STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K076	A. BUILDING B. WING	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heaven Sent Home Health Care Llc	716 SOUTH PARK AVENUE, ALEXANDRIA, IN, 46001

(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: March 10, 11 and 12, 2025 Complaint: IN113510 with unrelated deficiencies cited. 12 Month Unduplicated Skilled Admissions: 3 <u>Abbreviations</u> CM-Clinical Manager HHA-Home Health Aide RN-Registered Nurse POC-Plan of Care SN-Skilled Nurse SOC-Start of Care QR 3/14/25 A2	G0000	Heaven Sent Home Health Care is submitting the following Planof Correction in response to the CMS-2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Heaven Sent Home HealthCare that the findings and allegations contained herein are accurate andtrue representations of the quality of care and services provided to patientsof the Agency. Heaven Sent Home Health Care desires this Plan ofCorrection to be considered our Allegation of Compliance.”	

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure the POC included specific medication box set-up orders for 1 of 1 home visit observation with a SN (Patient #1) and failed to ensure the patient received all HHA services as ordered in the plan of care for 1 of 4 records reviewed with HHA services only (Patient #5). Findings include: 1. The agency policy "Care Planning", last updated 12/11/19, indicated the client will receive the services that are written in an individualized POC; if the HHA misses a visit,	G0572	G0572 All staffresponsible for scheduling have been educated on policy 2.06 (plan of care andfrequencies of ordered home visits) on 3/13/25. All clinical staff wereeducated on policy 2.55 (medication set up) on 3/13/25. The employee cited inthis deficiency has been counselled as of 3/13/25. All recordscited during this survey have been corrected by MD notification and orders of deficiency.A section of the audit tool had been changed to monitor all frequencies toensure compliance with state and federal regulations (hours per day and daysper week). A random audit of 50% of client charts have been audited, no furtherdeficient charts have been identified for frequencies of services outside ofthe stated frequency in the plan of care. All skillednurse medication set clients have been audited for appropriate supplies tocomplete the medication set up per physician orders. The agency has purchasedmedication boxes to have at the office in the	2025-03-13

	responsible physician of such missed visit and the HHA will make an attempt to re-schedule the visit. 2. The agency policy "Medication Set Up", last revised 6/29/19, indicated the nurse ensures that he/she is filling in the med-planner correctly; the nurse will clearly document what nursing tasks were performed and will document prescriptions refilled and whether the client has all medications available for the set up. 3. Patient #1's clinical record evidenced a POC for the certification period 2/08/25 to 4/08/25. The POC included orders for SN to complete medication review and weekly set up of ordered medications. The clinical record also evidenced an order for the following medications to be taken three times a day: Pregabalin 200 milligram (mg) capsule and Tizanidine HCl 4 mg tablet. During a home visit observation with Patient #1 and RN 1 on 3/10/25 at 2:43 PM, RN 1 was		instance that the client does nothave sufficient supplies, this will minimize any disturbance and/or inaccuracyin services provided to ensure the medication set is accurate per physicianorders. TheAdministrator and DON will do ongoing monitoring at least every 90 days andwith recertification visits to ensure this deficiency does not recur. The DON willcomplete, at a minimum, one supervision of a clinician medication set per monthto ensure compliance with state and federal regulations, the plan of care, andto ensure this deficiency does not recur. Thisdeficiency has been corrected as of 3/13/25.	

	weekly medications. Patient #1 has had a medication box with two slots for medications since SOC on 12/09/24. RN 1 gave Patient #1 a new pill box during the visit and set up the medications in the new pill box. RN 1 failed to place the Pregabalin and Tizanidine in the pill box. During an interview on 3/10/25 at 4:08 PM, Surveyor asked RN 1 how RN 1 set up the three times a day medications prior to bringing the new pill box on 3/10/25. RN 1 relayed she did not set up the three times a day medications and HHA's and family reminded Patient #1 to take the mid-day doses of Pregabalin and Tizanidine. During an interview on 3/10/25 at 4:08 PM, RN 1 relayed she only fills the pill box with the morning and evening medications and HHA's and family are responsible for reminding the patient to take his mid-day dose of Pregabalin and Tizanidine. During an interview on 3/12/25 at 9:44 AM, HHA 2 relayed he was not educated to remind			

doses of Pregabalin and Tizanidine.

During an interview on 3/12/25 at 12:44 PM, HHA 1 relayed she visits Patient #1 in the evening and was not educated to remind Patient #1 to take the mid-day doses of Pregabalin and Tizanidine.

During an interview on 3/12/25 at 2:36 PM, RN 1 verified the POC did not include information on how to fill the medication box and the HHA care plan didn't include specific instructions to remind the patient to take the mid-day dose of Pregabalin and Tizanidine.

4. Patient #5's clinical record evidenced a POC for the certification period 1/31/25 to 3/31/25. The POC included orders for HHA visits four hours a day, six days a week. The record failed to evidence HHA visits were completed six days a week for the weeks of 2/16/25, 2/23/25 and 3/02/24.

During an interview on 3/12/25 at 10:15 AM, RN 2 relayed she was unaware of Patient #5 not receiving HHA visits as ordered and she verified the clinical

	record did not include documentation of any missed visits. During an interview on 3/12/25 at 12:40 PM, the CM relayed the patient should have received all visits as ordered in the POC and if a visit was missed, the clinical record should include documentation of the missed visit. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 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;	G0574	G0574 All clinicalstaff were educated on medication reconciliation (policy 2.56) and plan of care (policy 2.06) on 3/14/25. All clinicianswere educated to visually inspect ALL medications in the home of clients and to ensureaccuracy of the entire plan of care. The employee cited inthis deficiency was counseled on 3/14/25. The record cited in this survey has been corrected by MD notification. An audit of 50% of the plan of care for client's was completed and, if warranted, notification to MD was completed for any noted discrepancies. This was	2025-03-18

	(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. Based on observation, record review, and interview, the home health agency failed to ensure the POC included all medications for 1 of 1 active record reviewed with a HHA home visit observation (Patient #2). Findings include: 1. The agency policy "Care Planning", last updated 12/11/19, indicated the individualized plan of care must include all medications and treatments, the types of services, supplies and equipment required. 2. Patient #2's clinical record evidenced a SOC on 4/18/24 and included a POC and medication profile for the certification period 2/12/25 to		completed by case managers, 3/13/25 through 3/18/25. Beginning 3/18/25, the DON willcomplete, at a minimum, one supervision of a skilled nurse visit for recertification per month and at least 50% of all new admissions to ensure completion and accuracy of the plan of care in compliance with state and federal regulations, and to ensure this deficiency does not recur. Thisdeficiency has been corrected as of 3/18/25	

failed to evidence the Registered Nurse (RN) Case Manager conducted a medication review or reconciliation of Patient #2's medications.

During a home visit observation conducted with Patient #2 and HHA 1 on 3/11/25 at 2:45 PM, Surveyor comparison of the home health agency's POC medication list against the medications in the home evidenced the following discrepancies:

a) Nystatin (used to treat a fungal or yeast infection) 100 units/gram twice a day was found in the home. This medication was not listed on the POC.

3. During the entrance conference on 3/10/25 at 9:46 AM, the CM relayed medications should be reconciled during every recertification visit and when any new medications are found in the home.

4. During an interview on 3/11/25 at 4:12 PM, Patient #2 relayed she uses the Nystatin cream twice a day.

	5. During an interview on 3/12/25 at 10:15 AM, RN 2 relayed she was unaware the Nystatin cream was not listed on the POC. 410 IAC 17-13-1(a)			
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 home health agency failed to ensure staff followed agency infection control policies and procedures related to equipment cleaning and hand hygiene for 2 of 2 home visit observations performed (RN 1 and HHA 1). Findings include:	G0682	G0682 Employeescited in this deficiency were counseled and re-educated on policy 2.82 (HandHygiene) on 3/14/25 and policy 5.10 (bag technique for equipment cleaning). Allclinicals were re-educated on bag technique and proper cleaning of reusable equipmentin the home (3/14/25). Re-education in-service was provided to all staff onpolicy 2.82 (hand hygiene) on 3/14/25 and 3/14/25. The clinicalmanager will be responsible for ongoing monitoring for compliance for homehealth aides at a minimum of once every 60 days. The DON will be responsiblefor monitoring compliance for the skilled clinicians during skilled nursevisits at least once monthly. This monitoring will be ongoing to ensurecompliance	2025-03-14

	1. The agency policy "Hand Washing/Hand Hygiene", last updated 2/08/19, indicated hand washing and hand antisepsis should be done before donning gloves and after removing gloves. 2. During a home visit observation conducted with Patient #1 and RN 1 on 3/10/25 at 2:43 PM, RN 1 was observed cleaning the stethoscope after use on Patient #1. RN 1 placed the clean stethoscope partially on a clean barrier. The diaphragm and ear tubes of the clean stethoscope were lying on the kitchen countertop. RN 1 failed to ensure the entire clean stethoscope was placed on a clean barrier. During an interview on 3/12/25 at 12:40 PM, the CM relayed the clean stethoscope should have been placed entirely on a clean barrier to air-dry. During an interview on 3/12/25 at 2:36 PM, RN 1 relayed the clean stethoscope should not have touched the kitchen counter. 3. During a home visit observation conducted with		with federal and state regulations ensuring this deficiency does notrecur. Thisdeficiency was corrected as of 3/14/25.	

	3/11/25 at 2:40 PM, HHA 1 was observed assisting Patient #2 remove their clothes before the shower. HHA 1 removed her gloves and failed to perform hand hygiene prior to putting on new gloves. After the shower, HHA 1 carried Patient #2's soiled clothing to the garage. HHA 1 then removed her gloves and failed to perform hand hygiene prior to putting on new gloves. Later in the visit, HHA 1 removed her gloves. While still holding the soiled gloves, HHA 1 removed 2 new gloves from the box and walked to the kitchen to throw the soiled gloves away. HHA 1 failed to perform hand hygiene. During an interview on 3/11/25 at 4:15 PM, HHA 1 relayed hand hygiene should have been performed anytime necessary, after touching things, every 30 minutes as often as possible. During an interview on 3/12/25 at 12:40 PM, the CM relayed hand hygiene should be performed when visibly soiled, anytime in contact with a new patient, new care area, before and after gloves. 410 IAC 17-12-1(m)			

N0000	Initial Comments This visit was for a State complaint survey of a Home Health Provider. Survey Dates: March 10, 11 and 12, 2025 Complaint: IN113510 with unrelated deficiencies cited. 12 Month Unduplicated Skilled Admissions: 3	N0000		

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
Sarah Barton	RN/DON	3/28/2025 9:53:18 AM