STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K011	A. BUILDING 00 B. WING	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEST HOME CARE SERVICES	325 N EASTERN AVE CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: September 21st, 22nd, and 23rd of 2020 Facility Number: 003083 Medicaid Number: 200367450A Provider Number: 15K011 Census = 47 Active Patients At this Emergency Preparedness survey, Best Home Care Services was found in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 484.102.	E 0000		
G 0000 Bldg. 00	This survey was for a federal and state relicensure in conjunction with an infection control focused COVID-19 survey. Survey Dates: September 21st, 22nd, and 23rd of 2020. Facility ID: 003083 Provider ID: 15K011 Medicaid ID: 200367450A Medicare/Medicaid	G 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Census: 12 month unduplicated census: 66 Active Patients: 47 Partially Extended Survey Announced 9/22/2020 at 4:00 p.m. These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Quality Review Completed on 10/7/2020 A4			
G 0436 Bldg. 00	484.50(c)(5) Receive all services in plan of care Receive all services outlined in the plan of care. Based on observation, record review, and interview, the agency failed to ensure patients received all services as ordered in the plan of care for 3 of 5 active records reviewed. (Patient 3, 4, and 6). Findings Include: 1. An undated document titled, Assessment and Documentation Policy and Procedure, was provided by the administrator on 9/22/2020 at 3:40 p.m. The document indicated, but was not limited to, "Purpose: To insure all clients are assessed and information is gathered at ... skilled nursing visits ... The RN/LPN will perform an assessment during all skilled nursing visits ... " 2. The complete clinical record for patient 4 was reviewed on 9/21/2020 for the certification period 7/18/2020 to 9/15/2020. The record indicated the following: A document titled Home Health Certification and	G 0436	G-436 The Administrator and the Clinical Manager have been educated on the requirement of frequency of RN to assess, eval, treat, and obtain VS and O2 sats. The Clinical Manager will educate all RN's concerning the Plan of Care/485 on the frequency of the RN to assess, eval, treat, and obtain VS and O2 sats. The Administrator and Clinical Manager will revise the Assessment and Documentation Policy and Procedure to reflect when the RN is to assess, eval, treat, and obtain VS and O2 sats. Completion Date: 10/20/2020	10/20/2020

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	Plan of Treatment/485 for the certification period of 7/18/2020 to 9/15/2020. The document indicated, but was not limited to, "RN to assess, eval, treat, and obtain VS [Vital Signs] ..." Skilled nurse visit notes for 7/20, 7/21, 7/22, 7/23, 7/24, 7/27, 7/28, 7/29, 7/30, 7/31, 8/3, 8/4, 8/5, 8/6, 8/7, 8/10, 8/11, 8/12, 8/14, 8/17, 8/18, 8/19, 8/20, 8/21, 8/24, 8/25, 8/26, 8/27, 8/28, 8/31, 9/1, 9/2, 9/3, and 9/4 of 2020 failed to evidence employee E, skilled nurse, obtained vital signs for patient 4. Supervisory Visit Notes for 7/18/2020, 7/27/2020, 8/10/2020, 8/20/2020, 9/7/2020, and 9/12/2020 failed to evidence that employee D, RN, obtained vital signs during the patient visit. 3. The complete clinical record for patient 3 was reviewed on 9/21/2020 for the certification period 8/19/2020 to 10/17/2020. The record evidenced the following: A document titled Home Health Certification and Plan of Treatment, Form 485 for the certification period of 8/19/2020 to 10/17/2020. The document indicated, but was not limited to, "RN to assess, eval, treat, and obtain VS [Vital Signs] ..." Supervisory Visit Notes for 8/14/2020 and 9/10/2020 failed to evidence that employee D, RN, obtained vital signs during the patient visit. 4. The complete clinical record for patient 6 was reviewed on 9/22/2020 for the certification period 6/23/20 to 8/21/20. The records evidenced the following: A document titled Home Health Certification and Plan of Treatment, Form 485 for the certification period of 6/23/2020 to 8/21/2020. The document indicated, but was not limited to, "RN to assess,			

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	eval, treat, and obtain VS [Vital Signs] ..." Supervisory Visit Notes for 7/21/20 and 8/20/2020 failed to evidence that employee D, RN, obtained vital signs during the patient visits. 5. During an observation on 9/22/2020 at 9:30 p.m. employee E failed to obtain patient 4's vitals signs. Employee E stated she does take patient 4's vital signs each visit when patient 4 is cooperative. The clinical record failed to evidence documentation of vital signs. 6. During an interview on 9/22/2020 at 11:39 am, employee B stated that vital signs were done during supervisory visits one time monthly by the nurse. The aides were not expected to do vital signs or pulse oximetry during visits unless certain parameters were given based on specific orders from the physician. 17-13-1(a)			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following 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;			

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	(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 may choose to include. Based on observation, record review, and interview, the agency failed to ensure the plan of care reflected current information related to the patients advanced directives in 1 of 3 home visit observations. (Patient 6). Findings include: A 10/31/2018 CMS Memorandum Ref: QSO-18-25-HHA indicated, but was not limited to, as a condition of participation according to §484.60(a)(2)(xv) the plan of care must include "Information related to any advanced directives ..." The complete clinical record for patient 6 was reviewed on 9/21/2020 and evidenced the following: A document titled Home Health Certification and Plan of Treatment, Form 485 for the certification period 6/23/2020 to 8/21/2020 indicated, but was not limited to, "Advance Directive: NO. Living Will: NO. Code Status: DNR [Do not Resuscitate] once filed with the office."	G 0574	G574 – The Administrator and Clinical Manager have been educated on the Advanced Directives and will ensure that the Code Status will be stated clearly as Full Code or DNR on the Aide Plan of Care. The Clinical Manager will check the Aide Plan of Care and the Plan of Care/485 to ensure the Advance Directives are the same. Administrator and Clinical Manager will be responsible for monitoring these corrective actions and ensure that this deficiency is corrected and will not recur. Completion Date: 10/01/2020	10/01/2020

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	A document titled Home Health Certification and Plan of Treatment, Form 485 for the certification period 8/22/2020 to 10/20/2020 indicated, but is not limited to, "Advance Directive: NO. Living Will: NO. Code Status: Full Code." An 11/1/2018 document titled Aide Care Plan last reviewed on 8/20/20 that indicated, but was not limited to, "Code Status: DNR once filed." Once filed was not clearly legible potentially indicating patient 6 was a DNR. During an observation on 9/22/2020 during a home visit for patient 6 a copy of an 11/1/2018 document titled Aide Care Plan last reviewed on 8/20/20 that indicated, but was not limited to, "Code Status: DNR once filed." where once filed was not clearly legible potentially indicating patient 6 was a DNR was located in the patient's admission packet. During an interview on 9/23/2020 at 10:03 a.m. with the administrator and clinical manager, the clinical manager stated patient 6's family wanted patient 6 to be a DNR but had not filed the proper paperwork. The family had been educated on the necessity of the paperwork. When asked why the aide care plan stated DNR once filed instead of Full Code, the clinical manager stated the aide knew the paperwork was not filed and would be updated if it were filed. The administrator and clinical manager acknowledged understanding of the potential implications that could result from having a code status documented as DNR while the patient was a full code. 17-13-1(a)(1)(C)(xiii)			

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G 0682 Bldg. 00	484.70(a) Infection Prevention 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 record review and interview, the agency failed to ensure staff were following acceptable standards of practice by actively documenting absence of illness or signs/symptoms of COVID-19 for 3 of 3 home visits observed. (Employee E, M, and Q) Findings include: 1. A 3/23/2020 CMS Infection Control Covid-19 questionnaire tool indicated, but was not limited to, "Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their temperature and documenting absence of illness (or signs/symptoms of COVID-19 as more information becomes available)?" Ref: QSO 20-20-All 2. During a home visit for patient 4 on 9/22/2020 at 9:40 p.m. Employee E, a licensed practical nurse, was asked if they self-screen for COVID-19 before entering a patient's home and if they take their temperature and document absence of illness. Employee E stated patient 4's mother screens the home health aide every morning before allowing Employee E to enter. Employee E stated they do not document an absence of symptoms. 3. During a home visit for patient for patient 3 on 9/22/2020 at 1:00 p.m., Employee M, a home health aide, was asked if they self-screen for COVID-19	G 0682	G682 – The Administrator and the Clinical Manager has been educated on Infection Prevention pertaining to documenting the absence of illness or signs/symptoms of COVID-19. The Administrator and Clinical Manager have made a Daily Employee Screening for Absence of COVID-19 Signs and Symptoms Policy. The Administrator and the Clinical Manager educated all Best Home Care Services field and office staff of properly documenting the absence of COVID-19 Signs/symptoms daily. All employees have been educated to report immediately to the Clinical Manager if their temperature is over 99.5 orally and/or if they have any signs/symptoms of COVID -19. Administrator and Clinical Manager will be responsible for monitoring these corrective actions and ensure that this deficiency is corrected and will not recur. Completion Date: 10/01/2020	10/01/2020

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	before entering a patient's home and if they take their temperature and document absence of illness. Employee M stated they do self-screen but do not document the absence of symptoms but would report the presence of symptoms to the clinical manager. 4. During a home visit for patient for patient 6 on 9/22/2020 at 2:00 p.m., Employee Q, a home health aide, was asked if they self-screen for COVID-19 before entering a patient's home and if they take their temperature and document absence of illness. Employee Q stated they self-screen in the morning before going to work but do not document the absence of symptoms. 5. During an interview on 9/22/2020 at 4:00 p.m. the administrator and alternate administrator acknowledged they do not require employees to document absence of symptoms only to report the presence of symptoms. 17-12-1(m)			
G 0716 Bldg. 00	484.75(b)(6) Preparing clinical notes Preparing clinical notes; Based on record review and interview, the skilled professional failed to ensure the medication administration documentation report reflected the dates the medication was administered in 1 of 5 active records reviewed (Patient 7), and failed to ensure documentation was accurate and reflected patients current health status in 1 of 2 closed records reviewed. (Patient 1) Findings include: 1. An undated job description for the Licensed	G 0716	The Administrator and Clinical Manager have been educated on preparing clinical notes concerning the medication administration documentation report, reflecting the month and year, as well as dates the medication was administered and ensuring the documentation is accurate. The Administrator and Clinical Manager will educate all RN/LPN's on documentation of medication and that all medication	10/20/2020

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	Practical Nurse was provided on 9/23/2020 at 10:23 a.m. by employee A. The document indicated, but was not limited to, "Duties and Responsibilities ... Administer those prescribed treatments and medications as permitted by state law. ... Document all client-related activities in a timely manner." 2. An undated policy titled Care Plan/ 485 Policy and Procedure was provided by the administrator on 9/22/2020 at 2:58 p.m. The document indicated, but was not limited to, "Purpose: to ensure client information is current and up to date. ... RN [Registered Nurse] makes a home visit at initial assessment, at recertification periods, and with any significant changes. ... data is gathered and entered to formulate/update plan of care." 3. The complete clinical record was reviewed for patient 7, for certification period 10/05/2018 on 9/22/2020 and evidenced the following: An undated document titled Medication Record indicated, but was not limited to, patient 7 received 2 puffs of Flovent (a medication used to suppress an immune response therefore reducing inflammation and promoting airflow in the lungs) twice a day every day for the entire month. The document, signed by employee G, failed to include a complete date including the month and year the medication was administered. A document titled Medication Record indicated, but was not limited to, patient 7 received 2 puffs of Flovent twice a day for the entire month. Patient 7 received Atropine (a medication used to relieve pain and swelling caused by inflammation in the eye) to the right eye twice a week for the entire month. The document, signed by employee G, failed to include a complete date including the		administration sheets must have the month and year documented on them. The Administrator and Clinical Manager will also educate all RN/LPN's the importance of documenting all medication administration to report the accuracy of all the medication administration. Administrator and the Clinical Manager will also educate all RN/LPN's that is for some reason a medication was not administered, the reason must be documented.The Administrator and Clinical Manager have been educated on the accuracy of the clinical notes such as the Plan of Care/485 to reflect the client's current health status. Completion Date: 10/20/2020	

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	month and year the medication was administered. A second undated document titled Medication Record indicated, but was not limited to, patient 7 received 2 puffs of Flovent twice a day every day for the entire month. The document, signed by employee G, failed to include a complete date including the month and year the medication was administered. Visit notes dated 7/29/2020, 7/31/2020, 8/4/2020, 8/5/2020, 8/6/2020, 8/13/2020, 8/15/2020, 8/17/2020, 8/18/2020, and 8/19/2020 indicated employee G applied Aquaphor (a medication used to prevent dry, rough, scaly, itchy skin and minor skin irritations) to patient 7's genitals. Employee G failed to document the administration of Aquaphor for 10 of the 10 visits reviewed with aquaphor administration. 4. The complete clinical record for patient 1 was reviewed on 9/21/2020 and evidenced the following: A 2/6/2019 document titled Initial Assessment indicated, but was not limited to, "Diagnosis ... Type I Diabetes ..." A document titled Home Health Certification and Plan of Treatment Form 485 for the certification period 4/1/2020 through 5/30/2020 indicated, but was not limited to, "Diagnosis 2: Type 2 Diabetes ... Clinical Summary ... Type I Diabetes ..." A document titled Comprehensive Adult Assessment signed by employee D, dated 5/28/2020 indicated, but was not limited too, "Secondary Diagnosis ... Type 2 DM E10.9 ..." 5. During an interview on 9/23/2020 at 11:12 a.m.			

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	the administrator and clinical manager indicated the medication administration records should have been properly dated with the time, day, month, and year of the medication administration. 6. During an interview on 9/23/2020 at 11:14 a.m. the clinical manager indicated the expectation of the skilled nursing staff is all medication administration was to be documented including the administration of Aquaphor. 7. During an interview on 9/23/2020 the clinical manager indicated the diagnosis on patient 2's record conflicted with other documents. The clinical manager stated that patient 2 could have possibly transitioned from Diabetes Type I to Diabetes Type 2 but the documentation should have accurately reflected the patient's current diagnosis. 17-14-1(a)(1)(E)			
G 0802 Bldg. 00	484.80(g)(3) Duties of a HH aide The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered. Based on record review and interview, the agency failed to ensure the home health aide followed the aide plan of care for 2 of 5 active records reviewed. (Patient 1 and 6). Finding's include:	G 0802	G802 - The Administrator and the Clinical Manager have been educated on the duties of the home health aides following the home health aide plan of care. Administrator and Clinical Manager will educated all home health aides on the importance	10/20/2020

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	1. An undated document titled "Duties and Responsibilities" for the home health aide was provided by employee A on 9/22/2020 at 3:06 p.m. The document indicated, but was not limited to, "Follow patient care plan established by the Registered Nurse ... maintain current and accurate clinical records and reports. Document patient care activities on a daily basis ... " 2. The complete clinical record was reviewed on 9/21/2020 for patient 1 for the certification period 5/31/2020 to 7/29/2020. The record evidenced the following: A document titled "Aide Care Plan" reviewed on 5/28/2020 by the clinical manager indicated, but was not limited to, "The following services are indicated for the above named client: Personal Care ... Oral Hygiene QD (Every Day) ... Shave QD (Every Day)..." A 6/5/2020 dated document titled "Nurse Aide Visit Slip" failed to evidence patient 1 received oral hygiene or was shaved. The document failed to indicate a reason why the indicated services where not performed for that visit. 4. The complete clinical record was reviewed for patient 6 on 9/22/2020 for the certification period 6/23/2020 to 8/21/2020. The record evidenced the following: A document titled "Aide Care Plan" reviewed last on 8/20/2020 by the clinical manager indicated, but was not limited to, "The following services are indicated for the above named client: Blood Sugar Checks QAM (Every Morning)..." On 7/13/20, 7/13/20, 7/21/20, 7/27/20, 7/28/20 (documented "out of needles by HHA), 8/3/20, and 8/10/20 the dated documents titled "Nurse		and ensuring the following of the home health aide care plan. Administrator and Clinical Manager will also educated the home health aides on documenting why a service was not performed as stated on the Plan of Care. Completion Date: 10/20/2020	

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	Aide Visit Slip" failed to evidence patient 6 had her Blood Sugar checked. The document failed to indicate a reason why the indicated service was not performed for those visits. On 9/23/20 at 11:12 a.m. an interview with employee B was conducted. Employee B stated that aides should be taking blood sugars on every shift as indicated. 17-14-1(m)			