STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K015	A. BUILDING B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITHFUL FRIENDS HOME HEALTHCARE INC	203 S WASHINGTON STREET, MARION, IN, 46952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	INITIAL COMMENTS This visit was for a Federal and State complaint survey of a Home Health Provider. Survey Dates: January 24, 25, 26, and 29, 2024. Complaint: IN103882 with related and unrelated deficiencies cited. 12 Month Unduplicated Skilled Admissions: 10 QR: 2/7/24 A 1	G0000		
G0438	Have a confidential clinical record 484.50(c)(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164. Based on record review and	G0438	the Facility's Security and Privacy Policy has been updated as of February 19, 2024 to include no social media posting of any kind is allowed. Nurse Educator to in service all staff that no social media posting or pictures of clients of any kind is permitted and that they are to always maintain a professional boundary and to practice in their scope. Nurse Educator also to in service all staff on the updated Security and Privacy Policy and HIPAA Policy. This will be completed by March 8, 2024.	2024-03-08

	interview, the home health agency failed to protect the confidentiality for 1 of 4 clinical records reviewed (Patient #4). Findings include: 1. An agency policy titled "Client Security and Privacy" indicated any patient photos taken are for the purpose of documentation and are only taken with the patient's written consent. An agency policy titled "Consent for Filming or Recording" indicated the agency requires patient consent to photograph patient. 2. A review of a complaint completed by the Director of Nursing (DON) on 05/03/2023 indicated Home Health Aide (HHA) 1 provided nail care to Patient #4 and posted a photo of patient's fingernails on social media. The clinical record for Patient #4 failed to evidence the agency received a written consent to photograph patient. 3. During an interview on 01/26/2024 at 1:00 PM, the DON indicated staff are not to post patient information nor		During Supervisory Visits starting March 8, 2024 Case Managers will ask if staff members are maintaining professionalism and confidentiality with regards to not taking pictures of any kind while in the home and will document client's response in the Supervisory Visit note. This will be part of the agency's normal Supervisory Visit process going forward. The DON will review all Supervisory Visits for any concerns or possible conflicts ongoing to ensure the deficiency does not re-occur. All deficiencies will be corrected by March 8, 2024.	

	photos on social media. 410 IAC 17-12-3(b)(4)			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to notify family members of changes in patient health or current needs in 1 of 4 active patient records reviewed (Patient #1). Findings include: The clinical record for Patient #1 failed to evidence documentation of interactions and communication with Patient's family. The emergency plan for Patient #1 identified Person 2 as Patient's emergency contact. During a phone interview on 01/24/2024 at 8:30 AM, Person 1 (a family member) indicated Patient #1 was moved to a nursing home, organized by agency staff member registered nurse (RN)1; RN 1 nor other	G0608	Nurse Educator instructed all staff to notify agency DON/Case Manager for any changes to client condition on March 8, 2024. Upon notification of change in client condition or any emergency agency DON/Case Manager will notify emergency contact immediately. This will be documented in the care coordination section of the client chart. In the event that emergency contact cannot be reached, and if applicable agency will defer to Adult Protective Services. Nurse Educator will have all Case Managers in serviced by March 8, 2024 to ensure that coordination of care is completed as outlined in Coordination of Client Services Policy and that all changes in condition are communicated to family and documented in the chart. To ensure the deficiency does not happen again DON will audit all on call notes daily to ensure any changes/emergencies were reported and the emergency contact was notified. DON will also audit all care coordination notes to ensure documentation of communication of changes/emergencies has been completed and all documentation of emergency contact response noted. These audits will begin March 8, 2024 and will be part of ongoing audit process. DON will be responsible for auditing on call notes daily and all care coordination notes ongoing. All in servicing for staff and Case Managers will be completed by March 8, 2024.	2024-03-08

	Person 1 relayed they did not know where RN 1 had moved Patient 1. During an interview on 01/25/2024 at 12:30 PM, RN 1 was unable to provide documentation of coordination or communication with Patient #1's family. RN 1 indicated there were conversations, though none were documented in the clinical record. During a phone interview on 1/29/2024 at 10:23 AM, Person 2 (a family member) the agency did not include them in any treatment decisions nor patient updates. 410 IAC 17 - 14 - 1(a)(1)(F)			
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on record review and interview, the agency failed to ensure potential or actual conflicts of interest and oversight of staff who were engaged in dual roles with patients and followed	G0984	The Administrator developed a Conflict-of-Interest Policy on February 19, 2024 with regards to the employment of family in relation to staff. The facility's Corporate Compliance Policy has been removed as of February 19, 2024. The facility's Abuse and Prevention Policy was updated on February 19, 2024, to remove social services and will now state that client's will be referred to LifeStream's. Nurse Educator to in service all staff on the Conflict-of-Interest Policy and the updated Abuse and Prevention Policy. This will be completed by March 8, 2024. The Administrator established an Ethics Committee for the facility on February 19, 2024. The committee will meet monthly and as needed to discuss any possible ethical	2024-03-08

	accepted standards regarding boundaries and agency policies regarding conflicts of interest and ethics in 2 of 4 active records reviewed (Patients #1 and 5). Findings include: 1. A review of the American Nurses Association (ANA) code of ethics statement, available at https: //www.nursingworld.org /practice-policy /nursing-excellence /ethics/ code-of-ethics -for-nurses/ indicated "... nurses must examine the conflicts ..." and "... Nurses who bill services ... must be especially aware of the potential conflicts of interest." Additionally, the code of ethics statement indicated "... nurses must maintain appropriate personal relationship boundaries." 2. A review of a conflict-of-interest policy indicated "All staff shall conduct business practice in such a manner that no conflict of interest, real or implied could be construed." Additionally, the policy indicated "... an actual or potential conflict of interest occurs when an [a] person is in		concerns. All meetings will have recorded minutes and will be tracked in QAPI. Upon admission the admitting nurse asks all clients for emergency contact information, if they would like to designate a personal representative, and if they have a healthcare POA. This information will be documented in the patient's emergency plan and Oasis. If a healthcare POA is in place or a court-ordered designee has been assigned the agency will require that a copy of paperwork establishing the individual be provided to the agency for placement in the clinical record. Contact information for POA/HCR/Personal Representative will be added to clinical record on the Oasis, emergency plan, and emergency form. All Case Managers will coordinate with clients and their respective representative at time of recert and when applicable for possible conflicts of interest and if any are identified DON will be notified and Ethics Committee meeting will be held within 24 hours to determine what the agencies course of action with regards to the potential conflict will be. In the event that the committee determines there is an actual conflict of interest, the agency will take all necessary precautions/steps to ensure the safety, health, and wellbeing of the client, including notification of outside agencies that can provide assistance when needed. DON and Case Managers will meet weekly to discuss and review any concerns, Ethics committee will meet monthly and as needed when concerns arise and QAPI will track, this will be ongoing. RN 1 has severed all ties personally with Patient #1. RN 1 has written letter to revoke POA and will have it notarized and placed in client chart by March 20, 2024. Patient #1 and Patient #1's family have been made aware of the revoking of POA as of March 18, 2024 and it is documented in Patient #1 chart. To ensure this never happens again DON/Administrator	

	a position to influence a decision that may result in a personal gain ….” 3. A review of a corporate compliance policy indicated ethical issues were a focus of their compliance plan. 4. A review of the abuse prevention plan policy indicated clients with limited caregiver support would be referred to social services for supervision and/ or money management services. 5. A review of a clinical decision-making policy indicated an agency code of ethics prohibited clinical staff from engaging in financial incentives. 6. A review of the ethics committee policy indicated the role of the ethics committee was to educate staff in the identification of ethical issues. 7. During an interview on 1/25/2024 beginning at 9:25 AM, the director of nursing (DON) indicated registered nurse (RN) 1 was the financial power of attorney (POA) for Patient #1. The DON indicated		will not allow staff to be POA/HCR of client, they will either be personal relationship or professional relationship but will never be both. DON/Administrator will audit all POA paperwork to ensure there are no further incidents of this by March 18, 2024 and will continue to audit POA paperwork ongoing. As of January 30, 2024, RN 2 is no longer HCR for Client #5. HCR is no longer required as the client's incompetency was based on a short-term issue. Client has since regained her mental faculties and has been deemed able to make her own decisions. Effective February 19, 2024 LPN 1 will no longer provide routine care in homes where RN 2 is Case Manager. Nurse Educator will have all staff in serviced and all necessary corrections completed by March 8, 2024. The information provided to the surveyors by RN 1 is not accurate. The employee has received education from DON as of February 19, 2024, regarding her actual job title and description and was placed in her personal file.	

	however it was not in Patient's clinical record. The DON relayed that RN 1 was not acting as POA, on behalf of the agency, therefore the document did not need to be in the clinical record. The DON indicated RN 2 was the designated health care representative (HCR) for Patient #5 and the paperwork was not in Patient #5's clinical record as the HCR was not on behalf of the agency. 8. The clinical record for Patient #1 failed to evidence a financial or medical decision – maker for the patient. The record indicated the patient had a diagnosis of dementia since 2018. The record evidenced documents initialed by the patient which were very shaky. A review of the POA agreement between RN 1 and Patient #1 evidenced a notary stamp dated August 15, 2022. The document was signed by RN 1 and Patient #1 placed their initials to sign the document. The document indicated Patient would need to provide a written notice to revoke the POA. 9. The clinical record for Patient #5 failed to evidence a medical			

	– decision maker. The record evidenced Patient #1 received 133 nurse visits during the time frame of 12/13/23 to 1/24/24. Of those visits, 128 were provided by RN 2 (Patient's healthcare representative) and licensed practical nurse (LPN) 1 (spouse of the healthcare representative). The record evidenced RN 2 completed the supervisory visits of LPN1, their spouse. 10. During an interview on 1/26/24 beginning at 1 PM, the DON and RN 1 indicated they did not believe there were any ethical issues or conflicts of interests with their staff, RN 1 and RN 2, in the role of patients' POA or HCR for Patient #1 and #5. When asked, RN 1 indicated Patient #1 had attended school through the 8th grade and indicated Patient was able to read and understand the POA document despite their dementia diagnosis and their limited education. RN 1 indicated Patient #1 can make their own decisions and the dementia diagnosis did not impair Patient's judgment. When asked about Patient #1's ability to write a notice of revocation			

	of the POA, RN 1 indicated it would be very difficult for Patient. DON and RN 1 relayed they did not think it was an ethical issue that RN 2 was the health care representative and the primary RN for Patient #5 nor did they see a conflict of interest that RN 2 supervises the LPN, their spouse. The DON and RN 1 indicated the agency did not have a process to review potential or actual ethical or conflict of interest situations. They indicated they did not believe the agency needed a process and responded that their policies reviewed were not relevant. DON indicated there were no more cases of employees acting as any clinical or financial decision – maker for any of their other patients. RN 1 indicated the agency did not have a social worker on staff and when asked, RN 1 indicated they were not aware of any community resources who might be able to assist their patient(s). 11. During the entrance conference on 01/24/24 at 9:40 AM, Registered Nurse (RN) 1 introduced self as the Compliance Director; wore a			

	individual as the Compliance Director.			
N0000	Initial Comments This visit was for a State complaint survey of a Home Health Provider. Survey Dates: January 24, 25, 26, and 29, 2024. Complaint: IN103882 was investigated; related and unrelated state deficiencies were cited. 12 Month Unduplicated Skilled Admissions: 10 QR: 2/7/24 A 1	N0000		
N0458	Home health agency administration/management 410 IAC 17-12-1(f) 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	N0458	The information provided to the surveyors by RN 1 is not accurate. RN 1 received education by DON regarding her actual job title and job description on February 19, 2024, and it has been placed in her personal file. Human Resource/DON will complete an audit to ensure all personal files have the appropriate job description by March 8, 2024.	2024-03-08

	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. (5) Annual performance evaluations. Based on interview and record review, the home health agency failed to ensure personnel files contained the receipt of a job description for 1 of 1 home health agency. Findings include: 1. During the entrance conference on 01/24/24 at 9:40 AM, Registered Nurse (RN) 1 introduced self as the Compliance Director; wore a name badge that identified individual as the Compliance Director. 2. During an interview on 01/25/24 at 4:15PM, RN 1 indicated she/he was the Compliance Director and had not received a job description for the Compliance Director position.		Human Resource/DON will continue to audit with every new hire to ensure appropriate job description until 100 percent compliance is met. All deficiencies will be corrected by March 8, 2024.	

	3. The employee record of RN 1 / Compliance Director failed to evidence a job description as the Compliance Director.			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.	N0460	Orientation process has now been reviewed with current Director of Nursing and Administrator. Director of Nursing personal file reviewed and updated to include the Director of Nursing orientation checklist as of February 19, 2024. Human Resource/DON will review all personnel files to ensure they have record of orientation by March 8, 2024. Human Resource/DON will continue to audit all new personnel files for appropriate orientation until 100 percent compliance is met. All deficiencies will be corrected by March 8, 2024.	2024-03-08

	Based on record review and interview, the agency failed to ensure the personnel files included orientation of the supervising nurse (Director of Nursing) for 1 of 1 home health agency. Findings include: A review of the employee file of the supervising nurse indicated an uncompleted orientation checklist for the supervising nurse. During an interview on 01/25/2024 at 4:15 PM, the Quality Director indicated the orientation checklist was not completed.			

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
Erica McCain	DON	3/18/2024 9:55:53 AM