PM, Corporate Staff 2, Director of HR with Entity R indicated HHA's are not required to have completed 2024 in-services until October 2024, and	G0778		

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G0778	Continued from page 20 they could not locate in-service hours for HHA 6, 7, 9, and 10 for the year of 2023. 410 IAC 17-14-1(k)	G0778		
G0798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. 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). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the Registered Nurse (RN) failed to identify seizure precautions on the aide care plan in 1 of 3 active records reviewed. (Patient #7) Findings include; 1. A review of an undated policy titled 'CARE PLANS 3-660' revealed, "... The Care Plan shall include ... A list of specific interventions with plans for implementation ...". 2. A review of the clinical record for Patient #7 revealed a document titled 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' with a start of care date of 05/31/2018 for the certification period of 06/28/2024 through 08/26/2024 signed by RN 2 on 06/25/2024. The Plan of Care for Patient #7 evidenced the following diagnoses but not limited to Epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures). Patient #7 was to receive Home Health Aide services 5 days a week for 9 hours per day. Skilled Nursing Interventions were but not limited to: Ease the patient to the floor if standing and keep them free from injury or objects during seizure activity. Note the type and length of activity. If the seizure lasted greater than 2-3 minutes call 911. After seizing, log roll the patient onto their side in a recovery position to prevent aspiration and promote breathing. Stay with the Patient until Emergency Medical Services arrive. Notify the nurse supervisor for any seizure activity. 3. A review of a document titled Aide Care Plan undated	G0798		

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G0798	Continued from page 21 and unsigned for Patient #7 failed to identify what seizure precautions the home health aide to take in the event of seizure activity. 4. On 08/13/2024 at 9 AM during a home visit, when queried what HHA 10 would do for Patient #7 in the event of a seizure, HHA 10 indicated they would try to get Patient #7 to the floor as safely as possible, try to keep the area free of objects, and protect their head. When queried how they learned those precautions, HHA #10 indicated Person Y, a family member taught them eveything they needed to know to care for Patient #7. 5. On 08/13/2024 at 12:17 PM, RN 2 indicated seizure precautions should be on the Home Health Aide Plan of Care for Patient #7. 6. On 08/13/2024 at 12:06 the acting Administrator indicated seizure precautions should list what should be done in the event of a seizure on the Home Health Aide Plan of Care. 410 IAC 17-13-2(a)	G0798		
G0800	Services provided by HH aide CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview the agency failed to ensure a home health aide followed a patient's plan of care to provide ordered hands-on personal care and within their scope of practice, in 1 of 2 home health aide visits. (Home Health Aide (HHA) 1) Findings include: 1. Review of an agency policy dated 05-01-2018, titled 'HOME HEALTH AIDE ASSIGNMENTS AND DUTIES #4042' indicated, "... Home Health Aides/CNAs (Certified Nursing Assistants) must follow written Patient Care Instructions as prepared by the RN (Registered Nurse)	G0800		

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(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
G0800	Continued from page 22 or other appropriate skilled professional ... The HHA's (Home Health Agency's) Home Health Aides/CNAs shall provide services that are ordered by the physician ... included in the plan of care ... Permitted to be performed under state law ... consistent with home health aide training ... The duties of the HHA's Home Health Aide/CNAs shall include: The provision of hands on personal care ... The performance of simple procedures as an extension of therapy or nursing services ..." 2. Review of an undated agency policy titled '3-751 HOME HEALTH AIDE CARE PLAN' indicated, "... All home health aide staff will follow the identified plan ..." 3. Review of the clinical record for Patient #10 with a Start of Care date of 09-26-2022 for the recertification period of 07-17-2024 to 09-14-2024 indicated the patient had diagnoses which included, but were not limited to: quadriplegia (having no use of extremities: hands, arms, legs, or feet). The record also indicated the patient was dependent for all Activities of Daily Living (or ADLs, the basic tasks that people perform every day to live independently in a household: bathing, dressing, toileting, transferring, eating, and continence) and Instrumental Activities of Daily Living (or IADLs, more complex sets of skills needed in order to live independently: using the telephone, shopping, preparing meals, housekeeping, using transportation, taking medication(s), and managing finances) and possessed a urostomy (surgically created opening in the abdominal wall through which urine passes) and colostomy (surgically created opening in the abdomen in which a piece of the colon (large intestine) is brought outside the abdominal wall to create a stoma through which digested food passes into an external pouching system), the record indicated the urostomy and colostomy were managed by Person S, family member/main caregiver. 4. On 08-13-2024 at 12:35 PM, during a home observation with Home Health Aide (HHA) 9 was interviewed regarding Patient #10, indicated had worked with the patient for approximately four years total, first with another home health agency and now this agency. When queried regarding tasks done for the patient, indicated they do not perform the 'shower' listed on the aide care nor shampooing, indicated Person S, the patient's family member/main caregiver, performs all this, as it was the patient's preference, but does sometimes help. HHA 9 indicated, they emptied the patient's urostomy bag and sometimes changed both the urostomy bag and colostomy bag for the patient. When queried as to who instructed them to do so, indicated Person S, had instructed them.	G0800		

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G0800	Continued from page 23 When queried if a nurse from the agency had ever instructed the aide to perform this activity, indicated no, not from this agency, but had received instruction from a nurse with the old agency. 5. On 08-13-2024 at 3:09 PM, when informed regarding HHA 9 changing Patient #10's urostomy and colostomy bags, the acting Administrator indicated was not aware any aide was changing such bags, indicated he believed this was not a task to be delegated to an aide to perform. Would be speaking with aide and ensuring this is rectified. 6. On 08-14-2024 at 10:40 AM, the acting Administrator indicated had verified HHA 9 had cared for no other patients, only Patient #10. 7. On 08-14-2024 at 11:18 AM, Person S, main caregiver for Patient #10, indicated has had HHA 9 with them for approximately 4 years. When queried as to what HHA 9 does for the patient, Person S indicated feeds, does laundry, picks up, and shaves the patient. When queried about showering, indicated the patient did not like to be showered by others, "I do the shower" three times per week, after work while the aide was still there, while the aide helped with changing bedding and preparing clean clothes. Person S indicated also does the shampooing. When queried as to changing the patient's urostomy and colostomy bags, indicated they do this themselves approximately three times a week or when needed and indicated affirmatively HHA 9 does this also, "[HHA 9] knows how to do it". Indicated sometimes, "[HHA 9] has to do it, I can't get home in time, if I'm at work". 8. On 08-14-2024 at 2:28 PM, Registered Nurse (RN) 2, the nurse case manager for Patient #10 was not aware HHA 9 had been changing urostomy or colostomy bags and indicated 'thought aides were not supposed to do that'. Indicated was not aware the aide was not providing showering or shampooing.	G0800		
G0940	Organization and administration of services CFR(s): 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	G0940		

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G0940	Continued from page 24 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. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to organize, manage, and administer its resources to achieve and maintain a high level of performance in the provision of Home Health care services to ensure personnel was current with their license/certificates, current with in-services, client intakes, and scheduling: the agency failed to ensure administrative and supervisory functions are not delegated to another agency or organization(G0940), the Agency failed to ensure the Governing Body hired an Administrator for the Agency (G0942), and the Agency failed to ensure the acting Administrator was involved in discharge for cause, oversight of human resources, and scheduling (G)948) The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which resulted in the agency not providing quality health care for the Condition of Participation of 42 CFR 484.105 for all 274 patients. 1. On 08/13/2024 at 1:15 PM, when queried the acting Administrator indicated Corporate Staff 2, HR Director is not an employee of the Agency but works for Entity R. The acting Administrator indicated the Agency had a contract with Entity R, a healthcare management company, and further indicated Entity R provided human resources for the Agency. 2. On 08/13/2024 at 1:22 PM, the acting Administrator provided a 'Management Agreement' between the Agency and Entity R, indicating Entity R would provide the following: Executive leadership/management, marketing, scheduling, client intake, human resources, payroll, and accounting services. 3. On 08/14/2024 at 12:55, Corporate Staff 2, Human Resource Director indicated they were an employee of Entity R. 4. 08/14/2024 at 12:35 PM, when queried what services the Agency would be able to contract, the acting Administrator indicated they did not know and would	G0940		

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G0940	Continued from page 25 have to look it up. 410 IAC 17-12-1(a)(1)(2)	G0940		
G0942	Governing body CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview the Governing Body failed to hire an Administrator for the Agency and failed to ensure the management and operation of the Agency was effective in 1 of 1 agency. Findings include: 1. A review of the Agency's Governing Body meeting minutes on 05/26/2024 evidenced the Governing Body approved to hire the current acting Administrator pending their acceptance of the position. 2. A review of the employee record for the Administrator evidenced a letter from Entity R a healthcare management company, Heal at Home, dated 05/07/2024 revealed, an offer of employment for the role of the Administrator with a start date of 05/28/2024, with the acting Administrator signing electronically on 05/08/2024. 3. Further review of the employee record for the acting Administrator evidenced a signed Administrator job description on 05/28/2024 but failed to evidence which Agency the Administrator was to be employed by. 4. On 08/14/2024 at 12:32, when queried of the letter from Entity R dated 05/07/2024, the acting Administrator indicated "it makes me look like I'm an employee of [Entity R]". 410 IAC 17-12-1(b)	G0942		
G0948	Responsible for all day-to-day operations	G0948		

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G0948	Continued from page 26 CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure the acting Administrator was involved in discharge for cause, oversight of human resources, and scheduling of home health aides in 1 of 1 agency. Findings include: 1. A review of the employee record for the acting Administrator evidenced a document titled 'Job Description: Administrator revised 2023' signed by the Administrator on 05/28/204 revealed, "ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES: 1. Planning, directing, and evaluating operations ... 5. Recruiting, employing, and retaining qualified personnel ... 9. Ensuring staff development including orientation, in-service education, continuing education, and evaluation of staff ...". 2. A review of a document titled 'Management Agreement' dated 01/01/2021, signed by CC, the owner of Entity R, and DD, the former Director of Nursing revealed Entity R, a healthcare management company "shall provide executive leadership/management, marketing, scheduling, client intake, human resources, payroll and accounting services ... TERMS The term of this agreement shall commence on January 1, 2021 and shall renew annually unless otherwise advised by either party in writing ...". 3. The acting Administrator failed to ensure discharged patients were discharged for cause, failed to document the communication with patient's, their families, the patient's physicians about the pending discharges, failed to ensure all employees had signed job descriptions along with job-specific orientation, failed to ensure all employees with certificates were current and in good standing, failed to ensure in-service hours were completed by all home health aides, failed to ensure all patients home health aide plan of care had the necessary information for the home health aide to perform their job adequately, failed to ensure all home health aide perform job duties within their scope of practice. 4. On 08/12/2024 at 11:59 AM, the acting Administrator indicated they realized that documentation had been very poor when speaking of the discharged patients, but	G0948		

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G0948	Continued from page 27 when queried if they knew why a patient could be discharged they indicated they didn't know all the reasons and would have to look it up. On 08/14/2024 at 12:32 PM, the acting Administrator indicated Entity R performs all interviews and hires home health aides, receives their training through Entity R, and were by scheduled Entity R. The acting Administrator further indicated Entity R tracks all renewables and yearly in-services. 410 IAC 17-12-1(c)(1)	G0948		