STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200911210A	A. BUILDING B. WING	04/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE'S TOUCH HOME HEALTH INC	2737 E 56TH ST STE E, INDIANAPOLIS, IN, 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This visit was for a Federal and State complaint survey of a Home Health Care agency. Survey Dates: 3/28/22, 3/30/22, 3/31/22, and 4/4/22. Complaint: 62155 - Substantiated with related and unrelated findings. Federal and State deficiencies were cited. Census: 21 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR by Area 3 on 4-13-2022	G0000	POC accepted on 5-16-2022 Deborah Franco, RN	2022-04-06
N0000	Initial Comments This visit was for a State complaint survey of a Home Health Provider.	N0000		2022-04-06

	Survey Dates: 3/28/22, 3/30/22, 3/31/22, and 4/4/22. Complaint: 62155 - Substantiated with findings, and unrelated findings. State deficiencies were cited. Census: 21 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR by Area 3 on 4-13-2022			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure patients received all services ordered in the plan of care for 2 (Patients 4 and 5) of 5 active and closed clinical records reviewed. Findings include: 1. A review of an agency policy titled 'Plan of Care,' dated 11/05/22, stated, "POLICY Home Care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that client needs	G0572	SURVEY PLAN OF CORRECTION 3877D-H1 TAGG0572 1. Describe what the Agency did to correct the deficient practice for each client cited:	2022-04-06

	are met and will be updated as necessary, but at least every sixty (60) days...PURPOSE To provide guidelines for Life's Touch Home Health Services staff to develop a plan of care individualized to meet specific identified needs...To assure that the plan meets state/federal guidelines, and all applicable laws and regulations...SPECIAL INSTRUCTIONS...The Plan of Care shall be completed in full to include:...C. Type, frequency, and duration of all visits/services...6. The client and other Life's touch personnel including Home Health Aide and/or Attendant shall participate in developing the plan of care. The client shall be informed of any changes in the Plan of Care...9. Professional staff shall promptly alert the physician to changes that suggest a need to alter the plan of care..." 2. A review of the clinical record for Patient 4 with a Start of Care of 9/29/21, and a recertification date of 12/30/21 to 2/27/22, with diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness), pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred, this thickened stiff tissue makes it more difficult for your lungs to work properly, as it worsens you become progressively more short of breath), had orders to receive home health aide visits 6 hours per day, 5 days per week for 26 weeks, "to support safely living at home alone...aide to assist with personal care...activities of daily living and instrumental activities of daily living; bathing, grooming, dressing, hair and nail care, skin care, ambulation, mobility, light housekeeping as pertains to care, sweeping, laundry, meal preparation and clean up, removal of trash." A review of agency documents titled Cancelled Events By Reason, and 60 Day Client Calendar, for Patient 4, between the dates of 12/30/21 to 2/27/22, on 1/3/22, 1/4/22, 1/5/22, were missed visits and the Patient 4 did not receive the 5 ordered care visits for the clinical week, 1/10/22, 1/11/22, and Patient 4 did not receive the 5 care visits ordered for the clinical		The Administrator/ClinicalManager has instructed all RNs and Hhas that patients are to receivethe services as ordered by the physician on the POC. This includesensuring visit frequencies are met as ordered on the POC and allvisit tasks are performed as ordered on the POC. The Clinical Leadership teamhas met and made guidelines for patients and staff that include thefollowing: a. The RN Case Manager will collaborate with the patient and physician to determine the services and visit frequency for each patient. b. The patients will have written visit schedules that includes the names of the Hhas assigned to making the visits. This is to ensure the patients know the names of the aides assigned to assist them with their care needs. A copy of their home health aide care plan is maintained in their home folders. c. Field staff are instructed to make the assigned home visits on the scheduled days at the scheduled times. When a scheduling conflict occurs, the	

	receive the 5 ordered care visits for the clinical week, 2/3/22, 2/4/22, 2/5/22, and Patient 4 did not receive the ordered care visits for the clinical week, 2/10/22 and 2/11/22, and Patient 4 did not receive the 5 ordered care visits for the calendar week. When visits were not provided as ordered, Patient 4 did not receive support with living safely at home alone, did not receive assistance with personal care, did not receive assistance with activities of daily living and instrumental activities of daily living; did not have assistance with bathing, grooming, dressing, hair and nail care, skin care, did not have needed assistance with ambulation, mobility, or incidental light housekeeping as pertained to care, sweeping, laundry, meal preparation and clean up, or removal of trash. The agency failed to ensure Patient 4 received all care visits as ordered in the plan of care. Review of the clinical record for Patient 5 with a Start of Care date of 10/27/21 and a recertification date of 12/26/21 to 2/23/22, with diagnoses that included but were not limited to Dissociative personality disorder (a mental health condition, having multiple distinct personalities. The various identities control a person's behavior at different times, can cause memory loss, delusions or depression), post-traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), fibromyalgia (widespread muscle pain and tenderness often accompanied by fatigue and altered sleep, memory, and mood), major depressive disorder, type 2 diabetes (chronic condition that affects the way the body processes blood sugar {glucose}), had orders to receive home health aide visits 4 hours per day, 5 days per week and 2 hours per day, 1 day per week for 60 days to, "assist with personal care needs: activities of daily living, instrumental activities of daily living, effective personal hygiene, assist with bathing, grooming, hair care, and skin care. Assist with safety during ambulation and transfers as needed, light housekeeping as requested, prepare meals and assist with food set-up, meal		scheduled staff will notify the Agency as soon as possible to ensure staffing can be provided by another staff Hha or SN. The Hha Care Plan is reviewed with each Hha to ensure they know what tasks are to be completed at the home visit. 2. Describe what the Agency did to correct the deficient practice for each client cited: The Agency provided multiplehome health aides to patients #4 and #5. The aides were unable tomeet the demands of patients 4 and 5 and both patients requestedtheir services be placed on hold. Patient #5 had been offered sixdifferent home health aides and did not like any of them. Subsequently, patients 4 and 5have successfully transferred services to another agency. 3. Describe the steps or the systemic changes the agency has made to ensure the deficient practice does not recur.	

	preparation, and clean up after meals, assist with laundry as requested." A review of agency documents titled Cancelled Events By Reason, and 60 Day Client Calendar, for Patient 5, for the time period of 12/26/21 to 2/23/22, missed care visits were on 12/27/22, 12/28/21, 12/29/21, 12/30/21, 12/31/21, and Patient 5 did not receive the 6 ordered care visits for the clinical week, 1/4/22, 1/5/22, 1/6/22, 1/7/22, and Patient 5 did not receive the ordered care visits for the clinical week. When the agency failed to provide care visits as ordered, Patient 5 did not receive assistance with assistance with personal care needs: activities of daily living, instrumental activities of daily living, effective personal hygiene, assistance with bathing, grooming, hair care, and skincare, nor assistance with safety during ambulation and transfers, light housekeeping as requested, assistance with meal preparation, assistance with food set-up, assistance with clean up after meals, assistance with laundry as needed. Patient 5 informed the agency on 2/22/22, he/she had gone to another agency. The agency failed to ensure Patient 5 received all care visits as ordered in the plan of care. 3. In an interview on 3/30/22 at 10:48 AM, the alternate clinical manager and clinical manager, when queried as to why Patient 4 requested discharge from the agency, both indicated that the patient decided to return to her, "original agency." In an interview on 3/31/22 at 4:13 PM, Patient 4 stated the reason for leaving the agency was "staffing" was not being provided, and indicated he/she expressed to the agency that if they had had better staffing he/she would have stayed. In an interview on 3/31/22 at 4:32 PM, Patient 5 stated the reason for leaving the agency was, "not enough people to come, wouldn't communicate about the schedule," and indicated		a. The RN Case Managers will perform a thorough evaluation of the patient's needs at time of admission and during all follow-up certification assessments. This will include a review of all tasks the aide is expected to accomplish at every visit and the availability and location of the laundry rooms, ease of access to the facilities, etc. in apartment buildings and individual patient homes. b. At time of Admission to Service the RN Case Manager will review with all patients the Agency's zero tolerance for use of illicit drugs; explaining the patients are not to use illicit drugs while agency staff are present. c. Agency leadership is actively recruiting new home health aides through advertising and attending job fairs. d. The Agency has certain home health aides assigned as "float aides" to make home visits when assigned staff are unable to make the scheduled visit. e. Every attempt will be made to make up all missed visits the same week of the missed visit. f. Physicians will be notified	

	one month" without care visits from the agency. Stated further, "I don't blame the company, I blame the quality of the staff hired." In an interview on 4/4/22 at 12:25 PM, the administrator and clinical manager nodded in agreement when queried if the agency had been experiencing difficulty keeping home health aides on staff. 410 IAC 17-13-1(a)		of all missed visits. g. Patients requesting a transfer of services to another agency will continue to receive all their services until the transfer transition to the new provider is completed. Agency management staff will assist with the patient transfer process to facilitate acceptance by the new provider by providing community resources to the patient and assisting the patient with contacting other agencies for availability of Hha staffing. The agency will collaborate with patient's physician to facilitate a timely transfer of services that minimizes any disruption of services. h. Missed visits will be documented with reason for missed visit and with additional documentation regarding outcome of staffing attempts made to provide patient care. The patient will be notified by the agency designee of the schedule/staffing change. 4. Describe how the corrective action will be	

			ongoing compliance. The Clinical Manager/designeewill audit 100% of all Hha visit notes on an ongoing basis to assessthe following: a. All visits were made per the assigned frequency and hours/visit b. All tasks were documented as being completed per the plan of care. 5. Date of corrective action: 04/06/2022. 6. Employee position responsible for ensuring ongoing compliance with G572. The Clinical Manager isresponsible for ensuring ongoing compliance with G572. ***LIFE'STOUCH HOME HEALTH SERVICES***	

CLIENTDISCHARGE PROCESS D-500

POLICY

Discharge Planning is initiated for every home care client at thetime of the client's admission for home care. When clients areadmitted for home health services, the expectation is that the clientwill be discharged to self care or care of family when goals are met.Discharging a client to another provider is permitted under limitedcircumstances that are documented in the admission notices.

PURPOSE

To facilitate the client's discharge or transfer to another entitywhen circumstances exist that this is the best solution for theclient.

To ensure continuity of care, treatment and services when needed.

To assure collaboration with the physician, client and/orrepresentative, family and other disciplines in planning fordischarge from the agency.

SPECIALINSTRUCTIONS

Discharge Procedure:

			1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client/family and/or client representative will participate in this process beginning with the initial assessment visit. 2. Client's needs for continuing care to meet physical and psychological needs are identified and clients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Clients are informed of the reason for discharge and anticipated needs for services after discharge. 3. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan. 4. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family/caregivers. 5. The Registered Nurse or Therapist shall review the clinical record to assure	

			A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family. 6. The Registered Nurse/Therapist shall ensure that the treatment goals and client outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing client needs. Clients willbe given the Notice of Discharge planning as indicated and/orappropriate Home Health Advance Beneficiary Notice to explain Agencydecision related to discharge from services. 7. Upon discharge to self-care, the client will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed, and follow-up visits for physician care. 8. To avoid charges of "abandonment" at the time of discharge agency documentation will include	

			the following: a. Evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge client from the agency. b. Evidence that the client no longer qualifies for home care services or there is no payer source for ongoing services. c. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated. In this situation, the decision will be made with the physician as well as the client and their representatives.	

d. Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file. A discharge summary is no longer required to be sent to the physician; however this could be the communication documentation that clarifies the discharge process and plan.

DischargeCriteria:

1. Criteria for discharge may include, but are not limited to the following:
   a. The client has reached defined goals and is no longer in need of home care.
   b. The client's care has become such that it is unsafe and medically inappropriate to maintain the client in his/her home.
   c. Client is non-compliant with the established plan of care. Client/Caregiver consistently refuses to cooperate in attaining treatment goals.
   d. Medical approval or supervision has been terminated. Or the physician fails to give or sign orders in a

timely manner.

e. The contracting payer terminates authorization for service.
f. The client terminates payment for service.
g. The client chooses to use another home health care company.
h. The client is hospitalized and the hospitalization period is greater than sixty (60) days or exceeds the current home care episode of care.
i. Client moves out of the agency's service area.
j. Services needed by the client are not provided by the agency.
k. No funding is available to provide the care.
l. The patient and/or family have threatened agency staff, have weapons in the home or the home is in some other way an unsafe environment for agency staff.

2. Criteria for transferring a patient to an acute or sub-acute care facility:
   a. The client has demonstrated deterioration, appearance of acute symptoms, adverse effects of medical treatment, or other

			change in status. b. There is a threat to client safety due to unsafe home environment, absence of physician, family, or caregiver involvement. 3. The client/representative and caregiver will be informed of the change in status and be encouraged to provide input to the physician regarding the Plan of Care. 4. The physician will order the client to be transferred, as appropriate. 5. Agency staff will document the following information: a. Initial reason for referral to home health agency. b. Client status (clinical, mental, psychological, cognitive, and functional) at the start of care. c. Description of all services provided by the agency to the clients. d. The start and end dates of care. e. A description of the client's clinical, mental, psychosocial, cognitive, and functional status at the end of care. f. The client's most recent drug profile.	

g. Any recommendations for follow-up care.
h. Name of person or organization assuming responsibility for care.
i. Instructions and referrals given to the client/family/caregiver.

6. Discharge OASIS will be conducted within 48 hours of (or knowledge of) discharge to the community or death at home.
   a. The discharge comprehensive assessment and OASIS data collection is required for all situations that result in an Agency discharge except to an inpatient facility or client death at home and should be performed in conjunction with a visit, if possible.
   b. If the discharge comprehensive assessment and OASIS data collection cannot be completed in conjunction with the last (discharge) visit, responses to the OASIS data items must be based on the clinical findings documented at the time of the last skilled visit and completed by the clinician who performed the last

			skilled visit. The visit date used to complete the OASIS assessment must be documented on the discharge comprehensive assessment. c. In cases with multiple disciplines and different discharge dates, there is only one Agency discharge on the date of the last skilled visit, and the Agency discharge is the only one that requires a comprehensive assessment and OASIS data collection. d. If both a Registered Nurse and a Therapist see the client on the same day of discharge either can perform the discharge comprehensive assessment and OASIS data collection.	
N9999	Final Observations Based on record review and interview, agency failed to ensure required staff members had	N9999	TAG# 9999 1. Describe what the Agency did to correct the deficient practice for each client cited:	2022-04-06

suspicion of use, and failed to perform yearly random screenings of 50 (fifty) percent of required staff, as required by Indiana Code 16-27-2.5, in 7 (employees A, B, C, D, E, F, G, and H) out of 7 employee records reviewed.

Findings include:

1. Review of an agency policy titled 'Controlled Substance Employee Testing' dated 3-21-201 stated, "POLICY Life's Home Health Services will requires New Applicants to undergo controlled substance testing in accordance with the state regulation. Life's Touch Home Health Services will require existing employees to undergo random controlled substance testing in accordance with the state regulations. This is: 1. A requirement for Home Health Agencies only. 2. Only applies to employees not licensed under Indiana Code Title 25 (i.e. RNs and LPNs) 3. This policy applies only to personnel with direct patient contact. 4. Life's Touch Home Health Services must have a Controlled Substances Policy and distribute that policy to all employees and applications and require acknowledgment of receipt of the policy by employees. 5. Annually, Random Controlled Substance Testing is required at least for 50% of the employees with direct patient contact and not licensed under Indiana Code Title 25 and upon reasonable suspicion that the employee is engaged in the illegal use of a controlled substance...PURPOSE To verify the safe and consistent direct patient care provided by Life's Touch Home Health Services and it's employees. To follow consistent guidelines for Controlled Substances Testing of employees not licensed under Code Title 25. SPECIAL INSTRUCTIONS 1. All employees with direct patient contact and not licensed under Code Title 25 will be given a copy of this policy upon hire and each employee will provide acknowledgment of receipt of this policy which will be placed in the employee's personnel record. 2. Life's Touch Home Health Services will randomly select and notify employees for Controlled Substance Testing and that employee has 24 hours to appear and complete the testing. 3. Life's Touch Home Health Services will maintain a log of all testing, dates of testing, employees tested, results, any actions taken, and be available for review. PROCEDURE 1. HR and/or Management staff will conduct drug screening for new hires, random screens, and any suspected employees who have had allegations reported, who have direct patient care, per administration instruction. HR/Management staff have been educated on proper procedure for drug screening. Employee

The Agency identified all homehealth aides hired in 2022 and has scheduled each of them for drugtesting. All affected employees must come into the office within 24hours of notification to complete the test. Employees testingpositive for drugs will have their employment with the agencyterminated.

Fifty percent of all existingemployees will be required to complete a random drug test annually. The employees will be selected at random and have a 24-hour window oftime to come to the office to complete the test. Refusal or failureto perform the test will result in immediate termination ofemployment with the agency.

All future new hires will haveto complete a drug screen performed at time of hire.

All the above test resultswill be logged and maintained by the Agency Administrator.

The Agency has developed a“Controlled Substance Policy,” distributed it to all employees,and reviewed the policy and employee responsibilities with allcurrent employees.

All patients and staff are tobe made aware of the “no-tolerance” policy as it relates to useof illegal substances. This policy will be

	results will be logged HR/Management staff to include employee name, results, date of screen..." Review of an undated agency form titled 'Life's Touch Drug Testing Log' revealed one handwritten entry, "2022". The remainder of the form was blank. The agency failed to evidence a log dated 2021. A review of employee F's record revealed an agency form titled 'Life's Touch Home Health Services...CLIA Waived 5-Panel Urine Drug Test' which revealed a drug screening had been performed on 3/25/22, the expiration date of the test was written in as, "2021-10-31", making the test invalid. A review of the six (6) remaining employee records (employees A, B, C, D, E, G, and H) failed to evidence a negative drug screening as required by Indiana Code 16-27-2.5 2. On 3/31/22 at 3:34 PM, alternate clinical manager indicated the agency had not been performing the required yearly random 50% percent testing, but then quickly stated, "I don't know". On 4/4/22 at 11:04 AM clinical manager confirmed there had been no valid drug testing done this year (2022) and the 2021 records were, "in storage". The agency failed to follow its Drug Testing policy and failed to ensure agency employees were properly drug screened as require in Indiana Code 16-27-2.5. B. Based on record review and interview agency also failed to ensure home health aides were educated not to assist a patient, with an identified history of drug use, in partaking of illicit drug use in 1 (patient 1 and home health aide employee F) of 5 clinical records reviewed. Findings Include:		reviewed with allemployees at time of hire and annually thereafter and all patients attime of admission to service. All staff are instructed tonotify the Administrator or Clinical Manager whenever a patientapproaches them to assist with the use of illegal substances, or theywitness the patient using illegal substances. Failure to report theabove will result in immediate termination of employment with theagency. 2. Describe the steps or the systemic changes the agency has made to ensure the deficient practice does not recur. The drug screening process isperformed at time of hire and randomly thereafter. Failure tosuccessfully pass the drug screening process will result in denial ofan offer of employment with the agency or the immediate terminationof an existing employee. The Agency will create apolicy defining the zero tolerance for employee and/or patientutilization of illegal substances and the Nursing Management Teamwill review the policy individually with employees and with eachpatient	

1. A review of an agency complaint log entry dated 11/11/21, typed up as a separate attachment, titled 'Concern regarding [Patient 1], revealed, "...5. Illegal Drug use - marijuana - Statements have been received by HHAs were patient has requested that the HHA light patients "blunt" or roll patient a joint. Patient's [relative] was informed of the allegations, and had no idea patient partook in illegal drug use. There was also an allegation that one day there was a bag of "coke" setting on the counter. The HHA's even know where patient keeps his marijuana. The HHA's have asked patient not to light the "pot" while they are there and patient will still continue to do so..."

2. Review of the clinical record for patient 1 revealed a Start of Care date of 8/24/20 and a recertification date of 1/27/22 to 3/37/22 with diagnoses that included but were not limited to multiple sclerosis (a potentially disabling disease of the brain and spinal cord [central nervous system]), chronic pain, muscle weakness, incontinence (a lack of voluntary control) of urine and feces, tobacco use, depression, severe tremors (involuntary quivering movement) with an inability to sign documents for him/herself, records also indicated the patient was unable to perform most tasks for him/herself, had orders for home health aide for 10 hours per day, 5 times per week for 60 days to perform bathing assistance, hair care, shampoo, mouth care, foot care, assistance with dressing/undressing, assistance with feeding, assistance with using the bathroom, meal preparation, assist with wheelchair, linen changes, making bed, personal care, accompany to medical visits.

3. On 3/30/22, at 3:42 PM, in a telephone interview, the representative for patient 1, person D, stated there have historically been multiple issues (theft of property, theft of narcotics, and medication mismanagement) with the agency but that currently, things were now better. Person D cited current ongoing issues in relation to the caliber of staff and lack of trustworthiness , indicated aide staff had too much autonomy and not enough oversite on the part of the agency, indicating there should be more accountability. When queried further for examples, person D was not willing to provide specifics. When queried about any knowledge of illegal substances being an issue or being present in patient 1 s home, person D sighed and stated, no, I m not aware there are .

and obtain the employees and patients signatures to confirmtheir awareness of the policy. The employee’s signed policy willbe filed in their personnel file.

The patient’s signaturevalidating awareness of the zero tolerance for utilization of illegaldrugs will be maintained with their admission documents. Agencystaff must understand that any use of illegal drugs will result inimmediate termination of employment. Patients must understand thatany use of illegal drugs will result in the immediate termination ofagency home health services.

3. Describe how the corrective action will be monitored to ensure ongoing compliance.

The RN Case Managers willfollow-up with a home visit regarding all reports of potentialillegal drug utilization in the patient’s home. Use of illegaldrugs will be considered grounds for termination of home healthservices.

Going forward all new hireswill be tested for the presence of

	On 4/4/22, at 10:33 AM and 10:56 AM, employee F, a home health aide, was interviewed concerning care and services for patient 1. Issues were identified concerning Quality of Care/Treatment. Employee F stated he/she had recently started employment with the agency and had their first with patient 1 on 3/28/22, and also stated that he/she had assisted patient 1 to smoke marijuana only one time recently by, putting it to [patient s] mouth and lighting it , indicating he/she had been instructed to do so by agency staff, but would not divulge who had given the directive, but also indicated he/she had been instructed not to partake of the marijuana him/herself. On 4/4/22, at 11:47 AM, in an interview with patient 1, when queried, denied the presence of any marijuana in the home, stated, no, no, no, that won t be happening in here . On 4/4/22, at 12:04 PM, the administrator and clinical manager were interviewed concerning patient 1. Both indicated they were aware that patient 1 had a history of marijuana use, but both indicated they were unaware employee F, a home health aide, had recently assisted the patient to smoke marijuana. When queried further administrator and clinical manager denied any involvement in directing employee F to do so. The clinical manager indicated they would be drug testing employee F. Administrator and clinical manager indicated they would be taking further action. The agency failed to ensure staff was educated against assisting patients with illicit drug use. 410 IAC 16-27-2.5		Managementstaff will conduct the drug screening process for all new hires. Allindividuals being tested must report for testing within 24 hours ofnotification. The Agency Drug Testing Logwill evidence testing results including the applicant/employee name,date of test, and test results. 4. Date of corrective action: 04/06/2022. 5. Employee position responsible for ensuring ongoing compliance with N9999. The Agency Administrator andClinical Manager are responsible for ensuring ongoing compliance withN9999.	

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