STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200130620A	A. BUILDING B. WING	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE LLC	504 N BRADNER AVE, MARION, IN, 46952

(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 State Department of Health in accordance with 42 CFR 484.102 Survey Dates: 8/16, 8/17, 8/18, 8/19, and 8/22/2022 Census: 61 At this Emergency Preparedness survey, Premier Home Health was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		2022-09-13
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home Health Provider.	G0000		2022-09-13

	This survey was announced as partially extended on 8/17/2022 at 3:15 PM. Survey Dates: 8/16, 8/17, 8/18, 8/19, and 8/22/2022. Facility Number: IN 010001 Census: 61 This deficiency report reflects State Findings cited in accordance with 410 IAC 17.			
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;	G0574	Patient #2. This patient's goals and outcomes were updated to be patient specific and measurable by the case manager on 8/23/2022. Clinical Supervisor conducted in-servicing with all professional staff titled Patient Centered Goals. This was completed on 9/9/2022 See attachment #1. During weekly case conference when patient is being reviewed for SOC/Recert the Clinical Supervisor will review with assigned case manager each patient's goals and outcomes to ensure the plan of care includes patient specific and measurable goals and outcomes and will be updated as needed. This process was started on 8/23/2022. This is on-going	2022-09-09

	(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 observation, document review, and interview, the agency failed to ensure the plan of care included patient specific goals for 1 of 1 patients (Patient #2) with a skilled nurse visit observation. Findings include: 1. During an observation of a skilled nurse visit with Patient #2 on 8/16/2022 at 1:00 PM, the patient was observed receiving a tube feeding (nutrition that goes through a tube into the stomach). Patient #2 was observed to be minimally responsive to the environment			

	reposition herself, and had limited verbal responses. 2. Clinical record review for Patient #2 included a plan of care for certification period 8/8/2022 – 10/6/2022 with goals that included to "eat small frequent meals ... adhere to diabetic diet ... demonstrate compliance with medication ... not miss any doses." The plan of care included "Nutrition and medication is to be given through ... tube ... Medications are to be crushed through ... tube." 3. During an interview on 8/17/2022 at 3:00 PM, the Clinical Supervisor confirmed the goals were not specific for a patient who received nutrition through a feeding tube and has all medication administered by a nurse.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are	G0580	Clinical Supervisor updated Policy C-635 Physician Orders on 9/7/2022 to include verbal orders will be written at the time they are received by agency staff. When agency staff obtain orders from the physician, they must inform the case manager/nurse/therapist providing care to the patient of the change. Orders can be intiated once the case	2022-09-08

	administered only as ordered by a physician or allowed practitioner. Based on document review and interview, the agency failed to ensure wound care was provided as ordered by the physician in 1 of 2 active patients (Patient #6) receiving wound care, with the potential to affect all patients requiring wound care. Findings include: 410 IAC 17-13-1(a) 1. Review of an agency policy titled "Physician Orders" dated 1/6/2022, indicated "... treatments and services provided ... must be ordered by a physician ..." and "... orders will be accepted ... from physicians who have a current license ...." 2. Review of the clinical record for Patient #6 evidenced an order from Physician A, signed on 8/10/2022. The order identified a faxed date of 8/10/2022, from Entity B. The wound care orders were "change dressing 3 times a week we will change when		manager/nurse/therapist has been notified. Staff will document in the EMR under communication notes which staff were notifed. Clinical Supervisor in-serviced and provided copy of policy to all professional staff. This was completed on 9/8/2022. See attachment #2. During weekly open chart review the Assistant Clinical Supervisor will include in her review, an audit of new orders received for care to ensure they are incorporated into patients chart timely, that staff providing care to the patient have been notified and that it is documented in the patients communication notes in the EMR. This was intiated 9/12/2022 and is on-going.	

patient has an appointment. Wash wounds right leg with wound cleanser, moisturize both legs, xeroform [medicated gauze dressing] and 4x4 [gauze pads] to wounds, wrap in kerlex [type of bandage roll] secure with tape, apply medigrips [tubular bandage] and farrow wraps [a type of compression wrap] to both legs."

An order, entered by Registered Nurse 2, indicated an order date of 8/10/2022, for wound care. The wound care order read, "1: Wound care: wash wounds with wound cleanse Moisturized both legs Xerofrom and 4 x 4 to wounds wrap in kerlix Secure with tape Apply medigrips and farrow wraps to both legs; read back and confirmed Start date: 8/10/2022." The order was electronically signed by Registered Nurse 2 on 8/15/2022 at 11:36 PM.

3. Review of a skilled nurse care visit note, dated 8/12/2022, completed by licensed practical nurse [LPN] #3 indicated wound care was provided during visit and used xeroform, covered

	with gauze pads and kerlex and secured with tape. The wound care frequency was listed as needed, 3 times per week. The documentation failed to evidence the wound care provided followed the new physician order received on 8/10/22 and to include the use wound cleanse and the use of medigrips and farrow wraps. 4. During an interview, on 8/18/2022 at 3:00 PM, the Clinical Supervisor indicated the wound care order was entered into the electronic medical record late and was not available for LPN #3 at the time of the 8/12/2022 nurse visit with Patient #6.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is,	G0798	Clinical Supervisor conducted an in-service titled Individualized Plan Of Care with all professional staff to ensure that all plans of care are indiviualized to each patient. This was completed on 9/13/2022. See attachment #3. During weekly case conference when patient is being reviewed for SOC/Recert the Clinical Supervisor will review with assigned case manager each patient's interventions to ensure the care plan includes evidence specific, individualized precautions and will be updated as needed. This process was started on 8/23/2022. This is on-going.	2022-09-13

physical therapist, speech-language pathologist, or occupational therapist).

Based on record review and interview, the home health agency failed to ensure the home health aide care plan was specific to the needs of the patient for 2 of 2 active patients reviewed who received home health aide services [Patients #2 and #3].

Findings include:

1. Agency policy C-751 titled "Home Health Aide Care Plan" indicated the purpose of the aide care plan was to provide a means of assigning duties to the Home Health Aide that are clear to the aide and to provide documentation that the client's care is individualized to his/her specific needs.

2. Record review for Patient #2, start of care (SOC) 06/25/2019, contained a plan of care (POC) for the certification period 08/08/2022 - 10/06/2022 that identified safety measures and

	included safe transfers, to keep pathways clear, fall precautions, needle and oxygen precautions, head of bed elevated, skin breakdown prevention, lock wheelchair with transfers, transfer precautions, safe surfaces, infection control, aspiration precautions, and ambulation precautions. An agency document titled "Multidisciplinary Care Plan" contained the Aide Care Plan that failed to evidence specific, individualized precautions for Patient #2. 3. Record review for Patient #3, SOC 02/25/2020, contained a POC for certification period 08/13/2022 - 10/11/2022 that indicated safety measures included safe transfers, keep pathways clear, fall precautions, needle precautions, skin breakdown prevention, bleeding precautions, home emergency plan, transfer			

	evacuation plans, ambulation precautions, and diabetic precautions. Agency document, titled "Multidisciplinary Care Plan" failed to evidence specific, individualized precautions for Patient #3. 4. During an interview on 08/22/2022, the clinical supervisor confirmed the safety precautions from the Plan of Care were not included in the HHA care plan.			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and	G0800	Clinical Supervisor completed in-service titled Personal Care with all Home Health Aides/CNA's on 8/30/22 that included Bed Bath. The in-service included handouts, (proper procedure for care) post test, hands on demonstration and return demonstration by aides. See attachment #4 Clinical Supervisor developed an on-site supervisory visit form for all home care staff. This was completed on 9/7/2022. The form will be completed by Clinical Supervisor with each employee's annual evaluation. This form includes hands on care observed.See attachment #5.This is on-going	2022-09-07

(iv) Consistent with the home health aide training.

Based on observation, document review and interview, the agency failed to ensure the Home Health Aide provided a bed bath consistent with Home Health Aide training in 1 of 1 patient observation of a bed bath (home health aide #1), with the potential to affect all patients requiring a bed bath.

Findings include:

1. Review of an agency document titled "Bathing the Bedbound Patient," dated 2022, indicated "...Remove the patient's clothing, keeping ... covered with a blanket ..." and "... provide perineal care last." According to the document, the patient is to remain covered unless that part of the body is being cleaned. The document also indicates the bed bath begins with the face and ends with the perineal area.

2. The personnel record for Home Health Aide (HHA) #1 evidenced 3 documents regarding HHA 1's performance of personal care; one was a certificate of completion for "Providing Personal Care," dated 1/19/2022; the second was an annual evaluation, dated 11/5/2021 that did not include a category for evaluating skill performance and indicated the aide was without deficiency in their performance of care; the third document was a skills competency, completed on 11/22/2019 which indicated a skill demonstration of a bed bath was completed without a deficiency.

3. Observation of HHA #1 while performing a bed bath for Patient #3, was condcted on 8/17/2022. During the first portion of the bed bath, HHA#1 used a blue washcloth to wash

	provided the blue wash cloth to Patient who then washed their face, HHA #1 then began cleaning patient's left leg and ankle, then repeated the procedure with the right leg, using the blue cloth. The blue washcloth was then rinsed and given to Patient #3 to rinse their face. Then the HHA cleaned Patient #3's genitalia, wiping from back to front, then rinsed and rolled Patient to the right and cleaned buttock and anus. Patient #3 was then rolled to the left and the left buttock was washed, rinsed, and dried. HHA#1 then dumped the water and returned with the basin and clean water and the two washcloths, blue and rust. For this portion of the bath, the rust washcloth was used to wash and the blue washcloth to rinse. HHA #1 then washed, rinsed, and dried Patient #3's chest, back and arms. Patient #3 remained uncovered throughout the bed bath. 4. During an interview on 8/17/2022 at 3:00 PM, the Clinical Supervisor confirmed the bed bath was not performed per agency policy.			

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