STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157621	A. BUILDING 00 B. WING	01/28/2021

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

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Date: January 25-28, 2021 Census = 46 active At this Emergency Preparedness survey, Better Living Home Health Care, Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 484.102(b)(5) Volunteers and Staffing.	E 0000		
E 0024 Bldg. 00	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and			

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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	Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the agency failed to include the use of volunteers within the emergency preparedness communication plan for the agency. Findings include: An undated policy titled Emergency Preparedness Plan In-Service was provided by the Administrator on 1/27/2021 at 2:30 p.m. The policy indicated, but was not limited to, "Establishes policies and procedures for the agency to follow." A review of the Emergency Preparedness Plan indicated that volunteers were not addressed in any way within the written policy. During an interview on 1/27/2021 at 2:30 p.m. the Administrator and Director of Nursing reviewed the Emergency Plan and acknowledged the plan did not indicate if the agency would use volunteers or emergency staff. The Administrator	E 0024	Administrator reviewed 42 CFR 484.402 (b) (5). The Emergency Preparedness Manual was updated on 1/29/2021, and while surveyors were present, to include that volunteers are not used with our Agency. To ensure that this deficiency does not recur the Administrator will review the Emergency Plan annually to ensure that it includes a policy on using Volunteers. The Administrator is responsible for ensuring compliance with this standard	01/29/2021

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	stated the agency would not be using volunteers.			
G 0000 Bldg. 00	This visit was for Recertification and State Licensure Survey, in conjunction with a covid-19 infection control survey. Survey Dates: 1/25, 1/26, 1/27, and 1/28 of 2021 Partially Extended Survey Announced 1/25/21 at 1:10 p.m. Facility Number: 012101 Census: 46 active These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Quality Review completed on 2/1/2021 A4	G 0000		
G 0412 Bldg. 00	484.50(a)(1)(i) Written notice of patient's rights (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; Based on observation, record review, and interview, the agency failed to provide in writing an understandable and accessible discharge/transfer policy to patients for 3 of 3 home visits (Patients 1, 4, and 5) which had the potential to affect all patients served by the home	G 0412	Administrator reviewed 410 IAC 17-12-3(a)(1)(A). The Admission packet was updated to include a Transfer/Discharge policy on 1/29/2021, to be given to all new admission patients. Additionally, since the completion of the	01/29/2021

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	health agency. Findings included: 1. A Home Health 2018 policy titled Client Discharge and Transfer Policy (Client Care Policy 3034) was provided by the Director of Nursing (DON) on 1/26/21 at 12:15 p.m. The policy indicated, but was not limited to, "PURPOSE To provide patient with the procedures and policies for transfer and/or discharge ..." 2. During a home visit with Patient 1 on 1/26/2021 at 9:30 a.m. the admission packet of the patient was reviewed. No discharge/transfer policy was available in the home or accessible to the patient. 3. During a home visit with Patient 4 on 1/26/2021 at 7:30 a.m. the admission packet of the patient was reviewed. No discharge/transfer policy was available in the home or accessible to the patient. 4. During a home visit with Patient 5 on 1/27/2021 at 1:54 p.m. the admission packet of the patient was reviewed. No discharge/transfer policy was available in the home or accessible to the patient. 5. An interview was conducted with the Administrator on 1/26/2021 at 10:20 a.m. The Administrator indicated that the policy was given at time of admission but if not that it is available upon request. After further discussion with the DON and case managers, it was determined at admission a written discharge and transfer policy was not given out to patients in the admission packet. 17-12-3(a)(1)(A)		survey, Administrator, has drafted and mailed a letter to all current clients with the updated Transfer/Discharge policy for their Client Information Records. To prevent this deficiency from recurring in the future Agency Administrator will review Admission packets yearly to ensure that all required policies will be included in the Client Information packet within the Admission Packet. The Agency Administrator will be responsible for ensuring the actions above have taken place	

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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 observation, record review, and interview, the agency failed to ensure standard infection control precautions were followed for 1 of 3 home visit observations. (Patient 1) Findings include: An undated policy titled Universal Body Substance Precaution was provided by the Administrator on 1/25/21 at 1:00 p.m. The policy indicated, but was not limited to, "F. Gloves should not be washed or disinfected for reuse ..." A 3/6/20 policy titled Handwashing was provided by the Director of Nursing on 1/26/21 at 12:32 p.m. The policy indicated, but was not limited to, "Personnel providing care/service in the home setting will wash their hands ... before and after each contact with a patient/client ... before and after gloves are used ... " A 2000 policy titled Bag Technique was provided by the Director of Nursing on 1/27/21 at 8:45 a.m. The policy indicated, but was not limited to, "Keep the bag closed during the visit ... If additional equipment or supplies are needed from the bag during the home visit, the handwashing procedure must be repeated ... " During a home visit on 1/26/2021 at 9:30 a.m. employee B, a registered nurse, was observed applying gloves and using patient 1's tape measure to measure the left arm fistula. Employee	G 0682	=""> p=""> =""> p=""> =""> p=""> /p> Administrator and Supervising Nurse reviewed 410 IAC 17-12-1(m). On 02/02/2021 the Supervising Nurse re-educated Employee B on infection control policies and procedures including Universal Precautions, Handwashing, and Nursing/Aide Bag Technique. Employee B demonstrated competency with handwashing, and described appropriate infection control procedures to follow when providing care. Further, on 02/05/202, the Agency's clinical staff was mailed re-education in the form of handouts, to be returned to the office no later than 02/12/2021 with signature and date of their understanding. To prevent this deficiency from recurring in the future, the Supervising Nurse will schedule home visits on 10% of clinical field staff quarterly, for four total quarters, to observe for continued compliance with accepted	02/02/2021

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	B applied hand sanitizer to his/her gloves and proceeded to disinfect the tape measure. Employee B applied more hand sanitizer onto the same gloves and assessed patient 1's lung sounds with a stethoscope then entered into his/her supply bag with gloves on to obtain a disinfectant wipe. Employee B failed to remove his/her gloves and perform hand hygiene before entering the supply bag. Employee B applied more hand sanitizer on the same gloves and rubbed the pill dispenser down. Employee B applied more hand sanitizer on the same pair of gloves and proceeded to handle patient 1's pills with the same gloves and fill the medication dispenser. Employee B failed to remove gloves and perform hand hygiene after filling the medication dispenser. Employee B proceeded to pour peroxide into a container. Employee B washed gloved hands in the sink with water then dried gloved hands with a paper towel. Employee B then opened his/her supply bag to obtain a disinfectant wipe to clean off the vital sign equipment (blood pressure cuff, oxygen saturation device, and stethoscope), placed the equipment back in the supply bag, applied hand sanitizer on gloved hands and proceeded to document on the tablet. Employee B then removed the gloves and reapplied new gloves without performing hand hygiene. Employee B began to clean the trach inner cannula (tube inserted into the body). Employee B failed to follow agency policy on infection control precautions. During an interview on 1/27/2021 at 3:00 p.m. the Administrator stated that gloves should not be disinfected and reused. 17-12-1(m)		infection control practices. Any staff member observed to be out of compliance shall receive immediate re-education and be reassessed. All home visits for infection control shall be documented in the personnel record of each employee as well as the Quality Assurance Plan and records for infection control monitoring. The Supervising Nurse will be responsible for ensuring the actions above have taken place. /p> ="" span="">	

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G 0710 Bldg. 00	484.75(b)(3) Provide services in the plan of care Providing services that are ordered by the physician as indicated in the plan of care; Based on observation, record review, and interview, the agency failed to perform tracheostomy care as indicated on the plan of care for 1 of 2 skilled nurse observations. (Patient 1) Finding include: A 2019 revised Registered Nurse job description was provided by the Administrator on 1/27/2021 at 8:05 a.m. The job description indicated, but was not limited to, "Provides professional nursing care by utilizing all elements of nursing process ..." The complete clinical record for patient 1 was reviewed on 1/25/2021, start of care date 9/25/18, with a certification period of 1/12/21 to 3/12/21, with orders for the skilled nurse to perform tracheostomy care and to clean inner cannula (tube inserted into the body) of trachea prn (as needed) as requested by the patient. Patient 1's diagnoses included, but were not limited to, legal blindness and kidney/pancreas transplant. During a home visit observation on 1/26/2021 at 9:30 a.m. employee A, a registered nurse, was observed during patient 1's home visit. Employee A failed to assess for redness, open areas, and drainage, to patient 1's tracheostomy (opening to the air way). During an interview on 1/27/2021 at 10:45 a.m. the Director of Nursing was asked if tracheostomy care included an assessment for skin breakdown, redness, or drainage, given that patient 1 was legally blind. The Director of Nursing indicated the nurse should have assessed the skin around	G 0710	The Administrator and Supervising Nurse reviewed IAC 410 17-14-1(a)(1)(H). The Supervising Nurse and Employee A reviewed the Registered Nurse job description, including the responsibility to follow agency policies and provide care according to the established Plan of Care (Dr orders) on 02/02/2021. Additionally, on 02/02/2021 the Supervising Nurse counseled all Registered Nurses who provide care and services to ensure that all care identified on the Plan of Care is provided. The Supervising Nurse identified all other patients with the potential to be affected by the same deficient practice and conducted a 100% review of all Plans of Care to ensure that all patients were receiving the care and services identified in the Plans of Care. No other deficiencies were identified. This review was completed on 02/03/2021. To prevent this deficiency for recurring in the future, The Supervising Nurse will monitor 10% of all nursing notes quarterly, for four total quarters, for accurate assessment documentation and initiation of services ordered on the Medical Plan of Care. The Supervising Nurse will be	02/02/2021

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	the tracheostomy. 17-14-1(a)(1)(H)		responsible for ensuring the actions above have taken place.	
G 0716 Bldg. 00	484.75(b)(6) Preparing clinical notes Preparing clinical notes; Based on record review and interview, the agency failed to ensure care coordination notes between clinicians administering services were documented in the patient's clinical record for 1 of 4 active records reviewed (Patient 5) and 2 of 3 closed records reviewed (Patient 2 and 3). Findings include: 1. A Home Health 2018 policy titled Care Coordination (Client Care Policy 3006) was provided by the Director of Nursing (DON) on 1/27/2021 at 2:50 p.m. The policy indicated, but was not limited to, "PURPOSE To ensure the coordination of services for each client ...POLICY It is the policy of Better Living to utilize a care coordination system to provide comprehensive, coordinated ...It is the responsibility of the RN/Case Manager to assign a clinician to be responsible for the coordination of care ...PROCEDURE 3. K Conduct case conferences and document in progress note ...5. Written evidence of care coordination will be documented in the client's clinical record." 2. The complete closed clinical record for patient 2, start of care date 5/4/2017, was reviewed on 1/25/2021, and included a plan of care for the certification period 10/15/2020 to 12/13/2020. The record lacked case conference and/or	G 0716	The Administrator and Supervising Nurse reviewed 410 IAC 17-14-1 (a)(1)(E). The Supervising Nurse also reviewed our policy “Care Coordination” and re-educated all RN Case Managers on responsibility of case conferences on 02/02/2021. The Supervising Nurse identified all other patients with the potential to be affected by the same deficient practice and conducted a 100% review of all patient records. The Supervising Nurse, RN Case Managers, and PT conducted a case conference phone call on 02/02/2021 for all patients with inter-disciplinary care. These notes were then entered into the patient’s communication notes in the appropriate place. To prevent this deficiency from recurring in the future: On 02/02/2021, the Supervising Nurse set a policy into place that bi-weekly and as needed, a case conference call will be conducted on any patients with inter-disciplinary care. The note will then be put into the patient’s	02/02/2021

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	communication notes showing collaboration between clinicians on updates/changes found in the electronic medical record for this patient for the entire certification period reviewed. 3. The complete closed clinical record for patient 3, start of care date 4/29/2020, was reviewed on 1/25/2021, and included a plan of care for the certification period 6/28/2020 to 8/26/2020. The record lacked case conference and/or communication notes showing collaboration between clinicians on updates/changes found in the electronic medical record for this patient for the entire certification period reviewed. 4. The complete clinical record for patient 5, start of care date 2/19/2018, was reviewed on 1/26/2021, and included a plan of care for the certification period 11/25/2020 to 1/23/2021. The record lacked case conference and/or communication notes showing collaboration between clinicians on updates/changes found in the electronic medical record for this patient for the entire certification period reviewed. 5. During an interview on 1/27/2021 at 10:25 a.m. the Director of Nursing (DON) stated prior to the pandemic there were weekly meetings between clinicians about patients. Since the pandemic this had been occurring on the phone or via email but not as a group, and instead there was more one on one or individually between clinicians that work with a patient. The DON could not explain why there were not notes documenting these communications for specified patients in the clinical record as stated in the facility policy. The DON acknowledged documentation should occur for all communication taking place. 17-14-1 (a)(1)(E)		chart. To monitor efficacy of the Plan of Correction and ensure future compliance the Supervising Nurse will have the records staff auditing 100% of Communication notes for inter-disciplinary patients, until 100% compliance is achieved for two consecutive months. Audits will begin on 03/04/2021, and will continue on a monthly basis until 100 % compliance is achieved for at least two consecutive months. The Administrator will be responsible for making sure all steps above are completed.	

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