

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2021
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NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP COD 331 KIMBER LN DEPT A EVANSVILLE, IN 47715
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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: 1/13, 1/14, 1/15, and 1/19 of 2021 Census = 129 active	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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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G 0000	<p>emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>*[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.</p> <p>Based on record review and interview, the agency failed to include the use of volunteers within the emergency preparedness communication plan for the agency for 1 of 1 agency.</p> <p>Findings include:</p> <p>A policy titled Specialty Home Health Care Emergency Preparedness Plan was provided by the Administrator on 1/19/2021 at 12:15 p.m. The policy indicated, but was not limited to, "Unless the emergency renders the agency office unstable, the Incident Command Center will be located at the main office ...".</p> <p>A review of the Emergency Preparedness Plan indicated that volunteers were not addressed in any way within the written policy.</p> <p>An interview was conducted with the administrator on 1/19/2021 at 12:10 p.m. The Administrator indicated that volunteers were not used by the agency and therefore were not included in the policy.</p>	E 0024	<p>CFR 484.102 (b) (5) Emergency Preparedness- Volunteers</p> <p>To correct this deficiency, on 1/20/2021, the Administrator, added the following policy statement to our current Emergency Preparedness Plan Incident Command Chart and to our Disaster Emergency Preparedness Plan policy: 'Specialty does not utilize volunteers. ' All staff will be notified of this policy update immediately by email.</p> <p>To prevent this from recurrence, this correction will be monitored for compliance by the Director of Operations, who will ensure use of volunteers is addressed in our Emergency Plan and Policy in all future updates.</p>	01/28/2021

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Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey, in conjunction with a covid-19 infection control survey.</p> <p>Survey Dates: 1/13, 1/14, 1/15, and 1/19 of 2021</p> <p>Partially Extended Survey Announced 1/19/21 at 8:30 a.m.</p> <p>Facility Number: IN002416</p> <p>Census: 129 active Home Visits: 7 Records Reviewed: 17</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 17.</p> <p>Quality Review completed on 1/26/2021 A4</p>	G 0000		
G 0682 Bldg. 00	<p>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.</p> <p>Based on observation, record review, and interview, the agency failed to ensure standard infection control precautions were followed for 1 of 7 home visit observations (Patient 1); and failed to screen visitors for Covid-19 upon entry into the agency for 3 of 4 survey visit dates.</p> <p>Findings include:</p> <p>1. An undated policy titled Handwashing was</p>	G 0682	<p>CFR 484.70 (a) Infection Prevention:</p> <p>To correct this deficiency, the Director of Clinical Services, will provide a remote learning training utilizing Microsoft TEAMS for all employees regarding hand hygiene and use of hand sanitizer gel, with special attention to proper use of hand sanitizer gel</p>	02/17/2021

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	<p>provided by the Administrator on 1/19/2021 at 10:49 a.m. The policy indicated, but was not limited to "Wash hands before and after the care of patients ... If gloves are worn, wash the hands after removing the gloves ..."</p> <p>2. Upon entrance to the office, no screening process including temperature checks, symptom check or questions about travel for either of the State Health Surveyors took place on 3 of 4 days (1/13/21, 1/14/21, and 1/15/21).</p> <p>3. An interview was conducted on 1/14/2021 at 8:05 a.m. with the Administrator. The administrator indicated that they don't really have any visitors to their office so there hasn't been a screening process with logs since the start of the pandemic.</p> <p>4. During a home visit on 1/15/2021 at 10:30 a.m. employee A, a registered nurse, was observed removing his/her gloves after disinfecting vital sign equipment (blood pressure cuff, stethoscope, oxygen saturation device). Employee A reapplied one glove to the right hand without performing hand hygiene. Employee A then documented on his/her tablet with the right gloved hand. Employee A removed the glove to the right hand and failed to perform hand hygiene.</p> <p>5. During an interview on 1/15/2021 at 3:15 p.m. the Administrator and Alternate Administrator were unable to provide any additional information.</p> <p>17-12-1(m)</p>		<p>between glove changes, and to following accepted standards of practice to prevent the transmission of infections and communicable diseases during home visits. We will review our current Policy regarding Infection Control and Prevention. This will be completed by February 17 for all employees.</p> <p>To prevent future recurrence, clinical staff will be monitored by the Director of Clinical Services, during shared visits to ensure all clinicians are following current accepted standards of practice of infection control and prevention during home visits, with special attention to monitoring for good hand hygiene and proper use of hand sanitizer gel between glove changes. Staff will be required to attend, at minimum, annual training on current Infection control standards of practice, including hand hygiene. The Administrator will ensure that all new employees are trained on our Infection Control policies and the current accepted standards of practice to prevent the transmission of infections and communicable disease, including hand hygiene and use of hand sanitizer gel between glove changes. QA will continue to monitor infections as a part of our PI plan.</p> <p>To correct screening deficiency,</p>	

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			<p>on 1/19/2021, the Administrator initiated a COVID-19 screening process for all non-employees entering the building. This screening includes utilizing a non-touch thermometer and taking the persons temperature before entering. Also asking current CDC recommended symptom check and travel questions. Both entrance doors will continue to be locked for entry - allowing for keypad entry only. These entrance doors have been keypad entry only since the COVID-19 pandemic and Public Health Emergency began in March 2020. Keypad entry allows only employees into the building who have the current keypad access code. Employees are COVID-19 self-screening and reporting daily. No entry will be allowed to for any persons who are symptomatic or have traveled internationally.</p> <p>To prevent recurrence, the Administrator will monitor and ensure entrance door COVID-19 screenings continue until the Public Health Emergency is lifted and accepted Infection Control standards of practice allow entry without screening.</p>	