| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/22/2021 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **THE MASTER'S TOUCH HOME CARE LLC** | **2647 WATERFRONT PARKWAY E DR STE 265 , INDIANAPOLIS, Indiana, 46214** |

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| G0000 | INITIAL COMMENTS<br><br>This visit was for a Federal Recertification and State Licensure Survey of a Medicaid Home Health Provider. A partially extended survey was announced on 11/19/2021 at 3:15 PM.<br><br>Survey dates: 11/16/2021 to 11/22/2021<br><br>Facility ID: 013677<br><br>Provider #: 15K139<br><br>Medicaid #: 701323570A<br><br>Census: 44<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 17.<br><br>Quality Review Completed on 12/06/2021 by Area 3 | G0000 | | |
| G0682 | Infection Prevention<br><br>CFR(s): 484.70(a)<br><br>Standard: Infection Prevention.<br><br>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and record review, the agency failed to ensure clinicians follow accepted standards of practice, including the use of standard precautions, to prevent transmission of infections and communicable diseases. Agency failed to follow infection prevention measures in 1 of 3 home visits conducted. (Patient #5)<br><br>Findings include:<br><br>In an undated policy titled 'Hand Hygiene Policy | G0682 | | |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| G0682 | Continued from page 1<br>No. 7-009' states, "Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC (Centers for Disease Control) regulations and guidelines for hand hygiene in healthcare settings. When hands are visibly dirty, contaminated with proteinaceous material, or are visibly soiled with blood or other body fluids, they should be washed with either a non-antimicrobial or antimicrobial soap and water. When hands are not visibly soiled, they should be washed using an alcohol-based hand rub for routinely decontaminating hands. An alternative to use of an alcohol-based hand rub is to wash hands with an antimicrobial soap and water." The policy further specifies that "3. Hand decontamination... should be performed: A. Before direct contact with patients... F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient."<br><br>On 11/17/21 at 12:00 pm, a home visit with patient #5 and home health aide D evidenced a breach in infection control. During bathing, patient #5 who was seated in a shower chair in a shower stall, requested employee D to, "fix" the bathmat. Employee D obliged and picked up the edge of a suctioned bathmat which was on the floor of the shower stall to readjust and straighten out mat, as at it had become bunched up under the feet of the seated patient. Employee D then proceeded to apply gloves and continued washing and rinsing patient, failing to perform hand hygiene after touching mat, nor before continuing to provide hands-on care to patient.<br><br>The findings of concern were reviewed with the Administrator and Clinical Manager on 11/17/21 at 3:15 pm. No further information or explanation was provided.<br><br>410 IAC 17-12-1(m) | G0682 | | |
| G0706 | Interdisciplinary assessment of the patient<br><br>CFR(s): 484.75(b)(1)<br><br>Ongoing interdisciplinary assessment of the patient;<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the agency failed to ensure the RN case managers assessed | G0706 | | |

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| G0706 | Continued from page 2<br>patients when a change in condition was identified in regards to a patient with a new onset of wheezing/ new medication order and a patient who had fallen and obtained a fracture for 2 of 5 active records reviewed. (Patients #3 and 5)<br><br>Findings include:<br><br>1. A review of an undated agency policy titled "Ongoing Assessments" Policy No. 1-017 revealed "Purpose, to provide guidelines for assessments of the patient during ongoing care. Under subtitle Procedure 3. Re-assessments should focus on: ... B. Changes in patient condition C. Changes in patient diagnoses..."2. During a home visit on 11/17/21 at 12:00 PM with patient #5, it was discovered that on 11/16/21, the patient had been prescribed a new medication called ipratropium bromide/albuterol sulfate by her Primary Care Physician for new-onset symptom of wheezing. Patient #5 indicated employee D, the home health aide, was aware and had assisted the patient in setting up the nebulizer for the patient to self-administer.<br><br>The clinical record for patient #5 was reviewed on 11/17/21. The clinical record contained a plan of care for the certification period of 11/5/21 through 1/4/22, with patient diagnoses, included but are not limited to, Chronic Obstructive Pulmonary Disease (a type of progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), Congestive Heart Failure (a chronic condition in which the heart cannot pump {systolic} or fill {diastolic} adequately). The plan of care revealed Patient #5 is receiving home health aide services 2-4 hours per day, 3-5 days per week. The clinical record failed to evidence that a nurse provided any visits to assess the patient when it was discovered that the patient had a new onset of wheezing and new medication.<br><br>During an interview on 11/18/21 at 9:00 AM, Employee G, RN was queried as to whether she had been made aware by the home health aide of a new medication in the home related to a new patient complaint of wheezing on 11/16/21, which Employee G stated the aide did not make her aware of this until approximately 3 PM on 11/17/21, after this surveyor's visit to the home. Employee G indicated she does not normally make a visit to the patient's home after changes in medication. When queried if a nurse would be making a visit in | G0706 | | |

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| G0706 | Continued from page 3<br>relation to reported change in condition, new wheezing, the nurse indicated she saw the patient on 11/2/21 for the Recertification visit and the patient's lungs were clear, "no respiratory distress", and "O2 [oxygen] sats were good". Employee G indicated she would visit the patient if he/she felt the patient was having difficulty breathing or had low O2 saturation readings. When reminded that the recertification visit was several days ago and wheezing is new for the patient, Employee G stated she had no upcoming plans for visiting or assessing the patient, stating the patient did not have orders for nursing services.3. The clinical record of patient #3 was reviewed on 11/17/2021. The clinical record contained a recertification assessment on 09/13/2021 that indicated the patient had fallen in the home, with Employee E, the Hha, present, and had sustained a fractured left wrist on 08/19/2021.<br><br>During a phone interview with patient #3 and Employee E on 11/17/2021 at 12:48 PM, patient #3 did confirm they had fallen on 08/19/2021 at approximately 10:30 AM, stating the reason they know this is because the Hha and patient #3 had returned from a veterinarian appointment at 10 AM and was back home by 10:30 AM. The patient stated they had walked into the kitchen unassisted by Hha to fix a glass of chocolate milk when they fell, stating "I hit my head, and I hurt all over." Employee E stated they heard the fall, asked if the patient was OK, the patient said"no, I am hurt." Employee E said they were getting ready to vacuum in the living room when the fall occurred, then entered the kitchen and patient #3 stated they needed Employee E to push the alarm (medical alert button). Employee E was instructed by the emergency personnel on how to care for patient #3 until the EMTs (emergency medical technicians) arrived. The patient was taken to the hospital by ambulance. Patient #3 stated the hospital did an x-ray of the left wrist and did a CT scan of the head, they didn't give the patient a splint or brace for the wrist, stating they would have to return the following day to the medical professional building to be given the brace, discharged to home, with written instructions.<br><br>The clinical record failed to evidence that a Registered Nurse provided had gone to the patient's home after the patient fell and after the hospital emergency visit, to reassess the patient's needs for home health. During an | G0706 | | |

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| G0706 | Continued from page 4<br>interview on 11/19/2021 at 11:30 Employee B stated since the patient had been seen in the hospital emergency room, the nursing staff does not follow up with the patient.<br><br>410 IAC 17-12-2(g) | G0706 | | |
| G0804 | Aides are members of interdisciplinary team<br><br>CFR(s): 484.80(g)(4)<br><br>Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures.<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and interview, the home health aide failed to notify their case manager or clinical manager of a new onset of symptoms and new medication for 1 of 3 home visits conducted. (Patient #5)<br><br>Findings include:<br><br>Review of a document titled 'Job Description': Home Health Aide', page 2 details aide duties, "notifying nursing supervisor of changing or unusual conditions." Additional duties include, "Monitor patients... and report on their condition." During a home visit on 11/17/21 at 12:00 PM, Patient #5 indicated they were prescribed a new medication called ipratropium bromide/albuterol by their Primary Care Physician for a complaint of new onset wheezing on 11/16/21. Patient #5 indicated Employee D, home health aide, was also aware and had assisted in setting up a nebulizer for the patient to self-administer the new medication.<br><br>The clinical record for Patient #5 was reviewed on 11/17/21. The clinical record contained a plan of care for the certification period of 11/5/21 through 1/4/22 with orders for home health aide services 2-4 hours per day, 3-5 days per week.<br><br>A review of the clinical record and the aide visit note on 11/16/21 failed to evidence that the aide reported the change in condition and the new medication to the case manager and/or clinical manager. | G0804 | | |

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| G0804 | Continued from page 5<br><br>During an interview on 11/18/21 at 9:10 AM, when queried as to whether she had been made aware by the home health aide of a new medication in the home related to a new patient complaint of wheezing on 11/16/21 Employee G, RN, stated the aide did not make her aware of this until approximately 3:00 PM on 11/17/21 after this surveyor visited the home. | G0804 | | |
| G0966 | Assure patient needs are continually assessed<br><br>CFR(s): 484.105(c)(4)<br><br>Assuring that patient needs are continually assessed, and<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and interviews, the agency failed to assure the patients needs are continually assessed of 2 out of 5 patients. (Patients #3 and #5)<br><br>Findings include:<br><br>1. A review of an undated agency policy Ongoing Assessments Policy No. 1-017 revealed "Purpose, to provide guidelines for assessments of patients during ongoing care. Under subtitle Procedure 3. Re-assessments should focus on: ... B. Changes in patient condition C. Changes inpatient diagnoses..."<br><br>2. The clinical record of patient #3 was reviewed on 11/17/2021. The clinical record contained a recertification assessment on 09/13/2021 that indicated the patient had fallen in the home, with Employee E, the Hha, present, and had sustained a fractured L wrist on 08/19/2021. During a phone interview with patient #3 and Employee E on 11/17/2021 at 12:48 PM, patient #3 did confirm they had fallen on 08/19/2021 at approximately 10:30 AM, stating the reason they know this is because the Hha and patient #3 had returned from a veterinarian appointment at 10 AM and was back home by 10:30 AM. The patient stated they had walked into the kitchen unassisted by Hha to fix a glass of chocolate milk when they fell, stating "I hit my head, and I hurt all over." Employee E stated they heard the fall, asked if the patient was OK, the patient said"no, I am hurt." Employee E said they were getting ready to vacuum in the living room when the fall occurred, then entered | G0966 | | |

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| G0966 | Continued from page 6<br>the kitchen and patient #3 stated they needed Employee E to push the alarm (medical alert button). Employee E was instructed by the emergency personnel on how to care for patient #3 until the EMTs (emergency medical technicians) arrived. The patient was taken to the hospital by ambulance.<br><br>Patient #3 stated the hospital did an x-ray of the left wrist and did a CT scan of the head, they didn't give the patient a splint or brace for the wrist, stating they would have to return the following day to the medical professional building to be given the brace, discharged to home, with written instructions.The clinical record failed to evidence that a Registered Nurse provided had gone to the patient's home after the patient fell and after the hospital emergency visit, to reassess the patient's needs for home health. During an interview on 11/19/2021 at 11:30 Employee B stated since the patient had been seen in the hospital emergency room, the nursing staff does not follow up with the patient.<br><br>3. During a home visit on 11/17/21 at 12:00 PM with patient #5, it was discovered that on 11/16/21, the patient had been prescribed a new medication called ipratropium bromide/albuterol sulfate by her Primary Care Physician for new-onset symptom of wheezing. Patient #5 indicated employee D, the home health aide, was aware and had assisted the patient in setting up the nebulizer for the patient to self-administer.The clinical record for patient #5 was reviewed on 11/17/21. The clinical record contained a plan of care for the certification period of 11/5/21 through 1/4/22, with patient diagnoses, included but are not limited to, Chronic Obstructive Pulmonary Disease (a type of progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), Congestive Heart Failure (a chronic condition in which the heart cannot pump {systolic} or fill {diastolic} adequately). The plan of care revealed Patient #5 is receiving home health aide services 2-4 hours per day, 3-5 days per week. The clinical record failed to evidence that a nurse provided any visits to assess the patient when it was discovered that the patient had a new onset of wheezing and new medication.<br><br>During an interview on 11/18/21 at 9:00 AM, Employee G, RN was queried as to whether she had been made aware by the home health aide of a new | G0966 | | |

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| G0966 | Continued from page 7<br>medication in the home related to a new patient complaint of wheezing on 11/16/21, which Employee G stated the aide did not make her aware of this until approximately 3 PM on 11/17/21 after this surveyor visited the home. Employee G indicated she does not normally visit the patient's home after changes in medication. When queried if a nurse would be visiting concerning the reported change in condition, new wheezing, the nurse indicated she saw the patient on 11/2/21 for the Recertification visit and the patient's lungs were clear, "no respiratory distress", and "O2 [oxygen] sats were good". Employee G indicated she would visit the patient if he/she felt the patient was having difficulty breathing or had low O2 saturation readings. When reminded that the recertification visit was several days ago and wheezing is new for the patient, Employee G stated she had no upcoming plans for visiting or assessing the patient, stating the patient did not have orders for nursing services. | G0966 | | |