

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>157318</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>05/07/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>PREFERRED HOME HEALTH CARE, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6920 PARKDALE PLACE, SUITE 110 , INDIANAPOLIS, Indiana, 46254</b>			
(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>INITIAL COMMENTS</p> <p>This visit was a Post-Condition revisit for a home health agency recertification and re-licensure survey conducted on 04/04/2025.</p> <p>Survey Dates: 05/07/2025</p> <p>12-Month Unduplicated Skilled Admissions: 1757</p> <p>During the post-condition revisit survey Preferred Home Health Care, one previously cited condition was recited. Twelve previously cited deficiencies were corrected. One previously cited deficiency was recited and one new deficiency was cited. Preferred Home Health Care was found to remain out of compliance with Condition of Participation 42 CFR 484.105, Organization and Administration of Services.</p> <p>Preferred Home Health Care continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning April 4, 2025 and continuing through April, 3, 2027.</p> <p>This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.</p> <p>Abbreviations</p> <p>HHA Home Health Aide</p> <p>CNA Certified Nursing Assistant</p> <p>RN Registered Nurse</p> <p>LPN Licensed Practical Nurse</p> <p>DON Director of Nursing</p>	G0000			

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
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G0000	<p>Continued from page 1</p> <p>POC Plan of Care</p> <p>SOC Start of care</p> <p>ROC Resumption of Care</p> <p>SN Skilled Nursing</p> <p>QAPI Quality Assessment and Performance Improvement</p> <p>EP Emergency Preparedness</p> <p>DME Durable Medical Equipment</p> <p>HHA Home Health Aide</p> <p>PT Physical Therapist</p> <p>PTA Physical Therapist Assistant</p> <p>OT Occupational Therapist</p> <p>OTA Occupational Therapist Assistant</p> <p>COTA Certified Occupational Therapist Assistant</p> <p>OASIS Outcome and Assessment Information Set</p> <p>QR completed on 5/14/2025.</p>	G0000		
G0940	<p>Organization and administration of services</p> <p>CFR(s): 484.105</p> <p>Condition of participation: Organization and administration of services.</p> <p>The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs.</p> <p>The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.</p> <p>This CONDITION is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed to evidence failed to inform and complete correct and</p>	G0940	05/02/2025	

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G0940	<p>Continued from page 2 accurate forms to Entity 33, regarding the agency's change in ownership, updated name change with the correct effective date, a document issued by Entity 34 (an entity of the head of department of the state) to receive a certificate of good standing, a new employer identification number from Entity 35 (an entity who enforces internal revenue laws), stock sold and evidence of Summit Home Care's ownership change, and the Articles of Organization and contracts with the changes between the agency and Summit Home Care when they were sold to Summit Home Care (G0948). Failed to evidence the closing of an old branch with the effective date, and the relocation of their branch location with the correct effective date (G0972). These deficiencies had a potential cumulative effect on all 260 patients and 64 employees.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.105, Organization and Administration of Services.</p> <p>Findings Include:</p> <p>410 IAC 17-12-1(a)(1)</p>	G0940		
G0948	<p>Responsible for all day-to-day operations</p> <p>CFR(s): 484.105(b)(1)(ii)</p> <p>(ii) Be responsible for all day-to-day operations of the HHA;</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed to inform and complete correct and accurate forms to the Center for Medicare and Medicaid Services, regarding the agency's change in ownership, updated name change with the correct effective date, a document issued by Entity 34 (an entity of the head of department of the state) to receive a certificate of good standing, a new employer identification number from Entity 35 (an entity who enforces internal revenue laws), stock sold and evidence of Summit Home Care's ownership change, and the Articles of Organization and contracts with the changes between the agency and Summit Home Care when they were sold to Summit Home Care for 1 of 1 home health agency.</p> <p>Findings Include:</p>	G0948		

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G0948	<p>Continued from page 3</p> <p>1. A review of an undated agency policy titled "Internal Control Systems/Accountabilities, Policy No. 2-039.1" indicated but was not limited to, " ... committed to prevention, detection, and to taking all appropriate action to assure compliance with all legal and regulatory statutes ..."</p> <p>2. A review of an application for a change of information to Center for Medicare and Medicaid Services (CMS), evidenced the agency submitted a change of name to Preferred Home Health Care Inc Doing Business as Summit Home Care requested with an effective date of 05/02/2025.</p> <p>The agency failed to provide the following documents to CMS, a document with a certificate of proof of good standing from Entity 34, a new employer identification form from Entity 35, stock sold and evidence of the agency's name change, and the Articles of Organization and contracts with the changes between the agency and Summit Home Care when they were sold to Summit Home Care.</p> <p>During an interview with the Administrator, Regional Director, Vice President of Nursing, and the Compliance Officer on 05/07/2025 at 5:00 PM, they explained they started doing business as Summit Home Care when they purchased the agency in the year 2020. They explained they were unaware the effective date had to reflect when they started doing business as Summit Home Care.</p> <p>410 IAC 17-12-1(c)(1)</p>	G0948		
G0972	<p>Report all branch locations to SA</p> <p>CFR(s): 484.105(d)(1)</p> <p>The parent HHA is responsible for reporting all branch locations of the HHA to the state survey agency at the time of the HHA's request for initial certification, at each survey, and at the time the parent proposes to add or delete a branch.</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and interview, the agency failed to ensure they notified the Center for Medicare and Medicaid Services, regarding the agency closing a branch, the date of the branch closure, and</p>	G0972		05/02/2025

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G0972	<p>Continued from page 4 the effective date of the new branch location for 1 of 1 agency branch.</p> <p>Findings Include:</p> <p>1. A review of an undated agency policy titled "Internal Control Systems/Accountabilities" indicated but was not limited to, " ... committed to prevention, detection, and to taking all appropriate action to assure compliance with all legal and regulatory statutes ..."</p> <p>2. During presurvey review on 05/02/2025, it was evidenced IDOH had 301 South East 21st Street, Suite B, Washington, Indiana 47501 as the agency's branch location.</p> <p>3. A review of an application for a change of information to Centers for Medicare and Medicaid Services, evidenced the agency added a branch at 201 East Main Street, Suite 305, Washington, Indiana 47501 with an effective date of 05/01/2025.</p> <p>The document failed to indicate they closed the branch at 301 South East 21st Street, Suite B, Washington, Indiana 47501 and the date of the closure. The document failed to evidence the correct effective date the agency added the branch at 201 East Main Street, Suite 305, Washington, Indiana 47501.</p> <p>During an interview with the Administrator, Regional Director, Vice President of Nursing, and the Compliance Officer on 05/07/2025 at 5:00 PM, they indicated they had sent in a letter, indicating the branch at 301 South East 21st Street, Suite B, Washington, Indiana 47501 had closed, to IDOH, and indicated they had not received a mail confirmation receipt to verify the submission of the document. They explained they documented the branch at 201 East Main Street, Suite 305, Washington, Indiana 47501 with an effective open date of 05/01/2025 because they were unaware until the last survey of the location acting as a branch. They indicated they were unaware of what date the new branch at 201 East Main Street, Suite 305, Washington, Indiana 47501 opened and thought the effective date was supposed to be the day they recognized the location as a branch.</p>	G0972		

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G0972	Continued from page 5 410 IAC 17-12-1(a)(2)	G0972		
G1022	<p>Discharge and transfer summaries</p> <p>CFR(s): 484.110(a)(6)(i-iii)</p> <p>(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or</p> <p>(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or</p> <p>(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed to ensure the discharge/transfer summary contained all the necessary elements and were sent to the physician for a patient transferred or discharged from the agency for 5 of 5 active clinical records reviewed (Patients #4, #5, #11, #12, and #19) and 2 of 5 inactive clinical records reviewed (Patients #13, and #14).</p> <p>Findings Include:</p> <p>1. Review of the clinical record for Patient #20 revealed a document titled "OASIS-E1 Transfer (OT)" dated 05/05/2025 and signed by OT 1. The document evidenced confirmation of being faxed to the physician on 05/07/2025, the SOC date, physician responsible for home health, and the reason for transfer to the hospital. The document failed to evidence the transfer date, reason for home health services, type and frequency of services provided, laboratory data, medication list, patient condition at transfer, outcomes in meeting goals, and transfer instructions.</p> <p>During an interview on 05/07/2025 at 4:21 PM, OT 1 indicated they were familiar with Patient #20 and completed Patient #20's transfer. When queried about what information should be included in a transfer</p>	G1022		04/30/2025

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G1022	<p>Continued from page 6 summary, OT 1 indicated "Seems a little silly, the questions are right in front of me when I do it"</p> <p>OT 1 failed to indicate the transfer date, reason for home health services, type and frequency of services provided, laboratory data, medication list, patient condition at transfer, outcomes in meeting goals, and transfer instructions.</p> <p>2. A review of Patient #11's inactive clinical record evidenced a document titled "OASIS-E1 Transfer" dated 05/01/2025 by the Administrator. The document evidenced the patient's SOC date was 02/06/2024 and they discharged from the agency to an inpatient facility. The document evidenced it was faxed to the patient's physician. The document failed to include the reason for the patient's home health care admission, the types of services and frequency, medications, and the patients outcome toward meeting their goals.</p> <p>3. During an interview with the Administrator and the Vice President of Nursing on 05/07/2025 at 4:36 PM, the Administrator indicated they input all the information into the transfer summary, but explained the transfer summary was not sent to the physician, the "OASIS-Transfer" document was the document faxed to the physician for Patients #11 and #20. They indicated they were going to start sending the transfer summary to the physicians.</p> <p>410 IAC 17-15-1(a)(6)</p>	G1022		