STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K015	B. WI		<u>00</u>		11/07/	
	ROVIDER OR SUPPLIER	HEALTHCARE INC			VASHI	SS, CITY, STATE, ZIP COD INGTON STREET 46952	•	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(E. CRO	ACH CORRECTIVE ACTION SHOULD BE ISS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE
G 0000 Bldg. 00	re-licensure home h complaint. This survey was and 10/30/19 at 4:50 PM. Complaint informat IN00213640- Subst. Facility #: 003961 Survey dates: Octor 7, 2019 Skilled Services: 42 Home Health Aide of Personal Service on Unduplicated Skilled Total active patients.	ion: antiated ber 29, 30, 31, and November conly: 19 ly: 66 dd Census: 127 s: 112	G 0	000				
	Total clinical record	ds reviewed: 10						
		reflect State Findings cited in 0 IAC 17. Refer to the State State Findings.						
	Quality Review con	npleted on 11/27/19 CS						
G 0372								
Bldg. 00	Based on record rev	riew and interview, the agency	G 0	372	1.	For each client cited in	the	11/15/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLE	TED
		15K015	B. W	ING		11/07/2	2019
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				WASHINGTON STREET		
FAITHFU	IL FRIENDS HOME	HEALTHCARE INC			N, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S BLANCE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	14	DATE
	failed to submit OA	SIS (outcome and assessment			deficiency, the agency in-serv	iced	
	information set) wit	thin 30 days of assessment			the RN case managers		
	completion for 1 of	5 skilled records requiring			responsible for those clients o	n	
	OASIS submissions	s (#5).			following up to ensure OASIS	are	
					submitted timely to the billing		
	Findings include:				department for entry into the C	QIES	
					system. The errors were also		
	An undated agency	policy titled, "Encoding and			shown to the Billing Departme	nt,	
		ta," Policy B-250 stated			and she was also re-educated	on	
		ode and electronically submit			timely submission of OASIS,		
	•	SIS assessment to the CMS			specifically meeting the 30-day	у	
	[Centers for Medica	are and Medicaid service]			mark from the date the		
	-	nys of completing the			assessment was completed, for	or	
	assessment of the cl	lient"			submission.		
					2. The agency reviewed 10		
		for patient #5 was reviewed on			of all hard-copy OASIS for Re		
		ted a start of care date of			SOC, ROC, Transfer and DC	in	
		d contained a plan of care for			charts to ensure that all other		
	the certification per	iod of 7/14/19-9/11/19.			OASIS was submitted into QIE	ES	
					within 30 days of the date of		
		recertification was completed			assessment.		
		SIS submission was not			3. To ensure the deficient		
	completed until 8/9	/19 (31 days).			practice does not occur again,		
	D	11/7/10 / 2 2/ 72 5 3			Clinical Director has re-educat	ted	
	_	on 11/7/19 at 3:36 PM, the			all RN CM's on the federal		
		that employee C was the only			regulatory guideline and agen	· .	
		mplete OASIS submissions			policy regarding timely OASIS		
	and they should trai	n someone else to do them.			submission to the billing		
					department for entry in the QII		
					system as well as the Billing D		
					has been instructed to notify the		
					Clinical Director and Administr		
					if an OASIS has not been rece		
					24 hours (Day 29) before it is		
					for entry into QIES. Furthermo		
					all OASIS will now be tracked	- 1	
					hand on a calendar by the Bill	iiig	
					Dept and RN CM's. A master	, l	
					copy kept by the Billing Dept.,		
			1		be reviewed daily by the agen	Cy	

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PRINTED: 12/16/2019

	F OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015		JILDING	ONSTRUCTION 00	(X3) DATE COMPL 11/07/	LETED
	PROVIDER OR SUPPLIEI	E HEALTHCARE INC		203 S \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET N, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0478					Administrator and Clinical Director. The Clinical Director Administrator will remind RN of in daily agency meetings of upcoming OASIS due within 3 days and will follow-up with RI CM's at day 25 and then with Billing Department to ensure OASIS is submitted timely for entry into QIES. Additionally, Clinical Director has been train to enter the OASIS information QIES in the event the billing the department is unable. 4. The agency QA will revi 100% of all OASIS for timely submission and the agency Administrator and Clinical Dire will be responsible for monitor this corrective action to ensure deficient practice will not re-occur. If any further deficie is found, disciplinary action wi taken.	cM's 0 N the ned not one ew ector ing ethe	
Bldg. 00							
	failed to ensure cor thoroughly investig the agency policy of investigation was to	view and interview, the agency inplaints received were gated / documented, and that lescribed how the becompleted for 4 of 4 od for patient records (#1, 5, 8,	G 0	478	1. For each client cited in the deficiency, the Administrator at Clinical Director have reviewed complaint documentation, note the deficiencies per the survey then reviewed its current complaint/investigation policy	and d the ed /,	11/22/2019

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Findings include:

1. An undated agency policy titled, "Client/family

complaint/grievance policy," Policy C-381 stated

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updated.

found that the policy was not

being followed and needed to be

Upon review of policy,

Administrator and Clinical Director

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12/16/2019 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K015 B. WING 11/07/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 S WASHINGTON STREET FAITHFUL FRIENDS HOME HEALTHCARE INC MARION. IN 46952 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE "... All persons with a grievance will receive a updated the policy to include a written notice of the investigators review which more thorough explanation of the will include the name of the contact person, steps steps necessary to complete an taken to investigate the grievance, the results of investigation of all complaints in the process and the date of completion" The compliance with the federal policy failed to to negate the steps to be taken to regulation. The agency added the investigate the complaint. following specific steps to investigation process; contacting 2. The clinical record for patient #1 was reviewed other clients of the employee(s) to on 10/29/19 and indicated a start of care date of see if the behavior is occurring 6/7/19. The record contained a plan of care for the elsewhere and documentation of certification period of 10/5/19-12/3/19. the dialogue and notifying the client of all steps taken to resolve Two agency documents titled "report of concern," the issue and final outcomes. The dated 2/5/19 were completed from patient #1 filing agency will provide the client and complaints. The first document stated "Client the employee, written reported that HHA only stayed 10 min [minutes] documentation of the complaint, investigation, resolve, and of his 1 hour scheduled visit on 1/26/19 and 1/27/19. States HHA was complaining that his outcome. The documentation will house was to cold." The employee was also include any actions taken interviewed and denied the allegation. The outside of agency such as police patient was informed that the complaint was involvement. discussed with the HHA and due to the second To ensure the deficient complaint the HHA was removed from the home practice does not re-occur, the and advised to have no further contact with Administrator and the Clinical patient #1. Director, has updated its "Report of Concern" form to include a The second document stated "Client reported that documentation component for HHA was in home on 2/3/19 and he had a money contacting other clients of the order on his night stand for \$120 and reports that employee, the dialogue between he fell asleep and when he woke up the money those clients and the investigator, order was gone and the HHA was gone." The a documentation component for client was informed to file a police report. The any outside sources utilized to resolution indicated the employee was suspended resolve the matter such as police, and was informed not to have contact with client. and a documentation component The employee never returned to the agency. for notification of the resolve and

The complaint documentation failed to evidence

the agency called other patients the HHA (home

health aide) cared for to see if this was a pattern or

outcome to the client, including

and the Clinical Director will be

The agency Administrator

the status of the employee.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	ING		11/07/	2019
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			VASHINGTON STREET		
EVITHEI	II EDIENDS HOME	E HEALTHCARE INC			N, IN 46952		
TAITIIL	TOWL	TIEAETHCAILE INC		WARIO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	other patients were	affected.			responsible for monitoring and		
					reviewing this corrective action	n to	
	_	on 11/7/19 at 3:24 PM, the			ensure this deficient practice v	vill	
	_	(DON) stated the agency			not re-occur. The Administrate	or	
	_	the matter. She stated the			and Clinical Director will review	V	
	1 ~	noney order down and it had			100% of all complaints for		
	_	s station. (This failed to be			thorough and complete		
	evidenced in the co	mplaint documentation).			documentation, and then all		
					complaints will be discussed a		
		ord for patient #5 was reviewed			reviewed monthly during QAP		
		dicated a start of care date of			Meetings.		
		d contained a plan of care for					
	the certification per	riod of 9/12/19-11/10/19.					
	A						
		nt titled "report of concern,"					
		d "Aide [employee L] claimed					
		she didn't do the visits. She					
	forged clients / care	_					
	_	"When aide was questioned					
		allegations but refused to sign					
	_	The resolution was that the					
		d and the patient was notified was spoken to. The agency					
	terminated.	patient that the aide was					
	terminated.						
	The complaint docu	umentation failed to evidence					
		ther patients the HHA cared					
		s a pattern or other patients					
	were affected.	s a pattern of other patients					
	were arrected.						
	4. The clinical reco	ord for patient #8 was reviewed					
		dicated a start of care date of					
		contained a plan of care for the					
	certification period						
	period						
	An agency docume	nt titled "report of concern,"					
	dated 10/24/16 regarding employee D stated						
	_	eet on 10/24/16 for the week of					
		6 et [and] claimed hours you					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K015	A. BUILDING B. WING	00	COMPLETED 11/07/2019	
		1011010	_	ADDRESS, CITY, STATE, ZIP COD	11/01/2010	
NAME OF F	PROVIDER OR SUPPLIEF	2		WASHINGTON STREET		
FAITHFU	IL FRIENDS HOME	HEALTHCARE INC		N, IN 46952		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG		28/19 employee D met with the	TAG		DATE	
		she had filled out the weekly				
	_	missing work and forgot to				
	1 *	he sheet. The complaint failed				
	to evidence a resolu	ition.				
	The complaint docu	umentation failed to evidence				
		ther patients the HHA cared				
		s a pattern or other patients				
	were affected.					
	5. The clinical reco	ord for patient #9 was reviewed				
		dicated a start of care date of				
		l services only and skilled				
	services beginning	on 10/17/19.				
	An agency docume	nt titled "report of concern,"				
		ing employee K stated				
		hours at 2 client's homes and				
		" The investigation stated the				
		viewed and claimed to be				
		personal life and had another The resolution was that the				
		inated and the patient was				
		oyee was spoken to.				
	The complaint door	umentation failed to evidence				
		ther patients the HHA cared				
	1 -	s a pattern or other patients				
	were affected.					
	6 During an interes	riew on 11/7/19 at 3:20 PM, the				
	_	sked if the agency called other				
		ate if allegations occurred with				
	ı ^	strator stated yes they did but				
		ted because she thought the				
		to be a summary of the				
	and investigation.	all the details of the complaint				
	and mycsugation.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K015		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 11/07/201			LETED		
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET		
FAITHFU	IL FRIENDS HOME	HEALTHCARE INC		MARIO	N, IN 46952		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	17-12-3(c)(1)(A) 17-12-3(c)(1)(B)						
	17-12-3(c)(1)(B) 17-12-3(c)(2)						
	(0)(2)						
G 0528							
Bldg. 00							
		view and interview, the	G 0	528	For each client cited in		11/13/2019
	*	essment failed to contain all			deficiency, the Clinical Direct		
		he current health status for 7			reviewed with the RN CM's th		
	of / complete record	ds reviewed (#1, 2, 3, 4, 5, 6, 7).			missing assessment compon		
	Findings include:				noted by the surveyor. The F CM's were then in-serviced o		
	Tindings include.				to complete a comprehensive		
	An undated agen	ncy policy titled			assessment and the thorough		
	_	ent assessment," Policy C-145			documentation guidelines set		
	stated "Special ins				in the regulation. The QA		
	_	essment must accurately			manager was also in-serviced	d on	
	reflect the client's st	tatus, and must include at a			the documentation to look for		
	minimum, the follow	wing information: The client's			regards to the deficient areas		
		hosocial, functional, and			noted by the surveyor. The F	RN	
	cognitive status"				CM's were then sent out		
	0 TEI 1: : 1	1.6			immediately to client homes t		
		ord of patient #1 was reviewed			perform an updated assessm		
		licated a start of care date of contained a plan of care for the			specifically of those areas for be missing/lacking document		
		of 10/5/19-12/3/19 that			so that the client chart includi		
	_	of, but not limited to,			care-plans could be updated	•	
		function of the bladder,			reflect the clients current hea		
	anemia, diabetes, ar	nd had a 24 french suprapubic			psychosocial, functional, and	•	
	catheter. The comp	rehensive recertification			cognitive status.		
		0/1/19 failed to evidence			2. The agency QA will rev		
		he type, cause, or recent labs			100% of all current comprehe	ensive	
		ny information regarding size,			assessments for complete		
		st catheter change was			documentation of all assessm		
		nformation regarding the			areas in the OASIS. For any		
	1 ^	eletal system regarding tures, extremity weakness, gait			deficiencies found, the RN CI responsible for the assessme		
	1 ^	unctional abilities regarding			will be required to go back ou		
	safety	anonomia domines regarding			client home and complete an		

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ENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15K015	B. W	ING		11/07	/2019
	PROVIDER OR SUPPLIER	E HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP COD 203 S WASHINGTON STREET MARION, IN 46952		WASHINGTON STREET		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3. The clinical reco on 10/29/19 & 10/3 care date of 5/24/19 of care for the certiful 9/21/19-11/19/19 the diabetic and had a with the skilled nurse (Somedications). The reassessment dated 9/4 wound assessment dated 9/4 wound care certiful managed her own of up medications). During an interview director of nursing at the wound care certiful the wound care certiful the wound care certiful the disposition of the stated that the elassess wounds on the patient had gone to day. 4. The clinical record certification period included diagnoses difficulties, and the (g-tube). The compassessment complete evidence the type are often/last time the greeding and if it is a failed to evidence with the evidence with the stated to evidence with the stated to evidence with the greeding and if it is a failed to evidence with the compasses with the greeding and if it is a failed to evidence with the compasses with the greeding and if it is a failed to evidence with the compasses with the greeding and if it is a failed to evidence with the compasses with the greeding and if it is a failed to evidence with the compasses with the greeding and if it is a failed to evidence with the compasses with the com	ord of patient #2 was reviewed 10/19 and indicated a start of 10. The record contained a plan at indicated the patient was a wound to the left heel, and that 1N) set up the patient's eccertification comprehensive 19/19 failed to evidence a 1/2 dressing change, who gave at if agency nurse was not a information that the patient that medications (SN did not set 11/7/19 at 8:53 AM, the stated the patient had gone to the ter on 9/16/19 so the nurse ents from the wound center assessment. Additionally, expectation is that nurses the recertification unless the the wound center the same 1. Additionally was reviewed 1. Additionally as the the wound center the same 1. Additionally the wound center the same 1. Additionally was reviewed 1. Additionally as the the wound center the same 1. Additionally the wound center the same 1.			updated assessment specificathe areas found by QA to be deficient and then update clie chart accordingly. Then at the of next recertification, any fund deficiencies will result in disciplinary actions. 3. To ensure the deficient practice does not re-occur, the agency QA manager has been in-serviced on completion of the OASIS and key documentation components that should reflect client's current health, psychosocial, functional, and cognitive status. The QA man will then review 100% of all comprehensive assessments ensure that all areas included the assessment documentation are specific, thorough, accurate and complete. Any deficiencin noted will be addressed by the Clinical Manager with the RN and disciplinary action will result at the Administrator and Clinical Director will be responsible for monitoring an reviewing this corrective action ensure this deficient practice not re-occur.	ent me ther ther the the on ct the nager to d in on ate, ies ies ie CM sult.	
	completed around t	he g-tube stoma.					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	ING		11/07/	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			VASHINGTON STREET		
FAITHFU	L FRIENDS HOME	HEALTHCARE INC		MARIO	N, IN 46952		
			1	Ц			ars)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
IAG		ord of patient #4 was reviewed		IAG			DATE
		dicated a start of care date of					
		d contained a plan of care for					
		riod of 6/18/19-8/16/19 that					
	-	t wore ankle braces and was					
	-	night to help sleep. The					
	comprehensive ped	iatric nursing assessment					
	completed on 6/13/	19 failed to evidence					
		the patient had difficulty					
		medications, or why the patient					
	·	eformity, to strengthen or					
	support legs while v	walking).					
	(The eliminal mana	1					
		ord of patient #5 was reviewed dicated a start of care date of					
		d contained a plan of care for					
		riod of 9/12/19-11/10/19 that					
	-	of, but not limited to, insulin					
	_	mellitus (IDDM) with orders					
	-	to "oversee client perform self					
		ulin administration 3x/day					
		7]" The comprehensive					
	recertification asses	ssment completed on 9/7/19					
	stated on page 10 of	f 24 that the blood sugar was					
		(patient), then further down in					
	-	m it stated "competency with					
		nurse takes Bld sugars [blood					
		essment failed to evidence					
	accurate and non co	onflicting information.					
	During an interview	on 11/7/19 at 11:58 AM, the					
		stated the patient can take her					
		nooses not to and is not					
	reliable at doing so.						
	remade at doing so.						
	7. The clinical reco	ord of patient #6 was reviewed					
		licated a start of care date of					
	2/18/19. The record	d contained a plan of care for					
		riod of 8/17/19-10/15/19 that					
	indicated diagnoses	included, but not limited to,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K015		(X2) MUL A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 11/07/	ETED	
	PROVIDER OR SUPPLIEF JL FRIENDS HOME	HEALTHCARE INC		203 S W	DDRESS, CITY, STATE, ZIP COD 'ASHINGTON STREET I, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	hip wounds, and ce comprehensive non assessment complet patient was on a puliquids. The assess swallowing problem diet, how the diet wany safety concerns 8. The clinical recon 10/30/19 and ind 11/5/18. The reconthe certification per indicated orders for placement of gastro milliliters (ml) air begrube feedings, addifferent formula mixed with infinity pump at 30 medications dissolve per g-tube followed 4.5 Shiley tracheote cleanse trach stomath shift as needed, such shift as needed for centimeter (cm) min months, cleanse are water daily and as reatheterize with a 1 as needed for bladd times per day with The pediatric comp 8/30/19 failed to evoften and by whome enteral feeding amonth of the patients of the comp and the pediatric comp 8/30/19 failed to evoften and by whome enteral feeding amonth of the patients of the comp and the pediatric comp 8/30/19 failed to evoften and by whome enteral feeding amonth of the patients of the p	reskilled recertification ted on 8/12/19 indicated the reed diet with honey thick ment failed to identify as, the need for the therapeutic ras tolerated, and if there was with aspiration risk. Ord of patient #7 was reviewed dicated a start of care date of dicated a start of care date of dicated a start of care for riod of 9/1/19-10/30/19 that the skilled nurse to check astomy (G-Tube) with 30 rolus via auscultation before minister 150 ml real food a 60 ml fluid and administer via ml/hour over 30 minutes, crush re in 30 ml water and administer 1 by 60 ml water flush, change romy (trach) once per week, with soap and water every tion excess secretions ever excess drainage, change 2.5 ckey button (g-tube) every 3 round g-tube with soap and needed soilage, straight 4 french catheter every 4 hours er retention, irrigate bladder 2 100 ml normal saline. The skilled russ is reviewed.					
	trach was to be char	be administered, how often nged and when the last time it site care information, suction					

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Event ID:

NPPM11 Facility ID: 003961

If continuation sheet Page 10 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15K015	B. Wl	NG		11/07	/2019
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
FAITHFU	JL FRIENDS HOME	HEALTHCARE INC	203 S WASHINGTON STREET MARION, IN 46952				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION what size suction catheter,	+	TAG	DEFICIENCY)		DATE
	and any information cauterizations.	-					
	director of nursing	iew on 10/31/19 at 4:41 PM, the stated the comprehensive contain all the updated health					
	17-14-1(a)(1)(B)						
G 0530							
Bldg. 00							
Ŭ			G 0	530	1. For each client cited in		11/20/2019
		view and interview, the agency			deficiency, the Clinical Directo		
		nprehensive assessment			reviewed with the RN CM's th		
		al patient goals, strengths, and entified by the patient for 3 of 7			missing assessment component noted by the surveyor. The R		
	complete records re				CM's were then in-serviced or		
	F	· ()-)-/-			to complete a comprehensive		
	Findings include:				assessment and the thorough	1	
	1 An undated a	nov policy titled			documentation guidelines set	forth	
	An undated ager "Comprehensive cli "The state of the	ient assessment," Policy C-145			in the regulation. The QA	lon	
	stated "Special in				manager was also in-serviced the documentation to look for		
	-	essment must accurately			regards to the deficient areas		
	_	tatus, and must include at a			noted by the surveyor. The R		
		wing information: The client's			CM's were then sent out	•	
		d care preferences"			immediately to client homes to		
	2 TL 1: 1	1 . C			perform an updated assessme		
		ord of patient #1 was reviewed			specifically of those areas fou		
		licated a start of care date of			be missing/lacking documents		
		contained a plan of care for the of 10/5/19-12/3/19 that			so that the client chart including care-plans could be updated to	_	
	-	of, (not limited to), pressure			reflect the clients current	i.o	
		lar dysfunction of the bladder,			strengths, care preferences, a	and	
		es. The comprehensive			goals.		
		sment dated 10/1/19 stated the			2. The agency QA will rev	iew	
	patient did not want	t personal goals and then			100% of all current comprehe		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	NG		11/07/	2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			VASHINGTON STREET		
FAITHFL	JL FRIENDS HOME	HEALTHCARE INC			N, IN 46952		
	T		1		,		are:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	-	TAG			DATE
	stated in the same s				assessments for complete		
		nfection." The record failed to			documentation of all assessme	ent	
	_	s the patient set up for			areas in the OASIS. For any	-	
	themselves.				deficiencies found, the RN CM		
	2 Th. 15 1	.1.6			responsible for the assessmer		
		ord of patient #3 was reviewed			will be required to go back out	to	
		licated a start of care date of			client home and complete an		
		contained a plan of care for the			updated assessment specifica	illy	
		of 8/29/19-10/27/19 that			the areas found by QA to be		
	_	of (not limited to) feeding			deficient and then update clier		
		hypoxia, and developmental ehensive pediatric nursing			chart accordingly. Then at tin		
					of next recertification, any furth	ner	
		ed on 8/26/19 failed to			deficiencies will result in		
	_	regiver driven goals,			disciplinary actions.		
	strengths, and care	preferences.			3. To ensure the deficient		
	4 Tri 11 1	1.6.4:			practice does not re-occur, the		
		ord of patient #6 was reviewed			agency QA manager has beer		
		licated a start of care date of			in-serviced on completion of th		
		d contained a plan of care for			OASIS and key documentation		
		iod of 8/17/19-10/15/19 that			components that should reflec		
	_	, but not limited to, severe y, incontinence, right hip			client's current strengths, care		
		al palsy. The comprehensive			preferences, and goals. The (
		cation assessment completed			manager will then review 100%		
		•			all comprehensive assessmen		
		evidence patient/caregiver ths, and care preferences.			ensure that all areas included		
	driven goals, streng	tils, and care preferences.			the assessment documentatio		
	5 During an interv	iew on 10/31/19 at 4:41 PM, the			are specific, thorough, accurated and complete. Any deficiencies		
	_	stated the comprehensive			· · · · · · · · · · · · · · · · · · ·		
		contain patient/caregiver			noted will be addressed by the Clinical Manager with the RN (
		ths, and care preferences.			and disciplinary action will resi		
	dirven goals, streng	tils, and care preferences.			4. The Administrator and	uit.	
	6 During an interv	iew on 11/7/19 at 10:20 AM,			Clinical Director will be		
		ated staff needed to ask			responsible for monitoring and	ı	
		they want for themselves, but			reviewing this corrective action		
	are not sure they cu	-			ensure this deficient practice v		
	and not bare they ea				not re-occur.	* 111	
					i not to occur.		
G 0534							

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	
		15K015	B. WING		11/07	
		10.10.10	_			
NAME OF F	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
	II EDIENDO HOME	LIEAL THOADE INC		WASHINGTON STREET		
FAITHFU	JL FRIENDS HOME	HEALTHCARE INC	MARIO	DN, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
Bldg. 00						
	Based on record rev	view and interview, the agency	G 0534	1. For each client cited in t	he	11/20/2019
	failed to ensure the	comprehensive assessment		deficiency, the Clinical Director	r	
	addressed the disch	arge planning needs for 3 of 7		reviewed with the RN CM's the	Э	
	complete records re	eviewed (#3, 4, 7).		missing assessment compone	nts	
				noted by the surveyor. The RI	N	
	Findings include:			CM's were then in-serviced on	how	
				to complete a comprehensive		
	An undated ager	ncy policy titled		assessment and the thorough		
	"Comprehensive cli	ient assessment," Policy C-145		documentation guidelines set f	forth	
	stated "Special in	structions The		in the regulation. The QA		
	comprehensive asse	essment must accurately		manager was also in-serviced	on	
	reflect the client's st	tatus, and must include at a		the documentation to look for v	with	
	minimum, the follow	wing information: The client's		regards to the deficient areas		
	medical nursing, rel	habilitative, social and		noted by the surveyor. The RI	N	
	discharge planning	needs"		CM's were then sent out		
				immediately to client homes to)	
	2. The clinical reco	ord of patient #3 was reviewed		perform an updated assessme	ent	
	on 10/31/19 and inc	licated a start of care date of		specifically of those areas four	nd to	
	9/3/18. The record	contained a plan of care for the		be missing/lacking documenta	tion	
	certification period	of 8/29/19-10/27/19 that		so that the client chart includin	ıg	
	indicated diagnoses	of (not limited to) feeding		care-plans could be updated to	0	
	difficulties, asthma,	, hypoxia, and developmental		reflect the clients discharge		
	delays. The compre	ehensive pediatric nursing		planning needs.		
	assessment complet	ted on 8/26/19 failed to		2. The agency QA will review	ew	
	evidence a complete	ed discharge plan on page 12		100% of all current compreher	nsive	
	of 14.			assessments for complete		
				documentation of all assessme	ent	
		ord of patient #4 was reviewed		areas in the OASIS. For any		
		licated a start of care date of		deficiencies found, the RN CM	l	
		d contained a plan of care for		responsible for the assessmen	nt	
		riod of 6/18/19-8/16/19 that		will be required to go back out	to	
	_	of (but not limited to) global		client home and complete an		
		y, Autism, urinary and bowel		updated assessment specifica	lly	
		comprehensive pediatric		the areas found by QA to be		
	_	completed on 6/13/19 failed to		deficient and then update clien	nt	
	evidence a complete	ed discharge plan.		chart accordingly. Then at tim	ne	
				of next recertification, any furth	ner	

4. The clinical record of patient #7 was reviewed

on 10/30/19 and indicated a start of care date of

deficiencies will result in

disciplinary actions.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	NG		11/07/	/2019
)	DOLUBED OF STITUTE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				WASHINGTON STREET		
FAITHFU	L FRIENDS HOME	HEALTHCARE INC	MARION, IN 46952				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d contained a plan of care for			3. To ensure the deficient		
	_	iod of 9/1/19-10/30/19. The			practice does not re-occur, the		
		nsive assessment dated idence completed information			agency QA manager has bee		
		"discharge plan," on page 12			in-serviced on completion of t OASIS and key documentation		
	(was not addressed)				components that should reflect		
	(was not addressed)	•			client's discharge planning ne		
	5. During an interview on 10/31/19 at 4:41 PM, the				The QA manager will then rev		
	~	stated the comprehensive			100% of all comprehensive	1011	
	assessment should contain discharge and rehab				assessments to ensure that a	II	
	information.				areas included in the assessn	nent	
					documentation are specific,		
	17-14-1(a)(1)(B)				thorough, accurate, and		
					complete. Any deficiencies ne	oted	
					will be addressed by the Clinic	cal	
					Manager with the RN CM and		
					disciplinary action will result.		
					4. The Administrator and		
					Clinical Director will be		
					responsible for monitoring and		
					reviewing this corrective actio		
					ensure this deficient practice	will	
					not re-occur.		
G 0536							
Bldg. 00							
		view and interview, the agency	G 0	536	1. For the client cited in th	е	11/20/2019
		comprehensive assessment			deficiency, the Clinical Director	or	
	contained a complet	te review of medications the			reviewed with the RN CM the		
	-	o ensure medication lists were			missing assessment compone		
	=	ed for 1 of 7 complete records			noted by the surveyor. The RI	N CM	
	reviewed (#2).				had a written order for the		
					medication but did not add the		
	Findings include:				medication to the med-profile.		
	1 4 1 4 1				Since this was an interim orde		
	1. An undated agen				and a medication reconciliation		
	_	ent assessment," Policy C-145			had been completed, the RN	CIVI	
	stated "Special ins				was instructed to update the	ha	
	comprenensive asse	essment must accurately			medication profile by adding t	ne	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		15K015	B. W	ING		11/07/2019
				CERTE	ADDRESS OF A STATE OF COR	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
FAITHELL	II EDIENDO HOME	LIEAL TUGABE ING			VASHINGTON STREET	
FAITHFU	IL FRIENDS HOME	HEALTHCARE INC		MARIO	N, IN 46952	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	reflect the client's st	atus, and must include at a			medication and the date in wh	ich
	minimum, the follow	wing information: A review of			the medication was started. T	
	all medications the	client is currently using"			RN CM will then, at time of ne	
		, ,			Recert, will update the POC to	
	2. The clinical record of patient #2 was reviewed				reflect this medication. All RN	
	on 10/29/19 & 10/30/19 and indicated a start of				CM's were then in-serviced on	
		. The record contained a plan			to complete and thoroughly	
	of care for the certif				document all medications, both	h
	9/21/19-11/19/19. A physicians order dated				Rx and OTC, currently used by	
	10/17/19 stated, "Since admission on 5/24/19,				the client with respect to the	'
	tramadol 50 mg [milligrams] 1 tab [tablet] PO [by				guidelines set forth in the	
	mouth] Q6hr/PRN [every 6 hours as needed] pain				regulation and the clients	
	should have been on the client's medication list				medication rights. The QA	
	" The RN failed to ensure tramadol was added				manager was also in-serviced	on
	to the medication lis				the documentation to look for	
	to the incurcation in				regards to the med-profile, inte	
	3 During an interv	iew on 11/7/19 at 9:27 AM, the			orders, and the POC.	211111
	-	stated the trauma should have			2. The agency QA will revi	ον.
		nedication profile and it was			100% of all current compreher	
	missed.	redication profite and it was			assessments and interim orde	
	missed.				for complete documentation of	
	17-14-1(a)(1)(B)				current medications the client	
	17 11 1(u)(1)(D)				taking. For any deficiencies	
					found, the RN CM responsible	for
					the assessment will be require	
					update the medication profile a	
					then the POC at time of Recer	
					Then at time of next recertifica	
					any further deficiencies will res	
					in disciplinary actions.	Suit
					3. To ensure the deficient	
					practice does not re-occur, the	`
					agency QA manager has beer	
					in-serviced on completion of the	
					OASIS and key documentation	
					components that should reflec	
					current list of medications the	ıa
						OA
					client is currently taking. The	
					manager will then review 100%	
					all comprehensive assessmen	เรเง

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NPPM11 Facility ID: 003961

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12/16/2019 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K015 B. WING 11/07/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 S WASHINGTON STREET FAITHFUL FRIENDS HOME HEALTHCARE INC MARION. IN 46952 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE ensure that all areas included in the assessment documentation are specific, thorough, accurate, and complete. Any deficiencies noted will be addressed by the Clinical Manager with the RN CM and disciplinary action will result. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur. G 0538 Bldg. 00 Based on record review and interview, the agency G 0538 For each client cited in the 11/20/2019 failed to ensure the comprehensive assessment deficiency, the Clinical Director contained detailed information regarding the reviewed with the RN CM's the patient's primary caregiver for 5 of 7 complete missing assessment components records reviewed (#1, 3, 4, 6, 7). noted by the surveyor. The RN CM's were then in-serviced on how Findings include: to complete a comprehensive assessment and the thorough 1. An undated agency policy titled, documentation guidelines set forth "Comprehensive client assessment," Policy C-145 in the regulation. The QA stated "...Special instructions ... The manager was also in-serviced on comprehensive assessment must accurately the documentation to look for with reflect the client's status, and must include at a regards to the deficient areas minimum, the following information: ... The client's noted by the surveyor. The RN primary caregiver(s), if any, and other available CM's were then sent out supports, including their willingness and ability to immediately to client homes to provide care, and their availability and schedules perform an updated assessment" specifically of those areas found to be missing/lacking documentation

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2. The clinical record of patient #1 was reviewed

6/7/19. The record contained a plan of care for the

on 10/29/19 and indicated a start of care date of

certification period of 10/5/19-12/3/19. The

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so that the client chart including

care-plans could be updated to

clients primary caregiver,

reflect detailed information on the

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	ING		11/07/	2019
		<u> </u>		QTDEET (ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET		
FAITHFI	II FRIENDS HOME	E HEALTHCARE INC			N, IN 46952		
	L I KILINDO HOME	- HEALTHOANE INC		IVIARIO	IN, IIN 70332		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ertification assessment dated			specifically when and what ca		
		the patient's caregiver was the			they are willing to provide and	d/or	
		Caregiver(s) assist with			assist with.		
		of daily living], IADLs			2. The agency QA will rev		
	_	ities of daily living] and/or			100% of all current comprehe	ensive	
		e has own medical conditions			assessments for complete		
		g to assist 'yes' Does			documentation of all assessm	nent	
	_	assisting the patient 'no' d/t			areas in the OASIS. For any	_	
		s she does not feel safe doing			deficiencies found, the RN CI		
	some care of client. The comprehensive				responsible for the assessme		
	assessment failed to evidence clear information				will be required to go back ou	t to	
	about the spouse's willingness and ability to care				client home and complete an		
	for the patient.				updated assessment specific	ally	
					the areas found by QA to be		
		ord of patient #3 was reviewed			deficient and then update clie		
		dicated a start of care date of			chart accordingly. Then at ti		
		contained a plan of care for the			of next recertification, any fur	ther	
		of 8/29/19-10/27/19, which			deficiencies will result in		
	_	s (not limited to) feeding			disciplinary actions.		
		patient had a gastrostomy			3. To ensure the deficient		
		prehensive pediatric nursing			practice does not re-occur, th		
		ted on 8/26/19 failed to			agency QA manager has bee		
		aregiver willingness and			in-serviced on completion of t		
	availability to prov	ide care and their schedule.			OASIS and key documentation		
					components that should refle		
		ord of patient #4 was reviewed			when and what care the prime	-	
		dicated a start of care date of			caregiver can provide. The C		
		d contained a plan of care for			manager will then review 100		
		riod of 6/18/19-8/16/19 that			all comprehensive assessme		
	_	s of (but not limited to) global			ensure that all areas included		
		ny, Autism, urinary and bowel			the assessment documentation		
		comprehensive pediatric			are specific, thorough, accura		
		completed on 6/13/19 failed to			and complete. Any deficienci		
		on regarding the primary			noted will be addressed by th		
		g willingness and ability to			Clinical Manager with the RN		
	provide care, availa	ability, and schedules.			and disciplinary action will res	sult.	
					4. The Administrator and		
		ord of patient #6 was reviewed			Clinical Director will be		
		dicated a start of care date of			responsible for monitoring an		
	2/18/19. The recor	d contained a plan of care for			reviewing this corrective action	n to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K015		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2019		
	PROVIDER OR SUPPLIER	HEALTHCARE INC	203 S	ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET DN, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive non assessment complete evidence informatic caregiver, including provide care, availa 6. The clinical record on 10/30/19 and including 11/5/18. The record the certification per pediatric compreher 8/30/19 failed to evithe primary caregivability to provide care. 7. During an intervidirector of nursing sassessment should complete the complete than the complete care.	iod of 8/17/19-10/15/19. The skilled recertification ed on 8/12/19 failed to on regarding the primary willingness and ability to bility, and schedules. Ind of patient #7 was reviewed licated a start of care date of d contained a plan of care for iod of 9/1/19-10/30/19. The nsive assessment dated idence information regarding er, including willingness and are, availability, and schedules. It wo no 10/31/19 at 4:41 PM, the stated the comprehensive contain primary caregiver less to provide care, and		ensure this deficient practice venot re-occur.	vill
G 0574					
Bldg. 00	interview, the agend care (POC) included the needs of the cordurable medical equeducation including nurse interventions reviewed (#1, 2, 3, 4). Findings include: 1. An undated agendary, Policy C-580 m. The plan of care	on, record review and by failed to ensure the plan of all measurable goals based on apprehensive assessment, all aipment (DME), diagnoses, frequency of, and skilled for 7 of 7 complete records 4, 5, 6, 7). The policy titled, "Plan of stated " Special instructions shall be completed in full to ment diagnosis(es), principle	G 0574	1. For each client cited in the deficiency, the Clinical Director reviewed with the RN CM's ear POC found to be deficient, not by the surveyor. The RN CM's were then in-serviced on how complete a comprehensive assessment and writing a plan care based off the assessment information. The Clinical Direct educated on the key component set forth in the regulation, that correspond and correlate with information obtained in the assessment. The QA managements.	r ch ed s to of t ctor nts,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K015 B. WING 11/07/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 S WASHINGTON STREET FAITHFUL FRIENDS HOME HEALTHCARE INC **MARION. IN 46952** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and secondary ... type, frequency, and duration of was also in-serviced on making all visits / services ...medical supplies and sure all comprehensive equipment required ... treatment goals ...other assessment areas are complete appropriate items" and how those assessment responses are then to be relaved 2. The clinical record of patient #1 was reviewed in the plan of care. The information on 10/29/19 and indicated a start of care date of should be concise and specific to 6/7/19. The record contained a plan of care for the the patient. The RN CM's wrote certification period of 10/5/19-12/3/19 that clarification Physician Telephone indicated diagnoses of pressure ulcers and Orders to clarify and correct any diabetes, medications, but not limited to, miralax missing components that could be and docusate (medications for constipation). updated with regards to goals, During a home visit observation on 10/31/19 at DME, Diagnosis, and frequency of 9:15 AM a trapeze bar over the bed and a education and SN visits. The RN motorized wheelchair were observed in the home. CM's and the QA manager were The plan of care failed to evidence a diagnosis of given a guide to assist with taking constipation, medications of lasix and potassium the information from the (which are on the medication list as starting assessment and developing a 8/5/19), measurable goals regarding diabetes, POC inclusive of all diagnosis, wound healing, further pressure ulcer prevention, measurable goals, DME, and the DME motorized wheelchair and trapeze bar, frequency of education and and a frequency for all education interventions to interventions. be completed. The agency QA manager reviewed 100% of current POC's 3. The clinical record of patient #2 was reviewed and the corresponding on 10/29/19 & 10/30/19 and indicated a start of assessments for deficiencies. care date of 5/24/19. The record contained a plan Any identified missing of care for the certification period of components of the POC were 9/21/19-11/19/19 which indicated the patient reviewed with the RN CM. If managed her own meds. The recertification applicable, the RN CM, through comprehensive assessment dated 9/19/19 stated Physician Telephone Orders the patient had pain, a heel wound, and clarified and corrected any constipation. The plan of care failed to evidence missing components on the POC. measurable goals for the wound, pain and Upon next recert, the POC will constipation, or specific education to be taught to then be updated to reflect those the patient with frequency to be completed. interim orders. The agency QA manager

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During an interview on 11/7/19 at 9:34 AM, the

director of nursing stated there was no goal

addressing the patient's wound.

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will review 100% of comprehensive

assessments and POC's to

ensure that the POC is a direct

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 B. WING			COMPLETED 11/07/2019	
		15K015	B. WI			11/07/2	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD			
FAITHFI	II FRIENDS HOME	HEALTHCARE INC			VASHINGTON STREET N, IN 46952			
	Г		1		I TOOOL			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1710	REGUENTORT OF	CESC IDENTIFICATION IN ORDER THOSE		ING	reflection of the assessment a		DATE	
	4. The clinical reco	ord of patient #3 was reviewed			any missing components of su			
		dicated a start of care date of			or conflicting information found			
	9/3/18. The record	contained a plan of care for the			be immediately addressed by			
		of 8/29/19-10/27/19, which			Clinical Director with the RN C	M		
	included diagnoses (not limited to) feeding				for possible disciplinary action			
		patient had a gastrostomy			4. The Administrator and			
	, ,	icated the skilled nurse (SN)			Clinical Director will be	.		
		tube care, G-tube feedings,			responsible for monitoring and			
		stration, and personal care. led to evidence the type and			reviewing this corrective action ensure this deficient practice v			
		now often the g-tube was to be			not re-occur	WIII		
	_	f feeding and if it is a bolus or			not re occur			
via pump. It also failed to evidence what type of								
		site care was to be completed						
	around the g-tube st	toma.						
		ord of patient #4 was reviewed						
		dicated a start of care date of						
		d contained a plan of care for						
		riod of 6/18/19-8/16/19 that t took melatonin nightly to						
	_	The comprehensive pediatric						
		completed on 6/13/19						
	_	t was a fall risk and a						
	_	e plan of care failed to						
		is of insomnia (trouble						
		surable goals related to safety						
	due to self harm, sle	eep issues, falls, or nutritional						
	risk.							
	6 The eliminal serve	ard of nations #5 was reviewed						
		ord of patient #5 was reviewed licated a start of care date of						
		d contained a plan of care for						
		riod of 9/12/19-11/10/19 that						
	_	of insulin dependant diabetes						
	mellitus (IDDM). The comprehensive							
	recertification assessment completed on 9/7/19							
		ad shortness of breath and						
	_	are failed to evidence						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE : COMPL 11/07/	ETED
	PROVIDER OR SUPPLIEF	HEALTHCARE INC	203 S \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET DN, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	r E RIATE	(X5) COMPLETION DATE
	7. The clinical reconnounce on 10/31/19 and incomprehensive per indicated diagnoses developmental dela comprehensive non assessment complete patient was on a puliquids. The plan of swallowing problem diet, how the diet was any safety concerns and	or pain or shortness of breath. ord of patient #6 was reviewed dicated a start of care date of d contained a plan of care for iod of 8/17/19-10/15/19 that to, but not limited to, severe y, and cerebral palsy. The -skilled recertification ted on 8/12/19 indicated the reed diet with honey thick of care failed to identify the need for the therapeutic ras tolerated, and if there was sewith aspiration risk. ord of patient #7 was reviewed dicated a start of care date of d contained a plan of care for iod of 9/1/19-10/30/19 that is of hydrocephalus, Pica, ectomy and a medication, but ra 50 milligrams (mg) daily for in. Additionally the plan of the urse was to instruct on ry guidelines, and good in practices. Lastly the plan of the storm (G-Tube) with 30 to solus via auscultation before minister 150 ml real food in 60 ml fluid an administer via ml/hour over 30 minutes, crush we in 30 ml water and administer in 150 ml water flush, change formy (trach) once per week, with soap and water every excess drainage, change 2.5 ckey button (g-tube) every 3				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	IA (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 11/07/2019		
	ROVIDER OR SUPPLIER	HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP COD 203 S WASHINGTON STREET MARION, IN 46952				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	water daily and as n catheterize with a 14 as needed for bladdetimes per day with 14 of care failed to evid feedings, straight cathed bladder, and chronic education; or measuracheotomy, gastro 9. During an intervidirector of nursing scontain all pertinent education, goals that))					
G 0644							
Bldg. 00	failed to ensure all c improvement (QAP analyzed to identify improvement and m quality of care for 1 Findings include: An undated agency improvement policy Agency shall establi improvement plan to	policy titled "Performance y," Policy #260 stated "Policy:	G 0644	1. There were no clients of in this deficiency 2. There were no clients of in this deficiency 3. The agency reviewed its current QAPI policy to ensure components in the standard a addressed in the current QAP program. The agency found although their data collection process was accurate, the aggregation and analyzation components were not being utilized appropriately to identification.	ited s all re I that		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	ING		11/07/2019	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			VASHINGTON STREET		
FAITHEI	II FRIENDS HOME	HEALTHCARE INC			N, IN 46952		
1 7111111111111111111111111111111111111	L I NILINDO HOME	TILALITIOANE INC		WARIO	iv, iiv 1 0302		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Purpose: To identify			opportunities for improvement		
	_	ent improve client and			monitoring the effectiveness a	nd	
		to evaluate all areas of			quality of care. The QAPI		
	_	nent plans to resolve the			manager was then in-serviced		
		s of the program To identify,			how to gather and utilize quali		
		esolve problems in client care			indicator data, including meas	ures	
		state and federal regulatory			derived from OASIS, client	,	
		cial Instructions:Data will be			infection, hospitalization, ER v		
		ted to measure process and			and fall logs, and other relevan	nτ	
	outcome. Data will be assessed to: Identify current level of performance evaluate the				data, the aggregation and	atifu,	
	_	esses Identify effectiveness			analyzation of this data to ider	-	
		systems identify areas to be			areas needing improvement, a also monitoring the effectivene		
		y strategies to stabilize or			and quality of care.	555	
	_	. evaluate whether outcomes			4. The Administrator and		
		ne plan will target the			Clinical Director will be		
		sting processes and outcomes			responsible for monitoring and	1	
	-	n new processes based on			reviewing this corrective action		
	priorities, standards	-			ensure this deficient practice v		
	P				not re-occur.	• • • • • • • • • • • • • • • • • • • •	
	The OAPI binder co	ontained meeting notes			not to occur.		
		ary to August 2019. Each					
	-	ed the number of falls,					
	-	zations, emergency room					
	-	urveys and performance					
	improvement at son	ne of them. The data was					
	collected to show th	ne number of occurrences.					
	However, the agenc	ey QAPI program failed to					
	analyze the data col	llected, identify trends, and					
	_	er the occurrences and to					
	assist the agency in	providing improved patient					
	outcomes.						
	-	y on 11/7/19 at 2:55 PM, the					
		that the agency looked at all					
		e indicators trended up or					
	· ·	they did not analyze the data					
	to assess for trends.						
	17-12-2(a)		1				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	NG		11/07/	2019
	ROVIDER OR SUPPLIER	HEALTHCARE INC		203 S V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON STREET N, IN 46952		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
G 0682							
Bldg. 00	interview, the agency followed standard prontrol policies for a (employees F, G, H) (#1, 2). Findings include: 1. An undated agenty "Handwashing / Handwashing / handwas) for 2 of 2 patients observed	G 0	682	1. For each client cited in deficiency, the HHA and SN whoth called into office for one cone in-servicing on the agency policies regarding Standard Precautions, Infection Control, Handwashing at the Sink vs. Handwashing was observed by the surveyor during the visit, and the correct way was shown. The employees had to complete be written test and a return demonstration showing their understanding of the 30 sec. Handwashing standard sec. Handwashing sec.	rere on , and Hand or heir e then The	11/25/2019
	client after remove Technique When de alcohol based hand one hand and rub has surfaces of hands ar When washing ha hands first with wat product recommend and rub hands toget thirty (30) seconds, and fingers" 2. During a home very 9:15 AM with patient employee G, license observed to provide handwashing technifailed to wash (scrulagency policy and cotimes underneath ru	ring glovesHand Hygiene contaminating hands with an rub, apply product to palm of ands together, covering all and fingers, until hands are dry ands with soap and water, wet er, apply an amount of led by manufacturer to hands ther vigorously for at least covering all surfaces of hand lisit observation on 10/31/19 at ant #1 (start of care 6/7/19), and practical nurse(LPN), was skilled care. During que observation employee G b) hands for 30 seconds per ompleted the handwash at mining water (not vigorously ogether). Completed 10			scrub that is to be done with hands not under water, and if using hand sanitizer, it must be rubbed in completely until han are dry. Both employees verbalized understanding of the difference between what they wrong during the visit and the correct way, as well as, they wable to give excellent return demonstration for both method 2. For all other clients, an agency wide in-service was he which all staff was re-educated Standard Precautions, Infection Control, and Handwashing at Sink vs. Hand Sanitizer. All st were given a reading, shown to correct way vs. the incorrect way to perform the technique, a writest, and were required to	e ds le did vere ds. leld in d on on the caff he vay	

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 11/07/2019		
	PROVIDER OR SUPPLIER	HEALTHCARE INC	203 S	ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET DN, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	second, 11 second, 3. During a home v 9:52 AM with patie employee H, home observed to provide handwashing technifailed to wash (scruagency policy. Corand 15 second hand 4. During a home v 12:07 PM with patie employee F, registe to provide skilled catechnique observati (scrub) hands for 30 and completed the hwater (not vigorous together). Complet 5. During an interv Director of Nursing not scrub hands und Additionally the DO sanitizer staff shoul	and 5 second hand washes. Fisit observation on 10/31/19 at nt #1 (start of care 6/7/19), health aide (HHA) was a personal care. During lique observation employee H b) hands for 30 seconds per impleted 18 second, 13 second, a washes. Fisit observation on 10/31/19 at lent #2 (start of care 5/24/19), ared nurse (RN), was observed lare. During handwashing on employee F failed to wash of seconds per agency policy landwash underneath running ly rubbing the hands lied an 8 second hand wash. Fisit observation on 10/31/19 at 4:46 PM, the (DON) indicated staff should		demonstrate the correct Handwashing/Hand Sanitizing technique while being observ Clinical Director. Any deficier addressed and corrected immediately. 3. In order to ensure this practice does not happen aga the agency has revised the H and LPN supervisory visit forr include a "Hand-washing Observation" element requirir CM's to observe handwashing during 60-day supervisory visit The RN CM's were in-service what is acceptable technique what is not, to address any deficiency on the spot, and th notify the Clinical Director of v is deficient so that she may address this with verbal/writte disciplinary action. 4. The Administrator and Clinical Director will be responsible for monitoring an reviewing this corrective actio ensure this deficient practice not re-occur.	g ed by noies iin, HA in to g RN g its. d on en to who in
G 0710 Bldg. 00					
. 2.3g. 00	failed to ensure the	riew and interview, the agency registered nurse (RN) followed 3 of 7 complete records	G 0710	1. For clients #2 and #5, t RN CM's over the cases were immediately notified of the deficiency regarding the dura of the visit that was put on the POC and the duration of whic SNs are charting. The RN C	tion e h the

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	ETED
		15K015	B. W	ING		11/07/2	2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L.			VASHINGTON STREET		
FAITHFU	IL FRIENDS HOME	HEALTHCARE INC			N, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	\perp	TAG	DEFICIENCY)		DATE
	_	ncy job description titled			were instructed to contact all \$	SN's	
	-	b description," stated duties			providing care to see how long	9	
	-	and carry out physician,			each SN needed to complete	all	
	chiropractor, podiat	rist, dentist, optometrist			the interventions and education	n	
	orders (oral or writt	en)"			required for the visit. It was		
					concluded that each SN could		
	2. An undated ager	ncy job description titled			complete the visit, with all		
	"registered nurse case manager job description"				interventions and education		
	stated duties included " Accept and carry out				completed as ordered in 35		
	physician, chiropractor, podiatrist, dentist, and				minutes. Next, the Clinical		
	optometrist orders (oral or written)"				Director contacted Medicaid a	s	
					they require the POC to reflec	t	
	3. An undated ager	cy job description titled			hours not minutes for billing		
	"licensed practical i	nurse" stated "Major task,			purposes as hours are billed a	is	
	duties, and responsibilities implement plan of				units, with one hour equal to c		
	care initiated by clin	nical case manager"			unit, and they do not allow for		
	-				or quarter units. Per Medicaio		
	4. The clinical reco	ord of patient #2 was reviewed			they will accept "up to one hou		
	on 10/29/19 & 10/3	0/19 and indicated a start of			on the POC and that was their		
	care date of 5/24/19	. The record contained a plan			recommendation to the Direct	or.	
	of care for the certif	fication period of			The RN CM's were instructed		
	9/21/19-11/19/19 th	nat indicated a skilled nurse (SN)			the Director to write a clarifica	-	
	frequency of 2 to 4	visits a day, 5 to 7 days per			Physician Telephone Order to		
	week, 1 hour visits.				change the wording on the PC		
					from 1hour/visit to "up to 1		
	The SN performed	visits on: 10/20/19 (2 visits),			hour/visit". For client #5, the	RN	
	•	10/18/19 (3 visits), 10/17/19 (3			CM was notified of the missing		
	, , , , , , , , , , , , , , , , , , , ,	visits), 10/15/19 (3 visits),			documentation in the Pediatric		
	, · · · · · · · · · · · · · · · · · · ·	10/13/19 (2 visits), 10/12/19 (4			Comprehensive Assessment		
	, , , , , , , , , , , , , , , , , , , ,	visits), 10/10/19 (3 visits),			was immediately required to		
		0/8/19 (3 visits), 10/7/19 (3			demonstrate knowledge of ho	_{w to}	
	` '	isits), 10/5/19 (3 visits), 10/4/19			perform G-Tube site care. Th		
		3 visits), 10/2/19 (3 visits),			CM was able to successfully		
		/30/19 (3 visits), 9/29/19 (2			demonstrate performance of t	_{his}	
		isits), 9/27/19 (3 visits), 9/26/19			task via Teach Back. The RN		
	, ,	3 visits), 9/24/19 (2 visits),			was in-serviced by the Clinica		
	, ,,	/22/19 (2 visits), and 9/21/19 (3			Director on writing a plan of ca		
	visits) all which we				based off the assessment		
	. 15165, all Willell We	To read man i nom.			information and carrying out a	,,	
	5 The clinical reco	ord of patient #3 was reviewed			MD ordered interventions. Th		
	J. The chilical reco	ra or patient iis was reviewed	1		I MP OIGCICG INCENTINOUS. III	COIN	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15K015 B. WING 11/07/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 S WASHINGTON STREET FAITHFUL FRIENDS HOME HEALTHCARE INC MARION. IN 46952 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE on 10/31/19 and indicated a start of care date of was then in-serviced on 9/3/18. The record contained a plan of care for the implementing the POC, written by certification period of 8/29/19-10/27/19 that the RN CM and following those included diagnoses (not limited to) feeding interventions, one of which was difficulties, and the patient had a gastrostomy G-Tube site care. The SN was (g-tube). It also indicated the skilled nurse (SN) also required to demonstrate was to complete G-tube care. knowledge of G-tube site care via Teach Back, of which she was The agency comprehensive pediatric nursing successful. assessment completed on 8/26/19 failed to The agency performed an evidence the nurse completed G-tube site care. audit of all nursing visit flowsheets for time in and time out to see Agency nursing visit notes dated 9/2/19 to what actual time was spent 10/19/19 failed to evidence the nurse completed performing the ordered g-tube site care. interventions and education on each Skilled client. The agency 6. The clinical record of patient #5 was reviewed also compared ordered on 10/30/19 and indicated a start of care date of interventions on the POC vs. what 9/17/18. The record contained a plan of care for the SN documented. The agency the certification period of 9/12/19-11/10/19 that also reviewed all skilled OASIS indicated a SN frequency of 5 to 7 days a week, 1 including pediatric OASIS to to 3 visits a day, 1 hour visits. ensure that the RN CM's were assessing and performing the The SN performed visits from 9/12/19 to 10/21/19 ordered interventions and all which were less than one hour. education during their recertification visits. The following 7. During an interview on 10/31/19 at 4:42 PM, the was determined: the duration director of nursing stated the nurses should be varies but is never more than one following the plan of care. hour, SN's were completing ordered interventions and 17-14-1(a)(1)(H) education as outlined in the POC, and the skilled and pediatric comprehensive assessments reflected that the RNCM's were following their POC ordered interventions and education during the recert visits. Based off this information, the agency determined that the wording on the

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POC for visit duration should be

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/07/2019
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
FAITHFU	L FRIENDS HOME	HEALTHCARE INC		WASHINGTON STREET ON, IN 46952	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	*	LSC IDENTIFYING INFORMATION	TAG	changed to reflect the actual spent. Per Medicaid guidance agency had decided that the wording for the duration of the visits on all POC's for skilled clients would be changed to 1 hour. This allows the SN use an hour to complete the order interventions and education to does not require the SN to be there if the visit is completed before the hour is up. All SN RNCM's, QA, and SN schedules were in-serviced regarding the change. The RN CM's were instructed to write clarification Physician Telephone Orders change the wording on the duration of the skilled POC's 1 hr/visit to "up to 1 hr/v". All descriptions for LPN, RN, and CM were reviewed with all agents.	time e, the e fup to up to red out e displaying is from job d RN lency
				nursing staff, emphasizing the that all interventions and edulisted on the POC must be performed and documented a such. If they are unable to complete a task that is ordered.	cation
				the SN is to notify the RN CN the case and the RN CM is to notify the MD if necessary make changes accordingly. 3. The agency RN CM stawill QA 100% of all SN flow sto ensure that all ordered interventions and education aperformed and documented. intervention or education is new performed and documented to Clinical Director will meet with	I over nen and aff heets are If an ot he

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K015	B. WI	NG		11/07/	2019
	PROVIDER OR SUPPLIER	HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP COD 203 S WASHINGTON STREET MARION, IN 46952				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECT		BROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
					SN and RN CM to see why an necessary disciplinary action r result. The SN staff has been made aware that failure to folke the POC and/or failure to document correctly will result i disciplinary action. 4. The Administrator and Clinical Director will be responsible for monitoring the corrective actions to ensure th deficient practice does not hap again.	may ow n a e	
G 0774							
Bldg. 00							
	health agency failed (HHA) employee files reviewed (D). Findings include: An undated agency education/staff devestated " The Home twelve (12) hours prin-services, or in the care" During the review of the list of current end D, home health aided unknown first patien file failed to evidence.	policy titled "In-service plopment," Policy # D-320 to heath aide must complete the ryear either in lecture, video to client home while providing to femployee files on 10/31/19, inployees included employee to the contact date. The employee to 12 hours of in-service mly had 11 inservices equaling	G 0°	774	1. No client was cited in the deficiency. 2. No client was cited in the deficiency. 3. For this deficiency, the agency now requires all staff to sign in on a sign-in sheet, and then as in-services are returned the HR department, the HR stamember will initial next to the local staff member name acknowled receipt of the in-service. The agency holds in-services the 3 week of every month, thereform and all in-service testing must graded and filed by Wednesdathe following week. The Office Manager and Clinical Director then audit 10% of all personner files to ensure in-services are complete, graded, and filed. A HHA staff that does not attend in-servicing during the assigner.	ed to eff HHA dging ord e be ay of e will el	12/02/2019

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	(X2) MULTIPLE CC A. BUILDING B. WING	LE CONSTRUCTION (X3) DATE SURVEY G 00 COMPLETED 11/07/2019	
	ROVIDER OR SUPPLIER	HEALTHCARE INC	203 S V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON STREET N, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	_	on 10/31/19 at 4:48 PM, the stated each inservice equals ion.		times, will be notified that they must report to the Clinical Dire within 48 hours to complete the in-services so that they may be graded and filed timely for auditing. A running list will be kept by the Office Manager and HR Department of all active employees and what in-service have been done, when they we done, when they were graded, and who completed each step the process. This is to ensure HR/Office Manager accountable for this task. Any employee we fails to attend and complete in-service training within the scheduled week and then fails meet with the Clinical Director be disciplined immediately. 4. The Administrator and the Clinical Director will be responsible for monitoring and reviewing this corrective action ensure this deficient practice was not re-occur.	ector e e d d es ere /filed of sillity ho to will he
G 0798					
Bldg. 00	ensure the Registere home health aide (Hindividualized with were to be complete reviewed with HHA Findings include:	riew, the agency failed to ad Nurse (RN) ensured the IHA) care plan was specific timeframe's the tasks ad for 4 of 5 complete records a services (#1, 2, 5, 6).	G 0798	1. For each client cited in deficiency, the RN CM over th cases and the Clinical Director reviewed each individual care for frequency of tasks to be completed and the wording "arneeded". The HHA care plan document used by the agency 2 columns addressing the frequency that can be checked	e r plan s

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	ING		11/07/	2019
				QTDEET (ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET		
FAITHFI	IL ERIENDS HOME	E HEALTHCARE INC			N, IN 46952		
		- HEALTHOAKE INO		IVIZATATO	14, 114 1 0002	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ted "Policy: A complete and			each task, one being every vi		
		an, identifying duties to be			and the other being weekly.		
	1 -	oe health aide, shall be			is also an empty column whe		
		istered nurse Purpose To			frequency can be typed in i.e.		
	1 ^	ation that the client's care is			M-W-F. Per the regulation, th		
	individualized to h	is / her specific needs"			home health aide cannot deci		
	2. The clinical record of patient #1 was reviewed				as to what and when care car		
					performed, however the clien		
		dicated a start of care date of			the right to choose. The ager	-	
	6/7/19. The record contained a plan of care for the certification period of 10/5/19-12/3/19. The aide				has determined that the word	-	
	*				"as needed" should be remov	ea	
	care plan failed to identify specific timeframe's (every visit or once a week for example) that all				from the HHA care plan and	4."	
	* /				replaced with "per client requi		
	tasks were to be completed.				or should list specific days for	any	
	2 The clinical rese	and of nations #2 was navioused			intervention/task that is not		
		ord of patient #2 was reviewed 30/19 and indicated a start of			performed every visit or week		
		9. The record contained a plan			This wording does not allow the HHA to determine when o		
	of care for the certi	_					
		The aide care plan failed to			care should be completed. A CM's and HHA's were then	II IXIN	
		meframe's (every visit or once a			in-serviced on this change with	th	
		that all tasks were to be			regards to the wording and ta		
	completed.	that all tasks were to be			frequency.	iSN.	
	Joinploted.				2. The RN CM's and Clini	cal	
	4. The clinical reco	ord of patient #5 was reviewed			Director reviewed 100% of all		
		dicated a start of care date of			care plans with regards to the		
		d contained a plan of care for			wording "as needed" and task		
		riod of 9/12/19-11/10/19. The			frequency. Any HHA care-pla		
		d "stand by assist for shower if			that was found to have		
		e unable to make any decision			tasks/interventions that do no	t get l	
	· ·	be given, must be lead by the			done every visit/weekly, will b	-	
		aide care and the homemaker			done per client request and		
		dentify specific timeframe's			labeled that way on the care	olans	
	(every visit or once	e a week for example) that all			a. For example: Client is		
	tasks were to be co				have HHA assist with shower		
					M-W-F-Sun and sponge bath	-	
	5. The clinical reco	ord of patient #6 was reviewed			Th, and Sa, and dressing eve		
	on 10/31/19 and in	dicated a start of care date of			visit. The client prefers to wa	-	
	2/18/19. The recor	d contained a plan of care for			her hair one to times per wee	k on	
	the certification per	riod of 8/17/19-10/15/19. The			random days. The HHA care		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/07/2019
	ROVIDER OR SUPPLIER	HEALTHCARE INC	203 S \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET DN, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.1.12
	, ,	I to identify specific visit or once a week for sks were to be completed.		would then reflect showering of done M-W-F-Sun, and sponge baths on T, Th, and Sa, dress every visit and hair shampoor task that can be done per the client request. 3. The agency QA manag will audit 100% of all client Hecare plans to ensure the word "as needed" has been remove and replaced with "per client request". The QA will also au ensure that all tasks specify a frequency of specific days, evisit, weekly, or per client request. Any future deficienci will be addressed by the Clinic Director with the RN CM for a immediate resolve. 4. The Administrator and Clinical Director will be responsible for monitoring the corrective actions to ensure the deficient practice does not re-occur	e ing as a er HA ing ed dit to ery fes cal n
G 0800					
Bldg. 00	failed to ensure the completed visits in a care (POC) orders f complete records re (#2, 6). Findings include: 1. An undated agent	niew and interview, the agency home health aide (HHA) accordance with the plan of or frequency for 2 of 5 viewed with HHA services accypolicy titled "Home health ed "Policy: A complete and	G 0800	1. For each client cited in deficiency, the HHA's perform visits in those homes were ca in to review with the RN CMs Clinical Director to explain wh task was performed that was on the care-plan. The HHA's in-serviced on how to read a care-plan with respect to the duties listed and when they are be performed. The HHA's we	ing illed and y a not were

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. WI	NG		11/07/	2019
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			WASHINGTON STREET		
FAITHFU	JL FRIENDS HOME	E HEALTHCARE INC		l	N, IN 46952		
	1				I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		d a	DATE
		an, identifying duties to be some health aide, shall be			also re-instructed on what to	do	
	1 -	istered nurse All home			should a client ask them to	d on	
		ill follow the identified plan"			perform a task that is not liste the care-plan. The were also		
	licatili aide stair wi	in follow the identified plan			re-educated on the fact that a		
	2 The clinical rec	ord of patient #2 was reviewed			tasks/interventions to be	III	
	on 10/29/19 & 10/30/19 and indicated a start of				performed have been written	hy an	
		9. The record contained a plan			RN and ordered by an MD, a	•	
		-			any care performed outside of		
	of care for the certification period of 9/21/19-11/19/19.				care-plan without seeking RN		
					direction prior to doing the		
	A HHA documenta	ation note completed for			intervention/task was a violate	tion of	
		25/19 indicated the HHA			the HHA Job Description and		
	shaved the patient which was not an ordered task				would result in disciplinary ac		
	on the aide care plan or plan of care.				2. The agency reviewed a		
	·	•			HHA flow sheets against the		
	A HHA documenta	ation note completed for noon			care-plan specific to that visit		
	care on 9/23/19, 9/	25/19, and 9/27/19 indicated the			Any discrepancies were brou		
	HHA completed ra	nge of motion on the patient			the attention of the RN CM ar	nd	
	which was not an o	ordered task on the aide care			Clinical Director to address		
	plan or plan of care	e.			immediately with both the clie	ent	
					and the HHA staff. The ager	псу	
		ation note completed for noon			then in-serviced all HHA field	staff	
		d 10/6/19 indicated the HHA			on how to read a care-plan w	ith	
	^	r/Tub/Bed/Comp/Part			respect to the duties listed an		
		with the patient but did not			when they are to be performe		
		of personal care was completed			HHA's were also re-educated		
	1	partial bed bath on aide care			what to do when a client asks		
	plan).				a task/intervention to be perfo		
					that is not on the care-plan.		
		ntion note completed for			HHA staff was re-educated or		
	_	23/19, 9/24/19, 9/25/19, and			fact that all tasks/intervention		
		he HHA dressed the patient ordered task on the aide care			written by an RN and ordered	-	
					an MD, and any care perform		
	plan or plan of care	.			outside of the care-plan without seeking RN direction prior to		
	3 The clinical roa	ord of patient #6 was reviewed			the care was a violation of the	•	
		dicated a start of care date of					
		rd contained a plan of care for			HHA Job Description and wor result in disciplinary action.	uiu	
		riod of 8/17/19-10/15/19			3. To ensure the deficient		
	I are continuation pe	1104 01 0/1 //17 10/13/17	ı		Jo. To chaute the delicient		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K015	A. BUILDING B. WING	00	COMPLETED 11/07/2019
	PROVIDER OR SUPPLIEF	: : HEALTHCARE INC	203 S \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON STREET DN, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	morning care on 10 a partial shower wh the aide care plan o 4. During an interv	iew on 10/31/19 at 4:42 PM, the stated the home health aide		practice does not happen agathe agency has put in place at HHA QA employee who will be responsible reviewing 100% of HHA flow-sheets with the care-plan to ensure that all tast assigned were completed, and catch any tasks that were documented as complete but listed on the care plan. Shoul discrepancy be found, the QA employee will notify the RN CI and the Clinical Director. This be addressed immediately wit the individual field staff and clit to see if any adjustments to the HHA care plan need to be dorn The RN CM will then contact the MD to see if an order may be obtained. 4. The Administrator and Clinical Director will be responsible for ensuring the deficient practice does not re-occur.	n e e e e e e e e e e e e e e e e e e e
G 0978					
Bldg. 00	failed to ensure a w with other agencies 1 of 1 shared agenc Findings include: The clinical record 10/30/19 and indica 11/5/18. The record	view and interview, the agency ritten agreement was in place providing care in the home for y patients reviewed (#7). of patient #7 was reviewed on ated a start of care date of d contained a plan of care for iod of 9/1/19-10/30/19 that	G 0978	1. For the client cited in the deficiency, the agency obtained contract with Hometown Home Healthcare, the provider of the client's Medicaid PA hours. To contract lists both agencies, the individual responsibilities to the patient, the services and order interventions to be provided we respect to their payor sources who to coordinate care with,	ed a e he neir e red ith

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K015	B. WI	NG		11/07/	2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			VASHINGTON STREET		
FAITHFI	IL ERIENDS HOME	HEALTHCARE INC			N, IN 46952		
17411111	ET RIENDO HOME	THE RETTION INC.		W/ (I CIO	14, 114 40002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n of Care: [entity A] is			liability, need for each agency	to	
	-	nt's MCD [Medicaid] PA [prior			have their own admission		
		hours]." The record failed to			documentation and their own		
	evidence a written a	agreement with entity A.			POC. The RN CM over the ca		
					was educated on the Coordina		
	_	y on 11/7/19 at 10:14 AM, the			of Care with the other agency		
	_	stated there was no contract in			that the contract was put in pla		
		because entity A was the			filed in the chart, and would ex	cpire	
	agency that provided the prior authorization Medicaid hours and they just completed respite				only if the client is discharged	N. 4	
					from either agency. The RN (JIVI	
	nursing.				was instructed on who to		
	17 12 2(4)				coordinate care with and that	inis	
	17-12-2(d)				is to be done every 60 days.		
					2. The agency reviewed al	I	
					client charts and no other		
					deficiencies were found. If on	e oi	
					the agency clients begins	r	
					receiving services with anothe agency, this agency will notify		
					agency immediately and a	uiai	
					contract will be drawn up as p	or	
					the regulation. RN CM's have		
					been instructed to ask upon re		
					if there are any other agencies		
					providing services and if so, the		
					RN CM will ask the client for the		
					contact information of the age		
					and the RN CM will notify the	- J	
					Clinical Director and		
					Administrator. The Clinical		
					Director and Administrator will		
					then contact the other agency	to	
					create a contract that will allow		
					each agency to provide their		
					respective services and that w	rill .	
					contain all information set fortl	n in	
					the federal regulation. The RN	N CM	
					assigned to the case will then	be	
					instructed who she is to		
					coordinate care with and how	often	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/07/2019		
	PROVIDER OR SUPPLIEI	REHEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP COD 203 S WASHINGTON STREET MARION, IN 46952				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DE COMPLETION DATE		
				3. To ensure the deficie does not re-occur, referral will be asked if any other h health agency has services client home, and if so, this will need the contact inform order to establish a contract federal regulation. Upon admission, the admit nurse also inquire about any othe services the client may be receiving or is planning to the The RN will emphasize the importance of notifying this agency as well as any othe health provider so the ager can establish a contract be the two as per federal regulation. Current clients we asked upon each recertificate to whether they have receive any health services from any of provider and if so, the client then be asked for contact information so that the age can establish contracts and coordination of care. 4. The Administrator and Clinical Director will be responsible for monitoring corrective actions to ensure deficient practice will not re-occur.	sources ome s in the agency nation in ct per e will er receive. s er home ncies etween alation will be action as ved or y home ther of will encies d and these		
N 0000							
Bldg. 00	This was a state re-	licensure home health survey	N 0000				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K015		A. BUILDI B. WING		00	COMPL 11/07/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD /ASHINGTON STREET		
FAITHFU	IL FRIENDS HOME	HEALTHCARE INC	М	ARIO	N, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	III PRE TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Complaint informat IN00213640- Subst Facility #: 003961 Survey dates: Octo	ion:					
	1 partial Total clinical record	only: 19 ly: 66 d Census: 127 s: 112 h home visits: 2 out home visits: 6 full records,					
N 0458	410 IAC 17-12-1(f						
Bldg. 00	employees shall be policies. All employees shall be so certification, or recognized perform the respective records of employ health services shall include document the job, including the job, including the job qualifications.	Personnel practices for e supported by written byees caring for patients in ubject to Indiana licensure, gistration required to ctive service. Personnel ees who deliver home all be kept current and mentation of orientation to the following: o description. ted criminal history					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. Wl	NG	_	11/07/	2019
		<u>-</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			WASHINGTON STREET		
FAITHFU	JL FRIENDS HOME	HEALTHCARE INC		MARIO	N, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		rent license, certification,					
	or registration.						
	(5) Annual performance evaluations.						
		view and interview, the agency	N 0	458	For the employees cited		12/06/2019
		t all employees had an			the deficiency, the agency mg		
	_	to their job description, record			staff reviewed the files along v		
	_	t patient contact date to ensure			the policies cited. The following	ng	
	_	and check was completed			actions were taken;	laa	
	within 3 days of first providing care, and that their				a. Each of the employee fi	ies	
	policy was updated to show a national criminal background check was required per Indiana				were updated to contain first patient contact dates		
	administrative code for 6 of 6 employee records				b. An orientation specific to	0	
	reviewed (D, E, H, I, J, K).		the each of the emplo		1	J	
	reviewed (D, E, H, I, J, K).				position was reviewed with the		
	Findings include:				employees and was placed in		
	i mamga merade.				file. A notation was made to s		
	1 An undated ager	ncy policy titled "Employee			that this was an update.	11000	
	_	n," Policy D-300 stated "Policy:			2. The agency reviewed 10	00%	
		s, students and members of the			of all currently active employe		
		new to the agency, will			include a first patient contact of		
		eral orientation program before			and a new and updated job		
		responsibilities. An orientation			orientation specific to the		
		ion orientation specific to staff			employees respective position	1	
	members; needs and	d specific responsibilities will			was reviewed with and signed		
		ing the general orientation.			the employee and then their		
	This orientation is t	ailored to the educational			personnel file was updated wit	th	
	background and exp	perience, type of care			the form and a notation was m	nade	
	provided, physical	and mental condition of			in each personnel file to note t	:he	
	clients, and the role	s and responsibilities of the			change.		
	position"				3. The agency has		
					implemented an audit process	for	
		y dated 8/8/14 and titled			all new employee files that is t	o be	
	_	and check," Policy #D-190			done prior to employees first		
		ees, upon hire, will have a			patient contact date. This aud		
	_	d criminal history background			will include a check to make s	ure	
		iana state police. Results of			that a national criminal		
		obtained prior to the			background check has been		
		it with a patient. Any			completed and returned to the		
		lived outside the state of			agency at three days prior to f		
	Indiana within 2 ye	ars of hire will have an			patient contact, this audit will a	also	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K015	B. W	ING		11/07/	2019
				CTD FET A	ADDRESS OF A STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
E 4 IT. IE.		LIEAL TUCABE INC			VASHINGTON STREET		
FAITHFU	JL FRIENDS HOME	HEALTHCARE INC		MARIO	N, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	expanded criminal	history background check done			ensure that an orientation spec	cific	
	[*] "	, ,			to the employees respective		
					position has been completed a	ınd	
	3. During the revie	w of employee files on			signed off on by both the		
	10/31/19, the list of current employees included				employee and the HR staff. T	he	
	employee D, home health aide, date of hire 10/2016				agency has also updated its	-	
		patient contact date. The			Criminal Background Check po	olicv	
	employee file failed to evidence the first patient				so that it aligns with federal an	-	
	contact date to ensure the criminal background				state regulations.	-	
	check completed on 9/2/16 was completed within 3				To ensure the deficient practic	e	
	days of first patient contact, and failed to				does not re-occur, the agency		
	evidence an orientation specific to the job duties				put in place an audit tool that		
	of the employee.				must be checked off and initial	ed	
	of the employee.				by HR staff and by the Office N		
	4. During the revie	w of employee files on			and Clinical Director. This aud	•	
	-	current employees included			tool will be a required component		
		health aide, date of hire 6/2017			of the Employee New Hire		
		patient contact date. The			Process and once complete w	ill	
	_	I to evidence the first patient			be placed in the front of the		
		re the criminal background			employee file. The Administra	tor	
		6/1/18 was completed within 3			and Clinical Director will be		
	days of first patient				responsible for monitoring this		
					corrective action to ensure tha		
	5. During the revie	w of employee files on			deficient practice does not		
	-	current employees included			re-occur. The Admin. and Clir	ical	
		health aide, date of hire 9/9/17			Director will audit 100% of all r		
		patient contact date. The			employee files monthly for one		
		I to evidence the first patient			year.		
		re the criminal background			,,,,,,,		
		1 9/7/17 was completed within 3					
	*	contact, or an orientation					
		uties of the employee.					
	*	1 3					
	6. During the revie	w of employee files on					
	_	current employees included					
		red nurse, date of hire 6/10/19					
		patient contact date. The					ļ
		I to evidence the first patient					ļ
		are the criminal background					
		1 6/5/19 was completed within 3					
	l		1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2019 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	ì í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/07/	ETED
	PROVIDER OR SUPPLIER	HEALTHCARE INC	-	203 S W	.ddress, city, state, zip cod VASHINGTON STREET N, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		contact, or an orientation uties of the employee.					
	10/31/19, the list of employee J, home h and unknown first p employee file failed contact date to ensu check completed on 3 days of first patien	w of employee files on Courrent employees included health aide, date of hire 9/24/19 patient contact date. The It to evidence the first patient the criminal background in 9/24/19 was completed within int contact, and an orientation luties of the employee.					
	10/31/19, the list of employee K, home hire and unknown f employee file failed contact date to ensu check completed on within 3 days of firs	w of employee files on Current employees included health aide, unknown date of first patient contact date. The date of the dat					
	administrator and d	iew on 10/31/19 at 4:47 PM, the irector of nursing stated they c of first patient contact dates.					
N 0462	410 IAC 17-12-1(h						
Bldg. 00	have direct patient physical examinat practitioner no mo (180) days before has direct patient examination shall ensure that the en	-					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPL	ETED		
		15K015	B. WING			11/07/2019			
				STREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIEF	R			WASHINGTON STREET				
FAITHFUL FRIENDS HOME HEALTHCARE INC				MARION, IN 46952					
	Г				T				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		_	TAG	DEFICIENCY)		DATE		
	patients.								
	Based on record review and interview, the agency		N 0	462	For the employee person	•			
	failed to ensure that and appropriate physical				files found to be deficient, two	•			
	examination was completed within the appropriate				the employees are no longer				
	timeframe's with the date the employee was				working for the company, and the				
	examined for 3 of 6 employee records				other employee was immediately				
	I, K).				pulled from the field and sent for				
	Findings include:				an employee physical so that her				
					personnel file could be updated.				
					2. For all other employee				
	1. An undated agency policy titled "Health				personnel files, the Administra				
	screening," Policy D-240, stated				Clinical Director, Office Mgr., a				
	"Pre-employment physical examination will be				HR staff audited 100% of all fi				
	performed by a physician or nurse practitioner as				The employee physical form a				
	mandated by state l	aw of agency policy"		Health Screening Policy were also					
					reviewed. It was concluded t	hat			
	2. During the review of employee files on				the physical form, which is				
	10/31/19, the list of current employees included				provided by the provider that of				
	employee H, home health aide, date of hire 9/9/17				the employee physicals, does				
	and unknown first patient contact date. The			have a clear and defini					
	employee file failed to evidence a physical			when the employee wa					
	examination.				by the provider. Therefore, th	е			
					agency has re-vamped the				
	3. During the review of employee files on				employee physical form to include				
	10/31/19, the list of current employees included				a space for the provider to provide				
	employee I, registered nurse, date of hire 6/10/19				a date of examination and is				
	and unknown first patient contact date. The				labeled as such. There were no				
	employee file failed to evidence a physical				other deficiencies found in the				
	examination.				audit. The HR staff has been				
					instructed to dispose of the old				
	4. During the review of employee files on				forms and to utilize the new				
	10/31/19, the list of current employees included				employee physical form effective				
	employee K, home health aide, unknown date of				immediately. In the event that the				
	hire and unknown first patient contact date. The				physical form is returned to th				
	employee file failed to evidence a date on the				agency without the date of exa				
	physical examination that the employee was				the employee will not be able				
	examined.				start field work until the form is				
					dated correctly. HR will send				
5. During an interview on 10/31/19 at 2:29 PM the				form back to the provider for o	late.				
	director of nursing	stated every employee should			3. The agency has dispose	ed			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K015	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/07/2019			
	PROVIDER OR SUPPLIE	R E HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP COD 203 S WASHINGTON STREET MARION, IN 46952					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		TE	(X5) COMPLETION DATE		
	have a physical in their employee file.			of all of the old employee physical forms and all HR staff has been instructed on the new form. This corrective action will be monitored by the Clinical Director and Administrator to ensure the deficient practice will not re-occur. One hundred percent of all personnel files will be audited prior to the employee going into patient homes to ensure that all information on the physical form is complete. This audit is now part of the hiring process and will be required from the date of correction forward. HR personnel has been made aware and provider is aware also.				

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