POC accepted on 10-18-2022
Deborah Franco, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K125	A. BUILDING B. WING	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preference Health Services Inc	3022 45TH STREET, HIGHLAND, IN, 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Medicaid Home Health Agency. Survey dates: 09-27, 09-28, 09-29-2022 Census: 17 QR by Area 3 on 10-04-2022	G0000	Preference Health Services is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by Preference Health Services that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. Preference Health Services does not, at this time, have an avenue at which to challenge these findings and, therefore, Preference Health Services' failure to dispute or challenge the alleged deficiencies cannot be taken as an admission that	2022-10-28

			the alleged facts occurred as presented in the statements. Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction. Preference Health Services desires this Plan of Correction to be considered our Allegation of Compliance."	
G0440	Payment from federally funded programs 484.50(c)(7)(i, ii, iii, iv) Be advised, orally and in writing, of- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f). Based on record review and interview, the agency failed to ensure all patients were notified in writing of the extent to which	G0440	**G0440** Director of nursing/designee will in-service nursing staff on proper way to complete consent form focusing on the area of payment to be completed at SOC by 10/14/22 Director of nursing/designee will audit all current patient consent forms by 10/14/22. Any current patient who does not have a properly completed consent form will be given one. Director of Nursing/designee will audit all starts of care done each week to ensure the consent form is complete and accurate. Once 100%	2022-10-14

	payment was expected from Medicaid, any out-of-pocket costs to the patient, or any charges the patient must pay for 1 of 6 active records reviewed. (Patient #5) Findings include: A review of the clinical record for Patient #5, start of care date 8/31/21, evidenced a document dated 8/31/21, titled "Consents, Authorization For Treatment, Financial Authorization & Release of Information." Patient #5's printed name was on the signature/authorized representative line followed by the printed name of Individual H, who was identified as a caregiver. The document indicated a home health aide frequency of up to 3 hours for 7 days a week and for 9 weeks. The document failed to indicate the frequency for skilled nursing visits and failed to indicate the insurance liability and out of pocket cost to the client for the skilled nursing and home health aide services. On 9/28/22 at 1:20 PM, the		quarter will be audited to ensure compliance is maintained. (Ongoing) The Administrator will be responsible for these corrective actions to ensure that this deficiency is corrected and will not recur.	

	administrator indicated all patients received skilled visits PRN (as needed) by a skilled nurse for physical assessment or to identify problems. The administrator indicated Patient #5's consent for treatment was blank and did not include notification of expected Medicaid payments, the frequency of skilled nurse visits, or the patient's liability for skilled nurse and home health aide visits.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure all patients received a comprehensive assessment that included the patient's current health status, past medical history, and active health and medical problems, including the patient's accurate health, psychosocial, functional, and cognitive status at the time of assessment, for 1 of 6 active records reviewed. (Patient #5)	G0528	**G0528** Director of nursing/designee will in-service nursing staff by 10/14/22 on completing and documenting a comprehensive assessment to include patient's health, psychosocial, functional and cognition. Assessment must be complete and accurate. Director of nursing/designee will audit 100% of current patient OASIS to ensure that comprehensive assessment is completed. Director of Nursing/designee	2022-10-14

	Findings include: A review of a comprehensive assessment for Patient #5, dated 8/25/22, 1 day prior to the certification period of 08/26 to 10/24/2022, indicated the patient was hospitalized from 8/18/22 - 8/24/22. An OASIS (Outcome and Assessment Information Set) Question M0032, resumption of care after hospitalization, was marked as not applicable and option #3, resumption of care after inpatient stay, was blank. The patient's diagnoses included a history of TIA (Transient Ischemic Attack, a temporary period of symptoms similar to those of a stroke that usually disappear within one hour) and cerebral infarction without residual deficits (stroke or damage to tissues in the brain due to loss of oxygen without leftover effects of the damage); cerebral infarction due to unspecified occlusion or stenosis of an artery (damage to tissues in the brain due to loss of oxygen due to blockage of an artery); essential hypertension (high blood pressure that is not the result of		will audit all comprehensive assessments submitted each week to ensure they are complete and accurate. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance is maintained. (Ongoing) The Administrator will be responsible for these corrective actions to ensure that this deficiency is corrected and will not recur.	

	a medical condition); non-dominant left-side hemiplegia (paralysis of the patient's non-dominant left side); and other generalized epilepsy, not intractable, with status epilepticus (abnormal electrical activity occurring in both hemispheres at the same time, not uncontrollable, lasting more than 5 minutes, or more than one seizure within a 5-minute period without returning to a normal level of consciousness between the seizures; indicates a critical situation requiring rapid medical intervention). The comprehensive assessment evidenced Patient #5's symptoms were poorly controlled and needed frequent adjustment in treatment and dose monitoring, the patient was alert, oriented, and attended adult daycare 5 times a week, which would not be possible with status epilepticus because status epilepticus is a seizure or series of seizures which last longer than 5 minutes and are considered a medical emergency. The functional limitations failed to identify paralysis, ambulation/mobility, use of			

	assistive devices, and risk of seizures. The patient's current immunization status was blank. The safety precautions failed to include a seizure plan, assistance with transfer and mobility, COVID-19 precautions, and failed to indicate an emergency plan was developed. A cultural assessment indicated religion was important to the patient but failed to indicate the patient was assessed for religious preference(s), impacts on care, or need for religious accommodations. The patient's respiratory, endocrine, psychosocial, and cardiac statuses were documented as WNL (Within Normal Limits), failed to indicate what parameters were normal for this patient, and failed to evidence the assessment included auscultation, palpation, and observation including, but not limited to, quality of respirations, lung sounds, capillary refill, pulse quality, heart sounds, presence or absence of edema, presence or absence of carotid bruits, signs/symptoms of elevated blood pressure, and depression. The abdominal assessment failed to evidence auscultation, palpation, and observation of			

	the abdomen including, but not limited to, bowel sounds, appearance, and quality and frequency of bowel movements. The neurological status failed to evidence the patient was assessed for current or residual signs/symptoms of stroke, seizures, and status epilepticus, per the diagnoses including, but not limited to recent/current seizures, type/cause/quality/quantity/duration of seizures, triggers, ability to safely manage seizures, pupil response, grip strength, reflexes, facial droop/smile, and sensory or motor function. The musculoskeletal status failed to indicate the patient had paralysis of the non-dominant side and failed to indicate the extent of hemiplegia and the effect on the patient's inability to use the affected side. The assessment failed to evidence the patient's cognitive status was assessed, including but not limited to, ability to read, write, communicate, and understand their own health and care needs. The patient required assistance for grooming and dressing the upper body, was totally dependent for lower body			

	dressing, was able to bear weight and pivot, was unable to transfer, was chairfast (unable to leave one's chair without assistance, unable to bear weight), and used a bedside commode with reminder or assistance. The assessment indicated skilled intervention was needed, failed to indicate the type of skilled care needed, and later in the assessment indicated no skilled services were indicated. The assessment failed to evidence information related to the patient's hospital stay, such as new diagnosis, residual deficits, decline, participation in physical or occupational therapy, or the reason for a 6-day hospital stay. The patient required assistance "in the AM" from a home health aide to get ready and meal preparation for adult daycare and failed to indicate specific needs such as hair care, dressing, hygiene, toileting, transfer, oral hygiene, peri care, medication reminders, and grooming. The patient required assistance in the PM for bathing, dressing, grooming, transferring, light house keeping (sic), meal prep/setup and medication reminders and failed to indicate specific needs			

	such as toileting, peri care, hair care, and oral hygiene. The assessment failed to indicate the patient's ability/method of managing meals and self-care needs during the 21 hours the aide was not present, whether or not Patient 5's housing was part of a group home that provided ongoing aide support, the need for specialized transportation to adult daycare, and failed to indicate the patient was assessed for compliance, management, and understanding of oral medications, including dose, route, reason, frequency, and time. The assessment failed to accurately reflect the patient's current health, psychosocial, and functional status and failed to include the patient's past pertinent medical history and accurate medical problems. On 9/28/22 at 1:20 PM, the comprehensive assessment was reviewed with the administrator, who indicated it contained inconsistent documentation and had missing information and she would need to review it. The administrator indicated knowing status epilepticus required emergency medical intervention and the diagnosis			

	was not consistent with a patient that was alert, oriented, received aide services at home and attended adult daycare 5 times a week. When asked for the patient's discharge information from the hospital, the administrator indicated it would be in the electronic medical record if the agency had it. The electronic medical record was reviewed with the administrator and failed to evidence information from the patient's 08/18 to 08/24/2022 hospital stay. 410 IAC 17-14-1(B)			
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure all patients received an accurate comprehensive assessment that included the patient's goals and care	G0530	**G0530** Director of nursing/designee will in-service nursing staff by 10/14/22 on completing and documenting a comprehensive assessment that is complete and accurate and includes patient's strengths, goals and care preferences. Director of nursing/designee will audit 100% of OASIS submitted each week to ensure	2022-10-14

	preferences, for 1 of 6 active records reviewed. (Patient #5), Findings include: A review of the recertification assessment for Patient #5, dated 8/25/22, evidenced the patient had no surrogate or patient representative and rented a room in a home with 3 roommates, one of whom also received Medicaid home health services, and who were "not responsible for assisting patient with daily care." The assessment failed to indicate if the patient lived in a supervised group home, or had an alternate caregiver or emergency contact for the time period when the agency aide was not present or the patient was not at adult daycare. The cultural assessment indicated religion was important to the patient and failed to indicate the ways in which religion was important, such as religious denomination/preference(s), impact on care, or specific religious accommodations. The assessment failed to evidence the patient was assessed for care preferences and failed to evidence patient stated goals.		that comprehensive assessment is completed and accurate. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance is maintained. (Ongoing) The Administrator will be responsible for these corrective actions to ensure that this deficiency is corrected and will not recur.	

	On 9/28/22 at 1:20 PM, the comprehensive reassessment was reviewed with the administrator, who indicated there were no patient-stated goals or care preferences, including specific religious care preferences.			
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the agency failed to ensure all patients received an accurate comprehensive assessment that included the patient's medical, nursing, rehabilitative, and discharge planning needs, for 1 of 6 active records reviewed. Findings include: A review of the comprehensive recertification assessment for Patient #5, dated 8/25/22, indicated the patient was hospitalized from 8/18/22 - 8/24/22, and indicated diagnoses of a personal history	G0534	**G0534** Director of nursing/designee will in-service nursing staff by 10/14/22 on completing and documenting a comprehensive assessment that is complete and accurate and includes patient's medical, nursing, rehabilitative, social and discharge planning needs. Director of nursing/designee will audit 100% of OASIS submitted weekly to ensure that comprehensive assessment is completed and accurate. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance is maintained. (Ongoing) The Administrator will be responsible for these corrective	2022-10-14

	of TIA (Transient Ischemic Attack (a temporary period of symptoms similar to those of a stroke that usually disappear within one hour) and cerebral infarction without residual deficits (damage to tissues in the brain due to loss of oxygen without leftover effects of the damage); essential hypertension (high blood pressure that is not the result of a medical condition); non-dominant left-side hemiplegia (paralysis of the patient's non-dominant left side); and other generalized epilepsy, not intractable, with status epilepticus (abnormal electrical activity occurring in both hemispheres at the same time, not uncontrollable, lasting more than 5 minutes, or having more than one seizure within that 5-minute period without returning to a normal level of consciousness between the two episodes). Symptoms were poorly controlled and needed frequent adjustment in treatment and dose monitoring. The patient was alert, oriented, and forgetful which was inconsistent with a diagnosis of seizures with status epilepticus. The patient was chairfast but able to wheel self, required assistance, reminder, or		actions to ensure that this deficiency is corrected and will not recur.	

	supervision for transfer on/off the toilet and assistance for grooming and upper body dressing, which was inconsistent with a diagnosis of hemiplegia, and was totally dependent for lower body dressing, which was inconsistent with GG0130C which indicated the patient required only supervision or touch assistance for toileting hygiene. The assessment failed to evidence the patient was assessed by a physical therapist and indicated a therapy threshold of zero. The patient had 2 or more hospitalizations within the last 6 months, 2 or more emergency department visits within the last 6 months, and was at current risk for pressure sores and rehospitalization. The assessment indicated to discharge "when patient is independent in management of medical needs" and failed to evidence how Patient #5, a chairfast, 68-year old with a history of seizures and status epilepticus, stroke, paralysis, incontinence, and dependence for activities of daily living, meals, and transportation, who received no therapy and no skilled nursing follow-up, would achieve independence in			

	management of medical needs. On 9/28/22 at 1:20 PM, the comprehensive reassessment was reviewed with the administrator, who indicated the assessment had inconsistent and conflicting medical information, did not evidence a skilled nursing need, and did not include an assessment for physical therapy. The administrator indicated the agency does not utilize a professional coder or coding company and the agency nurses and clinical manager assign the diagnosis codes when they are completing the assessment and plan of care. the administrator indicated the patient's diagnosis codes were chosen by the nurse completing the comprehensive assessment and reviewed by the clinical manager before being sent to the patient's physician on the plan of care. 410 IAC 17-14-1 (a)(1)(B)			
G0574	Plan of care must include the following	G0574	**G0574** Director of nursing/designee	2022-10-28

	484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the plans of care included the patient's rehabilitation potential,		will in-service nursing staff by 10/14/22 on completing and documenting a complete Plan of Care to include patient's rehabilitation potential, functional, safety measures, and pertinent interventions and patient-specific, measurable outcomes and goals. Director of nursing /designee will audit 100% of OASIS submitted weekly to ensure that comprehensive assessment is completed and accurate. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance is maintained. (Ongoing) Director of Nursing/designee will audit all current patient plans of care to ensure they contain all required elements. RN will contact MD for any plan of care that is missing required information and obtain order to add missing elements to plan of care. 10/28/22 Director of Nursing/designee will audit 100% of plans of care	

	measures, and pertinent interventions and patient-specific, measurable outcomes and goals, for 1 of 6 active records reviewed. (Patient #5) Findings include: A review of the plan of care for Patient #5, for the certification period of 8/26/22 – 10/24/22, indicated the patient's psychosocial status was WNL (Within Normal Limits) and failed to include any parameters to define what was WNL for this patient. The plan of care failed to evidence a seizure plan including, but not limited to, interventions to monitor and mitigate seizures, when to notify emergency personnel, and interventions for post-seizure management, The functional limitations failed to include ambulation/mobility, paralysis, seizures, specialized transportation, joint stiffness/pain, and transfer assistance. The plan of care indicated orders of "Home health aide duties may include but are not limited to: personal hygiene care, bathing/showering,		submitted weekly to ensure they contain all required information. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (Ongoing) The Administrator will be responsible for these corrective actions to ensure that this deficiency is corrected and will not recur	

	assisting with ambulation, assisting with transfers, turning/positioning, assistance with wound prevention, incontinent care, checking integumentary status, medication assistance and reminders, meal preparations, and light housekeeping and failed to evidence specific home health aide duties to be provided. Review of the patient's goals indicated the patient would be free of falls during the certification period, patient's skin integrity would remain intact during this episode, and the patient would have no hospitalizations during the certification period and failed to evidence skilled nurse, therapy, or home health aide interventions to facilitate the prevention of falls, hospitalizations, or skin breakdown. The plan of care failed to evidence patient-specific goals and interventions related to personal care, seizure precautions and management, hypertension, medication education and management, signs/symptoms and education related to cerebral infarct and TIA (transient ischemic accident).			

G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview the home health aide (HHA 3) failed to wear a mask while providing patient care in 1 of 3 home visits and failed to practice hand hygiene and gloving as part of infection control practices in 2 of 3 home visits. (Patients # 1 and 3) Findings Include: 5. During a home visit with Patient #1, on 9/29/22 at 7 AM, HHA (home health aide) #6 was observed completing hand hygiene with soap and water for less that 10 seconds. The aide donned gloves and assisted Patient #1 to ambulate to the shower, then undressed the patient and provided a full shower that included peri care. Upon completion of the shower, the aide dressed the patient in a	G0682	**G0682** Director of nursing/designee will in-service field staff by 10/14/22 on following accepted standards of practice, including the use of standard precautions, to include wearing face mask, proper hand hygiene and proper gloving process, to prevent the transmission of infections and communicable diseases. Director of nursing/designee will perform field checks on all field staff to ensure that infection control is being maintained. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance is maintained. (Ongoing) All aides will be in-serviced on proper process for giving a bath. 10/14/22 Director of nursing/designee will perform field checks on all aides to ensure bathing	2022-10-28

	brief and towel and assisted the patient to the bedroom. The aide was observed to dress the patient while wearing the same gloves worn throughout the patient's shower and peri care. The aide removed the gloves and donned new gloves without completing hand hygiene, then escorted the patient to the kitchen table. The aide discarded the gloves, completed hand hygiene with soap and water for less than 5 seconds, then donned new gloves and fed the patient oatmeal the aide had cooling in the freezer. The aide failed to perform hand hygiene between gloving and failed to perform standard hand hygiene for 20 - 30 seconds when using soap and water. 1. A review of an agency policy dated 4-3-20, titled "Wearing Mask for the Prevention of COVID -19," indicated, "Policy: Wearing Face masks is needed to minimize the presence of illness and to prevent the spread of the Covid-19 Coronavirus ... 1. Workers/Visitors are required to wear a face covering when		processes are being followed. 10/28/22 The Administrator will be responsible for these corrective actions to ensure that this deficiency is corrected and will not recur	

working in situations where social distancing cannot be maintained...."

2. A review of an undated agency policy titled "Handwashing/Hand Hygiene" indicated, "Policy: In an effort to reduce the risk for infection in clients and staff members, thorough hand washing/hand antisepsis is required of all employees ... 3. Indications for hand washing and hand antisepsis: ... c. When there is prolonged or intense contact with the client (bathing the client) ... d. Between tasks on the same client...

3. During a home visit on 09-28-22 at 7:05 AM for patient #3, the Certified Nursing Assistant, CNA #3, was observed entering patient #3's home without wearing a face mask. The CNA performed hand hygiene, donned gloves, and was observed giving the patient a complete bed bath as patient #3 was lying in their hospital bed in the living area. CNA #3 was observed to wash, rinse, dry, and apply lotion to

	the patient's face, arms, and back. The CNA removed patient #3's pajama bottoms and soiled brief. CNA #3 then washed, rinsed, and lotioned patient #3's legs then buttocks. Patient #3's family member obtained clean water in the basin, and the CNA received a clean washcloth without removing their gloves and performing hand hygiene. CNA#3 proceeded to wash, rinse and dry patient #3's perineal area, then applied a new brief and dressed patient #3 without removing their gloves, performing hand hygiene, and donning new gloves. The certified nursing assistant was never observed to have changed their gloves throughout the whole bath, using the same gloves for the entire bath. CNA #3 failed to wear a mask while bathing patient #3. These practices failed to follow infection control guidelines and the agency's policies. During an interview on 09-28-22 at 7:40 AM, CNA #3 stated, "I know I made a mistake. I should have changed my gloves. I could just kick			

	myself." 4. During an interview on 09-28-22 at 11:59 AM, the Administrator/Clinical Manager confirmed the employees are to wear masks when they provide patient care per the agency policy. 5. During the daily conference on 09-28-22 at 2:00 PM, the Administrator and Owner of the agency confirmed masks are to be worn by the employees. They further confirmed they were aware that CNA #3 did not change their gloves whiled completing the complete bed bath during the home visit with Patient #3.			

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

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