

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123                              |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| G0000   | <p>This visit was a home health agency federal recertification survey.</p> <p>Survey dates: 01/28/12 through 02/01/13</p> <p>Facility #: 005731</p> <p>Medicaid Vendor #: 200231350 A</p> <p>Surveyor: Marty Coons, RN, PHNS</p> <p>Total Census-453</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN<br/>February 6, 2013</p> | G0000   | G 0000  |                      |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123  |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |   |
| G0108   | <p><b>484.10(c)(1)</b><br/><b>RIGHT TO BE INFORMED AND PARTICIPATE</b><br/>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient had been informed, in advance, of the disciplines that would furnish care and the proposed frequency of visits in 8 (# 2, 3, 4, 7, 8, 10, 11 and 12) of 12 records reviewed creating the potential to affect all new admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a plan of care with a start of care date of 1-10-13 that identified the physician had ordered skilled nurse services 3 times per week and home health aide services 2 times per week for 9 weeks. The record included a "Home Health Admission Service Agreement" form, dated 1-10-13, that failed to evidence the patient had been informed of the skilled nurse and</li> </ol> | G0108   | <p>G 0108<br/>Expanded Policy and Procedures implemented on 2/8/2013: On the admission visit, the RN is to write the expect disciplines, frequency, and duration on the revised PHHC Home Health Admission Service Agreement, which has a specific section for this information. The RN will verbally explain this information and have the client initial the form to verify that all information is understood by the client or their representative and a written copy will be left in the clients' home (Policy &amp; Procedures Vol#2 C-140,f). In addition to the Home Health Admission Service Agreement, the admission RN will review and explain the clients' Plan of Care/485 which details services, treatment, and frequency. To insure that all current clients have a copy of the new updated Home Health</p> | 04/04/2013           |   |

|   |   |   |  |  |  |   |  |
|---|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                       |  | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE   |  |   |  |
|   | <p>home health aide services that would be provided.</p> <p>2. Clinical record number 3 included a plan of care with a start of care date of 12-21-12 that identified the physician had ordered skilled nurse services 1 time per week and home health aide services 1 time per week times 1 week, then 3 times per week for 2 weeks. The record included a "Home Health Admission Service Agreement" form, dated 12-24-12, that failed to evidence the patient had been informed of the skilled nurse and home health aide services that would be provided prior to or on the 12-21-12 start of care date.</p> <p>3. Clinical record number 4 included a plan of care with a start of care date of 4-5-12 that identified the physician had ordered home health aide services 5 times a week times 9 weeks. The record included a "Service Agreement &amp; Authorization" form, dated 4-26-12, that failed to evidence the patient had been informed of the home health aide services prior to or on the 4-5-12 start of care date.</p> <p>4. Clinical record number 7 included a plan of care with a start of care date of 10-18-12 that identified the physician had ordered skilled nurse services 1 time a month for 3 months. The record included</p> |   | <p>Admission Service Agreement, a copy will be presented to the client with the next RN supervisors visit per their Plan of Care schedule. Documentation in skilled visit notes will verify that this was delivered and reviewed. The Director of Nursing, Director of Quality Improvement, Administrator and the CQI staff will assure the Home Health Admission Service Agreement is completed and accurate during the admission audit process and follow-up as needed. All current clients should be updated no later than in the next 60 days.</p> |  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                       |  | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |  |
|---|--|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE   |  |   |  |
|   | <p>a "Home Health Admission Service Agreement" form, dated 10-18-12, that failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>5. Clinical record number 8 included a plan of care with a start of care date of 4-11-12 that identified the physician had ordered skilled nurse to assess and evaluate and for a home health aide 1 time a week times 1 week, then 3 times a week for 6 weeks. The record included a "Service Agreement &amp; Authorization" form, dated 4-11-12, that failed to evidence the patient had been informed of the skilled nurse and of the home health aide services that would be provided.</p> <p>6. Clinical record number 10 included a plan of care with a start of care date of 6-25-12 that identified the physician had ordered skilled nurse services 1 time a week times 2 weeks and physical therapy 2 times a week time 1 week then 3 times a week times 8 weeks. The record included a "Home Health Admission Service Agreement" form, dated 6-25-12, that failed to evidence the patient had been informed of the skilled nurse physical therapy services that would be provided.</p> <p>7. Clinical record number 11 included a plan of care with a start of care date of</p> |   |   |  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123                              |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
|   | <p>8-29-12 that identified the physician had ordered skilled nurse services 1 time a month times 2 months. The record included a "Home Health Admission Service Agreement" form, dated 8-29-12, that failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>8. Clinical record number 12 included a plan of care with a start of care date of 12-6-12 that identified the physician had ordered skilled nurse services 6 time a week times 1 week, the 12 times a week times 1 week, then 3 times a week times 1 week. The record included a "Home Health Admission Service Agreement" form, dated 12-6-12, that failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>9. On 1-31-13 at 4:30 PM, the director of nursing, employee G, indicated the new forms had space added to the form and the nurses had been instructed on the proper way of completing this information.</p> |   |   |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123 |
|---|--|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|--|---------------------|--|----------------------------|
|                          |  |                     |  |                            |

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123  |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |   |
| G0334   | <p><b>484.55(b)(1)</b><br/><b>COMPLETION OF THE COMPREHENSIVE ASSESSMENT</b><br/>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record review, the agency failed to ensure the comprehensive assessment was completed no later than 5 calendar days after the start of care for 1 (#6) of 12 records reviewed creating the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>Clinical record number 6, start of care 1-16-13, included a comprehensive assessment dated 1-22-13, 7 days after the start of care date.</p> | G0334   | <p>G 0334</p> <p>In-service was conducted on 2/8/2013 with admission RNs and admission professionals to address the deficiencies and to review the policy and procedures (Policy &amp; Procedures Vol#2 C140, 7,8,12). Reviewed P&amp;P that states, "The initial assessment will be completed within 48 hours of referral or within 48 hours of the client's return home, or on the physician ordered/client requested start of care date." Agency personnel will strive to complete the comprehensive assessment within 48 hours prescribed time frame, but will make sure that it is complete no later than 5 calendar days after the start of care. Another in-service was conducted 2/11/13 to ensure the Agency P&amp;Ps were clear and understood for the time frame in which the comprehensive assessments are completed. The Director of Nursing, the Director of Quality Improvement, the Administrator and the CQI staff will continue to educate, remind, and verify that assessments are</p> | 02/14/2013           |   |

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123                              |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| N0000   | <p>This visit was a home health agency state licensure survey.</p> <p>Survey dates: 01/28/12 through 02/01/13</p> <p>Facility #: 005731</p> <p>Medicaid Vendor #: 200231350 A</p> <p>Surveyor: Marty Coons, RN, PHNS</p> <p>Total Census-453</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN<br/>February 6, 2013</p> | N0000   | <p>completed no later than 5 days after the start of care.</p> <p>G 0000</p>                                    |                      |   |

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                       |  | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE   |  |   |  |
| N0504   | <p>410 IAC 17-12-3(b)(2)(D)(i)<br/>Patient Rights<br/>Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:<br/>(2) The patient has the right to the following:<br/>(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:<br/>(i) The home health agency shall advise the patient in advance of the:<br/>(AA) disciplines that will furnish care; and<br/>(BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient had been informed, in advance, of the disciplines that would furnish care and the proposed frequency of visits in 8 (# 2, 3, 4, 7, 8, 10, 11 and 12) of 12 records reviewed creating the potential to affect all new admissions to the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care with a start of care date of 1-10-13 that identified the physician had ordered skilled nurse services 3 times per week and home health aide services 2 times per week for 9 weeks. The record included a "Home Health Admission Service Agreement" form, dated 1-10-13, that failed to evidence the patient had been informed of the skilled nurse and</p> | N0504   | <p>N 0504<br/>Expanded Policy and Procedures implemented on 2/8/2013: On the admission visit, the RN is to write the expect disciplines, frequency, and duration on the revised PHHC Home Health Admission Service Agreement, which has a specific section for this information. The RN will verbally explain this information and have the client initial the form to verify that all information is understood by the client or their representative and a written copy will be left in the clients' home (Policy &amp; Procedures Vol#2 C-140,f). In addition to the Home Health Admission Service Agreement, the admission RN will review and explain the clients' Plan of Care/485 which details services, treatment, and frequency. To insure that all current clients have a copy of the new updated Home Health</p> | 04/04/2013   |  |   |  |

|   |   |   |  |                      |   |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123   |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE |   |
|   | <p>home health aide services that would be provided.</p> <p>2. Clinical record number 3 included a plan of care with a start of care date of 12-21-12 that identified the physician had ordered skilled nurse services 1 time per week and home health aide services 1 time per week times 1 week, then 3 times per week for 2 weeks. The record included a "Home Health Admission Service Agreement" form, dated 12-24-12, that failed to evidence the patient had been informed of the skilled nurse and home health aide services that would be provided prior to or on the 12-21-12 start of care date.</p> <p>3. Clinical record number 4 included a plan of care with a start of care date of 4-5-12 that identified the physician had ordered home health aide services 5 times a week times 9 weeks. The record included a "Service Agreement &amp; Authorization" form, dated 4-26-12, that failed to evidence the patient had been informed of the home health aide services prior to or on the 4-5-12 start of care date.</p> <p>4. Clinical record number 7 included a plan of care with a start of care date of 10-18-12 that identified the physician had ordered skilled nurse services 1 time a month for 3 months. The record included</p> |   | <p>Admission Service Agreement, a copy will be presented to the client with the next RN supervisors visit per their Plan of Care schedule. Documentation in skilled visit notes will verify that this was delivered and reviewed. The Director of Nursing, Director of Quality Improvement, Administrator and the CQI staff will assure the Home Health Admission Service Agreement is completed and accurate during the admission audit process and follow-up as needed. All current clients should be updated no later than in the next 60 days.</p> |                      |   |

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                       |  | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE   |  |   |  |
|   | <p>a "Home Health Admission Service Agreement" form, dated 10-18-12, that failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>5. Clinical record number 8 included a plan of care with a start of care date of 4-11-12 that identified the physician had ordered skilled nurse to assess and evaluate and for a home health aide 1 time a week times 1 week, then 3 times a week for 6 weeks. The record included a "Service Agreement &amp; Authorization" form, dated 4-11-12, that failed to evidence the patient had been informed of the skilled nurse and of the home health aide services that would be provided.</p> <p>6. Clinical record number 10 included a plan of care with a start of care date of 6-25-12 that identified the physician had ordered skilled nurse services 1 time a week times 2 weeks and physical therapy 2 times a week time 1 week then 3 times a week times 8 weeks. The record included a "Home Health Admission Service Agreement" form, dated 6-25-12, that failed to evidence the patient had been informed of the skilled nurse physical therapy services that would be provided.</p> <p>7. Clinical record number 11 included a plan of care with a start of care date of</p> |   |   |  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157318 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>02/01/2013 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>PREFERRED HOME HEALTH CARE- VINCENNES INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5250 E US 36, SUITE 850<br>AVON, IN 46123                              |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
|   | <p>8-29-12 that identified the physician had ordered skilled nurse services 1 time a month times 2 months. The record included a "Home Health Admission Service Agreement" form, dated 8-29-12, that failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>8. Clinical record number 12 included a plan of care with a start of care date of 12-6-12 that identified the physician had ordered skilled nurse services 6 time a week times 1 week, the 12 times a week times 1 week, then 3 times a week times 1 week. The record included a "Home Health Admission Service Agreement" form, dated 12-6-12, that failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>9. On 1-31-13 at 4:30 PM, the director of nursing, employee G, indicated the new forms had space added to the form and the nurses had been instructed on the proper way of completing this information.</p> |   |   |                      |   |