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 09/26/2024

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
G0000	INITIAL COMMENTS This was a post condition revisit for a home health provider. Facility number: 013641 Survey dates: 09/24/2024, 09/25/2024, and 09/26/2024 12 Month Unduplicated Skilled Admissions: 167 Active census: 254 Three previously cited conditions were corrected. One previously cited condition was	G0000	NA	

	deficiencies were corrected. Three previously cited deficiencies were re-cited, and one new deficiency was cited. Heal at Home LLC is in compliance with 42 CFR 484.50 Patient Rights, 42 CFR 484.58 Discharge Planning, and 42 CFR 484.105 Organization and Administration of Services. Heal at Home LLC is out of compliance with Conditions of Participation 42 CFR 484.80 Home health aide services. Heal at Home LLC continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning August 14, 2024, and continuing through August 13, 2026. QR completed by Area 3 on 9-30-2024.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi)	G0574	RN Case Manager assessed	2024-10-14

	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.		patient # 7 on 09/30/2024. A complete review of all DME in the home wascompleted and updated on the Plan of Care. A complete medication reconciliation was completed,and the plan of care was updated to include supplements that the patient wastaken. A complete skin assessment was completed, andthe wounds were identified, documented and the physician contacted. The physician office had not returned the RNcall as of 10/10/2024. The Administratorreached out to the clinic social worker on 10/11/2024 and will send updatedphotos and obtain orders, if provided. The Administrator / Director of Nursing discussedthe survey findings with LPN 1 on October 11, 2024. LPN was educated and informed on: Contacting the RN Case Manager, DON orAdministrator if:	

	Based on observation, record review and interview the agency failed to ensure the plan of care contained the durable medical supplies, medications, and treatments for 1 of 3 active record reviews (Patient #7). Findings include: 1. Review of the agency's undated policy titled '3-660 CARE PLANS' evidenced, "The Care Plan shall include, but not be limited ... a list of specific interventions with plans for implementation ...". 2. Review of the agency's undated policy titled '3-700 MEDICATION PROFILE' evidenced, "the medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed ... To provide documentation of changes in the medication regime as they happen, and support changes needed to the plan of care ...".		A newwound is identified on this or any patient that LPN 1 cares for If the primary care provider provides orders forwound care A medication or ointment is needed for thepatient so that the PCP can be contacted to obtain an order for the medicationor ointment, and it can be added to the plan of care If a family member or patient states certaincare should be provided as directed by the PCP, contact the RN Case Manager tocontact the PCP to verify and obtain orders for said care. Documenting complete and accurate assessments. Reviewing the plan of care and notifying the RNCase Manager if the patient requires any care, medications or DME that is notlisted on the plan of care. The administrator will meet with all RN CaseManagers on October 14, 2024, to review: All elements required on the	

	3. Review of the agency's undated policy titled '3-709 MEDICATION RECONCILIATION' evidenced, "medications includes ... herbals and nutraceuticals that the client takes in all places of residence ...". 4. A review of the clinical record for Patient #7 revealed a document titled 'HOME HEALTH CERTIFICATION AND PLAN OF CARE'(POC) with a start of care date of 04/10/2023 for the certification period of 08/02/2024 through 09/30/2024 signed by Registered Nurse (RN) 1. The POC revealed a list of durable medical equipment (DME) including 'Hospital bed, Hoyer Lift, Incontinent Supplies, Standard Walker'. The POC evidenced the skilled nurse (SN) interventions were documented as but not limited to: SN to assess skin for skin breakdown and skin care. Assess/document skin status q (every) shift and PRN (as needed). Implement skin breakdown precautions at all times.		plan of care Medication reconciliation to include supplements Review and discuss all DME that needs to bedocumented on the plan of care and review this list at each recertification Discuss and re-educate them on LPN supervision RN Case Managers will review all future start ofcares and recertification visits to verify that all items that are required onthe plan of care are present before submitting the plan of care for review bythe Coder, Administrator or DON. To prevent deficiencies in the future, theAdministrator and/or Director of Nursing will review 100% of all plans of carethat are completed by the RN Case Managers to verify all elements of the planof care are present and verify with the RN Case Managers if there are anyquestions. All charts will be modified for	

	The POC failed to evidence the following DME supplies suction canister, gait belt, positioner, syringes, respiratory equipment, tape, tube feed tubing and bag, and suction tubing, failed to evidence the following supplements Magnesium, Zinc, and Melon Bitters, and failed to evidence wound care orders. The record review of Patient #7 failed to evidence communication notes to the physician or RN, orders, or change orders to the physician regarding supplements, DME, or wound care. 5. During a home visit on 09/25/2024, Licensed Practical Nurse (LPN) 1 was observed providing skilled nursing care for Patient #7. Patient #7 was observed to have a suction canister attached to an external catheter, gait belt, positioner, syringes, respiratory equipment, supplements, tape, tube feed tubing and bag, suction tubing, and the following supplements Magnesium, Zinc, and Melon Bitters. Patient #7 was observed to have two pressure ulcers		months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going. Additional DME options are being added to theEMR to facilitate additions to the Plan of Care Chart review results will be reported to theQAPI Committee for review. This will be completed on October 14, 2024	

	(damage to an area of the skin caused by constant pressure on an area for a long time), one on the right buttocks and one on the superior (toward the head or upper) posterior (back) of the left leg, near the buttocks. LPN 1 washed the pressure ulcers, and buttocks, then rolled Patient #7 back on to their back. 6. During an interview on 09/25/2024, LPN 1 indicated the A & D ointment (skin protective ointment) is applied to the pressure ulcer on the right buttocks or Neosporin (antibacterial cream) is applied to the inferior posterior pressure ulcer twice a day. 7. During an interview on 09/25/2024, the Director of Nursing (DON) indicated if a communication regarding a change to the POC was present it would be found under the 'Orders' tab, but the communication does not typically occur. When questioned what would have been expected if a spouse mentions a patient is to have			

	wound care, the DON indicated the employee should reach out to the physician to verify and update the chart as needed. 410 IAC 17-13-1(a)(1)(D)(i-xiii)			
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 observation, record review and interview the agency failed to report a change in condition to the physician in 1 of 1 active patient records reviewed with a wound. (Patient #7) Findings include: 1. A review of the agency's undated policy titled '3-200 SKILLED NURSING SERVICES' evidenced that, " ... The Licensed Practical Nurse ... Reports findings and observations to the registered nurse and other members of the team to assure coordination	G0590	RN Case Manager assessed patient # 7 on 09/30/2024. A complete review of all DME in the home wascompleted and updated on the Plan of Care. A complete medication reconciliation was completed,and the plan of care was updated to include supplements that the patient wastaken. A complete skin assessment was completed, andthe wounds were identified, documented and the physician contacted. The physician office had not returned the RNcall as of 10/10/2024. The Administratorreached out to the clinic social worker on 10/11/2024 and will send updatedphotos and obtain orders, if provided.	2024-10-14

	changes or needs ...". 2. A review of the agency's policy titled 'CHANGE IN PATIENT'S CONDITION - REPORTING TO THE PHYSICIAN' dated 01/25/2018 evidenced that, "... the patient's primary care physician's office shall be called as soon as the nurse identifies a significant change in condition (non-emergent) ... Examples of 'significant changes' that should be reported to a physician include ... change in patient's skin integrity ...". 3. A review of Patient #7's skilled nursing visits for 09/24/2024 and 09/25/2024 signed by LPN 1, indicated there were no wounds, and failed to evidence communication with the physician or registered nurse. 4. During a home visit on 09/25/2024, Licensed Practical Nurse (LPN) 1 was observed providing skilled nursing care for Patient #7. During a bath, LPN 1 rolled Patient #7 on to their side to wash their back and buttocks. Patient #7 was observed to have two pressure ulcers (damage to an area of		The Administrator / Director of Nursing discussedthe survey findings with LPN 1 on October 11, 2024. LPN was educated and informed on: Contacting the RN Case Manager, DON orAdministrator if: A newwound is identified on this or any patient that LPN 1 cares for If the primary care provider provides orders forwound care A medication or ointment is needed for thepatient so that the PCP can be contacted to obtain an order for the medicationor ointment, and it can be added to the plan of care If a family member or patient states certaincare should be provided as directed by the PCP, contact the RN Case Manager tocontact the PCP to verify and obtain orders for said care. Documenting complete and accurate assessments. Reviewing the plan of care and	

	the skin caused by constant pressure on an area for a long time). One pressure ulcer was located on the inferior (low) medial (middle) of the right buttock and one pressure ulcer was located on the superior (toward the head or upper) posterior (back) of the left leg, near the buttocks. 5. During an interview on 09/25/2024, the Administrator indicated LPN 1 should have notified the registered nurse or physician regarding the new wound, or called the physician themselves. 6. During an interview on 09/26/2024, LPN 1 indicated the pressure ulcer on the right buttock has been chronic for the last two years they have been providing care; and, the severity of the wound varies. LPN 1 indicated the pressure ulcer on the superior posterior left leg was new as of Tuesday, 09/24/2024. When questioned if the physician had been made aware of the new wound, LPN 1 indicated he would notify the physician if the wound was not better in a few days. 410 IAC 17-13-1(a)(2)		notifying the RNCase Manager if the patient requires any care, medications or DME that is notlisted on the plan of care. The administrator will meet with all RN CaseManagers on October 14, 2024, to review: All elements required on the plan of care Medication reconciliation to include supplements Review and discuss all DME that needs to bedocumented on the plan of care and review this list at each recertification Discuss and re-educate them on LPN supervision RN Case Managers will review all future start ofcares and recertification visits to verify that all items that are required onthe plan of care are present before submitting the plan of care for review bythe Coder, Administrator or DON. To prevent deficiencies in	

			the future, theAdministrator and/or Director of Nursing will review 100% of all plans of carethat are completed by the RN Case Managers to verify all elements of the planof care are present and verify with the RN Case Managers if there are anyquestions. All charts will be modified for 100% compliance forthree months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going. Additional DME options are being added to theEMR to facilitate additions to the Plan of Care Chart review results will be reported to theQAPI Committee for review. This will be completed on October 14, 2024	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention.	G0682		2024-10-14

	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 observation, record review and interview, the agency failed to ensure employees maintained infection prevention practices in 1 of 3 home visits. (Licensed Practical Nurse, LPN 1) Findings include: 1. A review of the Centers for Disease Control and Prevention recommendation titled, 'Clinical Safety: Hand Hygiene for Healthcare Workers,' dated 02/27/2024, shows, "... that healthcare workers should wash their hands: before touching the patient, before touching a patient or patient's surroundings, after contact with contaminated surfaces, and immediately after glove removal ...". 2. During a home visit on 09/25/2024, Licensed Practical Nurse (LPN) 1 was observed providing skilled nursing care for Patient #7. LPN 1 was observed donning (putting on)		The Administrator / Director of Nursingdiscussed the survey findings with LPN 1 on October 11, 2024. LPN was educated and informed on: Hand Hygiene Care of gastrostomy tube site Proper technique for bed baths and the use andorder that bathing should occur Removal of gloves and hand hygiene before doingany other tasks to include tying a shoe or using a phone Reviewing the plan of care and notifying the RNCase Manager if the patient requires any care, medications or DME that is notlisted on the plan of care. The administrator will meet with all RN CaseManagers on October 14, 2024, to review: Infection control and hygiene Discuss and re-educate on LPN supervision	

	gloves without performing hand hygiene. LPN 1 washed Patient #7's head with a wash cloth, rinsed the same wash cloth in the basin, and moved on to the right arm. With gloved hands, LPN 1 obtained deodorant. LPN 1 applied deodorant to the right armpit, rinsed the same wash cloth in the basin, washed the left arm, and then applied deodorant to the left armpit. LPN 1 rinsed the same wash cloth in the basin and washed Patient #7's chest and around his gastrostomy tube (tube inserted into the stomach that brings nutrition and/or medication directly to the stomach) and down to the perineal area (area extending from anus to scrotum in male). Next, LPN 1 rinsed the same washcloth in the basin and washed Patient #7's legs and feet. LPN 1 placed the same washcloth back into the basin, and dried the areas they had washed. LPN 1 rolled Patient #7 on to their side, obtains the same wash cloth from the basin, and washed Patient #7's back and buttock, placed the same wash cloth back in the basin, and then rolled them back on to their back. With gloved hands, LPN 1 obtained lotion, and		Education was sent out to all RN and LPN's on10/11/2024 regarding hand hygiene and bed bath procedures. To prevent deficiencies in the future, the RNCase Managers will review hand hygiene and bed bath technique with HHA andLPN's during supervision and recertification visits. Infection Control will be added to the QAPI planwith each RN Case Manager to complete three to five observations each month,ongoing to verify 100% compliance. RN Case Managers to each performthree to five observations per month for three months, once 100% complianceachieved, perform three observations each month on going.	

	applied the lotion to Patient #7's left and right leg. With gloved hands, LPN 1 obtained gauze from the clean supply and applied the gauze below the stopper of the gastrostomy tube. With gloved hands, LPN 1 proceeded to place their foot on the end of the bed rail and tie their shoe, then go to the closet to obtain clothes for Patient #7. LPN 1 placed the belongings on the bed, and answered their cell phone. Next, LPN 1 dressed Patient #7, and adjusted the bed so the patient was in sitting position. LPN 1 doffed (removed) gloves without performing hand hygiene. LPN 1 failed to perform hand hygiene and glove changes at appropriate intervals, wash Patient #7's gastrostomy tube with clean water and wash cloth, and perform Patient #7's bath in an appropriate order. 3. During an interview on 09/25/2024, LPN 1 indicated hand hygiene should be performed before and after care. 4. During an interview on		The RN Case Managers will report their findingson their supervisory and recertification visits to the Administrator or DON. These Results will be reported to the QAPICommittee for review. This will be completed on October 14, 2024.	

	indicated the LPN should have done hand hygiene before donning gloves, should not have tied his shoe with gloves on, should not have answered his phone with gloves on, should not have touched different surfaces with gloves on, should not have used the same wash cloth for Patient #7's body, and should not have moved from a clean area to a dirty area when performing the bath. 410 IAC 17-12-1(m)			
G0750	Home health aide services 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.	G0750	The Administrator discussed the survey findingswith patient # 6 on September 27, 2024. Patient was educated and informed on: That the HHA is not able to complete any tasksthat are not on the plan of care. That if she feels she needs a task completed bythe HHA that is not on the plan of care, she should reach out to the RN CaseManager. That the HHA is not able to assist with the MACEprocedure	2024-10-14

	Based on record review and interview the agency failed to ensure the Registered Nurse (RN) had assigned specified duties to the home health aide, failed to ensure an appropriate aide care plan had been developed according to the patient's individualized needs (G0798); 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, thus 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 254 patients. *		in the following steps: Filling the bag with tap water. Using the roller clamp to remove air from thetubing or to start the enema. Cleaning the tubing. By depressing the plunger during flushing of theMACE tubing. That she is not able to direct the HHA tocomplete task that are not on the plan of care as this is considered self-directedcare. The RN Case Manager did a home visit andobserved the patient complete her MACE procedure without assistance. She can adjust the roller clamp by using herteeth and depress the plunger on her own. The patient and agency are trying to locatetubing with a thumb clip type controller that would allow the patient to startthe flow without utilizing her teeth. Orientation of all future home health aides willinclude instructions that they are unable	

			aboveduring her MACE procedure. The Administrator discussed with RegisteredNurse 1, on September 27, 2024, that during her comprehensive assessment sheshould not rely on the patient stating that they can complete a task but shouldobserve the patient completing the task. This will verify that the patient can complete the task and allow for amore accurate plan of care creation for the HHA. The Administrator discussed with RegisteredNurse 1 that during her comprehensive assessment she should review thedifferent types of transfers this patient requires with the different transferboards/devices. Education will be sent out to all HHA's onOctober 9, 2024, regarding allowable tasks. They will be educated on only completing tasksthat are listed on the plan of care and if the patient requests any tasks notон the plan of care, they are to reach out to the RN Case	

			Manager forassistance. The RN Case Manager will make the assessment andcontact the primary care provider for orders to add the task if appropriate. Systemic Changes: The Agency Policy was updated. Tasks listed on the mobile and online app islimited based on programing limitation. The taskswill be reviewed and modified to clarify the tasks for the HHA. KanTime (the software provider) has beencontacted regarding the HHA Care Plan and that information does not flow fromthe Plan of Care to the HHA Care Plan. Tickets have been placed with KanTime and theystate that the HHA is not able to view the HHA Care Plan on the mobile device. Everything that is on the HHA	

			Care Plan islocated on the Plan of Care that is in the home folder or is available to theHHA via the KanTime Mobile App. HHA's will be instructed to review the Plan ofCare for any questions about tasks or interventions that they should completeand to reach out to the RN Case Manager if they have any questions. Additional options have been added to theintervention section to allow the RN Case Manager to elaborate additionalinformation if needed. The administrator will meet with all RN CaseManagers on October 14, 2024, to review all aspects listed above along with: Discussion of orientation of staff to includeany special needs the patient needs. Review of any special transfer needs the patientmay have. Making it clear that the RN Case Manager isavailable for in home orientation if the home health aide is unclear on anytasks assigned. RN Case Managers will	

			observe the patient on anytasks that the patient may need assistance with to verify the patient is ableto complete the tasks without the HHA, if they are not in the scope of care forthe HHA. To prevent deficiencies in the future, theAdministrator and/or Director of Nursing will review 100% of all plans of carethat are completed by the RN Case Managers to review tasks assigned to the HHAto verify that they are within their scope of practice. All charts will be modified for 100% compliance forthree months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going. QA department will review 100% of HHA Aide visitnotes and report any abnormalities or concerns to the DON or Administrator. All charts will be modified for 100% compliance forthree months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going.	

			Results will be reported to the QAPI Committeefor review. This will be completed on October 14, 2024.	
G0798	Home health aide assignments and duties 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). Based on record review and interview the agency's Registered Nurse (RN) failed to ensure an appropriate aide care plan was developed according to the patients individualized needs, in 1 of 3 active clinical records reviewed. (Registered Nurse (RN) 1) Findings include: 1. A review of an agency policy titled 'SERVICES PROVIDED' 3-100' stated, "... Services will be coordinated by the registered nurse managing the care ... implementing, revising, and updating the plan	G0798	The Administrator discussed the survey findingswith patient # 6 on September 27, 2024. Patient was educated and informed on: That the HHA is not able to complete any tasksthat are not on the plan of care. That if she feels she needs a task completed bythe HHA that is not on the plan of care, she should reach out to the RN CaseManager. That the HHA is not able to assist with the MACEprocedure in the following steps: Filling the bag with tap water. Using the roller clamp to remove air from thetubing or to start the enema. Cleaning the tubing. By depressing the plunger	2024-10-14

	of care ..." 2. A review of an agency policy titled 'HOME HEALTH AIDE CARE PLAN 3-751' stated, "... All home health aide staff will follow the identified plan ... To provide documentation that the supervising Nurse oriented the assigned Aide to the client's care before initiating care ... To provide documentation that the client's care is individualized to his/her specific needs ..." 3. Review of the clinical record for Patient #6 with a start of care date of 10/21/2022 and a certification period of 08/11/2024 - 10/09/2024, with diagnoses which included, but were not limited to: Quadriplegia (paralysis [loss of muscle function in some or all of the body] of the legs and arms. The record further indicated the patient was wheelchair bound, had some function of the upper extremities, but was completely reliant for transfers, perineal care (the practice of cleaning the genital and rectal areas of the body), and mobility		tubing. That she is not able to direct the HHA tocomplete task that are not on the plan of care as this is considered self-directedcare. The RN Case Manager did a home visit andobserved the patient complete her MACE procedure without assistance. She can adjust the roller clamp by using herteeth and depress the plunger on her own. The patient and agency are trying to locatetubing with a thumb clip type controller that would allow the patient to startthe flow without utilizing her teeth. Orientation of all future home health aides willinclude instructions that they are unable to assist the patient, per aboveduring her MACE procedure. The Administrator discussed with RegisteredNurse 1, on September 27, 2024, that during her comprehensive assessment sheshould not rely on the patient stating that they can complete a task but shouldobserve the patient	

	assistance. The record indicated, 'the patient reports having MACE (Malone Antegrade Continence Enema: surgical procedure which creates a channel from the abdomen to the colon, allows enemas to be administered directly to the beginning of the colon, instead of through the rectum)', with recent replacement on 8/6/24 utilizing a g-tube (gastrostomy) tubing, as the larger-sized device helped to reduce leakage at the site. Skilled Nursing services were ordered every 56-60 days to complete their recertification, and Home Health Aide services were ordered 6 hours per day, 7 days per week. 4. A review of Patient #6's Aide Care Plan detailed tasks/duties the aide was to perform during each visit, which included, but was not limited to: "... Elimination Assistance (bedpan, bedside commode, toilet) ..." and failed to document what tasks were required, failed to detail what the patient was able to do on their own and what assistance was required by the home health aide. The care plan		completing the task. This will verify that the patient can complete the task and allow for amore accurate plan of care creation for the HHA. The Administrator discussed with RegisteredNurse 1 that during her comprehensive assessment she should review thedifferent types of transfers this patient requires with the different transferboards/devices. Education will be sent out to all HHA's onOctober 9, 2024, regarding allowable tasks. They will be educated on only completing tasksthat are listed on the plan of care and if the patient requests any tasks notон the plan of care, they are to reach out to the RN Case Manager forassistance. The RN Case Manager will make the assessment andcontact the primary care provider for orders to add the task if appropriate.	

	also stated, "... Mobility: Transfer (Mechanical lift/slide-board) ... Mobility: Transfer (Assistance (wheelchair, walker, cane) ... Mobility: Transfer bed/chair ..." and failed to document how the transfers would be performed, what mobility aides would be used for each of the different transfers, and failed to ensure patient preference or special instructions were included to ensure the safety of the patient during transfer. 5. A review of Patient #6's 'Journal Notes' evidenced an entry from RN 1, dated 09-19-2024 at 5:59 PM, indicated Home Health Aide (HHA) 4 was oriented to the patient's case via telephone and stated, "... Oriented [HHA 4] to the pt's POC and tasks needed to be performed on a regular basis, any special needs the patient may have, infection control and safety practices. HHA verifies that they can complete the delegated tasks. Instructed HHA to notify RN Case Manager of any concerns or if they need the RN Case		Systemic Changes: The Agency Policy was updated. Tasks listed on the mobile and online app islimited based on programing limitation. The taskswill be reviewed and modified to clarify the tasks for the HHA. KanTime (the software provider) has beencontacted regarding the HHA Care Plan and that information does not flow fromthe Plan of Care to the HHA Care Plan. Tickets have been placed with KanTime and theystate that the HHA is not able to view the HHA Care Plan on the mobile device. Everything that is on the HHA Care Plan islocated on the Plan of Care that is in the home folder or is available to theHHA via the KanTime Mobile App. HHA's will be instructed to review the Plan ofCare for any questions about tasks or interventions that they should completeand to reach out to the RN Case Manager if they	

	review any tasks. Advised to call the RN Case Manager with any concerns, incidents, etc. HHA stated they understood the information provided, did not require an on-site review of tasks at this time, and will contact agency if they have any questions or concerns ..." 6. On 09-25-2024 at 9:30 AM, Patient # 6 indicated their bowel routine involved filling a bag with 1000 cc of tap water to flush their MACE, and this would produce a watery bowel movement within about 15-20 minutes. Indicated she has had to provide caregivers with detailed instructions as to how these personal cares and transfers are to be done, and estimated has provided this instruction to 200-300 caregivers during the course of her disability. 7. On 09-25-2024 at 1:23 PM, Home Health Aide (HHA) 4 indicated had been oriented to Patient #6 via a phone call with RN 1. Had seen patient only twice, and indicated a majority of the visit was assisting patient		have any questions. Additional options have been added to theintervention section to allow the RN Case Manager to elaborate additionalinformation if needed. The administrator will meet with all RN CaseManagers on October 14, 2024, to review all aspects listed above along with: Discussion of orientation of staff to includeany special needs the patient needs. Review of any special transfer needs the patientmay have. Making it clear that the RN Case Manager isavailable for in home orientation if the home health aide is unclear on anytasks assigned. RN Case Managers will observe the patient on anytasks that the patient may need assistance with to verify the patient is ableto complete the tasks without the HHA, if they are not in the scope of care forthe HHA. To prevent deficiencies in the future, theAdministrator and/or Director of Nursing will	

	with transfers to wheelchair, to shower chair, and to bed, etc. Indicated had not been informed by the nurse regarding the patient's ostomies, and indicated knew they should never touch any openings, and had not done so with this patient. Indicated had helped to fill a bag with water which was used for the patients enema, but indicated that was all that had been done with the enema, "just filled water". Regarding the patient's mobility, HHA 4 indicated the patient utilized three different transfer boards, each used for specific transfers. Indicated Patient #6 had explained how to do everything. 8. On 09-25-2024 at 1:57 PM, HHA 1 indicated was often assigned to Patient #6 and followed the patient's morning routine which included, but was not limited to: assisting patient with transfers to the bathroom for toileting, which involved assisting the patient with flushing their MACE (equivalent to performing an enema). Indicated the assistance included filling a bag with		review 100% of all plans of carethat are completed by the RN Case Managers to review tasks assigned to the HHAto verify that they are within their scope of practice. All charts will be modified for 100% compliance forthree months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going. QA department will review 100% of HHA Aide visitnotes and report any abnormalities or concerns to the DON or Administrator. All charts will be modified for 100% compliance forthree months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going. Results will be reported to the QAPI Committeefor review. This will be completed on October 14, 2024.	

	lukewarm water and then letting the water and air run out of the bag's tubing until bag read "950", then clamped the tubing, opened an alcohol wipe and wiped the tip of the tube, would then give patient an alcohol wipe and the patient cleansed the MACE site themselves. The aide indicated they did not touch the patient's MACE site. Indicated would then hand the tubing to the patient, and the patient would connect this tube to their MACE opening. The aide reported they would then unclamp the tubing for the patient to allow the tap water from the bag to flow into the MACE opening (thereby providing an enema via the MACE). Indicated before this procedure was performed, they would use a syringe together with the patient. Indicated a cup was filled with water, the syringe was then filled with water from the cup, and then the fluid was introduced into the port of the MACE before the actual flushing began. When queried as to whether the patient had the ability to pull back or push down on the plunger of the syringe, HHA 1 indicated the patient could not pull back or push down the			

	plunger. When queried as to whether an RN had ever trained them to perform this procedure, indicated, "no". HHA 1 indicated they trained the other aides, since "I get [the routine] down pat". When queried as to how HHA 1 received orientation to a new case or a new patient, indicated the first time a patient is assigned, they get report and are told if this is a 'high need' patient, but orientation to patients "is a phone call only" but they could ask for a nurse to go on site with them if needed. 9. On 09-25-2024 at 3:22 PM, Registered Nurse 1 indicated she was unaware the HHA 1 had been assisting Patient #6 with instilling tap water into the patient's MACE site via a syringe and flushing daily. Indicated the patient had reported they managed their own MACE flushing, but RN 1 had not personally observed the patient's ability to perform their own care. Indicated had not watched the aide perform this care. Indicated when a home health aide is oriented to a			

	reviews the care plan and tasks, and when possible they try to have it in person with the patient, and indicated was not sure why they, "had not gone over that". Indicated if Patient #6 was truly unable to manage their MACE, perhaps there needed to be training for the aides regarding the tube while in the patient's home with the aides present, and checking-off aides for competency before an aide could care for the patient. 410 IAC 17-13-2(a)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview the agency failed to ensure a home health aide provided care within their scope of practice, in 1 of 2 home health aide visits. (Home Health Aide	G0800	The Administrator discussed the survey findingswith patient # 6 on September 27, 2024. Patient was educated and informed on: That the HHA is not able to complete any tasksthat are not on the plan of care. That if she feels she needs a task completed bythe HHA that is not on the plan of care, she should reach out to the RN CaseManager.	2024-10-14

(HHA) 1)

Findings include:

1. A review of an agency policy titled 'STANDARDS OF PRACTICE 3-110' stated, "... The agency staff will practice within the guidelines of their stated discipline ... All staff will be knowledgeable regarding laws and regulations governing home health care ..."

2. Review of the Job Description for HHA 1, signed 10-14-2021, stated, "... All duties are under the supervision, and in accordance with Heal at Home policies, CMS (Centers for Medicare and Medicaid Services) and ISDH (Indiana State Department of Health) guidelines and verbal or written instructions provided by the registered nurse ... Duties and Responsibilities: ... 13. Any other task assigned by the nursing supervisor within the scope of a home health aide ..."

That the HHA is not able to assist with the MACEprocedure in the following steps:

Filling the bag with tap water.

Using the roller clamp to remove air from thetubing or to start the enema.

Cleaning the tubing.

By depressing the plunger during flushing of theMACE tubing.

That she is not able to direct the HHA tocomplete task that are not on the plan of care as this is considered self-directedcare.

The RN Case Manager did a home visit andobserved the patient complete her MACE procedure without assistance. She can adjust the roller clamp by using herteeth and depress the plunger on her own.

The patient and agency are trying to locatetubing with a thumb clip type controller that would allow the patient to startthe flow without utilizing her teeth.

Orientation of all future home

	3. Review of the clinical record for Patient #6 with a start of care date of 10/21/2022 and a certification period of 08/11/2024 - 10/09/2024, with diagnoses which included, but were not limited to: Quadriplegia (paralysis [loss of muscle function in some or all of the body]paralysis of the legs and arms. The record further indicated the patient was wheelchair bound, has some function of the upper extremities, but was completely reliant for transfers, perineal care (the practice of cleaning the genital and rectal areas of the body), and mobility assistance. The record indicated, 'the patient reports having MACE(Malone Antegrade Continence Enema: surgical procedure that creates a channel from the abdomen to the colon, allows enemas to be administered directly to the beginning of the colon, instead of through the rectum)', with recent replacement on 8/6/24 utilizing g-tube (gastrostomy) tubing, as the larger-sized device helped to reduce leakage at the site. Skilled Nursing services were ordered every 56-60 days to complete their recertification, and Home		instructions that they are unable to assist the patient, per aboveduring her MACE procedure. The Administrator discussed with RegisteredNurse 1, on September 27, 2024, that during her comprehensive assessment sheshould not rely on the patient stating that they can complete a task but shouldobserve the patient completing the task. This will verify that the patient can complete the task and allow for amore accurate plan of care creation for the HHA. The Administrator discussed with RegisteredNurse 1 that during her comprehensive assessment she should review thedifferent types of transfers this patient requires with the different transferboards/devices. Education will be sent out to all HHA's onOctober 9, 2024, regarding allowable tasks. They will be educated on only completing tasksthat are listed on the plan of care and if the patient requests any tasks	

	Health Aide services were ordered 6 hours per day, 7 days per week. 4. A review of Patient #6's Aide Care Plan detailed the tasks/duties the aide was to perform during each visit, which included, but was not limited to: "... Elimination Assistance (bedpan, bedside commode, toilet) ..." The document failed to detail specifics of what the task required, what the patient was able to do on their own, and what assistance was required by the home health aide.		noton the plan of care, they are to reach out to the RN Case Manager forassistance. The RN Case Manager will make the assessment andcontact the primary care provider for orders to add the task if appropriate. Systemic Changes: The Agency Policy was updated. Tasks listed on the mobile and online app islimited based on programing limitation. The taskswill be reviewed and modified to clarify the tasks for the HHA. KanTime (the software provider) has beencontacted regarding the HHA Care Plan and that information does not flow fromthe Plan of Care to the HHA Care Plan.	

	5. On 09-25-2024 at 9:30 AM, Patient # 6 indicated their bowel routine involved filling a bag with 1000 cc of tap water to flush their MACE, and this would produce a watery bowel movement within about 15-20 minutes. Indicated has had to provide caregivers with detailed instructions as to how their personal cares and transfers are to be done, and estimated has provided this instruction to 200-300 caregivers during the course of his/her disability. 6. On 09-25-2024 at 1:57 PM, HHA 1 indicated was often assigned to Patient #6 and followed a morning routine which included, but was not limited to: assisting patient with transfers to the bathroom for toileting, which involved assisting the patient with flushing their MACE (equivalent to performing an enema). Indicated filled a bag with lukewarm water and would then let the water and air run out of the bag's tubing until the bag read "950", then would clamp the tubing, would open an alcohol wipe and wipe the tip of		Tickets have been placed with KanTime and theystate that the HHA is not able to view the HHA Care Plan on the mobile device. Everything that is on the HHA Care Plan islocated on the Plan of Care that is in the home folder or is available to theHHA via the KanTime Mobile App. HHA's will be instructed to review the Plan ofCare for any questions about tasks or interventions that they should completeand to reach out to the RN Case Manager if they have any questions. Additional options have been added to theintervention section to allow the RN Case Manager to elaborate additionalinformation if needed. The administrator will meet with all RN CaseManagers on October 14, 2024, to review all aspects listed above along with: Discussion of orientation of staff to includeany special needs the patient needs. Review of any special transfer needs the patientmay have.	

	patient an alcohol wipe and the patient cleansed the MACE site themselves. The aide indicated they did not touch the patient's site. Indicated would then give patient the tubing, and the patient would connect this tube to their MACE opening. The aide would then unclamp the tubing, to allow the tap water from the bag to flow into the MACE opening (providing an enema via the MACE). Indicated before this procedure was performed, they would use a syringe together with the patient by filling a cup with water, then filling a syringe with the water from the cup, and then this fluid would be introduced into the port of the MACE before the actual flushing began. When queried as to whether the patient had the ability to pull back or push down on the plunger of the syringe, HHA 1 indicated the patient could not do so. When queried as to whether an RN had ever trained them to perform this procedure, indicated, "no". HHA 1 indicated they trained the other aides, since "I get [the routine] down pat".		Making it clear that the RN Case Manager isavailable for in home orientation if the home health aide is unclear on anytasks assigned. RN Case Managers will observe the patient on anytasks that the patient may need assistance with to verify the patient is ableto complete the tasks without the HHA, if they are not in the scope of care forthe HHA. To prevent deficiencies in the future, theAdministrator and/or Director of Nursing will review 100% of all plans of carethat are completed by the RN Case Managers to review tasks assigned to the HHAto verify that they are within their scope of practice. All charts will be modified for 100% compliance forthree months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going. QA department will review 100% of HHA Aide visitnotes and report any abnormalities or concerns to the DON or Administrator.	

	7. On 09-25-2024 at 3:22 PM, Registered Nurse 1 indicated she was unaware HHA 1 had been assisting Patient #6 with instilling tap water into the patient's MACE site via a syringe, and was flushing it daily. Indicated the patient had reported they managed their own MACE flushing, but RN 1 had not personally observed the patient's ability to perform their own care. Indicated had not watched the aide perform this care. Indicated when a home health aide is oriented to a patient new to them, RN 1 reviewed the care plan and tasks, and when possible they would try to have it in person with the patient, and indicated was not sure why they, "had not gone over that". Indicated if Patient #6 was truly unable to manage their MACE, perhaps there needed to be training for the aides regarding the tube, in patient's home with the aides present, checking-off aides for competency before an aide could care for the patient. 8. On 09-25-2024 at 4:23 PM,		All charts will be modified for 100% compliance forthree months, once achieved, monitor 50% of all charts for two months, once achieved,monitor 25% of all charts on going. Results will be reported to the QAPI Committeefor review. This will be completed on October 14, 2024.	

	the Administrator indicated was unaware HHA 1 had been assisting Patient #6 with their bowel regimen. Indicated RN 1 ought to have had the Patient #6 demonstrate their abilities to manage their MACE, and not just ask the patient 'to talk them through it'. Indicated needed to have nurse perform aide competencies specific to this patient, in real time. 9. On 09-26-2024 at 9:18 AM, RN 1 indicated had just completed a follow-up visit with Patient #6 and HHA 1. Indicated had identified deficits: the patient would be unable to push down on the plunger of the syringe without having the aide hold the syringe in place. Indicated had also been strategizing with Administrator about how to appropriately manage the patient's needs with possible physical modifications of the equipment used for the bowel regimen, but no definitive plan was yet in place.			

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
Joey Hollis	RN, Administrator	10/15/2024 3:56:26 PM