STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K137	A. BUILDING B. WING	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MASTER'S TOUCH HOME CARE LLC	7275 N SHADELAND AVE SUITE 1, INDIANAPOLIS, IN, 46250

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider and Supplier. / Survey Date: 07-31-2024 and 08-01-2024 Census: /45 At this Emergency Preparedness survey, The Master's Touch Home Care was found to be out of compliance at 42 CFR 484.102 Emergency Preparedness Requirements for Medicare/Medicaid Participating Providers and Suppliers for Home Health Agencies. / QR completed by Area 3 on 8-6-2024.	E0000	Completed 8/15/2024	

E0001	Establishment of the Emergency Program (EP) 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local	E0001	**DEFICIENCY CITED: E0001** **484.102 Establishment of the Emergency Program (EP)** **Completion Date**: August 15, 2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** After a recent survey from the state, the Agency was foundto be out of compliance with having a *personalized* agencyEmergency Management Plan in place. On 8/13/2015, a personalized emergencymanagement plan was updated by the Administrator, to bring us into compliance. On 8/15/2024 the Administrator, oriented thegoverning body on their responsibilities during an emergency/hazard. The Governing Body reviewed the policies andprocedures in the event a disaster occurred affecting the organization or thecommunity and what their	2024-08-15

	CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the agency failed to ensure the comprehensive emergency preparedness program met all requirements to meet the health, safety, and security needs of their staff and patient population for 1 of 1 agency (E0001); failed to ensure an Emergency Preparedness Plan was in place and reviewed every 2 years, at minimum (E0004); failed to ensure a facility based and community based risk assessment utilizing an all-hazards approach (E0006); failed to ensure the agency addressed patient population, including, but not limited to, persons at-risk and continuity of operations, including delegations of authority and succession plans (E0007); failed to ensure the agency included a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials (E0009); failed to ensure a system to inform State and local emergency preparedness officials about patients in need of evacuation (E0019); failed to ensure the agency had a plan for the subsistence needs for staff and patients, whether they evacuated or sheltered in place; failed to ensure access to a plan or a system / defined procedure to track the		responsibilities would be. On 8/7/2024 leadership determined a hazardvulnerability analysis on clients based on their triage status. The Administrator analyzed the increasedhazards more prone to our community. On 8/7/24an Emergency Binder/On-Call Binder was created to include hard copies of thecensus report, client contact information, organizational chart, contact forlocal, state and federal agencies, and client POC's categorized according to triage/acuitystatus. Clients are already categorizedaccording to triage status upon every admission and at every recertification bythe case managers. This acuity level isaudited by the Clinical Manager with every assessment on the client's Plan ofCare. The Clinical Manager held anIn-Service on 8/8/2024, reviewing the policy # 4-001 and the policy, procedure androles were defined during the Nurse Meeting identifying on the chain of commandand a communication tree was updated to include the Administrator, , ClinicalManager, , Case Managers and Administration	

	location of on-duty staff and sheltered patients under the agency's care during an emergency (E0021); failed to ensure a system of medical documentation that would preserve patient information, protects the confidentiality of patient information, secures and maintains the availability of records (E0023); failed to ensure the use of volunteers in an emergency or other emergency staffing strategies to address surge needs during an emergency (E0024); failed to ensure a written emergency communication plan that contains how the facility coordinates patient care within the agency, across healthcare providers, and with state and local public health departments (E0029); failed to ensure that an emergency preparedness communication plan included all staffing addresses and phone numbers, entities providing services under arrangements, and patient physicians for all districts/ territories that the agency provided services to (E0030); failed to ensure Emergency Official contact information (E0031); failed to ensure a system in place for primary or alternate means for communication with staff, Federal, State, tribal, regional, and local emergency management agencies (E0032); failed to ensure a system was in place for sharing information and medical documentation for patients under the agency's care, as necessary, with other health providers to		which identifies staff membersresponsible for the notification of clients in the event of a local, state orfederal emergency. The ON-Call CaseManager will oversee delegating client contacts among the governing body in theevent of an emergency to ensure communication is maintained with any necessaryemergency personnel. The Binder will becarried by the ON-Call CM and will be updated upon SOC, RECERT or change inplan. On 8/15/2024 and in-service was given to theGoverning Body regarding the Emergency Management Plan along with thedelegation of clients via our communication tree. The Administrator, along withthe governing body and Case Managers, reviewed the policies and procedures inthe event a disaster occurred affecting the organization or the community. The policy was provided to the governing bodyand case managers, on 8/15/2024 and the roles were understood. The Clinical Manager, educated with anin-service to the Governing Body what the different acuity levels mean andverbalized understanding. Clients	

	maintain the continuity of care (E0033); and failed to ensure the agency developed and maintained an emergency preparedness training and testing program that is based on the emergency plan and the Training and Testing was reviewed annually (E0036). / The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition, /Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies. /at /42 CFR 484.102. Findings include: 1. On 08-01-2024 a review of an agency's policy titled 'EMERGENCY MANAGEMENT PLAN Policy No. 4-001' revealed, "... POLICY The organization will comply with all applicable, Federal, State, and local emergency preparedness requirements ... PROCEDURE ... Organization leadership will conduct a hazard vulnerability analysis (HVA) ... 1. The HVA is evaluated annually to reflect changes in organization, risk conditions, patient information, and changes in staff. 2. Staff will work with regional or		alreadyhave an Individualized Emergency Preparedness Plan that they develop with theirCase Mangers on upon admission and is reviewed every 60 days at recertificationin preparation of an unforeseen disaster or emergency. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** The Administrator will ensure that our Governing Bodydiscusses, reviews and evaluates the Emergency Management Plan at least every 2years according to CMS guidelines. Theannual meetings will be able to ensure patient safety and to ensure the policyis being maintained and client POCs are being updated as necessary. TheClinical Manager will continue to audit charts at admission and with every recertificationto ensure accurate triage/acuity levels are included in the client's plan ofcare. The Administrator, followed by theClinical Manager, will be responsible for ensuring that the Governing BodyMeetings	

	county emergency management planning agencies … A, Establishing priorities … B. Defining organization's role in relation to the community-wide emergency management program … C. Developing an "all-hazards: command structure … 3. Specific procedures that describe mitigation, preparedness, response, and recovery strategies, actions, and responsibilities will be developed for each priority emergency. 4. Based on the hazard vulnerability analysis and community planning activities, the organization's general emergency plan may be enhanced or revised according to identified potential emergencies and planning activities. 5. The Executive Director/Administrator … has been designated at key leadership who is responsible for all emergency activities… will determine the leadership command structure to ensure continuity of operations (See Addendum 4-001.B "Command Structure" and Addendum 4-001.C "Flow Chart of Alternate Roles and Responsibilities"). … Communication Plan The Organization will maintain an		are held every quarter at least every 2 years to review the EmergencyManagement Plan to ensure that this deficiency remains corrected and does notrecur. The results of the audits will bereported, reviewed and trended by the QAPI Nurse for compliance through theQuality Assurance Performance Improvement program quarterly to ensure 100%compliance. **Who isgoing to be responsible for numbers 1 and 2 above?** The Administrator **By what date will you have the deficiency corrected?** This deficiency was corrected on 8/15/2024.	

	emergency preparedness communication plan that complies with Federal, State, and local laws, and is reviewed and updated annually ... Training and Testing The Training and testing program is reviewed and updated at least annually. ... Testing 1. The Master's Touch Home Care will test the emergency management plan ... at least annually ... 2. The agency participates in a full-scale exercise that is a community-based or individual, facility-based ...". On 08-01-2024 a review of 'ADDENDUM 4-001.A PYRAMID PHONE COMMUNICATION PLAN' revealed "Primary Communication Method: (left blank), Alternate Communication Method: (left blank). On 08-01-2024 a review of 'ADDENDUM 4-001.B COMMAND STRUCTURE' was left blank. On 08-01-2024 a review of 'ADDENDUM 4-001.C FLOW CHART OF ALTERNATE ROLES AND RESPONSIBILITIES' was left			

	blank. On 08-01-2024 a review of 'ADDENDUM 4-001.D HAZARD VULNERABILITY ANAYLISIS' was left blank. On 08-01-2024 at 8:38 AM, a review of the EP binder revealed it was a 'sample' binder to be used to develop an agency's EP Program. 2. On 08-01-2024 at 8:40 AM, this writer queried the Administrator who was in charge of the Agency's Emergency Preparedness Program, and she indicated the Clinical Educator was in charge of the EP Program and they should be arriving at the agency soon. 3. On 08-01-2024 at 10:32 AM, the Clinical Educator indicated all patients have their EP plans in their binders in their homes and the staff are given an annual in-service on EP. When queried further if the agency had participated in a community-based exercise or conducted one annually, and if the program was developed and evaluated annually, they indicated they would have to			

	When queried about the EP binder that was provided to the surveyors, the Clinical Educator indicated the forms were blank, and there was missing documentation. 4. On 08-01-2024 at 3:00 PM, when the Administrator was queried about the Agency's EP Program, she indicated the Clinical Educator was in charge of it and was putting together the EP Program, knew the EP binder provided was a sample book for a guideline, and they were part of Coalition 5 (serves as a multidisciplinary, multi-agency group that assists in the coordination with local Emergency Management agencies) but hadn't participated in any activities.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification of a Home Health provider. Partially Extended survey on: 07-31-2024 at 3:42 PM.	G0000	Completed 8/15/2024	

Fully Extended survey on: 08-01-2024 at 3:06 PM.

Survey Date: 07-31 and 08-01-2024

12-Month Unduplicated Skilled Admissions: 68

Active Census: 45

This deficiency report reflects State Findings cited in accordance with 410 IAC 17. For additional state findings, refer to the State Form.

During this Federal Recertification Survey, The Master's Touch Home Care Limited Liability Company (LLC) was found to be out of compliance with Conditions of Participation 484.102 Emergency Preparedness and 484.105 Organization and Administration of Services.

	Based on the Condition-level deficiencies during the August 01, 2024, survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on November 10, 2020. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning August 01, 2024, and continuing through July 31, 2026. QR completed by Area 3 on 8-6-2024.			
G0372	Encoding and transmitting OASIS 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing	G0372	**DEFICIENCY CITED: G0372 484.45(a) Encoding and transmitting OASIS** **Completion Date**: August 15, 2024 **How are yougoing to correct the deficiency? If already**	2024-08-15

	the assessment of the beneficiary. Based on record review and interview, the agency failed to submit OASIS (Outcome Assessment Information Set) within 30 days of assessment completion for 2 of 5 active clinical records reviewed. (Patients #8 and 9 (3 times)) Findings Include: 1. A review of The Master's Touch Home Care policy revised December 2018, titled "OASIS Data Transmission" indicated but was not limited to, " ... The organization will encode and will encode and transmit each completed OASIS data for each applicable patient within thirty (30) days of the M0090 date, date assessment completed ... " 2. A review of an agency document titled "OASIS Agency Final Validation." The documents dated 07-01-2023 through 07-30-2024 were reviewed, for the reporting period of the year to date, which indicated Active Patient #9 had a section titled "RFA" listed as 01, indicating start of care OASIS assessment submitted on 07/17/2023 and		**corrected, include the followingsteps and state the date of correction.** During a recent state survey, the agency was found to be outof compliance for patient # 9 on 6/14/2023 and 7/17/2023 and was submitted morethan the 30 days allowed. Another late submission was found on 9/13/2023. Patient8 had a late submission of an OASIS on 6/24/2024. In July 2023 and again on August 8, 2024, Policy andProcedure # 6-044 was reviewed by the Clinical Manager, RN the personresponsible for OASIS data transmissions. A Performance Improvement planwas developed on 8/8/2024 to ensure the timely submission of our OASIS Assessments,which included the Administrator, ADON, Clinical Educator, and the ClinicalManager. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** The Clinical Manager Role and Responsibility Binder	

	the M0090 date of 06-14-2023 with message -3330 indicating record submitted late; more than 30 days after the M0090 date of the record. The validation reports indicated Patient #9 had section titled RFA listed as 04, indicating recertification OASIS assessment submitted on 09-13-2023 and the M0090 date of 08-11-2023 with message -3330 indicating record submitted late; more than 30 days after the M0090 date of the record. The validation reports indicated Patient #9 had section titled RFA listed as 04, indicating recertification OASIS assessment submitted on 06-13-2023 and the M0090 date of 08-11-2023 with message -3330 indicating record submitted late; more than 30 days after the M0090 date of the record. 3. A review of the active clinical record for Patient #9, with a start of care date of 06-14-2023, contained an initial comprehensive assessment dated 06-14-2023. The OASIS Assessment reason was for a start of care for the certification period 06-14-2023 through		wascreated and the ADON and Administrator are aware of the location of the BINDERin the event alternative staffing would need to be trained. TheADON was trained and provided with the policies and procedures on OASIS DataTransmission according to our policy and CMS standards. The policy for OASIS Data Transmission wasalso added to our already established Binder. The Clinical Manager will monitor this monthly to ensure 100% accuracyand timeliness of transmissions and the ADON followed by the Administrator willbe responsible in their absence and were educated on 8/8/2024 on theirresponsibilities to ensure they are submitted within the required 30-days. The results of the audits will be reported,reviewed and trended by the QAPI Nurse(s) for compliance through the QualityAssurance Performance Improvement program quarterly to ensure 100% compliance. **Who isgoing to be responsible for numbers 1 and 2 above?**	

	08-14-2023. The record contained a comprehensive assessment dated 08-11-2023, for the recertification period 08-13-2023 through 10-11-2024. The record contained a comprehensive reassessment dated 04-05-2024, for the recertification period 04-09-2024 through 06-07-2024. 4. A review of an agency document titled "OASIS Agency Final Validation." The documents dated 07-01-2023 through 07-30-2024 were reviewed, for the reporting period of the year to date, which indicated that Inactive Patients #8 had a section titled "RFA" listed as 01, indicating start of care OASIS assessment submitted on 06/24/2024 and the M0090 date of 04-08-2024 with message -3330 indicating record submitted late; more than 30 days after the M0090 date of the record. 5. A review of the active clinical record for Patient #8's start of care 04-08-2024, contained an		The Administrator **By what date will you have the deficiency corrected?** This deficiency was corrected on 8/15/2024	

	assessment dated 04-08-2024. The OASIS Assessment reason was for a start of care for the certification period 04-08-2024 through 06-06-2024. During a phone interview on 08/01/2024 at 3:31 PM, when queried regarding the submissions of OASIS, the Clinical Manager confirmed they submitted the agency OASIS and that they should be submitted within 30 days. The Clinical Manager further indicated they reviewed the error reports and did not have any, then indicated they may have had one. When queried regarding a review of the untimely submissions of Patients # 8, and 9, they were new then and were figuring the system out. When asked if there was a Performance Improvement Plan (PIP) for untimely submissions indicated there had not been.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status;	G0528	**DEFICIENCY CITED: G0528 484.55(c)(1) Health, psychosocial, functional, cognition**	2024-08-15

	Based on record review and interview the agency failed to ensure a complete psychosocial status assessment was completed on 1 of 5 active record reviews. (Patient #1) Findings include: 1. A review of an agency's policy dated December 2018 titled 'INITIAL AND COMPREHENSIVE ASSESSMENT Policy No. 1-016' revealed "PURPOSE To provide guidelines for the initial assessments … D. Patient's medical and psychosocial history …" 2. A review of the clinical record for Patient #1 revealed a document titled OASIS (the Outcome and Assessment Information Set is a group of standard data elements home health agencies integrate into their comprehensive assessment to collect and report quality data)-Start of Care (SOC) dated 01-05-2024 for the certification period of 01-05-2024 through 03-04-2024, signed by RN 1 which failed to evidence		**Completion Date:** August 15, 2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** The agency failed to ensure that a patient's comprehensiveassessment accurately reflected the patient's psychosocial status when 1 of 5records was reviewed by the ISDH. Policy# 1-016 was pulled and the case managers were reeducated, and an in-service wasgiven on 8/8/2024, by the Clinical Manager, on the required assessments needed withinitial and comprehensive, which include but not just limited to psychosocialstatus. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** To ensure 100% accuracy our charting system coordinator wasnotified, and the field has since been made mandatory by	

	assessed. A review of the clinical record for Patient #1 revealed a document titled OASIS-Recertification with a SOC of 01-05-2024 for the certification period of 03-05-2024 through 05-03-2024, signed by the Alternate Clinical Director which failed to evidence Psychosocial Problems were assessed. A review of the clinical record for Patient #1 revealed a document titled OASIS-Recertification with a SOC of 01-05-2024 for the certification period of 05-04-2024 through 07-02-2024, signed by RN 1 which failed to evidence Psychosocial Problems were assessed. A review of the clinical record for Patient #1 revealed a document titled OASIS-Recertification with a SOC of 01-05-2024 for the certification period of 07-03-2024 through 08-31-2024, signed by RN 1 which failed to evidence Psychosocial Problems were assessed.		the clinical managerto avoid missing that assessment with our clients in the future. To prevent a deficiency in our assessments, the ClinicalManager/Compliance Officer will review every assessment to ensure this sectionhas been completed with each submission. Chart audits will be done quarterly by the Clinical Manager/ComplianceOfficer to ensure 100% compliance. Theresults of the audits will be reported, reviewed and trended by the QAPI Nursefor compliance through the Quality Assurance Performance Improvement program quarterlyto ensure 100% compliance. **Who is going to be responsible for numbers 1 and 2 above?** The Clinical Manager **By what date will you have the deficiency corrected?** This deficiency was corrected on 8/15/2024.	

	3. On 08-01-2024 at 12:17 PM, an interview with RN 1 indicated there was a system to carry over information from prior assessments, and they copied over to the current assessment because it's too time-consuming to type all the diagnoses and codes. When RN 1 was queried how the psychosocial assessment was missed on all 4 assessments, they indicated they did not know. 4. On 08-01-2024 at 1:50 PM, an interview with the Alternate Clinical Manager, they indicated the psychosocial assessment was not completed and it should be, and clinicians can copy one assessment to another. 410 IAC 17-14-1(a)(1)(A) and (B)			
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	G0572	**DEFICIENCY CITED: G0572 484.60(a)(1) Plan of Care** **Completion Date:** August 15, 2024 **CORRECTIVE**	2024-08-15

	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 observation, record review, and interview, the agency failed to ensure the individualized plan of care included patient-specific interventions, specific education, and training provided by the Registered Nurse (RN), measurable outcomes, and goals identified by the home health agency in 1 of 2 active clinical records of patients with seizures. (Patient: #3) (Employees: Alternate Clinical Manager, Admin 3) Findings Include: 1. A review of The Master's Touch Home Care policy revision date December 2018 "Care Planning Process" indicated but was not limited to, " ... To provide direction to the clinicians providing direct patient care ... the plan of care will include ... Patient-specific interventions and education Reasonable,		**ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** A recent survey by the ISDH revealed that the care planningprocess was not individualized for all clients and that patient # 3, did nothave a seizure plan. Case Managers were provided with acopy of the policy and reeducated on 8/8/24 by the Clinical Manager, on theneed to make each care plan individualized according to policy # I-007. Seizure Precautions, Fall Precautions,Bleeding Precautions etc. to be included in each POC according to client'sneeds. On 8/7/2024, all home health aides were givenan in-service by the Clinical Educator on the importance of notifying the casemanagers of any change in condition which is not limited to but includesseizure activity. Thecaregiver was provided with the updates as well as reeducated by the ClinicalEducator, on 8/7/2024	

	measurable, and individualized goals and outcomes identified … ” 2. A review of the clinical record for Patient #3, start of care 08-17-2016, contained a plan of care for the recertification period 07-21-2024 through 09-19-2024, co-signed by the Alternate Clinical Manager, Admin 3, dated 07-16-2024. The plan of care evidenced Patient #3’s principal diagnosis, Autistic Disorder (a condition related to brain development that impacts how a person interacts with others, communicates, learns, and behaves), and other diagnoses of Seizures and Developmental Disorders of Speech and Language. The plan of care failed to evidence interventions, measurable, and patient-specific goals for Patient #3’s diagnosis of seizures. During a home visit at Patient #3's residence on 08-01-2024 at 10:05 AM, when asked where the patient was, HHA 2, Patient #3’s caregiver, indicated Patient #3 had a seizure two days ago and was sleeping. When queried regarding a seizure plan or education provided by the		on reporting and recording of changes in client status. On 8/7/2024 the Clinical Educators completed an In-Servicewith all home health aides and will continue to be the responsible ones forpreventing this deficiency in the future by educating staff at orientation andat minimal annually. On August 8, 2024, a seizure log wasalso implemented, for the case managers to complete in our EMAR when a seizureoccurs. On 8/14/24 Patient #3’s CarePlan was updated to include a seizure plan along with the aide care plan. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** The Clinical Educators will continue to educate by givingin-services at orientation and annually to immediately report a change incondition, which includes but is not limited to seizure activity. Case Manager’s will continue to educate staffwith each supervisory visit, SOC and recertification. The Clinical	

	they did not have a seizure plan or education from the agency; they just turned the patient on their side as instructed by Patient "3's neurologist. 3. During an interview with the Administrator and Alternate Clinical Manager, Admin 3, on 07-31-2024 at 3:42 PM, they indicated upon review of the clinical record for Patient #3, there was no seizure plan in the plan of care. They confirmed it was the agency's responsibility to have educated and documented a seizure plan in the plan of care. 410 IAC 17-12-1(a)		Manager willensure this education is being provided at orientation and annually. The results of the audits will be reported,reviewed and trended by the QAPI Nurse for compliance through the QualityAssurance Performance Improvement program quarterly to ensure 100% compliance. **Who is going to be responsible for numbers 1 and 2 above?** Clinical Manager **By what date will you have the deficiency corrected?** This deficiency was corrected on 8/15/2024	
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to ensure the Home Health Aide (HHA) coordinated care with the	G0606	**DEFICIENCY CITED: G0606 484.60(d)(3) Integrate all services** **Completion Date**: August 15, 2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the**	2024-08-15

	Registered Nurse (RN) in 1 of 1 active clinical record (Patient #3) reviewed with a change in the patient's condition. (Employees: HHA 2) Findings Include: 1. A review of The Master's Touch Home Care policy revision date December 2018 "Care/Service Coordination" indicated but was not limited to, " ... Care Coordination will include, but not be limited to: C. Regularly occurring telephone or email communication among team members ... E. Timely documentation of coordination of care activities ... I. Integration of services ... to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines ... 8. Written evidence of care coordination may be found in the plan of care/service, case conference summary forms, clinical notes in the patient's chart clinical record ... " 2. During a home visit at Patient		**date of correction.** The HHA responsible for Client #3 was reeducated by theClinical Educator on 8/7/2024 on the importance of reporting seizures alongwith any change in condition to the case manager assigned. To ensure The Master's Touch remains incompliance with our policy and procedures on client observation, the ClinicalEducator in-serviced all staff on 8/7/2024 to re-educate on the CDC standards andaccording to our policy. On 8/14/24 Patient #3's Care Plan was updatedto include a seizure plan along with the aide care plan. The caregiver wasprovided with the updated aide care plan as well as reeducated by the Clinical Educator,on 8/7/2024 on reporting and recording of changes in client status. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** Case Manager's will continue to educate staff with eachsupervisory visit, SOC and recertification. The Clinical Educators willcontinue to be the	

	10:05 AM, when asked where the patient was, HHA 2, Patient #3's caregiver, indicated Patient #3 had a seizure two days ago and was sleeping. The HHA further indicated they did not have a seizure plan from the RN and did not let the RN know about Patient #3's seizures. 3. A review of the clinical record for Patient #3, start of care 08-17-2016, contained a plan of care for the recertification period 07-21-2024 through 09-19-2024, co-signed by the Alternate Clinical Manager, Admin 3, dated 07-16-2024. The plan of care evidenced Patient #3's principal diagnosis, Autistic Disorder (a condition related to brain development that impacts how a person interacts with others, communicates, learns, and behaves), and other diagnoses of Seizures and Developmental Disorders of Speech and Language. A review of the agency documents titled "Team Conference/Coordination of Care Notes," dated 07-16-2024 through 07-31-2024, failed to evidence coordination of care between HHA 2 and Alternate		responsible ones for preventing this deficiency in thefuture by educating staff at orientation and at minimal annually. The Clinical Manager will audit chartsquarterly to ensure 100% compliance of proper notification between the HomeHealth Aides and the Case Managers. Theresults of the audits will be reported, reviewed and trended by the QAPI Nursefor compliance through the Quality Assurance Performance Improvement program quarterlyto ensure 100% compliance. **Who isgoing to be responsible for numbers 1 and 2 above?** Clinical Manager **By what date will you have the deficiency corrected? Thisdeficiency was corrected on 8/15/2024.** This deficiency was corrected on 8/15/2024.	

	managed Patient #3's case. During an interview on 08-01-2024 at 12:00 PM, when queried regarding Patient #3's seizures, last reported seizure, and protocols of reporting by HHAs, the Alternate Case Manager, Admin 3, reviewed Patient #3's clinical record and indicated Patient #3's last seizure was in March 2023. Admin 3 further stated, "No, the HHA did not report Patient #3's seizure." 410 IAC 17-12-2(g)			
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 ensure they coordinated care delivery to meet the patient's needs who received outside services from personal care agencies in 3 of 3 (Patients: #1, 4, and 5) active records reviewed, and 1 of 1 active record reviewed receiving	G0608	**DEFICIENCY CITED: G0608 484.60(D)(4) Coordinate care delivery** **Completion Date:** August 15, 2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** During a recent visit by the ISDH it was noted Patient # 4'schart did not include	2024-08-15

	dialysis treatments at an in-center facility. (Patient: #4) Findings Include: A review of the clinical record for Patient #1 revealed a Home Health Certification and Plan of Care document with a start of care date of 01-05-2024 for the certification period of 07-03/2024 through 08-31-2024 which evidenced Coordination of Care: Patient #6 was to receive services through Entity 4. The record failed to evidence care coordination of the type of services and frequency, with Entity 4. On 07-31-2024 at 12:14 Person 5, the office manager from Entity 4 indicated Patient #1 was receiving attendant care services through their agency 3-6 PM daily, and further indicated that the Agency had never reached out to them regarding services being provided. On 07-31-2024 at 3:52 PM, during an interview with RN 1 indicated they don't call other Agencies to find out days/hours of services are being provided,		coordination of care with the dialysis center. An in-service was given on 8/8/2024 to CaseManagers reviewing Policy # 1-014. CaseManagers were educated to coordinate services by phone call to outsideorganizations providing services such as dialysis, waiver services, chemotherapy,paracentesis, doctors, pharmacies etc. by phone call at each SOC and RECERT. The Case Managers are to include the name ofthe person spoken to, discipline and date in each assessment. Patient #4's Dialysis center was called on8/14/2024 to coordinate care and her file was updated and will be added to thenext team conference/care coordination notes moving forward. A care coordination form was also created bythe clinical manager for the case managers to utilize should they prefer to usevs making a phone call. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** The Clinical Manager/Compliance Officer	

	further indicated they didn't know if the Agency had a form for them to complete coordination of care and thought Patient #1 was to receive 3 hours a day of attendant care services. 1. A review of The Master's Touch Home Care policy revision date December 2018 "Care/Service Coordination" indicated but was not limited to, " ... Care Coordination will include, but not be limited to: E. Timely documentation of coordination of care activities ... J. Coordination of care delivery to meet the patient's needs, and involve the patient representative, and caregivers, as appropriate, in coordination of care activities 8. Written evidence of care coordination may be found in the plan of care/service, case conference summary forms, clinical notes in the patient's chart clinical record ... " 2. A review of the clinical record for Patient #4, start of care 06-30-2022, contained a plan of care for the recertification period 0-19-2024 through 08-17-2024 signed by the Clinical Manager, dated		will audit thecharts monthly to ensure that the client's assessment, plan of care andcoordination of care is completed for clients on dialysis and that utilizeoutside ancillary services. The resultsof the audits will be reported, reviewed and trended by the QAPI Nurse forcompliance through the Quality Assurance Performance Improvement program quarterlyto ensure 100% compliance. **Who isgoing to be responsible for numbers 1 and 2 above?** The Clinical Manager **By what date will you have the deficiency corrected?** The deficiency was corrected on dialysis patients on August 15,2024**.**	

	06-18-2024. The plan of care indicated in the "Coordination of Care" section evidenced that Patient #3 received in-center dialysis from Entity 1 and Attendant care services from Entity 3. A review of the agency documents titled "Team Conference/Coordination of Care Notes," dated 09-01-2023 through 07-31-2024, failed to evidence coordination of care with Entity 1 or Entity 3. During an interview on 07-31-2024 at 12:44 PM, Person 2, the Director of Operations for Entity 1, confirmed Patient #4 received dialysis treatments every Monday, Wednesday, and Friday at Entity 1. Person 2 further indicated their review of Patient#4's clinical record evidenced no communication or coordination of care with The Master's Touch Home Care. Person 2 indicated that the last interdisciplinary team meeting was on 07-22-2024, and there was no coordination of care with knowledge of Patient #4's services with The Master's Touch Home Care. 3. During an interview on			

	07-31-2024 at 3:00 PM, when queried regarding the coordination of care documentation with Entity 1 or Entity 3, reviewed the coordination care notes and record and stated, "We are not documenting communication." 4. During a home visit at Patient#5's residence on 08-01-2024 at 9:00 AM, noted a schedule on Patient #5's refrigerator that stated, "The Master's Touch Home Health Services ... Client Monthly Schedule ... For the Month August 2024." The schedule listed Home Health Aide (HHA) times and Attendant times noted daily. When queried about the Attendant hours on the schedule, Patient #5 indicated they received Attendant hours for their caregiver during the evening and night from 6:00 PM to 11:00 PM due to falls. A review of the clinical record for Patient #5, start of care 03-13-2024, revealed a plan of care for the recertification period 07-11-2024 through 09-08-2024, co-signed by the Alternate Clinical Manager,			

	care indicated in the section titled "Coordination of Care" evidenced "None." A review of the agency documents titled "Team Conference/Coordination of Care Notes," dated 03-13-2024 through 07-31-2024, failed to evidence coordination of care with Entity 3. During an interview on 08-01-2024 at 3:00 PM, the Alternate Clinical Manager, Admin 3, confirmed Patient #5 received a waiver for Attendant care services. Admin 3 indicated they did not coordinate care with Entity 3, the sister agency of The Master's Touch Home Care, a personal care attendant agency.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure the	G0682	**DEFICIENCY CITED: G0682 484.70(a) Infection Prevention** **Completion Date:** August 15, 2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the**	2024-08-15

	Home Health Aide (HHA) performed hand hygiene and glove changes while providing patient care in 1 of 2 HHA home visit observations. (Employees: HHA 2) Findings Include: 1. A review of The Master's Touch Home Care policy titled "Handwashing" indicated but was not limited to, " ... To prevent the spread of infection ... After Caring for client ... Before touching organic material ... After handling contaminated equipment ... " 2. During a home visit at Patient #5's residence on 08-01-2024 at 9:05 AM, observed HHA 2 providing range of motion exercises and ambulatory assistance to Patient #5. HHA 2 performed hand hygiene, donned gloves, and swept the kitchen floor. The HHA discarded their gloves in the trash receptacle and donned new gloves without performing hand hygiene. HHA 2, with gloved hands, assisted Patient #5 from a sitting position to stand from the couch using Patient #5's assistive device. Patient #5 ambulated in the		**followingsteps and state the date of correction.** An employee was noted during the recent ISDH survey homevisit with patient 5, and incorrectly performed donning & doffing ofdisposable gloves, hand hygiene and infection control has been re-educated andcounseled by the RN Clinical Educator on 8/7/2024 to ensure that theirpractices have immediately improved. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** To ensure The Master's Touch remains in compliance with ourpolicy and procedures on infection control, the Clinical Educator conducted an all-staffin-service on 8/7/2024 to re-educate on the CDC standards for hand washing,proper donning & doffing of disposable gloves, and infection controlpractices via policy handouts and demonstration handout. Infection control will be monitored by theCase Managers on the HHA supervisory visits and Case	

	apartment hallway with their walker with stand by assistance twice. HHA 2 assisted Patient #5, to the couch and held Patient #5's walker for Patient #5. The HHA moved the walker and asked Patient #5 if they wanted a drink, obtained a bottle of water from the refrigerator, and handed the bottle of water. HHA 2 failed to remove their gloves and perform hand hygiene after they touched Patient #5's walker before obtaining the bottle of water. During an interview on 08-01-2024 at 9:25 AM, HHA 2 indicated they had received infection control training from the agency. When queried regarding hand hygiene and glove changes while providing patient care, HHA 2 indicated gloves and hand hygiene were to be done after each procedure. HHA 2 stated, " I did not change my gloves after I touched the walker prior to going to the refrigerator to obtain a bottle of water." 410 IAC 17-12-1(m)		Managers were reeducatedon 8/15/24. This will be documented onthe supervisory visit note "Employee is following infection prevention and controlprocedures. Maintains standard/universal precautions: wears gloves for directcare and washes hand before and after care." The infection control in-service will continue to be given annually everyDecember by the Clinical Educators to all employees and staff members to ensureall our clients are not indirectly affected. Last all staff in-service was conducted on 12/15/2023 by ClinicalEducators and Nursing Mgmt. Upon hireall new employees will continue to receive competency at orientation to ensureproper hand washing, proper donning & doffing of gloves and infectioncontrol technique by our RN Clinical Educators. The Clinical Manager and/or RN's ADON or RN Clinical Educator(S) willaudit 100% of charts and supervisory visits for evidence of documentation ofteaching and observation of proper donning & doffing of disposable gloves,appropriate hand washing and infection control practices. The Clinical	

			Manager, along with the ClinicalEducators and RN Case Managers will be responsible for monitoring thesecorrective actions to ensure 100% accuracy and that this deficiency iscorrected and does not recur by monitoring staff at the supervisory visits andthe Clinical Manager will ensure that staff is educated annually by theclinical educators. The results of the audits will be reported, reviewed andtrended by the QAPI Nurse for compliance through the Quality AssurancePerformance Improvement program quarterly to ensure 100% compliance. **Who isgoing to be responsible for numbers 1 and 2 above?** Clinical Manager **By what date will you have the deficiency corrected?** This deficiency was corrected on 8/15/2024.	
G0940	Organization and administration of services 484.105	G0940	**DEFICIENCY CITED: G0940** **484.105 Organization andadministration of Services** **Completion Date**: August 15,	2024-08-15

	Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. G940 Based on observation and interview, the agency failed to evidence the Governing Body ensured lines of authority were established and managed the roles and responsibilities of administrator and alternate administrators/supervisors (G 942); failed to ensure a qualified alternate administrator was appointed and put in place in the event the administrator was not available (G 954); failed to ensure the Administrator completed and executed their responsibilities for the day-to-day activities of running the home care agency, including compliance with Emergency Preparedness, timely submissions of Outcome Assessment Information Set (OASIS), plan of care content, assessment content, coordination of care with other service providers, employees health files		2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** The Governing Body was updated on 1/11/2024 and an officialorientation was given by the Administrator on 8/15/2024. The governing body reviewed jobresponsibilities along with the Administrator and verbalized understanding oftheir roles on 8/15/2024, by signing their job descriptions. During the meeting Emergency Preparedness,OASIS, Plan of Care, Assessment content, coordination of care with otherservice providers, employee health files completion and updated, personnel jobdescriptions and job orientation were reviewed. We also reviewed the recent in-service given to staff on hand washing,infection control, donning & doffing of gloves and reporting changes incondition according to CMS standards and policy.	

	are completed and updated per policy, failed to ensure agency personnel received job descriptions and job orientation and infection control (G948). These deficiencies had a potential cumulative effect on all 45 patients and 78 staff. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.105, Organization and Administration of Services. Findings Include: *		**How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** To prevent lack of knowledge, the Administrator will meetwith the governing body every quarter, to ensure there have been no changes tostaffing and that job roles are understood, and that daily operation complianceis being met. To ensure dates are keptthe Clinical Manager will act as a liaison to ensure meetings are held everyquarter and a calendar has been created via teams with invites to ensuremeetings are not missed moving forward. The results of the audits will bereported, reviewed and trended by the QAPI Nurse for compliance through theQuality Assurance Performance Improvement program quarterly to ensure 100%compliance. **Who is going to be responsible for numbers 1 and 2 above?** Administrator **By what date will you have the deficiency corrected?**	

			This deficiency was corrected on 8/15/2024.	
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program.	G0942	**DEFICIENCY CITED: G0942 410 IAC 17-12-1(b)(1) Governing Body** **Completion Date:** August 15, 2024 **CORRECTIVE ACTION RESPONSE:** **How are you going to correct the deficiency? If already corrected,include the following steps and state the date of correction.** OnThursday, August 15, 2024, Administrator and the Clinical Manager, held agoverning board meeting with all board members. Administrator had each boardmember review responsibilities and job descriptions. All board members reviewed and signed jobdescriptions. It was explained to eachboard member the importance of meeting a minimum of at least once quarterly, orwhen significant agency changes	2024-08-15

	Based on record review and interview, the Governing Body failed to ensure full responsibility and legal authority for the agency's overall management and operation, compliance with state and federal regulations, and provision of all home health services; failed to periodically review the written bylaws; failed to review define the corporate structure, and clearly indicate lines of authority, and failed to review the policies and procedures to ensure they reflected current state and federal regulations for 1 of 1 agency. Findings Include: 1. A review of the undated The Master's Touch Home Care policy titled, "Governing Body" indicated but was limited to, "The Governing Body shall assume full legal authority and responsibility for the operation of The Master's Touch Home Care ... To ensure lines of authority are established ... Appoint a Qualified Administrator ... Adopt and periodically review and approve administrative and personnel policies, client care policies and		occur. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** The administrator informed each member of the importance ofregular governing board meetings. To ensure meetings are scheduled, theAdministrator has set up a recurring schedule of meetings for the next threeyears. Notifications will be changed as members of the board transition out andnew members are added. However, thecadence of regular quarterly meetings or more frequent meetings to discussstaff changes, budgets, or policy changes will occur as needed to maintaincompliance. The results of the auditswill be reported, reviewed and trended by the QAPI Nurse for compliance throughthe Quality Assurance Performance Improvement program quarterly to ensure 100%compliance. **Who isgoing to be**	

	procedures, bylaws as required by state licensure regulations … " 2. On 07-21-2024 at 11:02 AM, the Administrator provided an agency document titled " Organization Chart." The organization chart failed to evidence the Governing Body, and the Administrator and their lines of authority and delegation.		**and 2 above?** Administrator **By whatdate are you going to have the deficiency corrected?** OnAugust 15, 2024, Administrator held a governing body meeting. Moving forward we have scheduled a regularcadence of quarterly meetings. The Governing board will also meet as neededoutside of the regularly scheduled meetings to discuss all significant agencychanges including, but not limited to administrative staff changes, policy andprocedure changes, budgets, etc.	

	3. On 08-01-2024 at 2:34 PM, the Administrator provided an agency document titled, " Governing Body Meeting Agenda Minutes. The meeting minutes, dated April 5, 2021, indicated the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were terminated, and a new DON was hired. The document failed to state the name of the DON or governing body approval. The minutes indicated they reviewed and agreed to the operating and capital budget., and the meeting will be held yearly and quarterly. The governing body failed to meet yearly or quarterly, failed to review the agency's policies and procedures, and failed to review the bylaws. During an interview on 08-01-2024 at 2:51 PM, when queried about the Governing Body meetings and other meeting minutes to review, the Administrator indicated the Governing Body was to meet yearly and they needed to obtain new members for the Governing Body. The Administrator further confirmed April 2021, was the only meeting completed by the			

	Governing Body. 410 IAC 17-12-1(b)(1)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the Governing Body failed to ensure the Administrator completed and executed their responsibilities for the day-to-day activities of running the home care agency, including compliance with Emergency Preparedness, timely submissions of Outcome Assessment Information Set (OASIS), plan of care content, assessment content, coordination of care with other service providers, transfer summaries, employees health files were completed and updated per policy, failed to ensure agency personnel received job descriptions and job orientation and infection control for 1 of 1 agency. Findings Include: 1. A review of agency	G0948	**DEFICIENCY CITED: G0948 484.105(b)(1)(ii) Responsible for all day-to-day operations** **Completion Date:** August 15, 2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** During a recent state survey, the day-to-dayoperations-Administration-EP plan, timely submissions of OASIS, plan of care,assessment content, coordination of care, transfer summaries, employee's healthfiles completed, personnel received job descriptions and job orientation, and infectioncontrol were found to be out of compliance. Patient conferences have been in place since June 2023, were on paperhowever now done in our electronic system at SOC and every 60	2024-08-15

	documents including: Emergency Preparedness (See E 000), timely submission of OASIS (See G 372), comprehensive assessments (See G 528), plan of care being patient-specific interventions with measurable goals (See G 572), coordination of care delivery (See G 608), Infection Control (See G 682), and failed to ensure personnel files were updated with current medical requirements, and staff had been provided job descriptions and job orientation. During an interview on 08-01-2024 at 3:00 PM, when reviewing the concerns with the Administrator and Alternate Clinical Manager, Admin 3 confirmed they are not documenting communication or meetings regarding patient care. The Administrator indicated they were not aware of the documentation not being completed. 410 IAC 17-12-1(c)(1)		days. The Administrator did not execute their responsibilities forthe day-to-day activities of running the home care agency, assuringcompliance. On 8/15/2024, the governingbody was updated, after our last meeting on 1/11/2024. Orientation, reeducationand an in-service were given by the Administrator, to ensure day-to-dayactivities of the home care agency are being met and audited. The Alternate Clinical Manager was reeducatedon the team conferences that we've been having weekly at our nurse meetings,and this is what she is signing on a weekly basis. Team conferences have been implemented sinceJuly of 2023, in which they were originally on paper which is in a CaseConference Binder and however transitioned to our electronic charting system inAugust of 2023 and are completed at SOC, with each recertification and changein condition.	

			How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected? The Administrator will be responsible for ensuring thatday-to-day activities are being completed by the Clinical Manager. This will be done in our quarterly GoverningBody Meetings by the Administrator to ensure 100% compliance. The results of the audits will be reported,reviewed and trended by the QAPI Nurse for compliance through the QualityAssurance Performance Improvement program quarterly to ensure 100% compliance. **Who is going to be responsible for numbers 1 and 2 above?** Administrator **By what date will you have the deficiency corrected?** This was corrected on 8/15/2024.	

G0954	Ensures qualified pre-designated person 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Based on record review and interview, the agency failed to ensure there was a qualified, pre-designated person authorized in writing by the Administrator and Governing Body to assume the same responsibilities and obligations as the Administrator for 1 of 1 agency. Findings Include: 1. A review of an undated The Master's Touch Home Care policy, titled, "Governing Body" was provided by the Alternate Clinical Manager, Admin 3, on 08-01-2024, at 2:00 PM. The document indicated but was not limited to " ... To ensure lines of authority are established ... Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the provision of home care	G0954	**DEFICIENCYCITED: G0954 410 IAC 17-12-1(c)(1) Home Health Administration/ Management** **Completion Date**: August 15, 2024 **CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** OnThursday, August 15, 2024, Administrator met with the governing body to discussthe appointment of Clinical Manager as the alternate administrator. During thismeeting, the Governing body reviewed the job description for the alternateadministrator. It was determined that theClinical Manager is qualified and approved to be the alternate administrator inthe absence of the administrator.	2024-08-15

	state and federal regulations ... " 2. A review of the Indiana Department of Health agencies report completed by the Administrator on 03-03-2023 indicated the Clinical Manager was the Alternate Administrator. 3. During the entrance conference on 07-31-2024 at 9:20 AM, the Administrator, when asked who the Alternate Administrator was, indicated the Clinical Manager, who was out with COVID, was the Alternate Administrator. 4. A review of agency documents titled "Professional Advisory Committee Meeting Minutes," dated April 5, 2021, indicated the Governing body meeting would be held as needed, yearly and quarterly. The document further evidenced the termination of the Director of Nursing (DON), and a new DON was hired. The document failed to prove the governing body had approved and appointed the Clinical Manager and Alternate Administrator. During an interview on 08-01-2024 at 2:37 PM, the		**How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** The administrator informed each member of the importance ofregular governing board meetings. To ensure meetings are scheduled, theAdministrator has set up a recurring schedule of meetings for the next threeyears. Notifications will be changed as members of the board transition out andnew members are added. However, thecadence of regular quarterly meetings or more frequent meetings to discussadministrative staff changes, budgets, or policy changes will occur asfrequently needed to maintain compliance. The results of the audits will be reported, reviewed and trended by the QAPINurse for compliance through the Quality Assurance Performance Improvementprogram quarterly to ensure 100% compliance. **Who isgoing to be responsible for numbers 1 and 2 above: i.e., director, supervisor,etc.?**	

	Administrator, when queried regarding the governing body appointing/approving the Clinical Manager/Alternate Administrator, stated, " No, not going to say I have it. No, the governing body did not appoint her." The Administrator further indicated the governing body had not met since 2021. 5. A review of the Clinical Manager/Alternate Administrator's personnel record failed to evidence the employee was appointed to their position by the Governing Body.		Administrator **By whatdate are you going to have the deficiency corrected?** OnAugust 15, 2024, Administrator held a governing body meeting. Moving forward we have scheduled a regularcadence of quarterly meetings. The governing board will also meet as neededoutside of the regularly scheduled meetings to discuss all significant agencychanges to include, but not limited to administrative staff changes, policy andprocedure changes, budgets, etc.	
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still	G1022	**Deficiency ID: G1022** **484.110(a)(6)(i-iii) Discharge andTransfer Summaries** **Completion Date:** August 15, 2024 **CORRECTIVE ACTION RESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.**	2024-08-15

	receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview the agency failed to ensure a transfer summary was completed on 1 of 2 transfer patient reviews. (Patient #2) Findings include: 1. A review of an agency's policy dated December 2018 titled 'TRANSFER SUMMARY Policy No. 1-023' revealed "PURPOSE To define the requirements for the documentation of a patient transfer ... POLICY All patients transferred from the organization will have a transfer summary completed and filed in the clinical record PROCEDURE 1. Within 48 hours of transfer ... will complete a transfer summary that includes ... A. the reason for transfer B. The Physical and psychosocial status at the time of transfer ... C. Continuing symptom management needs D. Medication profile E. Summary of the care ... G. The existence of any Advance Directives ... H. Date of face-to-face encounter I. The date of transfer ..."		A review of the agency's transfer summary for patient #2 wasnot completed withing 48 hours as the policy states. The agency was found to be out of compliance basedon our policy. On 8/15/2024 policy I-024was pulled and the Case Managers were given an in-service and reeducated on thepolicy and expectations. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** To prevent this deficiency from recurring in the future, theClinical Manager will audit all transfer/discharges daily to ensure casemanagers are compliant with assessments to include reason for transfer,physical and psychosocial status, continuing symptom management needs,medication profile, summary of care, existence of advance directive, face toface encounter and the date of transfer. The results of the audits will bereported, reviewed and trended by the QAPI Nurse for compliance through theQuality Assurance Performance Improvement	

	2. A review of the clinical record for Patient #2 evidenced an order sent to Person 6, the attending physician for Patient #2, indicating the patient was taken to Entity 7 and services for skilled nursing were on hold. The record for Patient #2 failed to evidence a transfer summary had been created and sent to Entity 7. 3. On 08-01-2024 at 2 PM, the Alternate Clinical Director indicated no transfer summary had been sent to Entity 7, but there should have been. They further indicated they were the one who usually creates the discharge and transfer summaries, and they must have missed it. 410 IAC 17-15-1(a)(6)		program quarterly to ensure 100%compliance. **Who is going to be responsible for numbers 1 and 2 above?** Clinical Manager **By what date will you have the deficiency corrected?** This was corrected on 8/15/2024.	
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider.	N0000	Completed 8/15/2024.	

	Survey Dates:07-31-2024 and 08-01-2024 12-month Unduplicated Skilled Admissions: 68 QR completed on 8/09/2024.			
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. The agency failed to ensure the organizational chart listed the Governing Body, and Administrator control and lines of authority for the delegation of responsibility for 1 of 1 agency. Findings Include: 1. A review of an undated The Master's Touch Home Care	N0440	**DEFICIENCYCITED: N0440 410 IAC 17-12-1(a) Home Health Administration/ Management** **Completion Date**: August 15, 2024 **CORRECTIVE ACTION RESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** OnAugust 15, 2024, administrator revised The Master's Touch Home Care, INC, agencyorganizational chart and presented the revised document to the Governingbody. The revised organizational chartlists the	2024-08-15

	policy titled, " Governing Body" indicated, " ...The Governing Body shall assume full legal authority and responsibility for the operation of The Master's Touch Home Care ... Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the provision of home care services in accordance with state and federal regulations ... " 2. On 07-31-2024 at 11:02 AM, the Administrator provided a copy of an agency document titled, Organization Chart." The organization chart failed to evidence the Governing Body and administrator on the chart and their lines of authority. During an interview on 07-31-2024 at 3:42 PM, when queried regarding the organizational chart and missing delegations and lines of authority, the Administrator stated, "There is no Governing Body or Administrator on the diagram."		Governing body, and all positions employed by The Master's Touch HomeCare, INC. The organizational chart provides in writing the agency'sorganizational structure. Beginning with the Governing body flowing to theadministrative positions to reflect administrative control and lines ofauthority for the delegation of responsibility down to the patient. Administrator revised The Master's Touch Home Care, INC, agency organizational chart and presented the revised document to the Governing body. The revised organizational chart lists the Governing body, and all positions employed by The Master's Touch Home Care, INC. The organizational chart provides in writing the agency's organizational structure. Beginning with the Governing body flowing to the administrative positions to reflect administrative control and lines of authority for the delegation of responsibility down to the patient. **How are yougoing to prevent the deficiency from recurring in the future, even if**	

			alreadycorrected? The Administrator will make sure that the organizationalchart is reviewed at each scheduled Governing Body meeting moving forward toensure that it is current and correct. If changes within the hierarchical structure of administrative staffoccur, the organizational chart will be presented to the Governing body forreview and update. Once updated, the office manager will distribute theorganizational chart to all staff and the document will be posted in TheMaster's Touch Home Care, INC office. The results of the audits will be reported, reviewed and trended by the QAPINurse for compliance through the Quality Assurance Performance Improvementprogram quarterly to ensure 100% compliance. **Who isgoing to be responsible for numbers 1 and 2 above: i.e., director, supervisor,etc.?** Administrator **By whatdate are you going to have the deficiency corrected?**	

			OnAugust 15, 2024, Administratorrevised The Master's Touch Home Care, INC, agency organizational chartand presented the revised document to the Governing body. The revised organizational chart lists theGoverning body, and all positions employed by The Master's Touch Home Care,INC. The organizational chart provides in writing the agency's organizationalstructure. Beginning with the Governing body flowing to the administrativepositions to reflect administrative control and lines of authority for thedelegation of responsibility down to the patient.	
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	N0458	**DEFICIENCY CITED: N0458 410 IAC 17-12-1(f) HHA administration/management** **Completion Date**: August 15, 2024	2024-08-15

	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: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national criminal history background check or expanded criminal history check. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure employees had job descriptions and orientation to their role with the agency in 2 of 4 employee records reviewed. (Employees Administrative Staff 2 and 3) Findings include: 1. On 08-01-2024 a review of the employee record for Administrative Staff 2, the Clinical Manager failed to evidence they had received orientation to their role of Clinical Manager. 2. On 08-01-2024 a review of the employee record for		**CORRECTIVE ACTIONRESPONSE:** **How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** On 8/13/2024 the HR department was reeducated by the OfficeManager and Clinical Manager in their roles and responsibilities with orientationof staff or changes in roles based on the contents of 410 IAC -17-12-1, that personnelrecords of employees shall be kept current and should include documentation oforientation to the job, including the following: receipt of job description,qualifications, a copy of limited criminal history, a copy of current license,certification or registration, and annual performance evaluations. On 8/13/24 and 8/14/24 the Clinical Manager and AlternateClinical Manager received orientation to their current roles. **How are yougoing to prevent the deficiency from recurring in the future, even if**	

	Administrative Staff 3, the Alternate Clinical Manager failed to evidence they had read/signed their job description or had received orientation to their role of Alternate Clinical Manager. 3. On 08-01-2024 at 10:11 AM, Administrative Staff 5, HR assistant indicated the Clinical Manager did not have an orientation to their role as the Clinical Manager and didn't realize they needed a specific orientation. Administrative Staff indicated the Alternate Clinical Manager did not have a job description or orientation to their role as the Alternate Clinical Manager, again did not realize this was a requirement. 4. On 08-01-2024 at 10:15 the Administrator indicated they hadn't realized Administrative Staff 5 was not knowledgeable of the job descriptions and orientation requirements.		**alreadycorrected?** To prevent deficiency, 100% of HR files will be audited bythe HR director by 8/30/2024 for evidence of the points listed above. After completion of this audit, 25% of HRrecords will be audited quarterly by our QAPI program to ensure 100% compliance. **Who is going to be responsible for numbers 1 and 2 above?** Administrator **By what date will you have the deficiency corrected?** This was corrected on 8/15/2024.	
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall	N0464	**DEFICIENCY CITED: N0464 410 IAC 17-12-1(i) HHA administration/management** **Completion Date**: August 25, 2024	2024-08-25

ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:

(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.

(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.

(3) Any person with:

(A) a documented:

(i) history of tuberculosis;

(ii) previously positive test result for tuberculosis; or

(iii)completion of treatment for tuberculosis; or

(B) newly positive results to the tuberculin skin test;

must have one (1) chest rediograph to exclude a diagnosis of tuberculosis.

(4) After baseline testing, tuberculosis screening must:

(A) be completed annually; and

(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).

(5) Any person having a positive finding on a tuberculosis evaluation may not:

(A) work in the home health agency; or

(B) provide direct patient contact;

unless approved by a physician to work.

(6) The home health agency must maintain documentation of tuberculosis evaluations

CORRECTIVE ACTIONRESPONSE:

How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.

During the recent visit from the ISDH, it was found that theagency was not in compliance with their policy regarding TB screenings.

On 8/15/2024, the policy was reviewed and updated accordingto CMS guidelines, the annual screening requirement will be done atorientation, then annually in December along with the annual TB screeningquestionnaire. To immediately becomedeficient the clinical manager along with the nursing staff will complete a TBscreening on all nursing staff. Theagency will continue to do the 2-step PPD test as recommended of the Aging andDisability Division. CMS recommends annualTB In-Services which was implemented on 2/13/2024 by our Clinical Educator andis now completed upon orientation as

	showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the agency failed to ensure annual tuberculosis screening occurred annually in 4 of 5 employee records reviewed. (Employees Administrative Staff 2 and 3, RN 1, and HHA 2) Findings include: 1. A review of a policy titled 'TUBERCULOSIS EXPOSURE CONTROL PLAN Policy No. 7-002' revealed "... 7. All Personnel will be tested for TB according to the risk assessment identification ... and in accordance with federal, state, and/or local regulations ..." 2. On 08-01-2024 at 8:37 AM a review of the Clinical Supervisor employee record failed to evidence an Annual Risk Assessment for TB. 3. On 08-01-2024 at 8:37 AM a		well as an In-Service was again given on8/12/2024 to the Clinical Educators. **How are yougoing to prevent the deficiency from recurring in the future, even if alreadycorrected?** The Clinical Educator's will continue to monitor the stafffor compliance and completion of their annual In-Services along with their TBscreening questionnaires annually in December and upon orientation. The resultsof the audits will be reported, reviewed and trended by the QAPI Nurse forcompliance through the Quality Assurance Performance Improvement program quarterlyto ensure 100% compliance. **Who is going to be responsible for numbers 1 and 2 above?** Clinical Manager **By what date will you have the deficiency corrected?** This will be completed by August 25, 2024.	

	review of the Alternate Clinical Supervisor employee record failed to evidence an Annual Risk Assessment for TB. 4. On 08-01-2024 at 8:37 AM a review of RN 1 employee record failed to evidence an Annual Risk Assessment for TB 5. On 08-01-2024 at 8:37 AM a review of HHA 1 employee record failed to evidence an Annual Risk Assessment for TB. 6. On 08-01-2024 at 10:05 AM, Administrative Staff 5, the HR assistant indicated they had all staff take an annual quiz on TB but hadn't realized each employee was required to perform an Annual Risk Assessment for TB. 7. On 08-01-2024 at 10:15 AM, the Administrator indicated they had thought the only requirement was to have employees take the annual quiz that was graded.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Jenkins	RN Clinical Manager	8/19/2024 12:43:25 PM