STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
G 0000 Bldg. 00	This was a federal recertification and state re-licensure home health survey with one (1) complaint. This survey was announced as fully extended on 10/30/19 at 4:50 PM Complaint information: IN00213640- Substantiated Facility #: 003961 Survey dates: October 29, 30, 31, and November 7, 2019 Skilled Services: 42 Home Health Aide only: 19 Personal Service only: 66 Unduplicated Skilled Census: 127 Total active patients: 112 Record reviews with home visits: 2 Record review without home visits: 6 full records, 2 partial Total clinical records reviewed: 10 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings. Quality Review completed on 11/27/19 CS	G 0000		
G 0372 Bldg. 00	Based on record review and interview, the agency	G 0372	1. For each client cited in the	11/15/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	failed to submit OASIS (outcome and assessment information set) within 30 days of assessment completion for 1 of 5 skilled records requiring OASIS submissions (#5). Findings include: An undated agency policy titled, "Encoding and reporting OASIS data," Policy B-250 stated "...Agency will encode and electronically submit each completed OASIS assessment to the CMS [Centers for Medicare and Medicaid service] system within 30 days of completing the assessment of the client ...." The clinical record for patient #5 was reviewed on 10/30/19 and indicated a start of care date of 9/17/18. The record contained a plan of care for the certification period of 7/14/19-9/11/19. An agency OASIS recertification was completed on 7/9/19. The OASIS submission was not completed until 8/9/19 (31 days). During an interview on 11/7/19 at 3:36 PM, the administrator stated that employee C was the only person trained to complete OASIS submissions and they should train someone else to do them.		deficiency, the agency in-serviced the RN case managers responsible for those clients on following up to ensure OASIS are submitted timely to the billing department for entry into the QIES system. The errors were also shown to the Billing Department, and she was also re-educated on timely submission of OASIS, specifically meeting the 30-day mark from the date the assessment was completed, for submission. 2. The agency reviewed 100% of all hard-copy OASIS for Recert, SOC, ROC, Transfer and DC in charts to ensure that all other OASIS was submitted into QIES within 30 days of the date of assessment. 3. To ensure the deficient practice does not occur again, the Clinical Director has re-educated all RN CM's on the federal regulatory guideline and agency policy regarding timely OASIS submission to the billing department for entry in the QIES system as well as the Billing Dept has been instructed to notify the Clinical Director and Administrator if an OASIS has not been received 24 hours (Day 29) before it is due for entry into QIES. Furthermore, all OASIS will now be tracked by hand on a calendar by the Billing Dept and RN CM's. A master copy kept by the Billing Dept., will be reviewed daily by the agency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Administrator and Clinical Director. The Clinical Director and Administrator will remind RN CM's in daily agency meetings of upcoming OASIS due within 30 days and will follow-up with RN CM's at day 25 and then with Billing Department to ensure OASIS is submitted timely for entry into QIES. Additionally, the Clinical Director has been trained to enter the OASIS information to QIES in the event the billing the department is unable. 4. The agency QA will review 100% of all OASIS for timely submission and the agency Administrator and Clinical Director will be responsible for monitoring this corrective action to ensure the deficient practice will not re-occur. If any further deficiency is found, disciplinary action will be taken.	
G 0478 Bldg. 00	Based on record review and interview, the agency failed to ensure complaints received were thoroughly investigated / documented, and that the agency policy described how the investigation was to be completed for 4 of 4 complaints reviewed for patient records (#1, 5, 8, 9). Findings include: 1. An undated agency policy titled, "Client/family complaint/grievance policy," Policy C-381 stated	G 0478	1. For each client cited in the deficiency, the Administrator and Clinical Director have reviewed the complaint documentation, noted the deficiencies per the survey, then reviewed its current complaint/investigation policy and found that the policy was not being followed and needed to be updated. 2. Upon review of policy, Administrator and Clinical Director	11/22/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"... All persons with a grievance will receive a written notice of the investigators review which will include the name of the contact person, steps taken to investigate the grievance, the results of the process and the date of completion ...." The policy failed to to negate the steps to be taken to investigate the complaint. 2. The clinical record for patient #1 was reviewed on 10/29/19 and indicated a start of care date of 6/7/19. The record contained a plan of care for the certification period of 10/5/19-12/3/19. Two agency documents titled "report of concern," dated 2/5/19 were completed from patient #1 filing complaints. The first document stated "Client reported that HHA only stayed 10 min [minutes] of his 1 hour scheduled visit on 1/26/19 and 1/27/19. States HHA was complaining that his house was to cold." The employee was interviewed and denied the allegation. The patient was informed that the complaint was discussed with the HHA and due to the second complaint the HHA was removed from the home and advised to have no further contact with patient #1. The second document stated "Client reported that HHA was in home on 2/3/19 and he had a money order on his night stand for $120 and reports that he fell asleep and when he woke up the money order was gone and the HHA was gone." The client was informed to file a police report. The resolution indicated the employee was suspended and was informed not to have contact with client. The employee never returned to the agency. The complaint documentation failed to evidence the agency called other patients the HHA (home health aide) cared for to see if this was a pattern or		updated the policy to include a more thorough explanation of the steps necessary to complete an investigation of all complaints in compliance with the federal regulation. The agency added the following specific steps to investigation process; contacting other clients of the employee(s) to see if the behavior is occurring elsewhere and documentation of the dialogue and notifying the client of all steps taken to resolve the issue and final outcomes. The agency will provide the client and the employee, written documentation of the complaint, investigation, resolve, and outcome. The documentation will also include any actions taken outside of agency such as police involvement. 3. To ensure the deficient practice does not re-occur, the Administrator and the Clinical Director, has updated its “Report of Concern” form to include a documentation component for contacting other clients of the employee, the dialogue between those clients and the investigator, a documentation component for any outside sources utilized to resolve the matter such as police, and a documentation component for notification of the resolve and outcome to the client, including the status of the employee. 4. The agency Administrator and the Clinical Director will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	other patients were affected. During an interview on 11/7/19 at 3:24 PM, the director of nursing (DON) stated the agency called police about the matter. She stated the police tracked the money order down and it had been cashed at a gas station. (This failed to be evidenced in the complaint documentation). 3. The clinical record for patient #5 was reviewed on 10/30/19 and indicated a start of care date of 9/17/18. The record contained a plan of care for the certification period of 9/12/19-11/10/19. An agency document titled "report of concern," dated 3/25/19 stated "Aide [employee L] claimed she did visits when she didn't do the visits. She forged clients / caregivers name." The investigation stated "When aide was questioned she admitted to all allegations but refused to sign counseling form." The resolution was that the aide was terminated and the patient was notified that the employee was spoken to. The agency failed to notify the patient that the aide was terminated. The complaint documentation failed to evidence the agency called other patients the HHA cared for to see if this was a pattern or other patients were affected. 4. The clinical record for patient #8 was reviewed on 10/31/19 and indicated a start of care date of 7/7/16. The record contained a plan of care for the certification period of 9/5/16-11/3/16. An agency document titled "report of concern," dated 10/24/16 regarding employee D stated "Turned in flow sheet on 10/24/16 for the week of 10/17/16 to 10/23/16 et [and] claimed hours you		responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur. The Administrator and Clinical Director will review 100% of all complaints for thorough and complete documentation, and then all complaints will be discussed and reviewed monthly during QAPI Meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	did not do." On 10/28/19 employee D met with the DON and reported she had filled out the weekly flow sheet prior to missing work and forgot to adjust the time on the sheet. The complaint failed to evidence a resolution. The complaint documentation failed to evidence the agency called other patients the HHA cared for to see if this was a pattern or other patients were affected. 5. The clinical record for patient #9 was reviewed on 10/31/19 and indicated a start of care date of 5/31/18 for personal services only and skilled services beginning on 10/17/19. An agency document titled "report of concern," dated 7/5/19 regarding employee K stated "Employee claimed hours at 2 client's homes and never did the visits." The investigation stated the employee was interviewed and claimed to be having problems in personal life and had another job that paid more. The resolution was that the employee was terminated and the patient was informed that employee was spoken to. The complaint documentation failed to evidence the agency called other patients the HHA cared for to see if this was a pattern or other patients were affected. 6. During an interview on 11/7/19 at 3:20 PM, the administrator was asked if the agency called other patients to investigate if allegations occurred with others. The administrator stated yes they did but it was not documented because she thought the complaints just had to be a summary of the complaint and not all the details of the complaint and investigation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	17-12-3(c)(1)(A) 17-12-3(c)(1)(B) 17-12-3(c)(2)			
G 0528 Bldg. 00	Based on record review and interview, the comprehensive assessment failed to contain all information about the current health status for 7 of 7 complete records reviewed (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. An undated agency policy titled, "Comprehensive client assessment," Policy C-145 stated "...Special instructions ... The comprehensive assessment must accurately reflect the client's status, and must include at a minimum, the following information: The client's current health, psychosocial, functional, and cognitive status ...." 2. The clinical record of patient #1 was reviewed on 10/29/19 and indicated a start of care date of 6/7/19. The record contained a plan of care for the certification period of 10/5/19-12/3/19 that indicated diagnoses of, but not limited to, neuromuscular dysfunction of the bladder, anemia, diabetes, and had a 24 french suprapubic catheter. The comprehensive recertification assessment dated 10/1/19 failed to evidence information about the type, cause, or recent labs regarding anemia, any information regarding size, type, or when the last catheter change was completed, or any information regarding the patient's musculoskeletal system regarding presence of contractures, extremity weakness, gait characteristics, or functional abilities regarding safety.	G 0528	1. For each client cited in the deficiency, the Clinical Director reviewed with the RN CM's the missing assessment components noted by the surveyor. The RN CM's were then in-serviced on how to complete a comprehensive assessment and the thorough documentation guidelines set forth in the regulation. The QA manager was also in-serviced on the documentation to look for with regards to the deficient areas noted by the surveyor. The RN CM's were then sent out immediately to client homes to perform an updated assessment specifically of those areas found to be missing/lacking documentation so that the client chart including care-plans could be updated to reflect the clients current health, psychosocial, functional, and cognitive status. 2. The agency QA will review 100% of all current comprehensive assessments for complete documentation of all assessment areas in the OASIS. For any deficiencies found, the RN CM responsible for the assessment will be required to go back out to client home and complete an	11/13/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3. The clinical record of patient #2 was reviewed on 10/29/19 & 10/30/19 and indicated a start of care date of 5/24/19. The record contained a plan of care for the certification period of 9/21/19-11/19/19 that indicated the patient was a diabetic and had a wound to the left heel, and that the skilled nurse (SN) set up the patient's medications. The recertification comprehensive assessment dated 9/19/19 failed to evidence a wound assessment / dressing change, who gave insulin to the patient if agency nurse was not present, and correct information that the patient managed her own oral medications (SN did not set up medications). During an interview on 11/7/19 at 8:53 AM, the director of nursing stated the patient had gone to the wound care center on 9/16/19 so the nurse used the measurements from the wound center appointment on the assessment. Additionally, she stated that the expectation is that nurses assess wounds on the recertification unless the patient had gone to the wound center the same day. 4. The clinical record of patient #3 was reviewed on 10/31/19 and indicated a start of care date of 9/3/18. The record contained a plan of care for the certification period of 8/29/19-10/27/19 which included diagnoses of (but not limited to) feeding difficulties, and the patient had a gastrostomy (g-tube). The comprehensive pediatric nursing assessment completed on 8/26/19 failed to evidence the type and size of the g-tube, how often/last time the g-tube was changed, the rate of feeding and if it is a bolus or via pump. It also failed to evidence what type of site care was to be completed around the g-tube stoma.		updated assessment specifically the areas found by QA to be deficient and then update client chart accordingly. Then at time of next recertification, any further deficiencies will result in disciplinary actions. 3. To ensure the deficient practice does not re-occur, the agency QA manager has been in-serviced on completion of the OASIS and key documentation components that should reflect the client's current health, psychosocial, functional, and cognitive status. The QA manager will then review 100% of all comprehensive assessments to ensure that all areas included in the assessment documentation are specific, thorough, accurate, and complete. Any deficiencies noted will be addressed by the Clinical Manager with the RN CM and disciplinary action will result. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	5. The clinical record of patient #4 was reviewed on 10/30/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated the patient wore ankle braces and was on melatonin every night to help sleep. The comprehensive pediatric nursing assessment completed on 6/13/19 failed to evidence documentation that the patient had difficulty sleeping requiring medications, or why the patient had ankle braces (deformity, to strengthen or support legs while walking). 6. The clinical record of patient #5 was reviewed on 10/30/19 and indicated a start of care date of 9/17/18. The record contained a plan of care for the certification period of 9/12/19-11/10/19 that indicated diagnoses of, but not limited to, insulin dependent diabetes mellitus (IDDM) with orders for skilled nursing to "oversee client perform self accuchecks and insulin administration 3x/day [three times per day] ...." The comprehensive recertification assessment completed on 9/7/19 stated on page 10 of 24 that the blood sugar was monitored by "self" (patient), then further down in the endocrine system it stated "competency with use of glucometer: nurse takes Bld sugars [blood sugars] ...."The assessment failed to evidence accurate and non conflicting information. During an interview on 11/7/19 at 11:58 AM, the director of nursing stated the patient can take her blood sugars, but chooses not to and is not reliable at doing so. 7. The clinical record of patient #6 was reviewed on 10/31/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 8/17/19-10/15/19 that indicated diagnoses included, but not limited to,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	severe developmental delay, incontinence, right hip wounds, and cerebral palsy. The comprehensive non-skilled recertification assessment completed on 8/12/19 indicated the patient was on a pureed diet with honey thick liquids. The assessment failed to identify swallowing problems, the need for the therapeutic diet, how the diet was tolerated, and if there was any safety concerns with aspiration risk. 8. The clinical record of patient #7 was reviewed on 10/30/19 and indicated a start of care date of 11/5/18. The record contained a plan of care for the certification period of 9/1/19-10/30/19 that indicated orders for the skilled nurse to check placement of gastrostomy (G-Tube) with 30 milliliters (ml) air bolus via auscultation before g-tube feedings, administer 150 ml real food formula mixed with 60 ml fluid and administer via infinity pump at 30 ml/hour over 30 minutes, crush medications dissolve in 30 ml water and administer per g-tube followed by 60 ml water flush, change 4.5 Shiley tracheotomy (trach) once per week, cleanse trach stoma with soap and water every shift as needed, suction excess secretions ever shift as needed for excess drainage, change 2.5 centimeter (cm) mickey button (g-tube) every 3 months, cleanse around g-tube with soap and water daily and as needed soilage, straight catheterize with a 14 french catheter every 4 hours as needed for bladder retention, irrigate bladder 2 times per day with 100 ml normal saline. The pediatric comprehensive assessment dated 8/30/19 failed to evidence size, type,site care, how often and by whom the g-tube was to be changed, enteral feeding amount, frequency, how medications were to be administered, how often trach was to be changed and when the last time it was changed, trach site care information, suction			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	frequency and with what size suction catheter, and any information regarding straight cauterizations. 9. During an interview on 10/31/19 at 4:41 PM, the director of nursing stated the comprehensive assessment should contain all the updated health information. 17-14-1(a)(1)(B)			
G 0530 Bldg. 00	Based on record review and interview, the agency failed to ensure comprehensive assessment contained individual patient goals, strengths, and care preferences identified by the patient for 3 of 7 complete records reviewed (#1, 3, 6). Findings include: 1. An undated agency policy titled "Comprehensive client assessment," Policy C-145 stated "...Special instructions ... The comprehensive assessment must accurately reflect the client's status, and must include at a minimum, the following information: ... The client's strengths, goals, and care preferences ...." 2. The clinical record of patient #1 was reviewed on 10/29/19 and indicated a start of care date of 6/7/19. The record contained a plan of care for the certification period of 10/5/19-12/3/19 that indicated diagnoses of, (not limited to), pressure ulcers, neuromuscular dysfunction of the bladder, anemia, and diabetes. The comprehensive recertification assessment dated 10/1/19 stated the patient did not want personal goals and then	G 0530	1. For each client cited in the deficiency, the Clinical Director reviewed with the RN CM's the missing assessment components noted by the surveyor. The RN CM's were then in-serviced on how to complete a comprehensive assessment and the thorough documentation guidelines set forth in the regulation. The QA manager was also in-serviced on the documentation to look for with regards to the deficient areas noted by the surveyor. The RN CM's were then sent out immediately to client homes to perform an updated assessment specifically of those areas found to be missing/lacking documentation so that the client chart including care-plans could be updated to reflect the clients current strengths, care preferences, and goals. 2. The agency QA will review 100% of all current comprehensive	11/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	stated in the same section no "s/s [signs/symptoms] infection." The record failed to evidence clear goals the patient set up for themselves. 3. The clinical record of patient #3 was reviewed on 10/31/19 and indicated a start of care date of 9/3/18. The record contained a plan of care for the certification period of 8/29/19-10/27/19 that indicated diagnoses of (not limited to) feeding difficulties, asthma, hypoxia, and developmental delays. The comprehensive pediatric nursing assessment completed on 8/26/19 failed to evidence patient/caregiver driven goals, strengths, and care preferences. 4. The clinical record of patient #6 was reviewed on 10/31/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 8/17/19-10/15/19 that indicated diagnoses, but not limited to, severe developmental delay, incontinence, right hip wounds, and cerebral palsy. The comprehensive non-skilled recertification assessment completed on 8/12/19 failed to evidence patient/caregiver driven goals, strengths, and care preferences. 5. During an interview on 10/31/19 at 4:41 PM, the director of nursing stated the comprehensive assessment should contain patient/caregiver driven goals, strengths, and care preferences. 6. During an interview on 11/7/19 at 10:20 AM, the administrator stated staff needed to ask patients what goals they want for themselves, but are not sure they currently are.		assessments for complete documentation of all assessment areas in the OASIS. For any deficiencies found, the RN CM responsible for the assessment will be required to go back out to client home and complete an updated assessment specifically the areas found by QA to be deficient and then update client chart accordingly. Then at time of next recertification, any further deficiencies will result in disciplinary actions. 3. To ensure the deficient practice does not re-occur, the agency QA manager has been in-serviced on completion of the OASIS and key documentation components that should reflect the client's current strengths, care preferences, and goals. The QA manager will then review 100% of all comprehensive assessments to ensure that all areas included in the assessment documentation are specific, thorough, accurate, and complete. Any deficiencies noted will be addressed by the Clinical Manager with the RN CM and disciplinary action will result. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur.	
G 0534				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	Based on record review and interview, the agency failed to ensure the comprehensive assessment addressed the discharge planning needs for 3 of 7 complete records reviewed (#3, 4, 7). Findings include: 1. An undated agency policy titled "Comprehensive client assessment," Policy C-145 stated "...Special instructions ... The comprehensive assessment must accurately reflect the client's status, and must include at a minimum, the following information: ... The client's medical nursing, rehabilitative, social and discharge planning needs ...." 2. The clinical record of patient #3 was reviewed on 10/31/19 and indicated a start of care date of 9/3/18. The record contained a plan of care for the certification period of 8/29/19-10/27/19 that indicated diagnoses of (not limited to) feeding difficulties, asthma, hypoxia, and developmental delays. The comprehensive pediatric nursing assessment completed on 8/26/19 failed to evidence a completed discharge plan on page 12 of 14. 3. The clinical record of patient #4 was reviewed on 10/30/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated diagnoses of (but not limited to) global developmental delay, Autism, urinary and bowel incontinence. The comprehensive pediatric nursing assessment completed on 6/13/19 failed to evidence a completed discharge plan. 4. The clinical record of patient #7 was reviewed on 10/30/19 and indicated a start of care date of	G 0534	1. For each client cited in the deficiency, the Clinical Director reviewed with the RN CM's the missing assessment components noted by the surveyor. The RN CM's were then in-serviced on how to complete a comprehensive assessment and the thorough documentation guidelines set forth in the regulation. The QA manager was also in-serviced on the documentation to look for with regards to the deficient areas noted by the surveyor. The RN CM's were then sent out immediately to client homes to perform an updated assessment specifically of those areas found to be missing/lacking documentation so that the client chart including care-plans could be updated to reflect the clients discharge planning needs. 2. The agency QA will review 100% of all current comprehensive assessments for complete documentation of all assessment areas in the OASIS. For any deficiencies found, the RN CM responsible for the assessment will be required to go back out to client home and complete an updated assessment specifically the areas found by QA to be deficient and then update client chart accordingly. Then at time of next recertification, any further deficiencies will result in disciplinary actions.	11/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	11/5/18. The record contained a plan of care for the certification period of 9/1/19-10/30/19. The pediatric comprehensive assessment dated 8/30/19 failed to evidence completed information in the section titled "discharge plan," on page 12 (was not addressed). 5. During an interview on 10/31/19 at 4:41 PM, the director of nursing stated the comprehensive assessment should contain discharge and rehab information. 17-14-1(a)(1)(B)		3. To ensure the deficient practice does not re-occur, the agency QA manager has been in-serviced on completion of the OASIS and key documentation components that should reflect the client's discharge planning needs. The QA manager will then review 100% of all comprehensive assessments to ensure that all areas included in the assessment documentation are specific, thorough, accurate, and complete. Any deficiencies noted will be addressed by the Clinical Manager with the RN CM and disciplinary action will result. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur.	
G 0536 Bldg. 00	Based on record review and interview, the agency failed to ensure the comprehensive assessment contained a complete review of medications the patient was taking to ensure medication lists were accurately maintained for 1 of 7 complete records reviewed (#2). Findings include: 1. An undated agency policy titled, "Comprehensive client assessment," Policy C-145 stated "...Special instructions ... The comprehensive assessment must accurately	G 0536	1. For the client cited in the deficiency, the Clinical Director reviewed with the RN CM the missing assessment component noted by the surveyor. The RN CM had a written order for the medication but did not add the medication to the med-profile. Since this was an interim order and a medication reconciliation had been completed, the RN CM was instructed to update the medication profile by adding the	11/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	reflect the client's status, and must include at a minimum, the following information: ... A review of all medications the client is currently using ...." 2. The clinical record of patient #2 was reviewed on 10/29/19 & 10/30/19 and indicated a start of care date of 5/24/19. The record contained a plan of care for the certification period of 9/21/19-11/19/19. A physicians order dated 10/17/19 stated, "Since admission on 5/24/19, tramadol 50 mg [milligrams] 1 tab [tablet] PO [by mouth] Q6hr/PRN [every 6 hours as needed] pain should have been on the client's medication list ...." The RN failed to ensure tramadol was added to the medication list. 3. During an interview on 11/7/19 at 9:27 AM, the director of nursing stated the trauma should have been added to the medication profile and it was missed. 17-14-1(a)(1)(B)		medication and the date in which the medication was started. The RN CM will then, at time of next Recert, will update the POC to reflect this medication. All RN CM's were then in-serviced on how to complete and thoroughly document all medications, both Rx and OTC, currently used by the client with respect to the guidelines set forth in the regulation and the clients medication rights. The QA manager was also in-serviced on the documentation to look for with regards to the med-profile, interim orders, and the POC. 2. The agency QA will review 100% of all current comprehensive assessments and interim orders for complete documentation of current medications the client is taking. For any deficiencies found, the RN CM responsible for the assessment will be required to update the medication profile and then the POC at time of Recert. Then at time of next recertification, any further deficiencies will result in disciplinary actions. 3. To ensure the deficient practice does not re-occur, the agency QA manager has been in-serviced on completion of the OASIS and key documentation components that should reflect a current list of medications the client is currently taking. The QA manager will then review 100% of all comprehensive assessments to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			ensure that all areas included in the assessment documentation are specific, thorough, accurate, and complete. Any deficiencies noted will be addressed by the Clinical Manager with the RN CM and disciplinary action will result. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur.	
G 0538 Bldg. 00	Based on record review and interview, the agency failed to ensure the comprehensive assessment contained detailed information regarding the patient's primary caregiver for 5 of 7 complete records reviewed (#1, 3, 4, 6, 7). Findings include: 1. An undated agency policy titled, "Comprehensive client assessment," Policy C-145 stated "...Special instructions ... The comprehensive assessment must accurately reflect the client's status, and must include at a minimum, the following information: ... The client's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, and their availability and schedules ...." 2. The clinical record of patient #1 was reviewed on 10/29/19 and indicated a start of care date of 6/7/19. The record contained a plan of care for the certification period of 10/5/19-12/3/19. The	G 0538	1. For each client cited in the deficiency, the Clinical Director reviewed with the RN CM's the missing assessment components noted by the surveyor. The RN CM's were then in-serviced on how to complete a comprehensive assessment and the thorough documentation guidelines set forth in the regulation. The QA manager was also in-serviced on the documentation to look for with regards to the deficient areas noted by the surveyor. The RN CM's were then sent out immediately to client homes to perform an updated assessment specifically of those areas found to be missing/lacking documentation so that the client chart including care-plans could be updated to reflect detailed information on the clients primary caregiver,	11/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	comprehensive recertification assessment dated 10/1/19 evidenced the patient's caregiver was the spouse and stated "Caregiver(s) assist with (ADL's [activities of daily living], IADLs [instrumental activities of daily living] and/or medical cares): wife has own medical conditions ... Caregiver(s) willing to assist 'yes' ... Does caregiver feel safe assisting the patient ... 'no' d/t [due to] back issues she does not feel safe doing some care of client. The comprehensive assessment failed to evidence clear information about the spouse's willingness and ability to care for the patient. 3. The clinical record of patient #3 was reviewed on 10/31/19 and indicated a start of care date of 9/3/18. The record contained a plan of care for the certification period of 8/29/19-10/27/19, which indicated diagnoses (not limited to) feeding difficulties, and the patient had a gastrostomy (g-tube). The comprehensive pediatric nursing assessment completed on 8/26/19 failed to evidence primary caregiver willingness and availability to provide care and their schedule. 4. The clinical record of patient #4 was reviewed on 10/30/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated diagnoses of (but not limited to) global developmental delay, Autism, urinary and bowel incontinence. The comprehensive pediatric nursing assessment completed on 6/13/19 failed to evidence information regarding the primary caregiver, including willingness and ability to provide care, availability, and schedules. 5. The clinical record of patient #6 was reviewed on 10/31/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for		specifically when and what care they are willing to provide and/or assist with. 2. The agency QA will review 100% of all current comprehensive assessments for complete documentation of all assessment areas in the OASIS. For any deficiencies found, the RN CM responsible for the assessment will be required to go back out to client home and complete an updated assessment specifically the areas found by QA to be deficient and then update client chart accordingly. Then at time of next recertification, any further deficiencies will result in disciplinary actions. 3. To ensure the deficient practice does not re-occur, the agency QA manager has been in-serviced on completion of the OASIS and key documentation components that should reflect the when and what care the primary caregiver can provide. The QA manager will then review 100% of all comprehensive assessments to ensure that all areas included in the assessment documentation are specific, thorough, accurate, and complete. Any deficiencies noted will be addressed by the Clinical Manager with the RN CM and disciplinary action will result. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the certification period of 8/17/19-10/15/19. The comprehensive non-skilled recertification assessment completed on 8/12/19 failed to evidence information regarding the primary caregiver, including willingness and ability to provide care, availability, and schedules. 6. The clinical record of patient #7 was reviewed on 10/30/19 and indicated a start of care date of 11/5/18. The record contained a plan of care for the certification period of 9/1/19-10/30/19. The pediatric comprehensive assessment dated 8/30/19 failed to evidence information regarding the primary caregiver, including willingness and ability to provide care, availability, and schedules. 7. During an interview on 10/31/19 at 4:41 PM, the director of nursing stated the comprehensive assessment should contain primary caregiver schedules, willingness to provide care, and availability.		ensure this deficient practice will not re-occur.	
G 0574 Bldg. 00	Based on observation, record review and interview, the agency failed to ensure the plan of care (POC) included all measurable goals based on the needs of the comprehensive assessment, all durable medical equipment (DME), diagnoses, education including frequency of, and skilled nurse interventions for 7 of 7 complete records reviewed (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. An undated agency policy titled, "Plan of care," Policy C-580 stated "... Special instructions ... The plan of care shall be completed in full to include: ... All pertinent diagnosis(es), principle	G 0574	1. For each client cited in the deficiency, the Clinical Director reviewed with the RN CM's each POC found to be deficient, noted by the surveyor. The RN CM's were then in-serviced on how to complete a comprehensive assessment and writing a plan of care based off the assessment information. The Clinical Director educated on the key components, set forth in the regulation, that correspond and correlate with the information obtained in the assessment. The QA manager	11/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and secondary ... type, frequency, and duration of all visits / services ...medical supplies and equipment required ... treatment goals ...other appropriate items ...." 2. The clinical record of patient #1 was reviewed on 10/29/19 and indicated a start of care date of 6/7/19. The record contained a plan of care for the certification period of 10/5/19-12/3/19 that indicated diagnoses of pressure ulcers and diabetes, medications, but not limited to, miralax and docusate (medications for constipation). During a home visit observation on 10/31/19 at 9:15 AM a trapeze bar over the bed and a motorized wheelchair were observed in the home. The plan of care failed to evidence a diagnosis of constipation, medications of lasix and potassium (which are on the medication list as starting 8/5/19), measurable goals regarding diabetes, wound healing, further pressure ulcer prevention, the DME motorized wheelchair and trapeze bar, and a frequency for all education interventions to be completed. 3. The clinical record of patient #2 was reviewed on 10/29/19 & 10/30/19 and indicated a start of care date of 5/24/19. The record contained a plan of care for the certification period of 9/21/19-11/19/19 which indicated the patient managed her own meds. The recertification comprehensive assessment dated 9/19/19 stated the patient had pain, a heel wound, and constipation. The plan of care failed to evidence measurable goals for the wound, pain and constipation, or specific education to be taught to the patient with frequency to be completed. During an interview on 11/7/19 at 9:34 AM, the director of nursing stated there was no goal addressing the patient's wound.		was also in-serviced on making sure all comprehensive assessment areas are complete and how those assessment responses are then to be relayed in the plan of care. The information should be concise and specific to the patient. The RN CM's wrote clarification Physician Telephone Orders to clarify and correct any missing components that could be updated with regards to goals, DME, Diagnosis, and frequency of education and SN visits. The RN CM's and the QA manager were given a guide to assist with taking the information from the assessment and developing a POC inclusive of all diagnosis, measurable goals, DME, and frequency of education and interventions. 2. The agency QA manager reviewed 100% of current POC's and the corresponding assessments for deficiencies. Any identified missing components of the POC were reviewed with the RN CM. If applicable, the RN CM, through Physician Telephone Orders clarified and corrected any missing components on the POC. Upon next recert, the POC will then be updated to reflect those interim orders. 3. The agency QA manager will review 100% of comprehensive assessments and POC's to ensure that the POC is a direct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	4. The clinical record of patient #3 was reviewed on 10/31/19 and indicated a start of care date of 9/3/18. The record contained a plan of care for the certification period of 8/29/19-10/27/19, which included diagnoses (not limited to) feeding difficulties, and the patient had a gastrostomy (g-tube). It also indicated the skilled nurse (SN) was to complete G-tube care, G-tube feedings, medication administration, and personal care. The plan of care failed to evidence the type and size of the g-tube, how often the g-tube was to be changed, the rate of feeding and if it is a bolus or via pump. It also failed to evidence what type of SN intervention for site care was to be completed around the g-tube stoma. 5. The clinical record of patient #4 was reviewed on 10/30/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated the patient took melatonin nightly to assist with sleep. The comprehensive pediatric nursing assessment completed on 6/13/19 indicated the patient was a fall risk and a nutritional risk. The plan of care failed to evidence a diagnosis of insomnia (trouble sleeping), and measurable goals related to safety due to self harm, sleep issues, falls, or nutritional risk. 6. The clinical record of patient #5 was reviewed on 10/30/19 and indicated a start of care date of 9/17/18. The record contained a plan of care for the certification period of 9/12/19-11/10/19 that indicated diagnoses of insulin dependant diabetes mellitus (IDDM). The comprehensive recertification assessment completed on 9/7/19 stated the patient had shortness of breath and pain. The plan of care failed to evidence		reflection of the assessment and any missing components of such or conflicting information found will be immediately addressed by the Clinical Director with the RN CM for possible disciplinary action. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	measurable goals for pain or shortness of breath. 7. The clinical record of patient #6 was reviewed on 10/31/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 8/17/19-10/15/19 that indicated diagnoses, but not limited to, severe developmental delay, and cerebral palsy. The comprehensive non-skilled recertification assessment completed on 8/12/19 indicated the patient was on a pureed diet with honey thick liquids. The plan of care failed to identify swallowing problems, the need for the therapeutic diet, how the diet was tolerated, and if there was any safety concerns with aspiration risk. 8. The clinical record of patient #7 was reviewed on 10/30/19 and indicated a start of care date of 11/5/18. The record contained a plan of care for the certification period of 9/1/19-10/30/19 that indicated diagnoses of hydrocephalus, Pica, Asthma, and Tracheotomy and a medication, but not limited to, Septra 50 milligrams (mg) daily for infection prevention. Additionally the plan of care indicated the nurse was to instruct on hydration and dietary guidelines, and good infection prevention practices. Lastly the plan of care indicated orders for the skilled nurse to check placement of gastrostomy (G-Tube) with 30 milliliters (ml) air bolus via auscultation before g-tube feedings, administer 150 ml real food formula mixed with 60 ml fluid an administer via infinity pump at 30 ml/hour over 30 minutes, crush medications dissolve in 30 ml water and administer per g-tube followed by 60 ml water flush, change 4.5 Shiley tracheotomy (trach) once per week, cleanse trach stoma with soap and water every shift as needed, suction excess secretions every shift as needed for excess drainage, change 2.5 centimeter (cm) mickey button (g-tube) every 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	months, cleanse around g-tube with soap and water daily and as needed soilage, straight catheterize with a 14 french catheter every 4 hours as needed for bladder retention, irrigate bladder 2 times per day with 100 ml normal saline. The plan of care failed to evidence diagnoses for: tube feedings, straight catheterization, irrigation of the bladder, and chronic antibiotic use; frequency of education; or measurable goals related to tracheotomy, gastrostomy, or catheterization. 9. During an interview on 10/31/19 at 4:41 PM, the director of nursing stated the plan of care should contain all pertinent diagnoses, medications, education, goals that are measurable, treatments and care, frequency of interventions, education and visits, and DME. 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(ii) 17-13-1(a)(1)(D)(ix) 17-13-1(a)(1)(D)(xii)			
G 0644 Bldg. 00	Based on record review and interview, the agency failed to ensure all quality assurance performance improvement (QAPI) data was aggregated and analyzed to identify opportunities for improvement and monitor the effectiveness and quality of care for 1 of 1 agency. Findings include: An undated agency policy titled "Performance improvement policy," Policy #260 stated "Policy: Agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical	G 0644	1. There were no clients cited in this deficiency 2. There were no clients cited in this deficiency 3. The agency reviewed its current QAPI policy to ensure all components in the standard are addressed in the current QAPI program. The agency found that although their data collection process was accurate, the aggregation and analyzation components were not being utilized appropriately to identify	11/21/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and other processes. ... Purpose: ... To identify areas for improvement ... improve client and agency outcomes ...to evaluate all areas of concern and implement plans to resolve the issues. ... Objectives of the program ... To identify, address, track and resolve problems in client care services ... To meet state and federal regulatory requirements ...Special Instructions: ...Data will be systemically collected to measure process and outcome. Data will be assessed to: Identify current level of performance ... evaluate the stability of the processes ... Identify effectiveness of communication systems ... identify areas to be improved ... Identify strategies to stabilize or improve processes... evaluate whether outcomes were achieved ....The plan will target the performance of existing processes and outcomes and identify / design new processes based on priorities, standards and resources ...." The QAPI binder contained meeting notes monthly from January to August 2019. Each month they discussed the number of falls, infections, hospitalizations, emergency room visits, satisfaction surveys and performance improvement at some of them. The data was collected to show the number of occurrences. However, the agency QAPI program failed to analyze the data collected, identify trends, and create a plan to lower the occurrences and to assist the agency in providing improved patient outcomes. During an interview on 11/7/19 at 2:55 PM, the administrator stated that the agency looked at all the data to see if the indicators trended up or down. They stated they did not analyze the data to assess for trends. 17-12-2(a)		opportunities for improvement and monitoring the effectiveness and quality of care. The QAPI manager was then in-serviced on how to gather and utilize quality indicator data, including measures derived from OASIS, client infection, hospitalization, ER visit, and fall logs, and other relevant data, the aggregation and analyzation of this data to identify areas needing improvement, and also monitoring the effectiveness and quality of care. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
G 0682 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure all staff followed standard precautions and infection control policies for 3 of 3 observations (employees F, G, H) for 2 of 2 patients observed (#1, 2). Findings include: 1. An undated agency policy titled "Handwashing / Hand Hygiene," Policy D-330 stated "... In an effort to reduce the risk for infection in clients and staff members, thorough handwashing / hand antisepsis is required of all employees. ... Indications for hand washing and hand antisepsis: ... between tasks on the same client ... after removing gloves ...Hand Hygiene Technique When decontaminating hands with an alcohol based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry ... When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by manufacturer to hands and rub hands together vigorously for at least thirty (30) seconds, covering all surfaces of hand and fingers ...." 2. During a home visit observation on 10/31/19 at 9:15 AM with patient #1 (start of care 6/7/19), employee G, licensed practical nurse(LPN), was observed to provide skilled care. During handwashing technique observation employee G failed to wash (scrub) hands for 30 seconds per agency policy and completed the handwash at times underneath running water (not vigorously rubbing the hands together). Completed 10	G 0682	1. For each client cited in the deficiency, the HHA and SN were both called into office for one on one in-servicing on the agency policies regarding Standard Precautions, Infection Control, and Handwashing at the Sink vs. Hand Sanitizer. The Clinical Director showed each employee how their technique was observed by the surveyor during the visit, and then the correct way was shown. The employees had to complete both a written test and a return demonstration showing their understanding of the 30 sec. hand scrub that is to be done with hands not under water, and if using hand sanitizer, it must be rubbed in completely until hands are dry. Both employees verbalized understanding of the difference between what they did wrong during the visit and the correct way, as well as, they were able to give excellent return demonstration for both methods. 2. For all other clients, an agency wide in-service was held in which all staff was re-educated on Standard Precautions, Infection Control, and Handwashing at the Sink vs. Hand Sanitizer. All staff were given a reading, shown the correct way vs. the incorrect way to perform the technique, a written test, and were required to	11/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	second, 11 second, and 5 second hand washes. 3. During a home visit observation on 10/31/19 at 9:52 AM with patient #1 (start of care 6/7/19), employee H, home health aide (HHA) was observed to provide personal care. During handwashing technique observation employee H failed to wash (scrub) hands for 30 seconds per agency policy. Completed 18 second, 13 second, and 15 second hand washes. 4. During a home visit observation on 10/31/19 at 12:07 PM with patient #2 (start of care 5/24/19), employee F, registered nurse (RN), was observed to provide skilled care. During handwashing technique observation employee F failed to wash (scrub) hands for 30 seconds per agency policy and completed the handwash underneath running water (not vigorously rubbing the hands together). Completed an 8 second hand wash. 5. During an interview on 10/31/19 at 4:46 PM, the Director of Nursing (DON) indicated staff should not scrub hands under running water. Additionally the DON agreed when using hand sanitizer staff should not be fanning their hands to dry but rather continue to rub until dry. 17-12-1(m)		demonstrate the correct Handwashing/Hand Sanitizing technique while being observed by Clinical Director. Any deficiencies addressed and corrected immediately. 3. In order to ensure this practice does not happen again, the agency has revised the HHA and LPN supervisory visit form to include a "Hand-washing Observation" element requiring RN CM's to observe handwashing during 60-day supervisory visits. The RN CM's were in-serviced on what is acceptable technique, what is not, to address any deficiency on the spot, and then to notify the Clinical Director of who is deficient so that she may address this with verbal/written disciplinary action. 4. The Administrator and Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur.	
G 0710 Bldg. 00	Based on record review and interview, the agency failed to ensure the registered nurse (RN) followed the plan of care for 3 of 7 complete records reviewed (#2, 3, 5). Findings include:	G 0710	1. For clients #2 and #5, the RN CM's over the cases were immediately notified of the deficiency regarding the duration of the visit that was put on the POC and the duration of which the SNs are charting. The RN CM's	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	1. An undated agency job description titled "registered nurse job description," stated duties included "... Accept and carry out physician, chiropractor, podiatrist, dentist, optometrist orders (oral or written) ...." 2. An undated agency job description titled "registered nurse case manager job description" stated duties included "... Accept and carry out physician, chiropractor, podiatrist, dentist, and optometrist orders (oral or written) ...." 3. An undated agency job description titled "licensed practical nurse" stated "Major task, duties, and responsibilities ... implement plan of care initiated by clinical case manager ...." 4. The clinical record of patient #2 was reviewed on 10/29/19 & 10/30/19 and indicated a start of care date of 5/24/19. The record contained a plan of care for the certification period of 9/21/19-11/19/19 that indicated a skilled nurse (SN) frequency of 2 to 4 visits a day, 5 to 7 days per week, 1 hour visits. The SN performed visits on: 10/20/19 (2 visits), 10/19/19 (3 visits), 10/18/19 (3 visits), 10/17/19 (3 visits), 10/16/19 (3 visits), 10/15/19 (3 visits), 10/14/19 (3 visits), 10/13/19 (2 visits), 10/12/19 (4 visits), 10/11/19 (4 visits), 10/10/19 (3 visits), 10/9/19 (4 visits), 10/8/19 (3 visits), 10/7/19 (3 visits), 10/6/19 (2 visits), 10/5/19 (3 visits), 10/4/19 (3 visits), 10/3/19 (3 visits), 10/2/19 (3 visits), 10/1/19 (2 visits), 9/30/19 (3 visits), 9/29/19 (2 visits), 9/28/19 (4 visits), 9/27/19 (3 visits), 9/26/19 (2 visits), 9/25/19 (3 visits), 9/24/19 (2 visits), 9/23/19 (3 visits), 9/22/19 (2 visits), and 9/21/19 (3 visits) all which were less than 1 hour. 5. The clinical record of patient #3 was reviewed		were instructed to contact all SN's providing care to see how long each SN needed to complete all the interventions and education required for the visit. It was concluded that each SN could complete the visit, with all interventions and education completed as ordered in 35 minutes. Next, the Clinical Director contacted Medicaid as they require the POC to reflect hours not minutes for billing purposes as hours are billed as units, with one hour equal to one unit, and they do not allow for half or quarter units. Per Medicaid, they will accept "up to one hour" on the POC and that was their recommendation to the Director. The RN CM's were instructed by the Director to write a clarification Physician Telephone Order to change the wording on the POC from 1hour/visit to "up to 1 hour/visit". For client #5, the RN CM was notified of the missing documentation in the Pediatric Comprehensive Assessment and was immediately required to demonstrate knowledge of how to perform G-Tube site care. The RN CM was able to successfully demonstrate performance of this task via Teach Back. The RN CM was in-serviced by the Clinical Director on writing a plan of care based off the assessment information and carrying out all MD ordered interventions. The SN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	on 10/31/19 and indicated a start of care date of 9/3/18. The record contained a plan of care for the certification period of 8/29/19-10/27/19 that included diagnoses (not limited to) feeding difficulties, and the patient had a gastrostomy (g-tube). It also indicated the skilled nurse (SN) was to complete G-tube care. The agency comprehensive pediatric nursing assessment completed on 8/26/19 failed to evidence the nurse completed G-tube site care. Agency nursing visit notes dated 9/2/19 to 10/19/19 failed to evidence the nurse completed g-tube site care. 6. The clinical record of patient #5 was reviewed on 10/30/19 and indicated a start of care date of 9/17/18. The record contained a plan of care for the certification period of 9/12/19-11/10/19 that indicated a SN frequency of 5 to 7 days a week, 1 to 3 visits a day, 1 hour visits. The SN performed visits from 9/12/19 to 10/21/19 all which were less than one hour. 7. During an interview on 10/31/19 at 4:42 PM, the director of nursing stated the nurses should be following the plan of care. 17-14-1(a)(1)(H)		was then in-serviced on implementing the POC, written by the RN CM and following those interventions, one of which was G-Tube site care. The SN was also required to demonstrate knowledge of G-tube site care via Teach Back, of which she was successful. 2. The agency performed an audit of all nursing visit flowsheets for time in and time out to see what actual time was spent performing the ordered interventions and education on each Skilled client. The agency also compared ordered interventions on the POC vs. what the SN documented. The agency also reviewed all skilled OASIS including pediatric OASIS to ensure that the RN CM's were assessing and performing the ordered interventions and education during their recertification visits. The following was determined; the duration varies but is never more than one hour, SN's were completing ordered interventions and education as outlined in the POC, and the skilled and pediatric comprehensive assessments reflected that the RNCM's were following their POC ordered interventions and education during the recert visits. Based off this information, the agency determined that the wording on the POC for visit duration should be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			changed to reflect the actual time spent. Per Medicaid guidance, the agency had decided that the wording for the duration of the visits on all POC's for skilled clients would be changed to "up to 1 hour". This allows the SN up to an hour to complete the ordered interventions and education but does not require the SN to be there if the visit is completed before the hour is up. All SN's, RNCM's, QA, and SN scheduling were in-serviced regarding this change. The RN CM's were instructed to write clarification Physician Telephone Orders to change the wording on the duration of the skilled POC's from 1hr/visit to "up to 1hr/v". All job descriptions for LPN, RN, and RN CM were reviewed with all agency nursing staff, emphasizing the fact that all interventions and education listed on the POC must be performed and documented as such. If they are unable to complete a task that is ordered, the SN is to notify the RN CM over the case and the RN CM is then to notify the MD if necessary and make changes accordingly. 3. The agency RN CM staff will QA 100% of all SN flow sheets to ensure that all ordered interventions and education are performed and documented. If an intervention or education is not performed and documented the Clinical Director will meet with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			SN and RN CM to see why and if necessary disciplinary action may result. The SN staff has been made aware that failure to follow the POC and/or failure to document correctly will result in a disciplinary action. 4. The Administrator and Clinical Director will be responsible for monitoring the corrective actions to ensure the deficient practice does not happen again.	
G 0774 Bldg. 00	Based on record review and interview, the home health agency failed to ensure all home health aide (HHA) employee files evidenced 12 hours of completed inservices for 1 of 5 HHA employee files reviewed (D). Findings include: An undated agency policy titled "In-service education/staff development," Policy # D-320 stated "... The Home heath aide must complete twelve (12) hours per year either in lecture, video in-services, or in the client home while providing care ...." During the review of employee files on 10/31/19, the list of current employees included employee D, home health aide, date of hire 10/2016 and unknown first patient contact date. The employee file failed to evidence 12 hours of in-service training for 2018 (only had 11 inservices equaling 11 hours).	G 0774	1. No client was cited in this deficiency. 2. No client was cited in this deficiency 3. For this deficiency, the agency now requires all staff to sign in on a sign-in sheet, and then as in-services are returned to the HR department, the HR staff member will initial next to the HHA staff member name acknowledging receipt of the in-service. The agency holds in-services the 3rd week of every month, therefore and all in-service testing must be graded and filed by Wednesday of the following week. The Office Manager and Clinical Director will then audit 10% of all personnel files to ensure in-services are complete, graded, and filed. Any HHA staff that does not attend in-servicing during the assigned	12/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an interview on 10/31/19 at 4:48 PM, the director of nursing stated each inservice equals one hour of instruction. 17-14-1(h)		times, will be notified that they must report to the Clinical Director within 48 hours to complete the in-services so that they may be graded and filed timely for auditing. A running list will be kept by the Office Manager and HR Department of all active employees and what in-services have been done, when they were done, when they were graded/filed and who completed each step of the process. This is to ensure HR/Office Manager accountability for this task. Any employee who fails to attend and complete in-service training within the scheduled week and then fails to meet with the Clinical Director will be disciplined immediately. 4. The Administrator and the Clinical Director will be responsible for monitoring and reviewing this corrective action to ensure this deficient practice will not re-occur.	
G 0798 Bldg. 00	Based on record review, the agency failed to ensure the Registered Nurse (RN) ensured the home health aide (HHA) care plan was individualized with specific timeframe's the tasks were to be completed for 4 of 5 complete records reviewed with HHA services (#1, 2, 5, 6). Findings include: 1. An undated agency policy titled "Home health	G 0798	1. For each client cited in the deficiency, the RN CM over the cases and the Clinical Director reviewed each individual care plan for frequency of tasks to be completed and the wording “as needed”. The HHA care plan document used by the agency has 2 columns addressing the frequency that can be checked for	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	aide care plan," stated "Policy: A complete and appropriate care plan, identifying duties to be performed by the hoe health aide, shall be developed by a registered nurse ... Purpose ... To provide documentation that the client's care is individualized to his / her specific needs ...." 2. The clinical record of patient #1 was reviewed on 10/29/19 and indicated a start of care date of 6/7/19. The record contained a plan of care for the certification period of 10/5/19-12/3/19. The aide care plan failed to identify specific timeframe's (every visit or once a week for example) that all tasks were to be completed. 3. The clinical record of patient #2 was reviewed on 10/29/19 & 10/30/19 and indicated a start of care date of 5/24/19. The record contained a plan of care for the certification period of 9/21/19-11/19/19. The aide care plan failed to identify specific timeframe's (every visit or once a week for example) that all tasks were to be completed. 4. The clinical record of patient #5 was reviewed on 10/30/19 and indicated a start of care date of 9/17/18. The record contained a plan of care for the certification period of 9/12/19-11/10/19. The aide careplan stated "stand by assist for shower if needed" (HHA's are unable to make any decision when care should be given, must be lead by the aide careplan. The aide care and the homemaker careplan failed to identify specific timeframe's (every visit or once a week for example) that all tasks were to be completed. 5. The clinical record of patient #6 was reviewed on 10/31/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 8/17/19-10/15/19. The		each task, one being every visit and the other being weekly. There is also an empty column where a frequency can be typed in i.e. M-W-F. Per the regulation, the home health aide cannot decide as to what and when care can be performed, however the client has the right to choose. The agency has determined that the wording “as needed” should be removed from the HHA care plan and replaced with “per client request” or should list specific days for any intervention/task that is not performed every visit or weekly. This wording does not allow for the HHA to determine when or if care should be completed. All RN CM’s and HHA’s were then in-serviced on this change with regards to the wording and task frequency. 2. The RN CM’s and Clinical Director reviewed 100% of all HHA care plans with regards to the wording “as needed” and task frequency. Any HHA care-plan that was found to have tasks/interventions that do not get done every visit/weekly, will be done per client request and labeled that way on the care plans a. For example: Client is to have HHA assist with showering M-W-F-Sun and sponge bath on T, Th, and Sa, and dressing every visit. The client prefers to wash her hair one to times per week on random days. The HHA care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	aide care plan failed to identify specific timeframe's (every visit or once a week for example) that all tasks were to be completed. 17-13-2(a)		would then reflect showering to be done M-W-F-Sun, and sponge baths on T, Th, and Sa, dressing every visit and hair shampoo as a task that can be done per the client request. 3. The agency QA manager will audit 100% of all client HHA care plans to ensure the wording “as needed” has been removed and replaced with “per client request”. The QA will also audit to ensure that all tasks specify a frequency of specific days, every visit, weekly, or per client request. Any future deficiencies will be addressed by the Clinical Director with the RN CM for an immediate resolve. 4. The Administrator and Clinical Director will be responsible for monitoring the corrective actions to ensure the deficient practice does not re-occur	
G 0800 Bldg. 00	Based on record review and interview, the agency failed to ensure the home health aide (HHA) completed visits in accordance with the plan of care (POC) orders for frequency for 2 of 5 complete records reviewed with HHA services (#2, 6). Findings include: 1. An undated agency policy titled "Home health aide care plan," stated "Policy: A complete and	G 0800	1. For each client cited in the deficiency, the HHA’s performing visits in those homes were called in to review with the RN CMs and Clinical Director to explain why a task was performed that was not on the care-plan. The HHA’s were in-serviced on how to read a care-plan with respect to the duties listed and when they are to be performed. The HHA’s were	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	appropriate care plan, identifying duties to be performed by the home health aide, shall be developed by a registered nurse ... All home health aide staff will follow the identified plan ...." 2. The clinical record of patient #2 was reviewed on 10/29/19 & 10/30/19 and indicated a start of care date of 5/24/19. The record contained a plan of care for the certification period of 9/21/19-11/19/19. A HHA documentation note completed for morning care on 9/25/19 indicated the HHA shaved the patient which was not an ordered task on the aide care plan or plan of care. A HHA documentation note completed for noon care on 9/23/19, 9/25/19, and 9/27/19 indicated the HHA completed range of motion on the patient which was not an ordered task on the aide care plan or plan of care. A HHA documentation note completed for noon care on 10/5/19 and 10/6/19 indicated the HHA completed "Shower/Tub/Bed/Comp/Part [complete/partial]" with the patient but did not identify what type of personal care was completed (was indicated for partial bed bath on aide care plan). A HHA documentation note completed for evening care on 9/23/19, 9/24/19, 9/25/19, and 9/27/19 indicated the HHA dressed the patient which was not an ordered task on the aide care plan or plan of care. 3. The clinical record of patient #6 was reviewed on 10/31/19 and indicated a start of care date of 2/18/19. The record contained a plan of care for the certification period of 8/17/19-10/15/19		also re-instructed on what to do should a client ask them to perform a task that is not listed on the care-plan. The were also re-educated on the fact that all tasks/interventions to be performed have been written by an RN and ordered by an MD, and any care performed outside of the care-plan without seeking RN direction prior to doing the intervention/task was a violation of the HHA Job Description and would result in disciplinary action. 2. The agency reviewed all HHA flow sheets against the HHA care-plan specific to that visit. Any discrepancies were brought to the attention of the RN CM and Clinical Director to address immediately with both the client and the HHA staff. The agency then in-serviced all HHA field staff on how to read a care-plan with respect to the duties listed and when they are to be performed. HHA's were also re-educated on what to do when a client asks for a task/intervention to be performed that is not on the care-plan. The HHA staff was re-educated on the fact that all tasks/interventions are written by an RN and ordered by an MD, and any care performed outside of the care-plan without seeking RN direction prior to doing the care was a violation of the HHA Job Description and would result in disciplinary action. 3. To ensure the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A HHA documentation note completed for morning care on 10/15/19 indicated the HHA gave a partial shower which was not an ordered task on the aide care plan or plan of care. 4. During an interview on 10/31/19 at 4:42 PM, the director of nursing stated the home health aide should follow the plan of care.		practice does not happen again, the agency has put in place an HHA QA employee who will be responsible reviewing 100% of all HHA flow-sheets with the care-plan to ensure that all tasks assigned were completed, and to catch any tasks that were documented as complete but not listed on the care plan. Should a discrepancy be found, the QA employee will notify the RN CM and the Clinical Director. This will be addressed immediately with the individual field staff and client to see if any adjustments to the HHA care plan need to be done. The RN CM will then contact the MD to see if an order may be obtained. 4. The Administrator and Clinical Director will be responsible for ensuring the deficient practice does not re-occur.	
G 0978 Bldg. 00	Based on record review and interview, the agency failed to ensure a written agreement was in place with other agencies providing care in the home for 1 of 1 shared agency patients reviewed (#7). Findings include: The clinical record of patient #7 was reviewed on 10/30/19 and indicated a start of care date of 11/5/18. The record contained a plan of care for the certification period of 9/1/19-10/30/19 that	G 0978	1. For the client cited in the deficiency, the agency obtained a contract with Hometown Home Healthcare, the provider of the client's Medicaid PA hours. The contract lists both agencies, their individual responsibilities to the patient, the services and ordered interventions to be provided with respect to their payor sources, who to coordinate care with,	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	stated "Coordination of Care: [entity A] is responsible for client's MCD [Medicaid] PA [prior authorization] hrs [hours]." The record failed to evidence a written agreement with entity A. During an interview on 11/7/19 at 10:14 AM, the director of nursing stated there was no contract in place with entity A because entity A was the agency that provided the prior authorization Medicaid hours and they just completed respite nursing. 17-12-2(d)		liability, need for each agency to have their own admission documentation and their own POC. The RN CM over the case was educated on the Coordination of Care with the other agency and that the contract was put in place, filed in the chart, and would expire only if the client is discharged from either agency. The RN CM was instructed on who to coordinate care with and that this is to be done every 60 days. 2. The agency reviewed all client charts and no other deficiencies were found. If one of the agency clients begins receiving services with another agency, this agency will notify that agency immediately and a contract will be drawn up as per the regulation. RN CM's have been instructed to ask upon recert if there are any other agencies providing services and if so, the RN CM will ask the client for the contact information of the agency and the RN CM will notify the Clinical Director and Administrator. The Clinical Director and Administrator will then contact the other agency to create a contract that will allow for each agency to provide their respective services and that will contain all information set forth in the federal regulation. The RN CM assigned to the case will then be instructed who she is to coordinate care with and how often	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			3. To ensure the deficiency does not re-occur, referral sources will be asked if any other home health agency has services in the client home, and if so, this agency will need the contact information in order to establish a contract per federal regulation. Upon admission, the admit nurse will also inquire about any other services the client may be receiving or is planning to receive. The RN will emphasize the importance of notifying this agency as well as any other home health provider so the agencies can establish a contract between the two as per federal regulation requires. Current clients will be asked upon each recertification as to whether they have received or are planning to receive any home health services from any other provider and if so, the client will then be asked for contact information so that the agencies can establish contracts and coordination of care. 4. The Administrator and Clinical Director will be responsible for monitoring these corrective actions to ensure the deficient practice will not re-occur.	
N 0000 Bldg. 00	This was a state re-licensure home health survey	N 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	with one (1) complaint. Complaint information: IN00213640- Substantiated Facility #: 003961 Survey dates: October 29, 30, 31, and November 7; 2019 Skilled Services: 42 Home Health Aide only: 19 Personal Service only: 66 Unduplicated Skilled Census: 127 Total active patients: 112 Record reviews with home visits: 2 Record review without home visits: 6 full records, 1 partial Total clinical records reviewed: 9 Quality Review completed on 11/27/19 CS			
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure that all employees had an orientation specific to their job description, record was kept of the first patient contact date to ensure a criminal background check was completed within 3 days of first providing care, and that their policy was updated to show a national criminal background check was required per Indiana administrative code for 6 of 6 employee records reviewed (D, E, H, I, J, K). Findings include: 1. An undated agency policy titled "Employee orientation program," Policy D-300 stated "Policy: All staff, volunteers, students and members of the Board of directors new to the agency, will participate in a general orientation program before beginning any job responsibilities. An orientation department or position orientation specific to staff members; needs and specific responsibilities will be provided following the general orientation. This orientation is tailored to the educational background and experience, type of care provided, physical and mental condition of clients, and the roles and responsibilities of the position ...." 2. An agency policy dated 8/8/14 and titled "Criminal background check," Policy #D-190 stated "All employees, upon hire, will have a request for a limited criminal history background check set to the Indiana state police. Results of this check must be obtained prior to the employee's first visit with a patient. Any employee who has lived outside the state of Indiana within 2 years of hire will have an	N 0458	1. For the employees cited in the deficiency, the agency mgmt. staff reviewed the files along with the policies cited. The following actions were taken; a. Each of the employee files were updated to contain first patient contact dates b. An orientation specific to the each of the employees position was reviewed with the employees and was placed in their file. A notation was made to show that this was an update. 2. The agency reviewed 100% of all currently active employees to include a first patient contact date and a new and updated job orientation specific to the employees respective position was reviewed with and signed by the employee and then their personnel file was updated with the form and a notation was made in each personnel file to note the change. 3. The agency has implemented an audit process for all new employee files that is to be done prior to employees first patient contact date. This audit will include a check to make sure that a national criminal background check has been completed and returned to the agency at three days prior to first patient contact, this audit will also	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	expanded criminal history background check done ...." 3. During the review of employee files on 10/31/19, the list of current employees included employee D, home health aide, date of hire 10/2016 and unknown first patient contact date. The employee file failed to evidence the first patient contact date to ensure the criminal background check completed on 9/2/16 was completed within 3 days of first patient contact, and failed to evidence an orientation specific to the job duties of the employee. 4. During the review of employee files on 10/31/19, the list of current employees included employee E, home health aide, date of hire 6/2017 and unknown first patient contact date. The employee file failed to evidence the first patient contact date to ensure the criminal background check completed on 6/1/18 was completed within 3 days of first patient contact. 5. During the review of employee files on 10/31/19, the list of current employees included employee H, home health aide, date of hire 9/9/17 and unknown first patient contact date. The employee file failed to evidence the first patient contact date to ensure the criminal background check completed on 9/7/17 was completed within 3 days of first patient contact, or an orientation specific to the job duties of the employee. 6. During the review of employee files on 10/31/19, the list of current employees included employee I, registered nurse, date of hire 6/10/19 and unknown first patient contact date. The employee file failed to evidence the first patient contact date to ensure the criminal background check completed on 6/5/19 was completed within 3		ensure that an orientation specific to the employees respective position has been completed and signed off on by both the employee and the HR staff. The agency has also updated its Criminal Background Check policy so that it aligns with federal and state regulations. To ensure the deficient practice does not re-occur, the agency has put in place an audit tool that must be checked off and initialed by HR staff and by the Office Mgr. and Clinical Director. This audit tool will be a required component of the Employee New Hire Process and once complete will be placed in the front of the employee file. The Administrator and Clinical Director will be responsible for monitoring this corrective action to ensure that the deficient practice does not re-occur. The Admin. and Clinical Director will audit 100% of all new employee files monthly for one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	days of first patient contact,or an orientation specific to the job duties of the employee. 7. During the review of employee files on 10/31/19, the list of current employees included employee J, home health aide, date of hire 9/24/19 and unknown first patient contact date. The employee file failed to evidence the first patient contact date to ensure the criminal background check completed on 9/24/19 was completed within 3 days of first patient contact, and an orientation specific to the job duties of the employee. 8. During the review of employee files on 10/31/19, the list of current employees included employee K, home health aide, unknown date of hire and unknown first patient contact date. The employee file failed to evidence the first patient contact date to ensure the criminal background check completed on 12/31/18 was completed within 3 days of first patient contact, or an orientation specific to the job duties of the employee. 9. During an interview on 10/31/19 at 4:47 PM, the administrator and director of nursing stated they had never kept track of first patient contact dates.			
N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	patients. Based on record review and interview, the agency failed to ensure that and appropriate physical examination was completed within the appropriate timeframe's with the date the employee was examined for 3 of 6 employee records reviewed (H, I, K). Findings include: 1. An undated agency policy titled "Health screening," Policy D-240, stated "...Pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by state law of agency policy...." 2. During the review of employee files on 10/31/19, the list of current employees included employee H, home health aide, date of hire 9/9/17 and unknown first patient contact date. The employee file failed to evidence a physical examination. 3. During the review of employee files on 10/31/19, the list of current employees included employee I, registered nurse, date of hire 6/10/19 and unknown first patient contact date. The employee file failed to evidence a physical examination. 4. During the review of employee files on 10/31/19, the list of current employees included employee K, home health aide, unknown date of hire and unknown first patient contact date. The employee file failed to evidence a date on the physical examination that the employee was examined. 5. During an interview on 10/31/19 at 2:29 PM the director of nursing stated every employee should	N 0462	1. For the employee personnel files found to be deficient, two of the employees are no longer working for the company, and the other employee was immediately pulled from the field and sent for an employee physical so that her personnel file could be updated. 2. For all other employee personnel files, the Administrator, Clinical Director, Office Mgr., and HR staff audited 100% of all files. The employee physical form and Health Screening Policy were also reviewed. It was concluded that the physical form, which is provided by the provider that does the employee physicals, does not have a clear and definite date of when the employee was examined by the provider. Therefore, the agency has re-vamped the employee physical form to include a space for the provider to provide a date of examination and is labeled as such. There were no other deficiencies found in the audit. The HR staff has been instructed to dispose of the old forms and to utilize the new employee physical form effective immediately. In the event that the physical form is returned to the agency without the date of exam, the employee will not be able to start field work until the form is dated correctly. HR will send the form back to the provider for date. 3. The agency has disposed	12/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K015		11/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	have a physical in their employee file.		of all of the old employee physical forms and all HR staff has been instructed on the new form. This corrective action will be monitored by the Clinical Director and Administrator to ensure the deficient practice will not re-occur. One hundred percent of all personnel files will be audited prior to the employee going into patient homes to ensure that all information on the physical form is complete. This audit is now part of the hiring process and will be required from the date of correction forward. HR personnel has been made aware and provider is aware also.	