STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157621	A. BUILDING B. WING	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER LIVING HOME HEALTH CARE, INC	2040 WASHINGTON AVENUE, EVANSVILLE, IN, 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	INITIAL COMMENTS This visit was for a Federal and State complaint survey of a Home Health Provider. 04/17/2023-04/18/2023 12 Month Unduplicated Skilled Census: 21 These deficiencies reflect State findings in accordance with 410 IAC 17 QA completed on 4/24/2023 by A4.	G0000		
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure all services outlined in	G0436	Administrator reviewed CFR(s):484.50(c)(5). Administrator reviewed the Health Care Patient Bill of Rights. Operations Dept will continue torecruit employees to fill these	2023-05-25

	the plan of care were provided for 1 of 3 active record reviews. (Patient #5) Findings include: An undated Home Health Care Patient Bill of Rights was provided on 04/17/2023 at 1:50 PM. The policy indicated, but was not limited to, "You have the right to file complaints with the home health agency and/or the Indiana State Department of Health: Regarding treatment or care that is (or fails to be) furnished ... You have the right to: ... The care to be furnished ... any factors that could impact treatment effectiveness ... receive all services outlined in the plan of care." The clinical record for patient #5, start of care (SOC) date 02/05/2023, certification date 03/21/2023 to 05/19/2023, was reviewed on 04/17/2023 which included a plan of care (POC) with orders for home health aide services two times a week for one week and three times a week for eight weeks. The agency failed to ensure home health aide visits were conducted on 03/29/2023,		open visits. Administrator will review 100% ofopen visits weekly to make sure all patients are receiving care they have the right to. If we are continously unable to staff, we will have to discharge services.	

	04/05/2023, 04/07/2023, and 04/12/2023. Review of a fax to the physician dated 04/05/2023 and 04/14/2023 indicated the agency was unable to provide a caregiver. During an interview on 04/18/2023 at 11:30 AM the Administrator indicated the agency was unable to provide a caregiver on the above dates and are currently hiring for home health aides. 410 IAC 17-13-1(a)			
G0484	Document complaint and resolution 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to ensure complaints were recorded in the complaint log for 1 of 1 home health agency. Findings include: A 2022 policy titled Client Concerns was provided by the Administrator on 04/17/2023 at 1:50 PM. The policy indicated,	G0484	Administrator reviewed CFR(s):484.50(e)(1)(ii). Administrator reviewed current client concerns policy. Then policy was reviewed withcurrent Supervising Nurse on 4.26.23. As of 4.28.23 all patient complaints wasin the patient complaint binder. Administrator will review 100% ofclient complaints monthly to make sure all are being properly filed in the complaintlogbook	2023-04-28

	but was not limited to, "(Better Living) staff members encourage clients to express their concerns about their care or services freely … 6. The VP of Professional Services of Better Living: A. Reviews all completed and reviewed client concerns forms. … D. Files completed client concerns forms in Better Living's client concerns administrative file." During an interview on 04/17/2023 at 11:50 AM Patient #1 indicated he/she voiced a complaint with past employee Registered Nurse (RN) 1 about not receiving treatment supplies. On 04/17/2023 review of the 2023 Complaint Logbook did not evidence patient #1's complaint. During an interview on 04/17/2023 at 12:45 PM the Administrator indicated he/she was aware of patient #1's complaint and was aware Patient #1 was filing a complaint with the Office of the Attorney General. At that time, the Administrator indicated the complaint form should have been filed out by past employee		sent to Supervising nurse and Administrator. Supervising nurse is the only one to put complaints in the binder and files indiceident with State if needed.	

	RN #1 and on file at the agency but wasn't. The Administrator acknowledged he/she failed to follow up to ensure the complaint was on file. 410 IAC 17-12-3(c)(2)			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to ensure the initial assessment was completed within 48 hours of referral for 1 of 2 closed record reviews. (Patient #1) Findings include: A 2022 policy titled Client Plan of Care was provided on 04/17/2023 at 1:50 PM. The policy indicated, but was not limited to, "1. Better Living Services are furnished to clients:	G0514	Administrator and SupervisingNurse reviewed CFR(s): 484.55(a)(1). Administratorand Supervising Nurse reviewed the plan of care policy for Better Living. Supervising nurse will re-educateall RN Case Managers on the Better Living Home Health Plan of care policy andthe timeliness of doing the initial evaluations by 5.25.23 Supervising nurse will monitor 10%of all patient files quarterly for one year to ensure the Plan of Care policy is followed and start ofcares are done timely	2023-05-25

	care established and periodically reviewed by a Doctor of Medicine ... 7. If a physician refers a client with a verbal order for a plan of care that cannot be completed until after an evaluation, the physician is contacted to approve any additions or modifications ..." The clinical record for Patient #1, start of care (SOC) date 02/14/2023, certification date 02/14/2023 to 03/31/2023, was reviewed on 04/17/2023. The clinical record included a referral date 02/01/2023 and a start of care date 02/14/2023. The agency failed to include documentation of the reason why a physician's order was not obtained for a delayed start of care date from the referral date. During an interview on 04/17/2023 at 3:15 PM the Administrator indicated the agency was waiting for Patient #1 to be discharged from another agency and confirmed there was no documentation in the record regarding a delayed start of care date. 410 IAC 17-14-1(a)(1)(A)			

G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure all medications and treatments were specified and included on the plan of care and medication profile for 1 of 2 closed record reviews. (Patient #1) Findings include: An undated Home Health Care Patient Bill of Rights was provided on 04/17/2023 at 1:50 PM. The policy indicated, but was not limited to, " ... You have the right to file complaints with the home health agency and / or the Indiana State Department of Health: Regarding treatment or care that is (or fails to be) furnished ... You have the right to: ... The care to be furnished ...	G0536	Administrator and SupervisingNurse reviewed CFR(s): 484.55(c)(5). Clinical Supervisor review the PatientsBill of Rights Policy regarding medications. To preventthis deficiency for recurring in the future, the Supervising Nurse will counselall Registered Nurses who provide care and services to ensure that all medicationsare listed on plan of care, that the anatomical **location for medication islisted, and that stop dates for all antibiotics are listed on the Plan of Care.This counseling will be completed by 5.25.23** The Supervising Nurse will monitor 10% of all nursing notesquarterly for accurate medicaiton documentation on the Medical Plan of Care.	2023-05-25

	treatment effectiveness … receive all services outlined in the plan of care … Before care is furnished you have the right to be advised of : The extent to which payment for home health services may be expected from Medicare, Medicaid … known to the Agency." The clinical record for Patient #1, start of care (SOC) date 02/14/2023, certification date 02/14/2023 to 03/31/2023, was reviewed on 04/17/2023 which included a plan of care (POC). Review of the plan of care failed to include the specific type of medication that was to be prescribed for Patient #1's bilateral lower legs. Review of the Medication Profile indicated the agency failed to include the anatomical location of where Nystatin (antifungal medication) was to be applied, failed to include a stop date for Sulfamethoxazole-Trimethoprim DS (antibiotic), and failed to add Oxygen orders/instructions. During an interview on 04/17/2023 at 3:15 PM the Administrator was unsure as to why all medications were not specified or included on the			

	profile. 410 IAC 17-14-1(a)(1)(B)			
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; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician	G0574	Administrator and Supervising Nurse reviewed CFR(s):484.60(a)(2)(i-xvi). Administrator reviewed Plan ofCare policy with Supervising Nurse. The Supervising Nurse identified all otherpatients with the potential to be affected by the same deficiency and conducteda 100% review of all Plans of Care to ensure that all patients were receivingthe care and services identified in the Plans of Care. Supervising nurse willhave to educate each nurse on the procedure to have to free text thisinformation into each chart on the Plan of Care. this will be completed by 5/25/2023 To prevent this deficiently from happening again,the Supervising Nurse will re-educate all RN Case Managers on the Plan of	2023-05-25

	or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the plan of care specified orientation, a psychosocial assessment, and cognitive status on the plan of care 4 of 5 record reviews, with the potential to affect all active records (Patients #1, #3, #4, #5) and failed to ensure all Durable Medical Equipment (DME) were included on the plan of care for 1 of 2 closed record reviews. (Patient #1) Findings include: 1. A 2022 policy titled Client Plan of Care was provided on 04/17/2023 at 1:50 PM. The policy indicated; but was not limited to, "1. Better Living Services are furnished to clients: … B. Following a written plan of care established and periodically reviewed by a Doctor of Medicine … 4. Changes in the plan of care are documented through written and signed modifications to the plan of care … 5. Clients … are notified of modifications in the plan of care. Documentation of the notification is included in the clinical record. "		CarePolicy. She will also make sure all chartsare updated with the detailed Mental, Psychosocial, and cognitive statues. Thiswill be done by 5/25/2023	

	2. The clinical record for Patient #1, start of care (SOC) date 02/14/2023, certification date 02/14/2023 to 03/31/2023, was reviewed on 04/17/2023. The clinical record included a plan of care (POC) that described Patient #1's mental status, psychosocial, and cognitive status as "oriented". The agency failed to specify Patient #1's mental status on the POC as indicated, but not limited to, the patient's orientation to person, place, and time. The agency failed to complete a psychosocial assessment (interpersonal relationships in the immediate family, financial status, homemaker/household needs, family social problems, and transportation needs) and cognitive status assessment (reasoning, remembering, learning) on Patient #1's POC.			

	Review of Patient #1's Skilled Nursing Visit Note dated 02/20/2023 indicated Patient #1 had a wheelchair, wound care, oxygen, and a trach (opening through the neck to breathe). Review of the POC dated 02/14/2023 failed to indicate the listed DME supplies that were on the Skilled Nursing Note.			

	3. The clinical record for Patient #3, start of care (SOC) date 09/25/2018, certification date 03/03/2023 to 05/01/2023, was reviewed on 04/17/2023 which included a plan of care (POC) that described Patient #3's mental status, psychosocial, and cognitive status as "oriented". The agency failed to specify Patient #3's mental status on the POC as indicated, but not limited to, the patient's orientation to person, place, and time. The agency failed to complete a psychosocial assessment (interpersonal relationships in the immediate family, financial status, homemaker/household needs, family social problems, and transportation needs) and cognitive status assessment (reasoning, remembering, learning) on Patient #3's POC. 4. The clinical record for Patient #4, start of care (SOC) date 11/20/2019, certification date 03/04/2023 to 05/02/2023, was reviewed on 04/17/2023 which included a plan of care (POC) that described Patient #4's mental status, psychosocial, and cognitive status as "oriented". The agency failed to specify Patient #4's mental status on			

	the POC as indicated, but not limited to, the patient's orientation to person, place, and time. The agency failed to complete a psychosocial assessment (interpersonal relationships in the immediate family, financial status, homemaker/household needs, family social problems, and transportation needs) and cognitive status assessment (reasoning, remembering, learning) on Patient #4's POC. 5. The clinical record for Patient #5, start of care (SOC) date 02/05/2023, certification date 03/21/2023 to 05/19/2023, was reviewed on 04/17/2023 which included a plan of care (POC) that described Patient #5's mental status, psychosocial, and cognitive status as "oriented, forgetful". The agency failed to specify Patient #5's mental status on the POC as indicated, but not limited to, the patient's orientation to person, place, and time. The agency failed to complete a psychosocial assessment (interpersonal relationships in the immediate family, financial status, homemaker/household needs, family social problems, and transportation needs) and			

	cognitive status assessment (reasoning, remembering, learning) on Patient #5's POC. 6. During an interview on 04/18/2023 at 12:00 PM the Administrator confirmed the mental status, psychosocial, and cognitive status on the plan of care specified orientation but did not go into detail on mental status, psychosocial, and cognitive status. 410 IAC 17-13-1(a)(1)(D)(i-xiii)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure staff followed physician orders for 1 of 2 closed record reviews. (Patient #1) Findings include: A revised 01/02/2019 Registered Nurse job description was provided by the Administrator on 04/17/2023 at	G0580	Administrator and SupervisingNurse reviewed CFR(s): 484.60(b)(1):); Supervising nurse reviewed the RN Jobdescription. TheSupervising Nurse identified all other patients with the potential to beaffected by the same deficient practice and conducted a 100% review of all charts to ensure thatnurses were only providing care they had orders for . No otherdeficiencies were identified. This review was completed on 05/05/2023. To preventthis deficiency for recurring in the future, the Supervising Nurse will counselall Registered Nurses and LPNs who provide care and services to ensure they are onlyproviding care that we have dr orders for. This counseling will be completed by 5/25/2023 The Supervising Nurse will monitor 10% of all nursing notesquarterly for ensuring we have dr orders for all treatments being provided.	2023-05-25

	indicated; but was not limited to, "4. Administers medication and treatment as prescribed by the physician. ... 6. Completes, maintains, and submits accurate and relevant clinical notes regarding clients' condition and care given." Review of Prep Notes Communication dated 03/06/2023 by past employee RN 1 indicated a call was placed to the physician regarding the need for new leg wraps to complete Patient #1's treatment. RN 1 requested new orders if AccuWraps (2 layer compression system delivers therapeutic compression to manage swelling) could not be obtained. RN 1 indicated the home visit was moved to 03/07/2023 due to lack of supplies to complete the treatment.			

	Review of Prep Notes Communication dated 03/07/2023 by past employee RN 1 indicated a home visit was conducted but failed to indicate physician treatment orders were followed or new treatment orders were obtained to complete Patient #1's treatment. During an interview on 04/17/2023 at 3:15 PM the Administrator confirmed there was no follow-up orders or documentation of new treatment orders or instructions received on Patient #1. The Administrator indicated past employee RN 1 obtained AccuWrap supplies from Entity 2. 410 IAC 17-13-1(a)			
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on record review and interview, the Registered Nurse	G0710	Administrator and Supervisingnurse reviewed CFR(s): 484.75(b)(3); Supervising nurse reviewed the RN job description TheSupervising Nurse identified all other patients with the potential to beaffected by the same deficient practice and conducted a	2023-05-25

	failed to ensure agency policy was followed regarding documentation for 1 of 2 closed record reviews. (Patient #1) Findings include: A revised 01/02/2019 Registered Nurse job description was provided by the Administrator on 04/17/2023 at 12:45 PM. The job description indicated;, but was not limited to, "6. Completes, maintains, and submits accurate and relevant clinical notes regarding clients' condition and care given." Review of Prep Notes Communication dated 03/06/2023 and 03/07/2023 by past employee Registered Nurse 1 (RN 1) failed to ensure complete and accurate clinical notes were maintained regarding follow-up treatment orders and documentation of where he/she found additional AccuWrap (2-layer compression system delivers therapeutic compression to manage swelling) supplies to complete the Patient #1's treatment. During an interview on 04/17/2023 at 3:15 PM the Administrator confirmed there		100% review of all chartsto ensure that nurses were only providing care they had orders for on the planof care. No other deficiencies were identified. This review wascompleted on 05/05/2023. To preventthis deficiency for recurring in the future, the Supervising Nurse will counselall Registered Nurses who provide care and services to ensure they are onlyproviding care that we have dr orders for. This counseling will be completed by 5/25/2023 The Supervising Nurse will monitor 10% of all nursing notesquarterly for ensuring we have dr orders for all treatments being provided.	

	was no follow-up orders or documentation received on Patient #1's AccuWraps. The agency failed to follow agency policy regarding the documentation of complete and accurate clinical notes. 410 IAC 17-14-1(a)(1)(H)-RN			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the agency failed to ensure staff prepared and maintained clinical notes for 1 of 2 closed record reviews. (Patient #1) Finding include: A revised 01/02/2019 Registered Nurse job description was provided by the Administrator on 04/17/2023 at 12:45 PM. The job description indicated; but was not limited to, "4. Administers medication and treatment as prescribed by the physician. ... 6. Completes,	G0716	Administrator reviewed CFR(s):484.75(b)(6): Administrator and Supervising Nurse reviewed RN Job description TheSupervising Nurse identified all other patients with the potential to beaffected by the same deficient practice and conducted a 100% review of all chartsto ensure that nurses were entering complete prep/communication notes in the clientschart. No other deficiencies were identified. This review wascompleted on 05/05/2023. To preventthis deficiency for recurring in the future, the Supervising Nurse will counselall Registered Nurses who provide care and services to ensure they are enteringthorough prep/clinical/communication notes in the clients charts. This counseling will be completed by5/25/2023 The Supervising Nurse will monitor 10% of all nursing notesquarterly for accurate clinical/prep notes in the patients chart.	2023-05-25

and relevant clinical notes regarding clients' condition and care given."

Review of Prep Notes Communication dated 03/06/2023 by past employee RN 1 indicated a call was placed to the physician regarding the need for new leg wraps to complete Patient #1's treatment. RN 1 requested new orders if AccuWraps (2 layer compression system delivers therapeutic compression to manage swelling) could not be obtained. RN 1 indicated the home visit was moved to 03/07/2023 due to lack of supplies to complete the treatment.

Review of Prep Notes Communication dated 03/07/2023 by past employee RN 1 indicated a home visit was conducted but failed to document specific new treatment orders or where he/she found additional AccuWrap supplies to complete the treatment.

During an interview on 04/17/2023 at 3:15 PM the Administrator confirmed there was no follow-up orders or

	documentation received on Patient #1. The agency staff failed to complete and maintain accurate clinical notes. 410 IAC 17-14-1(a)(1)(E)-RN			

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
Kasey White	Administrator	5/10/2023 8:00:09 AM