STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K137	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2024

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 Dates: 09-16-2024 and 09-17-2024 Census: 42	E0000		

	At this Emergency Preparedness Survey, The Master's Touch Home Health, LLC. was found to be out of compliance with 42 CFR 484.102 Emergency Preparedness requirements for Medicare/Medicaid Suppliers and Providers for Home Health Agencies. QR completed by Area 3 on 9-24-2024.			
E0036	EP Training and Testing 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing	E0036	**DEFICIENCY CITED:E0036 484.102 EP Training and Testing** **Completion Date:9/26/2024** **CORRECTIVE ACTIONRESPONSE:** **How are you goingto correct the deficiency? If already corrected, include the following stepsand state the date of correction.** A tabletop drill exercise was completed with all employees and nurseswith FLOODING as our hazard. On 9/25/2024, a mass email and text message drillwere performed with all caregivers. 56 out of 72	2024-09-26

	program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview the agency failed to ensure their Emergency Preparedness program had been tested by failing to conduct		responses were returned fromthe caregivers, placing us at a compliance rate of **77%.** 20/21 text messages wereconfirmed by the administrative staff putting us at compliance **95%** compliance. The Nursing/Emergency Binder was again reviewed with the GB to ensure anunderstanding of roles and responsibilities. The On-Call Nurse will activate the plan and delegate the phone callswith the GB, nurses, and schedulers, and a log will be kept. The ClinicalManager is on standby as a backup and between them and the Administrator, wewill confirm that the plan has been executed in the event of a hazard. The EP Binder includes the client's POCs and is divided according toclient triage status. It also includes state and local emergency numbers and apaper log for documentation. The 1135 Waiver policy was also introduced in the event of a hazard,which would free us from certain COPs. We concluded our tabletop drill with anafter-action review of how the exercise worked and	

	a tabletop or full-scale exercise, in 1 of 1 home health agencies surveyed. Findings include: 1. Review of an agency document titled 'EMERGENCY MANAGEMENT PLAN Policy No. 4-001' stated, "... Testing: 1. The Master's Touch Home Care will test the emergency management plan, at each site included in the plan, at least annually ... 2. The agency participates in a full-scale exercise that is community-based or individual, facility-based ... 3. An additional exercise is conducted and may include, but not limited to: A. A second full-scale exercise ... B. A tabletop exercise that includes a group discussion, emergency scenarios and prepared questions designed to challenge an emergency plan ..." 2. Review of the agency's Emergency Preparedness Binder failed to evidence required testing of their emergency plan had been conducted. The binder failed to evidence a completed tabletop or full-scale		brainstormed as a group onhow to improve our process's outcome and ensure our assigned patients' safety.In conclusion, the exercise was a success and ran smoothly. This simulationallowed the group to better provide solutions to situations that might occur inan emergency event. Upon completing the tabletop drill, caregivers and staff were updatedduring the all-staff in-service meeting on 10/3/2024. The RN Case Manager willprovide updated information and steps in case an all-hazard/state emergencyshould occur at each start of care when developing the client's individualizedemergency preparedness plans. The Master's Touch has also implemented, duringthe patient satisfaction survey, a question regarding emergency preparedness asa reminder to have a backup plan in the event of an emergency and to also havean Emergency Kit available.	

	exercise. 3. On 09-16-2024 at 3:45 PM when queried as to whether testing had been done, the Administrator indicated she had not gotten that far yet, and indicated would be reaching out to the regional coalition to partake in a full-scale exercise.		**How are you goingto prevent the deficiency from recurring in the future, even if alreadycorrected?** The EP will be reviewed annually. Tabletop drills will be conducted atleast every six weeks. To ensure that staff are aware of emergency processesare in place for different types of emergencies. Regular tabletop drills willalso allow The Master's Touch to evaluate strengths and areas that needimprovement in our EP plan and outlined procedures. The Indiana D5 Healthcare Coalition hosts a tabletop drill twice yearly.Master's Touch Home Care, INC, a coalition member, will participate in thedrill scheduled for Friday, November 8, 2024, from 9:00 AM to 2:00 PM. Movingforward, TMTHC will participate in the Indiana D5 Healthcare Coalition tabletopexercises annually. Also, the 1135 Waiver was implemented in our policy in the event of anational disaster or emergency. **Who is going to beresponsible for numbers 1**	

			and 2 above? The Agency Administrator. **By what date willyou have the deficiency corrected?** This deficiency was corrected on 9/26/2024.	
G0000	INITIAL COMMENTS This visit was for a post condition revisit survey of a home health provider. Facility number: 013677 Survey dates: 09/16/2024 and 09/17/2024 12-Month Unduplicated Skilled Admissions: 42 Active Census: 45 Two previously cited conditions	G0000		

	cited deficiencies were corrected. Two previously cited deficiencies were re-cited. No new citations were cited. The agency was found to be in compliance with Conditions of Participations 42 CFR 484.102 Emergency Preparedness, and 42 CFR 484.105 Organization and Administration of Services. The Master's Touch Homecare LLC continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning August 1, 2024, and continuing through July 31, 2026. QR completed by Area 3 on 9-24-2024.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention.	G0682	**DEFICIENCY CITED: G0682 484.70(a) Infection Prevention** **CORRECTIVE ACTIONRESPONSE:**	2024-10-03

	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 Home Health Aides (HHA) and Registered Nurse (RN) performed hand hygiene and glove changes while providing patient care in 3 of 3 home visit observations, (HHA1 and 2)(RN 1) and failed to ensure the RN used proper bag technique in 1 of 1 home visit observation. (RN 1) Findings include: 8. During a home visit on 09/16/2024 at 1:00 PM, RN 1 was observed providing skilled nursing care for Patient #2. RN 1 placed their nursing bag on Patient #2's floor, and began palpating (touch) Patient # 2's foot. RN 1 performed hand hygiene, picked up nursing bag from floor, placed it on the couch, and proceeded to obtain equipment from nursing bag and placed equipment on the arm of the couch. RN 1 checked		**How are yougoing to correct the deficiency? If already corrected, include the followingsteps and state the date of correction.** Employees were noted during the recent post conditionrevisit survey, to incorrectly perform donning & doffing of disposablegloves, hand hygiene, bag procedure technique and infection control. The staff involved were immediatelyre-educated and counseled by the Nursing CM and Administrator. The staff have been sent videos on hand hygiene,bag technique and donning and doffing of gloves to review. Then on 10/3/2024 an all-staff in-serviceevent to be held which includes hand washing hygiene, donning and doffing ofgloves, and bag procedure with return demonstration to ensure that theirpractices have immediately improved. TheAdministrator also ordered and provided new bags with disposable cloths anddisinfectant wipes were provided. **Planof Correction: Hand Hygiene**	

	Patient #2's temperature, and returned the thermometer into the nursing bag. RN 1 removed gloves from nursing bag and placed them on the couch. RN 1 obtained Patient #2's blood pressure, and placed blood pressure cuff into the nursing bag. RN 1 donned (put on) gloves, and began the assessment. After the assessment was complete, RN 1 placed their nursing bag back onto the floor, and with the gloves still on, RN 1 proceeded to record findings from the assessment using paper and pen. RN 1 removed gloves, and began to cut gauze to be used between Patient 2's toes before placing Circaid wraps(adjustable compression leg wrap). The used scissors were placed into nursing bag. RN 1 donned gloves, and placed the used stethoscope (medical instrument used to listen to someone's heart or breathing) into the nursing bag. At the conclusion of placing the Circaid wraps, RN 1 removed gloves, and without performing hygiene helped adjust Patient #2.		1. Amandatory meeting to be held for all field and office staff on Oct. 3, 2024, atThe Masters Touch Home Care office regarding “Hand Hygiene”. 2. RN toverbalize and demonstrate to all field and office staff proper hand washing. 3. RN toprovide written step by step directions to the field and office staff at TheMasters Touch Home Care the written policy for Hand Washing for theirreference. 4. RN toverbally review with the field and office staff when hand washing is needed,type, intensity, duration, and sequence of activities. -Beforehaving direct contact with patients. -Aftercontact with a patient’s intact skin -When movingfrom a contaminated body site to a clean body site during patient care. -Aftercontact with inanimate objects -Beforecontact with clients who are susceptible to infection (such as newborns orimmunosuppressant clients).	

N0000	Initial Comments . This re-visit was for a State Complaint Survey of a Home Health Provider, conducted by the Indiana Department of Health. Survey Dates: 09/16/2024 and 09/17/2024 12-month unduplicated skilled admissions: 42 The Master's Touch Home Care LLC was found to be in compliance with 410 IAC 17. QR completed by Area 3 on 9-25-2024.	N0000		

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
Amanda Jenkins	RN Clinical Manager	9/27/2024 12:13:14 PM