STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157668	A. BUILDING B. WING	07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOMECARE OF INDIANA	8455 KEYSTONE CROSSING, INDIANAPOLIS, IN, 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102, for a Medicare participating Home Health Agency. Survey Dates: 06-29, 06-30, and 07-05-2023 Census: 68 At this Emergency Preparedness survey, Premier Homecare of Indiana, was found to be in compliance with the requirements of Emergency Preparedness for Medicare and Medicaid participating providers and suppliers at 42 CFR 484.102. QR completed on 7/07/2023 by A3.	E0000	*POC accepted on 8-1-2023* *Deborah Franco, RN*	

G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 06-29, 06-30, and 07-05-2023 12-Month Unduplicated Skilled Admissions: 410 Census:68 Partially Extended Survey Announced 06-30-2023 at 10:38 AM. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR completed 07/07/2023 by A3.	G0000		
G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Based on record review, and	G0414	G0414 - To ensure all patients are provided with the name and contact information for Administrator and Clinical Director in the future, agency will incorporate specifically providing that information during phone call discussion with patient prior to initiating service. This will be documented in patient chart. The information will also be pre-printed in the Admission Booklet that is provided to patient by clinician at time of initial evaluation. Agency will provide all current patients with names/contact information via letter on agency letterhead.	2023-07-26

	interview, the agency failed to provide the Administrator's name and contact information to 7 of 7 active clinical records reviewed. (Patients: #1, 2, 3, 4, 5, 6, and 7) Findings Include: 1. During a home visit at Patient #2's residence on 06-30-2023 at 1:30 PM, observed the Registered Nurse (RN), RN 1, complete an assessment and wound care. A review of Patient #2's agency booklet titled, "Indiana Homecare Services Premier Homecare of Indiana" failed to provide the contact information and name of the Administrator. 2. During a home visit at Patient #3's residence on 06-30-2023 at 3:15 PM, observed the Physical Therapist (PT), PT 1, complete an assessment and standing balance training. When asked to review the agency booklet, Patient #3 indicated it was locked in their caregiver's office, Person #2. Patient #3 further indicated they had not received information on the agency Administrator or contact information. During an interview on 07-03-2023 at 2:48 PM, Patient		Business Operations Manager will confirm that all current patients receive letter of information. Business Operations Manager to ensure Admission Booklets are pre-printed and up-to-date. Business Operations Manager will also monitor weekly to ensure that all patients receive this information.	

	#3's caregiver, Person #2, indicated they had not received an agency booklet for Patient #3. Person 2 further confirmed that they did not know who the Administrator was or how to contact them. 3. During a phone interview on 07-05-2023 at 1:20 PM, Patient #4 confirmed they were not provided the Administrator's name or contact information. 4. On 06-30-2023 at 12:40 PM a home visit at Patient #5's residence was conducted. Licensed Practical Nurse (LPN) 1 was observed performing a physical assessment and assessed Patient #5's surgical incision. An Admission booklet was unable to be produced at Patient #5's residence. During an interview on 07-05-2023 at 9:11 AM, Person 3, Patient #5's caregiver, indicated if they had an issue with the agency or had a concern, they would contact Person 4, the former Clinical Manager, at a number not listed in the Admission booklet. 5. On 06-30-2023 at 3:00 PM a home visit at Patient #6's residence was conducted. RN 2			

	was observed performing a physical assessment and assessed Patient #6's Jejunostomy tube (a surgically inserted plastic tube placed in the abdomen to help provide nutrition and medication). A review of Patient #6's Admission booklet failed to provide the contact information and the name of the Administrator. 6. During an interview on 07-05-2023 at 1:27 PM, Patient #7 indicated they were unsure of whom to contact from the agency if they had a concern. 7. During an interview on 07-05-2023 at 1:40 PM, Patient #1 indicated the Admission booklet did not include the Administrator's name and contact information.			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments;	G0434	G0434 - To ensure that patient's are informed of their ongoing care and treatment they may receive and their frequency of visits, clinicians will provide a copy of each patient's Plan of Care, which includes their medication list in layman's terms as well. Internal operations process has been adjusted to provide printed Plans of Care directly to clinician for each patient once complete. In lieu of mailing Plans of Care to patients, clinicians will hand-deliver the document, review it with patient and provide that document to patient to keep in their Admission Booklet that is provided at initial evaluation. Also included will be their pre-printed calendar schedule, which will	2023-07-24

	(ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review, and interview, the agency failed to ensure that the patients were informed of the frequency of visits and ongoing care and treatment they may receive, as evidenced in 6 of 7 active records reviewed. (Patients: #1, 2, 3, 5, 6, and 7) Findings Include: 1. A review of an undated agency policy, was provided by the Administrator, on 07-05-2023 at 3:15 PM. The "Home Care Client Bill of Rights" indicated but was not limited to, "... 6. Clients will be informed of their right to participate in planning care, or treatment and in planning changes in the care or treatment. This includes ...informed in advance of care to be furnished, the discipline, the frequency of visits, the type of care..."		provide their schedule and frequency of visits. Clinical staff were educated on the new process at company-wide inservice on 7-19-23. Business Operations Manager will monitor the provision of the documents to clinicians, delivery and review with patient. This will be monitored until further notice.	

	2. During a home visit at Patient #2's residence on 06-30-2023 at 1:30 PM, observed the Registered Nurse (RN), RN 1, complete an assessment and wound care. A review of Patient #2's agency booklet titled, "Indiana Homecare Services Premier Homecare of Indiana" failed to contain the disciplines' scheduled visit frequencies, treatments, or Patient #2's plan of care. During an interview on 06-30-2023 at 2:05 PM, the caregiver for Patient #2, Person 2 indicated they were not provided a schedule. The staff called the night before to tell them when they would be coming for their visit. During an interview on 06-30-2023 at 2:15 PM, RN 1 confirmed that they get the scheduled list of patients that need visits from the office the evening before on their tablets, and then that evening, they call the patients and schedule a time for their visits. 3. During a home visit on 06-30-2023 at 3:15 PM, Patient #3's residence on 06-30-2023 at			

	Therapist (PT), PT 1, complete an assessment and balance exercises. Patient #3 indicated they did not have a schedule. They would call the night before their visit. During an interview on 06-30-2023 at 3:45 PM, PT 1 confirmed that Patient #3 does not have a written schedule. PT 1 further indicated they called the night before to let Patient #3 know when they would be there. 4. During an interview on 07-05-2023 at 9:25 AM, the Director of Nursing (DON) confirmed that the clinicians called the patients the night before to schedule their visits. 4. On 06-30-2023 at 12:40 PM a home visit at Patient #5's residence was conducted. LPN 1 was observed performing a physical assessment and assessed Patient #5's surgical incision. An Admission booklet was unable to be produced at Patient #5's residence. A current plan of care, medication profile, and a visit schedule were unable to be found during the home visit. During an interview on			

	07-05-2023 at 9:11 AM, Person 3, Patient #5's caregiver, indicated the agency did not provide a visit schedule. 5. On 06-30-2023 at 3:00 PM a home visit at Patient #6's residence was conducted. RN 2 was observed performing a physical assessment and assessed Patient #6's Jejunostomy tube (a surgically inserted plastic tube placed in the abdomen to help provide nutrition and medication). Patient #6 provided their Admission Booklet from the agency, and it contained Patient #6's current plan of care. A review of Patient #6's Admission booklet failed to include a medication profile and a visit schedule. 6. During an interview on 07-05-2023 at 1:27 PM, Patient #7 indicated they were unsure if they were provided their plan of care and visit schedule from the agency. 7. During an interview on 07-05-2023 at 1:40 PM, Patient #1 indicated they were not provided a current plan of care and visit schedule from the agency.			

	410 IAC 17-12-3(b)(2)(AA)(BB)(ii)(AA)(BB)			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment was individualized to the patient for 1 of 4 patients observed during a home visit. (Patient #5) Findings Include: 1. A review of a Premier Homecare of Indiana policy was provided by the Administrator on 07-05-2023 at 3:08 PM. The policy titled "Comprehensive Assessment" Policy No. C-145 indicated but was not limited to, "... thorough, well-organized, comprehensive and accurate assessment ... 9. Client needs are assessed and care guidelines established based on the assessment data ... " 2. During an observation of Licensed Practical Nurse (LPN) 1 at Patient #5's residence on	G0528	G0528 - Inservice on 7/19/23 for all clinical staff to better educate on completion of comprehensive assessment that is individualized to the patient. DON to review all comprehensive assessments and plans of care to ensure accuracy based on individual patient status at time of assessment. QAPI program to audit all current assessments for accuracy on bi-weekly basis. Clinical staff to make necessary adjustments. Once 100% accuracy is achieved and maintained, audit frequency will decrease to monthly.	2023-07-19

	06-30-2023 at 12:40 PM. It was observed that Patient #5 had an Indiana pouch (a surgically inserted pouch that stores and eliminates urine) and a Colostomy (an opening created in the bowel to assist in the elimination of waste from the body and bypass damaged bowel). On 07-05-2023 at 10:10 AM, Patient #5's clinical record was reviewed. The record evidenced a document titled "Premier HomeCare of Indiana- SOC (sic Start of Care) OASIS-E (ver 23.1) (SOC)", dated 04-30-2023 at 8:23 PM. The section titled "Review of Systems – Genitourinary Status" indicated but was not limited to, "… Elimination Pattern: Voids Normally…". The section titled "Review of Systems – Bladder/Bowel" indicated but was not limited to, "… Urinary Incontinence or Urinary Catheter Presence: 0 – No incontinence or catheter (includes… ostomy for urinary drainage) …". The clinical record failed to reflect Patient #5's current health status regarding bladder and bowel requirements.			

	On 07-05-2023 at 10:10 AM, Patient #5's clinical record was reviewed. The record evidenced a document titled "Premier HomeCare of Indiana- ROC (sic Resumption of Care) OASIS-E (ver 23.1) (ROC)", dated 06-08-2023 at 7:21 PM. The section titled "Review of Systems – Genitourinary Status" indicated but was not limited to, "… Elimination Pattern: Voids Normally…". The section titled "Review of Systems – Bladder/Bowel" indicated but was not limited to, "… Urinary Incontinence or Urinary Catheter Presence: 0 – No incontinence or catheter (includes… ostomy for urinary drainage) … Ostomy for Bowel Elimination… 0 – Patient does not have an ostomy for bowel elimination…". The clinical record failed to depict Patient #5's current health status. 2. During an interview with the Administrator and Interim Director of Clinical Services on 07-05-2023 at 3:13 PM, the Interim Director of Clinical Services indicated the comprehensive assessments were to be individualized and patient-specific. The Interim			

	confirmed that a patient with a catheter did not void independently without assistance. 410 IAC 17-14-1(a)(1)(A)(E)			
G0574	Plan of care must include the following 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;	G0574	G0574 - Inservice on 7/19/23 for all clinical staff to better educate on completion of plan of care that is individualized to include all pertinent diagnoses, all supplies and equipment necessary to ensure the patient's needs are met in their home, to ensure documentation of patient-specific needs, all safety measures, and nutritional requirements. DON to review all comprehensive assessments and plans of care to ensure accuracy based on individual patient status at time of assessment. QAPI program to audit all current assessments for accuracy on bi-weekly basis. Clinical staff to make necessary adjustments. Once 100% accuracy is achieved and maintained, audit frequency will decrease to monthly.	2023-07-19

(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 implement its policy requiring the plan of care to be individualized to include all pertinent diagnoses, all supplies, and equipment necessary to ensure the patient's needs were met in their home, failed to ensure documentation of patient-specific needs, all safety measures, and nutritional requirements for 7 or 7 active clinical records reviewed. (Patients: #1, 2, 3, 4, 5, 6, and 7)

Findings Include:

1. A review of an updated agency policy, was provided by the Administrator, on 07-05-2023 at 3:15 PM. The "Plan of Care" indicated but was not limited to, "...1. An individualized Plan of Care...shall be required for each client...2. The Plan of Care shall be completed in full...a. All pertinent diagnosis (es).... k. Specific dietary or nutritional requirements or restrictions...l. Medications, treatments, and procedures...m. Medical supplies and equipment..."

2. A review of the clinical record for Patient #2, with a start of care date of 06-26-2023,

	contained a plan of care for the initial certification period from 06-26-2023 to 08-24-2023. The plan of care indicated but was not limited to the following diagnoses: Encounter for change and removal of surgical wound dressing, Peritoneal abscess (infected material localized in the tissue that lines the abdominal wall), Hypertensive Heart Disease with Heart Failure (high blood pressure over a long period of time affecting the pumping of blood in the heart), Rheumatic tricuspid insufficiency (a condition in which the heart's mitral valve doesn't close tightly allowing blood flow back in the heart), Constipation, Atrial Fibrillation (Irregular rapid heart rate casing poor blood flow), Ileostomy (a surgical opening onto the surface of the skin to the intestine which waste passes out of into a bag), and Urostomy (a surgical opening to the urinary system that urine can pass into a bag). The "Supplies" section failed to list urostomy supplies, ileostomy supplies, wound vac, wound vac dressing kits, occlusive dressing, normal saline, and 4 x 4 gauze sponges. The plan of care failed to list parameters to notify the			

	physician for temperature, respiration, pulse, oxygen saturation, and blood pressure. During an interview on 07-05-2023 at 9:35 AM, the Director of Nursing confirmed all supplies, and nutrition should be listed on the plan of care. 3. During a home visit at Patient #3's residence on06-30-2023 at 3:15 PM, observed the Physical Therapist (PT), PT 1 complete an assessment and balance and endurance exercises. Observed a bedside commode, quad cane, and Patient #3 used their rollator walk for ambulation. During the exercises noted Patient #3 wearing disposable briefs when they bent over. Patient #3 indicated they sleep on the couch in a sitting position and their caregiver brings out their Continuous Positive Airway Pressure (CPAP) machine (a machine which pushes air into the lungs through the nose) they use at night. Patient #3 indicated they wear a stimulation back brace during the day that stimulates bone growth that was on the couch. Patient #3 confirmed they take their blood pressure			

with the blood monitor on the side table.

A review of the clinical record for Patient #3, with a start of care dates of 03-27-2023, contained a plan of care for the recertification period from 05-21-2023 to 07-19-2023. The plan of care indicated but was not limited to the following diagnoses: Spondylosis of the lumbar region (degeneration of the discs and vertebrae in the lower back), Spinal Stenosis (narrowing of the spinal canal), Multiple Sclerosis (a disease in which immune systems eats away at the protective covering of the nerves), Sleep Apnea (serious sleep disorder in which breathing repeatedly stops and starts), Essential Hypertension (high blood pressure), and Spondylolisthesis (a spinal disorder which the vertebrae bone slips forward onto the bone below it). The section titled “Supplies indicated failed to list CPAP machine, CPAP masks, tubing, pillows, back brace stimulator, disposable briefs, blood pressure monitor, bedside commode, rollator walker, and quad cane. The “Nutrition” section indicated “None” and failed to list Patient

	#3's individualized diet. The plan of care failed to list parameters to notify the physician for temperature, respiration, pulse, oxygen saturation, and blood pressure.			

	4. A review of the clinical record for Patient #4, with a start of care date of 03-29-2023, contained a plan of care for the recertification period from 05-28-2023 to 07-26-2023. The plan of care indicated the following diagnoses: Non-Pressure Ulcer Right Foot with Fat layer Exposed (a wound that has subcutaneous fat in the depth), and Type 2 Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugars). The section titled "Nutrition" stated "Diet as Tolerated" and failed to be Patient #4's individualized diet. The "Supplies" section indicated "Oxygen" but failed to list insulin pen needles, glucometer, glucometer strips, wound vac, wound vac supplies, kerlex, normal saline, and 4 x 4 gauze. The plan of care failed to list parameters to notify the physician for blood sugars, temperature, respiration, pulse, oxygen saturation, and blood pressure. During an interview on 07-05-2023 at1:20 PM, Patient #4, indicated they were being seen for wound care with a wound vac to the right foot.			

	they used insulin pens for administering their insulin, checked their blood sugars with their machine and check their blood sugars. 4. On 06-29-2023 at 4:10 PM, Patient #1's clinical record was reviewed. Patient #1 had a Start of Care (SOC) date of 06-23-2023. The certification period reviewed was from 06-23-2023 to 8-21-2023. The plan of care indicated the following diagnoses: Urinary Tract Infection (an infection caused by bacteria entering the urethra and infecting the urinary tract), Crohn's Disease with rectal bleeding (a disease, causing inflammation in the digestive tract and causing rectal bleeding), Chronic Pancreatitis (inflammation of the pancreas causing damage), Common variable immunodeficiency (a disease were the body has difficulty preventing infections and is at an increased risk of infections). The plan of care included a section titled "Supplies", it indicated but was not limited to, "... Heparin Flush, Injection Cap, Central Line Dressing Kit, Oxygen, Extension Tubing Set, Gravity Tubing, Rolling Walker,			

	Cane, Alcohol Swabs…". The plan of care indicated in the section titled "Additional Services", Patient #1 had a Variable Positive Airway Pressure (VPAP) machine for sleeping at night. The section indicated but was not limited to, "… Home care skilled nurse to provide… education regarding IV (sic intravenous) antibiotics and administration…". The section titled "Supplies" failed to evidence the VPAP machine Patient #1 used at night and an IV pole to hang the IV antibiotics. The section titled "Nutrition" indicated "Diet as Tolerated". The plan of care failed to list all the durable medical equipment the patient had or would need. The plan of care failed to ensure Patient #1's nutrition was individualized to the patient. 5. During an observation of Licensed Practical Nurse (LPN) 1 providing wound care at Patient #5's residence on 06-30-2023 at 12:40 PM, it was observed that Patient #5 had an Indiana pouch (a surgically inserted pouch that stores and eliminates urine) and a Colostomy (an opening created in the bowel to assist in the			

	elimination of waste from the body and bypass damaged bowel). A hand-held urinal was observed in Patient #5's residence. On 07-05-2023 at 10:10 AM, Patient #5's clinical record was reviewed. Patient #5 had a (SOC) date of 04-20-2023. The certification period reviewed was from 04-20-2023 to 06-18-2023. The plan of care indicated the following diagnoses: Abscess of epididymis or testis (a condition where a pus-filled sac develops in the scrotum), Type 2 Diabetes Mellitus with hyperglycemia (a chronic condition that affects the way the body processes sugar, high blood sugar), Postoperative pelvic peritoneal adhesions (scar tissue that built up and connected 2 internal body structures after pelvic surgery), and history of malignant carcinoid tumor of the rectum (tumor found in the rectum). The plan of care included a section titled "Supplies", it indicated but was not limited to, "... 4 X 4 dressing, ABD pads...". The plan of care failed to evidence diabetic supplies, ostomy supplies, and a hand-held urinal			

	listed in the “Supplies” section of the plan of care. The plan of care included a section titled “Nutrition”, the section indicated, but was not limited to, “Diet as Tolerated”. The plan of care failed to evidence a patient-specific and individualized diet for Patient #5. On 07-05-2023 at 10:10 AM, Patient #5’s clinical record was reviewed. Patient #5 had a (SOC) date of 04-20-2023. The certification period reviewed was from 06-19-2023 to 08-17-2023. The plan of care indicated the following diagnoses: Abscess of epididymis or testis (a condition where a pus-filled sac develops in the scrotum), Type 2 Diabetes Mellitus with hyperglycemia (a chronic condition that affects the way the body processes sugar, high blood sugar), Postoperative pelvic peritoneal adhesions (scar tissue that built up and connected 2 internal body structures after pelvic surgery), and history of malignant carcinoid tumor of the rectum (tumor found in the rectum). The plan of care section titled “Supplies” indicated but was not limited to,			

	"... Ostomy wafers, Stomahesive Paste, Cover Dressing, Ostomy Bags...". The plan of care failed to evidence diabetic supplies, wound care supplies, and a hand-held urinal listed in the "Supplies" section of the plan of care. The plan of care included a section titled "Nutrition", the section indicated, but was not limited to, "Diet as Tolerated". The plan of care failed to evidence a patient-specific and individualized diet for Patient #5. 6. On 06-30-2023 at 3:00 PM, a home visit at Patient #6's residence was conducted. Registered Nurse (RN) 2 was observed performing a physical assessment and assessed Patient #6's Jejunostomy tube (J-tube) (a surgically inserted plastic tube placed in the abdomen to help provide nutrition and medication). During the home visit, it was observed that Patient #6 had a broken IV pole and had adhesive bandages for their J-tube. On 07-05-2023 at 11:40 AM, Patient #6's clinical record was reviewed. Patient #6 had a SOC			

certification period reviewed was from 05-24-2023 to 07-22-2023. The plan of care indicated the following diagnoses: Hypokalemia (low potassium levels in the blood), Intestinal Malabsorption (the body does not absorb nutrients effectively), chronic pain, encounter for gastrostomy (J-tube was placed in the small intestine), and abdominal pain. The plan of care included a section titled, "Supplies", the section indicated but was not limited to, "... Rolling walker, Dietary/Feeding Supplement, Cane, Tubing, Feeding Bags, Shower Chair, Long handled sponge, Grab bars/safety rails...". The plan of care failed to include Patient #6's IV pole for their tube feeds, tube feeding pump, and adhesive pads for the J-tube. The plan of care included a section titled "Nutrition", the section indicated but was not limited to, "... Full Liquid Diet... Promote with Fiber...". The section titled "Additional Services" indicated but was not limited to, "... have an IV pole with feeding tube pump for 22 hours a day...". The plan of care failed to evidence the rate, titration frequency, and goal rate for the tube feedings.

G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to notify the physician of missed visits and changes to the plan of care for 3 of 7 active clinical records reviewed. (Patients: #3, 5, and 7) Findings Include: 5. A review of the clinical record for Patient #3 with a start of care date of 03-27-2023. The record contained a plan of care for the recertification period for 05-21-2023 to 07-019-2023. The plan of care contained order for Physical Therapy (PT) 2 times a week for 3 weeks, and PT for 1 week for 2 weeks. A review of the agency documents titled, "Physical Therapy Visit Notes" indicated the following: the week of	G0590	G0590 - Inservice on 7/19/23 for all staff to review agency's newly approved Clinical Documentation Policy and educate on procedures to follow when there is a missed visit or changes to the plan of care for patient. Clinicians will follow Policy and notify MD when missed visits occur or when care plan changes, also placing communication in patient's chart. ADON will monitor to ensure that MD is notified of any and all missed visits and changes in care plan, as well as notations in patient's charts. QAPI program to audit missed visits and care plan changes for accuracy on bi-weekly basis. Clinical staff to make necessary adjustments. Once 100% accuracy is achieved and maintained, audit frequency will decrease to monthly.	2023-07-19

	05-27-2023 no PT visits were documented, and the week of 05-28-2023 through 06-03-2023 no PT visits were documented. A review of the agency documents titled, "Communication Notes" dated 0404-2023 through 06-30-2023 failed to evidence the physician was notified of the missed visits and the changes to the plan of care PT frequency. During an interview on 07-03-2023 at 3:37 PM, Patient #3 confirmed they were not seen for 2 weeks by the PT during the timeline of 05-21-2023 through 06-03-2023. 6. During an interview on 067-05-2023 at 2:28 PM the Director of Nursing (DON), and the Administrator confirmed they were unable to provide the documentation of the physician being notified of Patient #3's missed visits and changes to the plan of care 410 IAC 17-13-1(a)(2) 1. A Premier Homecare of Indiana policy titled "Services Provided" Policy No. C-100 was			

	provided by the Administrator on 07-05-2023 at 3:08 PM. The policy indicated but was not limited to, "... If the agency for any reason is unable to complete a scheduled visit, arrangements will be made to provide the service through reasonable means...". During an interview on 07-05-2023 at 3:13 PM with the Administrator, they indicated they were unable to find the missed visit policy and physician notification policy. 2. On 07-05-2023 at 10:10 AM, Patient #5's clinical record was reviewed. The clinical record contained a document titled "Skilled Nursing Visit Note" dated 05-15-2023 for the visit date of 05-11-2023 signed by Licensed Practical Nurse (LPN) 1. The document indicated but was not limited to, "... Actions taken by Clinician: HHA supervisor made aware, no further actions needed...". The clinical record failed to evidence the physician was made aware of the missed visit and the plan of care frequency not being followed by the agency. 3. On 07-05-2023 at 12:40 PM,			

	Patient #7's clinical record was reviewed. The clinical record contained a document titled "Occupational Therapy Visit Note" dated 07-02-2023 for the visit date of 06-29-2023 signed by Occupational Therapist (OT) 1. The document indicated but was not limited to, "...Reason visit not made: Patient unavailable / Unable to contact patient...". The clinical record failed to evidence the physician was made aware of the missed visit and the plan of care frequency not being followed by the agency. 4. During an interview on 07-05-2023 at 3:13 PM with the Administrator and Interim Director of Clinical Services, when queried regarding the proper procedure for a missed visit, they indicated they would chart the missed visit, write a note, and call the provider to inform them of the missed visit. The Interim Director of Clinical Services indicated they were having to do a lot of education about the procedure for missed visits.			
G0614	Visit schedule	G0614	G0614 - To ensure patients know their service schedule, including the frequency of visits and personnel providing care, agency inserviced	2023-07-24

	484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on record review, and interview, the agency failed to provide the patients with a visit schedule to 6 of 7 active records reviewed. (Patients: #1, 2, 3, 5, 6, and 7) Findings Include: 1. A review of an undated agency policy, was provided by the Administrator, on 07-05-2023 at 3:15 PM. The "Home Care Client Bill of Rights" indicated but was not limited to, "... 6. Clients will be informed of their right to participate in planning care, or treatment and in planning changes in the care or treatment. This includes ...informed in advance of care to be furnished, the discipline, the frequency of visits, the type of care..." 2. During a home visit at Patient #2's residence on residence on 06-30-2023 at 1:30 PM, observed the Registered Nurse (RN), RN 1, complete an assessment and wound care. A review of Patient #2's agency		staff on 7-19-23 on importance of completing the provided pre-printed calendar with patient at initial visit(s) and discuss with patient the importance of committing to that schedule. Agency incorporated into training the requirement to provide patients with their visit schedule, including frequency of visits and newly updated and approved company policy regarding Services Provided. Current patients will receive updated service schedule 'calendar' and notation will be made in patient chart. Administrator will monitor to ensure that all current and future patients receive service schedule calendar. This will be monitored until further notice.	

	booklet titled, "Indiana Homecare Services Premier Homecare of Indiana" failed to provide a schedule for Patient #2's plan of care, making them aware of the staff providing care, including the day of week with frequency. During an interview on 06-30-2023 at 2:05 PM, the caregiver for Patient #2, Person 2 indicated they were not provided a schedule. The staff called the night before to tell them when they would be coming for their visit. RN 1 confirmed that is how they schedule Patient #2's visits. 3. During a home visit on 06-30-2023 at 3:15 PM, Patient #3's residence on 06-30-2023 at 3:15 PM, observed the Physical Therapist (PT), PT 1, complete an assessment and balance exercises. Patient #3 indicated they did not have a schedule. They would call the night before their visit. During an interview on 06-30-2023 at 3:45 PM, PT 1 confirmed that Patient #3 does not have a written schedule. PT 1 further indicated they called the night before to let Patient			

	#3 know when they would be there. 4. During an interview on 07-05-2023 at 9:25 AM, the Director of Nursing (DON) confirmed that the clinicians called the patients the night before to schedule their visits. 5. During an interview on 07-05-2023 at 10:10 AM, the Administrator confirmed the clinicians were provided blue calendars forms for the patients to be provided their schedules in their residences 3. On 06-30-2023 at 12:40 PM a home visit at Patient #5's residence was conducted. Licensed Practical Nurse (LPN) 1 was observed performing a physical assessment and assessed Patient #5's surgical incision. An Admission booklet was unable to be produced at Patient #5's residence. The admission booklet failed to include a schedule of visits. During an interview on 07-05-2023 at 9:11 AM, Person 3, Patient #5's caregiver, indicated the agency did not provide a visit schedule. 4. On 06-30-2023 at 3:00 PM a			

	home visit at Patient #6's residence was conducted. RN 2 was observed performing a physical assessment and assessed Patient #6's Jejunostomy tube (a surgically inserted plastic tube placed in the abdomen to help provide nutrition and medication). Patient #6 provided their Admission Booklet from the agency, and it contained Patient #6's current plan of care. A review of Patient #6's Admission booklet failed to include a schedule of visits. 5. During an interview on 07-05-2023 at 1:27 PM, Patient #7 indicated they were unsure if they were provided a visit schedule from the agency. 6. During an interview on 07-05-2023 at 1:40 PM, Patient #1 indicated they were not provided a visit schedule from the agency.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel	G0616	G0616 - To ensure patients have a current medication profile, including medication name, dosage and frequency and which medications will be administered by home health agency personnel, clinicians will provide a copy of each patient's Plan of Care, which will include their medication list in layman's terms. Internal operations process has been adjusted to provide printed Plans of Care directly to clinician for each patient once complete. In lieu of mailing Plans of Care to patients,	2023-07-19

	acting on behalf of the HHA. Based on record review and interview, the agency failed to ensure the patients had a current medication profile in their Admission booklet in 3 of 4 home visits. (Patients: #2, 3, and 6) Findings Include: 3. During a home visit at During a home visit at Patient #2's residence on residence on 06-30-2023 at 1:30 PM, observed the Registered Nurse (RN), RN 1, complete an assessment and wound care. Review of the age3ncy booklet failed to contain a medication list in layman's terms. or a plan of care. During an interview on 06-30-2023 at 2:00 PM, Patient #2's caregiver, Person 2, confirmed that they were not provided a medication list or a plan of care from Premiere Homecare of Indiana. 4. During a home visit on 06-30-2023 at 3:15 PM, Patient #3's residence on 06-30-2023 at 3:15 PM, observed the Physical Therapist (PT), PT 1, complete		clinicians will hand-deliver the document, review it with patient and provide that document to patient to keep in their Admission Booklet that is provided at initial evaluation. Also included will be their pre-printed calendar schedule, which will provide their schedule and frequency of visits, as agreed upon with patient. Clinical staff were educated on the new process at company-wide inservice on 7-19-23. Business Operations Manager will monitor the provision of the documents to clinicians, delivery and review with patient. This will be monitored until further notice.	

	exercises. Patient #3 indicated they had not received a medication list form the agency. Patient #3 further indicated the agency booklet was locked in their caregiver's office. During an interview on 007-03-2023 at 3:37 PM, Patient #3's caregiver, Person 1, confirmed they had not received a medication list from Premiere Homecare of Indiana. Person 1 further indicated they set up and provide Patient #3's medication and they get their medication list from the Patient's electric online portal from the physician.			

	1. A review of a Premier Homecare of Indiana policy was provided by the Administrator in the Admission booklet on 06-29-2023 at 2:00 PM. The policy indicated but was not limited to, "... Patient Rights and Responsibilities... Decision Making... Participate in, consent to or refuse care in advance of and during treatment and be fully informed in advance about your care/service... the care, treatments and services to be provided... frequency of visits... any factors that could impact treatment effectiveness...". 2. On 06-30-2023 at 3:00 PM a home visit at Patient #6's residence was conducted. Registered Nurse (RN) 2 was observed performing a physical assessment and assessed Patient #6's Jejunostomy tube (a surgically inserted plastic tube placed in the abdomen to help provide nutrition and medication). Patient #6 provided their Admission Booklet from the agency, and it contained Patient #6's current plan of care. A review of Patient #6's Admission booklet failed to include a medication profile.			

G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure that infection control practices were upheld according to the agency's policy in 1 of 4 home visits for hand hygiene. (Patient: #2) Findings Include: 1. A review of an Indiana Homecare Services policy, with the revision date of 03-02-2023, was provided by the Administrator on 07-05-2023 at 3:13 PM. The "Standard Precautions" indicated but was not limited to, " ... 1. Hand Hygiene ... includes both handwashing with either plain or antiseptic-containing soap and water, and use of alcohol-based products ... Hand Hygiene should be preformed at a minimum: Before contact with a patient. Before performing an aseptic task (e.g., ... performing wound care.)	G0682	G0682 - Staff to be inserviced on Handwashing / Hand Hygiene Policy. Agency's new and updated policy was approved by governing body on 7/13/23 to be presented and educated at company-wide inservice on 7/19/23. All staff participated and provided written confirmation of education and commitment to follow policy. Director of Nursing to monitor staff for adherence and will ensure ongoing education is incorporated into quarterly inservicing program.	2023-07-19

	After removal of personal protective equipment (PPE) ... " 2. Centers for Disease Control last updated January, 2021. When to Perform Hand Hygiene. Retrieved from cdc.gov/hand hygiene/providers/index.html indicated, "Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient. Before performing an aseptic task [e.g., placing an indwelling device] or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal. Wash with Soap and Water: When hands are visibly soiled. ... After known or suspected exposure to spores ... When using alcohol-based hand sanitizer: Put product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. ... The CDC Guideline for Hand Hygiene in Healthcare Settings recommends: When			

	cleaning your hands with soap and water, wet your hands first with water, apply the amount of product ... and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. ... Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right time. ... When and How to Wear Gloves: Wear gloves ... when ... contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur ... Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled ... moving from work on a soiled body site to a clean body site on the same patient or in another ..." 3. During a home visit at Patient #2's residence on 06-30-2023 at 1:30 PM, the Registered Nurse			

	completing an assessment and wound care. RN 1 failed to perform hand hygiene upon entering Patient #2's home. RN 1 failed to perform hand hygiene prior to donning gloves and accessing supplies needed from their bag. RN 1 obtained vital signs, cleaned their equipment, placed the equipment back in the back, removed their gloves, pulled their hair up in a hair scrunchie, donned new gloves, and failed to perform hand hygiene. RN 1 obtained a blue drape from their bag, failed to remove their gloves, and perform hand hygiene prior to getting in their bag. RN 1 turned off the wound vac machine (a wound therapy treatment that uses negative pressure to promote wound healing) and removed the transparent dressing and black foam, placing the old dressing on the drape, obtained a syringe of normal saline and 4 x 4 gauze, cleansed the wound, and failed to remove their gloves, perform hand hygiene and don new gloves after removing Patient #2’s dressing. RN 1 measured the lower abdominal wound 3 centimeters (cm) x .3 cm x .3 cm. obtained a new wound vac canister (the			

container that the wound drainage is suctioned to) and discarded the old wound vac canister, and gloves, in the trash reciprocal. RN 1 donned new gloves and failed to perform hand hygiene, obtained scissors from their uniform top pocket, cut the transparent dressing, cut the black foam, and applied it to the wound. RN 1 failed to perform hand hygiene and don new gloves after obtaining scissors from their pocket.

4. A review of the Employee Record for RN 1 on 07-05-2023 at 10:37 AM, with a of 05-09-2023, contained an agency document titled, "Position: RN Case Manager," signed and dated by RN 1 on 05-09-2023. The job description indicated but was not limited to, "... a. Demonstrates knowledge of safety infection control practices by compliance with policies and procedures. ..."

During an interview on 07-05-2023 at 9:25 AM, the Director of Nursing (DON) confirmed hand hygiene is to be completed prior to patient care, after touching the patient, after gloves are removed after a

	soiled dressing is removed, and any time doing a new procedure.			
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on observation, record review, and interview, the agency failed to ensure all nurses appropriately and accurately assessed patients according to professional standards for 1 of 4 home visits completed. (Patient #2) Findings Include: 1. A review of an updated agency policy, was provided by the Administrator on 07-05-2023 at 3:13 PM. The "Skilled Nursing Services" indicated but was not limited to, "... 1. The registered nurse: a. Provides services in accordance with agency policy and nursing standards of practice. B. Performs the initial assessments/evaluation visit. C. Regularly reevaluates the clients needs..."	G0984	G0984 - To ensure that agency services are provided in accordance with current clinical practice guidelines and accepted professional standards of practice, agency will hold inservice training on 8-2-23 for clinical staff to review newly approved agency Standards of Practice and Skilled Professional Services Policies, as well as education utilizing "How to Conduct a Head-to-Toe Assessment" from Nurses.org to ensure that all patients are appropriately and accurately assessed according to professional standards. DON will monitor charted patient assessments to ensure accurate and appropriate assessments and will provide education upon hire and regularly thereafter to all clinicians. Nurses.org document will be incorporated into Orientation Program for all clinicians. DON will audit 25% of patient charts to ensure that accurate and appropriate assessments are being performed and documented. If DON finds that accurate and appropriate assessments are not being performed, she will re-educate clinician and require clinician to complete appropriate and accurate assessment and chart accordingly. This audit of 25% of patient charts will continue monthly until 100% accuracy is achieved.	2023-08-02

2. Constantine, L., MSN, RN, C-FNP. (2004, June 15). Overview of Nursing Health Assessment. Retrieved January 16, 2019, from rn.com "... PULMONARY ASSESSMENT: When examining the pulmonary system ... Inspect the thoracic cage, palpate the thoracic cage, Auscultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth, Auscultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds ... "

3. Nurse.org, dated April 7, 2020, indicated but was not limited to: "How to Conduct a Head-to-Toe Assessment: ... LENGTH OF ASSESSMENT ... the duration of the exam is directly in correlation to the patient's overall health status. Health patients with limited health histories may be completed in less than 30 minutes ... The Order of a Head-to-Toe Assessment: 1. GENERAL STATUS: Vital signs; ... Temperature; ... Pain. 2. HEAD, EARS, EYES, NOSE, THROAT ... 3.

	to lung sounds front and back; Assess respiratory expansion level; Ask about coughing; Palpate thorax. 5. CARDIAC: Palpate the carotid and temporal pulses bilaterally; Listen to the heartbeat. 6. ABDOMEN: ... Ask about problems with the bowel or bladder. 7. PULSES: Check pulses in arms/legs/feet including, Radial, Femora, Posterior tibial, Dorsalis pedis. 8. EXTREMITIES: ... Check capillary refill on fingernails/toenails. 9. SKIN: Check skin turgor; Check for lesions, abrasions, rashes; Check for tenderness, lumps, and lesions; Check if the patient is pale, clammy, dry, cold, hot, or flushed. 10. NEUROLOGICAL: Oriented x3; Assess gait; Check coordination; Assess reflexes; Check Glasgow Coma Scale..." 4. During a home visit at Patient #2's residence on 06-30-2023 at 1:30 PM, the Registered Nurse, RN 1, was observed completing an assessment and wound care. RN 1 failed to listen to anterior and posterior lung sounds and assess the apical heart sounds for a cardiovascular assessment. RN 1 failed to listen to Patient			

#2's bowel sounds.

A review of the clinical record for Patient #2, the start of care 06-26-2023, contained an initial plan of care for the certification period of 06-26-2023 to 08-24-2023. The initial plan of care that indicated but was not limited to diagnoses; Encounter for change and removal of surgical wound dressing, Peritoneal abscess (infected material localized in the tissue that lines the abdominal wall), Hypertensive Heart Disease with Heart Failure (high blood pressure over a long period of time affecting the pumping of blood in the heart), Rheumatic tricuspid insufficiency (a condition in which the heart's mitral valve doesn't close tightly allowing blood flow back in the heart), Constipation, Atrial Fibrillation (Irregular rapid heart rate casing poor blood flow), Ileostomy (a surgical opening onto the surface of the skin to the intestine which waste passes out of into a bag), and Urostomy (a surgical opening to the urinary system that urine can pass into a bag). The plan of care included orders for skilled nursing to provide services three times a week for eight

	weeks to assess and evaluate; wound care, intravenous antibiotic, and ostomy. During an interview on 07-05-2023 at 9:35 AM, the Director of Nursing (DON), indicated a nursing assessment should be completed head to toe on every patient. The DON further indicated the assessment should include auscultating heart sounds, bowels sounds, and lung sounds.			

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
Dona Wright	Administrator	7/27/2023 9:41:13 AM