STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	6855 SHORE TERRACE SUITE 240, INDIANAPOLIS, IN, 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 Survey Dates: 10-07-2024, 10-08-2024, 10-09-2024, and 10-10-2024 Active Census: 796 At this Emergency Preparedness survey, Help at Home Skilled Care was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR completed by Area 3 on	E0000		

	10-15-2024.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of Home Health Provider in conjunction with one (1) Complaint, IN00109676 Survey Dates: 10-07-2024, 10-08-2024, 10-09-2024, and 10-10-2024 12-month unduplicated skilled admissions: 17 This deficiency report reflects States findings in accordance with 410 IAC 17. QR completed by Area 3 on 10-17-2024,	G0000		
G0464	Advise the patient of discharge for cause 484.50(d)(5)(i) (i) Advise the patient, representative (if any), the physician(s) or allowed practitioner(s),	G0464	On 10/8/24, Administrator provided written education to allbranch managers and RNCMs on the Indianapolis license regarding properdischarge process and provided a	2024-10-25

	issuing orders for the home health 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) that a discharge for cause is being considered; Based on record review and interview, the agency failed to ensure discharge planning and documentation included involving the physician, patient, and patient family in 1 of 6 active record reviews. (Patient #1) Findings include: 1. A review of a policy titled 'Client Discharge Process' indicated "... 2. Client's needs for continuing care ... clients are told in a timely manner of the need to plan for discharge or transfer ... 3. The physician will be involved in the discharge plan ... 4. The physician will order the discharge and/or transfer ... 5. The agency will notify all clients, the client's legal representative ... at least 15 calendar days before the services are stopped ... f. The agency must ... attempt to provide services ... it's continuing attempts to provide the services must be documented ... 11. To avoid charges of "abandonment" ...		discharge checklist to ensure compliance withall steps necessary. On 10/11/24, Administrator provided direction to RN#3regarding proper process for follow up required for patient#1. On 10/22/2024, Administrator re-distributed the agency's DischargePolicy to all admin staff. Acknowledgement to be verified by signedattestation. Administrator/Alternate Administrator willtrack for 100% compliance with signed attestation to be achieved prior to10/25/2024. The deficiency will be corrected in the future, by the Administrator/AlternateAdministrator being notified prior to discharge for all clients moving forward.Administrator/Alternate Administrator will directdischarge process and ensure compliance with proper discharge planningaccording to agency discharge policy for 100% of patient discharges. Allpatient discharges will be tracked and reviewed by Administrator/AlternateAdministrator as part of QAPI data collection.	

	documentation will include ... a. Evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge ..." 2. A review of the clinical record for Patient #1 evidenced a Home Care Certification/Recertification Plan of Care Order dated 08/05/2024 for the certification period 08/08/2024 through 10/06/2024 and signed by RN 3 revealed Patient #1 was to receive skilled nursing services 12 hours a day for 2 days a week and 8 hours a day for 2 days a week. A review of the clinical record for Patient #1 on 10/08/2024 evidenced as of 10/06/2024 there had not been a recertification completed, and the last skilled nursing visit conducted was 10/04/2024. The clinical record of Patient #1 failed to evidence			

	a recertification hadn't been completed, the disruption of care, or MD notification/orders for changes with care. 3. During an interview on 10/07/2024 at 2:18 PM with Person C, a family member to Patient #1, indicated Patient #1 wasn't currently being seen, the nursing staff that was to see Pt #1 was on medical leave, and wouldn't be back for 2 months, typically Patient #1 was seen on Monday, Tuesday, Thursday and Friday. Person C indicated the agency had known about the situation for some time, and hadn't bothered to find another nurse to care for Patient #1. 4. During an interview on 10/08/2024 at 2:05 PM with RN 3, they indicated they had discussed with Person C about the agency not being able to continue to care for Patient #1 but hadn't documented the conversation, and indicated they hadn't discussed the situation with the Administrator or the Physician. RN 3 indicated the plan was to discharge			

	completed the paperwork or the documentation 5. During an interview on 10/08/2024 at 2:55 PM with Person H, a Registered Nurse from Entity G office, the ordering Physician for Patient #1 indicated they had not received notification of the agency discharging or placing Patient #1 on hold. 6. During an interview on 10/08/2024 at 4:53 PM with Person C, when queried if the agency had educated them on discharge, Person C asked this writer if the agency was discharging Patient #1. This writer told Person C they needed to speak with the agency. When queried if Person C was actively looking for another agency, Person C indicated they had made several calls to agencies, with some indicating they could not service Patient #1, and had yet to receive call back from others. When queried how Person C received information on the home care agencies, they indicated that RN 3 had			

	provided them with a few agency names and phone numbers. 7. During an interview on 10/08/2024 at 1:05 PM with the Administrator, when queried if the agency had planned on discharging the patient, they indicated since recruitment efforts were unsuccessful, they didn't have a choice but to either place Patient #1 on hold for 2 months or discharge, but thought discharge would be the better option. The Administrator indicated there was no documentation of discussion of placing Patient #1 on hold or of pending discharge. 410 IAC 17-12-2(1)			
G0484	Document complaint and resolution 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview the agency failed to	G0484	On 10/22/2024, Administrator provided written education toAdmin staff regarding grievance process. On 10/22/2024, Administrator re-distributed the Complaintand Grievances Policy to all Admin staff. Acknowledgement to be	2024-10-25

	document the existence of a patient's complaint, nor a resolution, for 1 of 1 known undocumented complaint investigated. Findings include: 1. A review of an agency policy revised 01-10-2024, titled 'Complaints and Grievances' stated, "... To establish a procedure for channeling complaints to the appropriate person for resolution and to respond to the client/family ... A grievance is any formal or informal written or verbal expression of dissatisfaction that is not solved at that time by staff present ... 4. Client complaints received by an employee will be documented under the client profile ... 5. A grievance will be filed by the agency and forwarded to the appropriate parties by administrator/designee for investigations and evaluation of the complaint. 2. A review of an agency document titled 'Grievances [3rd quarter]' failed to evidence a complaint had been made by		verified by signedattestation. Administrator/Alternate Administrator will track for 100%compliance with signed attestation to be achieved prior to 10/25/24. On 10/22/2024, Administrator reviewed grievance/complaintlogs with each Branch Manager to ensure 100% compliance withgrievances/complaints reported for calendar year. The deficiency will be corrected in the future by the Administrator/AlternateAdministrator being notified of all complaints/grievances immediately.Administrator/Alternate Administrator will direct grievance investigationthrough resolution and ensure documentation is complete. Administrator/AlternateAdministrator will audit communication notes for each branch at least one aquarter. Administrator/Alternate Administrator will review grievance log foreach branch monthly. Any deficiencies noted will be directed to the branchstaff for correction. Once deficiencies are corrected by the branch,	

	Patient #3. 3. A review of the clinical record for Patient #3 failed to evidence the patient's complaint/grievance had been documented or reported. 4. On 10-09-2024 when queried if they had spoken to the office about these concerns, Patient #3 indicated they had spoken to Administrative Staff 6, the office manager in the office about their concerns last month. 5. On 10-09-2024 at 12:41 PM, when queried as to whether the patient had expressed their dissatisfaction related to Home Health Aide services not being rendered, Registered Nurse (RN) 1 indicated recalled admitting Patient #3 recently, and recalled the patient being 'upset'. Indicated the patient had 'lots of concerns' they had expressed to the nurse. When queried as to what was done about this, RN 1 indicated had shown Patient #3 the number to		theAdministrator/Alternate Administrator will complete a final review.	

	call and told the patient to 'please feel free to call [administrative staff]'. When queried as to whether RN 1 had reported the patient's complaint themselves, indicated could not recall and 'would have to look at my notes'. When queried as to where such documentation might be found, indicated if they had documented the complaint it would appear in the patient's comprehensive assessment, and added, education notes would have been written within the visit note. Indicated had reported the patient's concerns to Administrative Staff 5, branch manager, either after the visit or the next day and had since had multiple conversations with Administrative Staff 5 about it. 6. On 10-09-2024 1:06 PM, Administrative Staff 5, indicated was well familiar with Patient #3 and their grievance related to not receiving Home Health Aide services as ordered. Indicated understood the issue was related to the patient's funding source having experienced recent changes which resulted in a delay in the patient's care.			

	When queried as to whether the complaint had been documented, indicated since it was felt the issue laid with the funding source and was felt to be an 'external' issue, this was not documented as a complaint. Indicated normally would still try to help and might send follow-up email or text message. Indicated had this issue been considered a complaint, it would have been documented under activities/communication notes in the client or caregiver's file and provided no further documentation. 7. On 10-09-2024 at 3:05 PM, when queried as to what would constitute a complaint, the Administrator indicated any written or verbal complaints of abuse, neglect, theft, any dissatisfaction, an employee would be expected to report these to the branch manager and Administrator. Indicated further employees can document these in 'communications', under a tab in the agency's Electronic Medical Record (EMR) system,			

	Administrator indicated complaints can be documented in 'visit notes', and that she should be notified as well, as staff are expected to 'notify us [the Administrator and Alternate Administrator]'. The Alternate Administrator indicated Patient #3's complaint is a constant issue at the branch level, 'would assume a lot would be documented'. Indicated further, 'hours decrease is an issue across the board'. 8. On 10-10-2024 at 9:47 AM, Administrative Staff 6 indicated had spoken with Patient #3, who had been 'upset' after speaking with the patient's Case Manager with Entity A, as they had informed Patient #3 of changes initiated by the patient's funding source which meant their current caregiver could no longer provide the patient's waiver hours due to also being the patient's family member. Indicated the patient was offered an alternate caregiver for the waiver hours and the patient refused, stating only wanted same caregiver. Administrative Staff indicated			

	Authorization (PA) hours for the patient and was told 'no', only wanted their family member to care for them. When queried if this expression of dissatisfaction would be considered a complaint, indicated 'yes'. When queried as to where this would be documented, indicated normally would be documented under 'activities' in the patient's EMR and indicated 'everything should be there, everything that was documented'. When queried as to a resolution, indicated resolution was not documented. 410 IAC 17-12-(c)(2)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure field staff followed appropriate infection control practices per agency policy while providing patient care in 2 of 3	G0682	On 10/9/24, Administrator provided a copy of the handhygeine policy as well as written education to all caregivers on theIndianapolis license regarding proper hand hygeine. On 10/21/24, Administrator scheduled HHAs # 2 and 3 to demonstrateproper hand hygiene in a lab setting. RNCM will observe and document competencywith this skill. Proof	2024-10-25

	home health aide (HHA) home visits conducted. (HHA 2 and HHA 3) Findings include: 1. A review of a policy with a revised date of 01/12/2024 titled 'Hand Hygiene' indicated, "... 1. The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: ... 15. Immediately after glove removal ... Using soap and water ... once hands are dry, use a clean paper towel to turn off the water ..." 2. On 10/08/2024 a home visit was conducted to observe home health aide (HHA) 2 provide personal care to Patient #9. HHA 2 assisted Patient #9 into the bathroom, to the toilet, and without performing hand hygiene, donned gloves, assisted removing brief, threw the brief in trash, removed socks, gown, and removed t-shirt. At this time, Patient #9 indicated they preferred to not take a shower, so HHA 2 asked if they could wash Patient #9 while they sat on a chair next to		of compliance with this observation will be maintainedin the caregiver record prior to 10/25/24. The deficiency will be corrected in the future by eachcaregiver completing hand hygiene education upon hire and annually. Movingforward RNCM will observe hand hygiene and re-educate, if applicable, at leasttwice per year using home observation form. Proof of compliance with thisobservation will be maintained within the EMR.	

	the sink. Patient #9 was agreeable to this. HHA 2 brought the walker over to Patient #9, assisted Patient #9 to stand so HHA 2 could clean Patient #9 peri area, then doffed their gloves, and donned a clean pair of gloves before placing a towel on the chair, then assisted Patient #9 to sit on the chair. HHA 2 opened the cabinet to retrieve a towel and placed over Patient #9 lap, turned the water on at the sink to warm up, reached in the cabinet for a wash cloth, wet the cloth, applied a facial cleanser to face, and wiped off with cloth, then began washing arms, front and back. Once completed, took another towel from the cabinet to dry Patient #9 off, applied lotion to Patient #9 face, arms and legs. Went to bedroom to retrieve undergarments. HHA 2 then began to wash legs and feet, rinsed, dried, and applied lotion. HHA 2 doffed their gloves, then donned a clean pair of gloves. Once dressed, HHA 2 returned to the kitchen sink, washed their hands, and turned the water off with bare hand.			

	HHA 2 failed to perform hand hygiene between glove changes and failed to use a dry paper towel to turn the water off. 3. On 10/08/2024 a home visit was conducted to observe HHA 3 provide personal care to Patient #2. HHA 3 without performing hand hygiene, donned a clean pair of gloves, began gathering clothes for Patient #2, made Patient's #2 bed, went to the bathroom, turned the water on in the shower to warm up, while Patient #2 was undressing. HHA 3 assisted Patient #2 into the shower, assisted with washing their back, and legs. HHA 3 doffed their gloves, and donned a clean pair of gloves, and assisted Patient #2 out of shower, assisted with drying patient, doffed their gloves, and donned a clean pair of gloves. HHA 3 applied lotion to Patient #2's face, then brushed their hair. HHA 3 assisted Patient #2 to their bedroom, and Patient #2 requested privacy to get dressed. HHA 3 went to the kitchen, doffed their gloves, went to the kitchen sink, washed their hands, then turned			

the water off with their bare hand.

HHA 3 failed to perform hand hygiene between glove changes and failed to use a dry paper towel to turn the water off.

4. On 10/08/2024 at 8:43 AM when queried about when hand hygiene should be performed HHA 2 indicated they should perform hand hygiene between changing gloves.

5. On 10/08/2024at 10:39 AM when queried about when hand hygiene should be performed HHA 3 indicated they don't always wash their hands between glove changes because it hard for them to put gloves back on, and should have used a paper towel to turn the water off.

6. On 10/08/2024 at 4 PM the Administrator indicated the HHAs have been trained to wash their hands between glove changes, and to use paper

	towels to turn the water off. 410 IAC 17-12-1(m)			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Armuth	Governing Body	10/22/2024 2:45:10 PM