

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

PRINTED: 07/28/2021

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157603		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/14/2021	
NAME OF PROVIDER OR SUPPLIER CARING FIRST HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP COD 28441 STATE ROUTE 1 W HARRISON, IN 47060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
N 0000 Bldg. 00	<p>This visit was for a State Licensure Survey in conjunction with a Complaint Investigation Survey.</p> <p>Complaint IN00251042 - substantiated without related findings.</p> <p>Survey Dates: July 12th, 13th, and 14th of 2021</p> <p>Facility Number: 011642</p> <p>QR completed 7/19/2021 A4</p>			N 0000			
N 0458 Bldg. 00	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ol style="list-style-type: none"> (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. <p>Based on record review and interview, the agency failed to ensure that personnel records were kept</p>			N 0458	<p>N458 On 7/14/21, the HR Director printed current home health aide</p>		07/30/2021

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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.

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

PRINTED: 07/28/2021

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157603		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/14/2021	
NAME OF PROVIDER OR SUPPLIER CARING FIRST HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP COD 28441 STATE ROUTE 1 W HARRISON, IN 47060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
N 9999 Bldg. 00	<p>current for 2 of 6 records reviewed. (Employee C and D)</p> <p>Findings include:</p> <p>A 2/3/17 revised document titled Employee Handbook indicated, but was not limited to, " ... Employee Personnel File to Include: ... valid professional license ... ".</p> <p>A personnel record review of Employee C, with a hire date of 7/18/2011 was conducted on 7/14/2021. The record failed to evidence a current home health aide license.</p> <p>A personnel record review of Employee D, with a hire date of 1/4/20011 was conducted on 7/14/2021. The record failed to evidence a current home health aide license.</p> <p>During an interview with Employee C on 7/14/2021 at 11:50 a.m., when asked about the missing renewed license, Employee C responded "Oh, ok. Can I add the updated license to them now?" The updated license was then provided and placed in the personnel records at 12:10 p.m.</p>			N 9999	<p>licenses for employees C and D, placed it in their respective HR folders, and showed this to surveyor.</p> <p>The Administrator in-serviced the HR Director on 7/21/21 on the contents of 410 IAC 17-12-1(f) that personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) receipt of job description, (2) qualifications, (3) a copy of limited criminal history pursuant to IC 16-27-2, (4) a copy of current license, certification, or registration, and (5) annual performance evaluations.</p> <p>100% of HR files will be audited by the HR Director by 7/30/21 for evidence of the 5 points listed above. After completion of this audit, 25% of HR records will be audited quarterly for evidence of the same.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		08/06/2021
	410 IAC 16-27-2.5 Section 2.(a) A home health agency must: (1) have a written drug testing policy that is distributed to all employees; and (2) require each				N9999 The Administrator in-serviced the Clinical Manager on 7/21/2021 on the contents of 410 IAC 16-27-2.5 that Section 2(a) a home health		

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

PRINTED: 07/28/2021

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157603		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/14/2021	
NAME OF PROVIDER OR SUPPLIER CARING FIRST HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP COD 28441 STATE ROUTE 1 W HARRISON, IN 47060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50 %) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance ...</p> <p>Based on record review and interview, the agency failed to perform annual random drug testing on 50% of its employees for 2 of 2 Home Health Aide records reviewed. (Employee C, D)</p> <p>Findings include:</p> <p>A 7/1/2017 revised policy titled Drug Testing indicated, but was not limited to, " ... annually thereafter ... the agency will then ... identify the number of Covered Employees the Agency must randomly test ... ".</p> <p>During personnel record reviews on 7/14/2021 at 10:00 a.m., records for Employee's C and D failed to evidence any annual random drug testing was being performed.</p> <p>During an interview with Employee B on 7/13/2021 at 4:30 p.m., when reviewing documents that were needed for the following day, when verification of compliance of Indiana Drug Screen Requirements was requested, Employee B stated "I'll be completely honest, we haven't been doing that one. I figured, no big deal, we'll take the hit and turn in a plan of correction."</p>				<p>agency must (1) have a written drug testing policy that is distributed to all employees, and (2) requires each employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50%) of the home health agency's employees who: (A) have direct contact with patients, and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance...</p> <p>On 7/21/21 the Clinical Manager determined there are 22 affected employees in the annual sampling thus, 11 employees will be randomly selected for drug testing for the year 7/1/21-6/30/22. These employees will be drug tested by 8/06/21.</p> <p>The Clinical Manager has placed a reminder on her calendar for July 1st of each year. The Administrator and HR Director are aware of the annual drug testing as well and will be implemented each year thereafter. The annual drug testing policy will be reviewed annually in order to act as additional measure to complete the annual employee drug testing. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and</p>		

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

PRINTED: 07/28/2021
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157603		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/14/2021	
NAME OF PROVIDER OR SUPPLIER CARING FIRST HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP COD 28441 STATE ROUTE 1 W HARRISON, IN 47060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					will not recur.		