

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
G000000	<p>This was a partial extended federal home health recertification survey.</p> <p>Survey Dates: 3-7-13, 3-8-13, 3-11-13, 3-12-13, and 3-13-13</p> <p>Facility #: 005315</p> <p>Medicaid Vendor #: 100264040A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Census: 232 skilled patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 18, 2013</p>	G000000					

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 that other safeguards provide sufficient protection to the patients. (see 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
G000116	<p>484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>Based on clinical record and document review and interview, the agency failed to ensure patients had been informed of the hours of operation of the toll-free hotline number and that it could be used to voice complaints regarding the implementation of the advance directive requirement in 20 (#s 1 through 20) of 20 records reviewed creating the potential to affect all of the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. Clinical records numbered 1 through 20 each included an "RN/PT Initial Assessment" form that evidenced the patients had received the agency's booklet titled "Deaconess Home Care Patient Education and Safety Resource Guide." The booklet included the toll-free number</p>	G000116	G116 - The Deaconess Home Care Admission Education booklet will add the hours of operation for the State of Indiana's Home Care Hotline. Until the booklets are re-printed, a label with this information will be added to each booklet on the pages where this hotline information is located; locations include the Welcome letter and the Patient Rights information. The information in the booklet will be reviewed each time prior to re-printing to ensure the information in the booklet is complete. Re-printing occurs 2-3 times a year dependent on the amount of booklets used. The Home Care Manager will be responsible for the information in the booklet and for monitoring this corrective action to ensure this deficiency is corrected and will not recur.	03/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>established by the State to be used to voice complaints, but failed to include the hours of operation of the hotline number.</p> <p>The information provided to patients regarding the use of the hotline number failed to inform the patients the hotline number could be used to voice complaints regarding the implementation of the advance directive requirements. The booklet states, "Indiana's Home Care Hotline has been established to assist you with unresolved concerns. State of Indiana's Home Care Hotline: 1-800-227-6334. All reported concerns are investigated by the Indiana State Department of Health."</p> <p>2. The alternate administrator, employee G, stated, on 3-7-13 at 10:00 AM, "No, it's not there."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, interview, and review of documents and agency policy, the agency failed to ensure employees cleansed their hands, used approved cleanser, and changed gloves appropriately in 4 (#s 1, 4, 9, and 10) of 10 home visit observations completed creating the potential for the spread of disease causing organisms among staff and the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. The agency's 1-27-12 "Handwashing/Hand Hygiene" policy number C-207 states, "Hands should be washed for the following: Before providing patient care in the home . . . Before putting on gloves, After glove removal (immediately) . . . Handwashing may occur via soap and running water of via an alcohol based waterless hand rinse."</p> <p>A. The agency's 1-27-12 "Infection Control in the Home" policy number C-85 states, "The Home Care / Hospice Care staff will follow appropriate infection</p>	G000121	G121 - A staff in-service will be provided by the Manager on 3/26/13 and again on 4/03/13, in order to include staff on vacation or unavailabe at the time of the first in-service, regarding standards of wound care and appropriate infection control procedures which include standards of gloving, de-gloving, and use of alcohol based hand sanitizer with each glove change, before, and after as well as correct timing of putting on the protective apron. A review of wound care identifying what is considered clean versus what is considered dirty to avoid the transfer of germs will also be included.A Deaconess Hospital Infection Disease nurse will provide an in-service for the clinicians on April 9, 2013 to review practice standards related to infection control.The Home Care Quality Specialist RN will implement a wound care skills checklist and complete a competency review and post test with each nurse twice a year - April and October. An artificial limb borrowed from the hospital will be utilized in this mock wound care competency review. The first skills day is scheduled for	04/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>control procedures while administering patient care in the home setting . . . If the staff cannot, or prefer not, wash their hands in the patient's home, they will use the alcohol-based antiseptic hand cleanser provided . . . General Rules of PPE [personal protective equipment] . . . You must use appropriate protective equipment each time you perform a task . . . Glove Removal . . . Remove gloves when they become contaminated, damaged, or before leaving work area. Wash your hands thoroughly. Aprons. Plastic disposal apron will be used for on-hands, patient care and when tasks or procedures may generate splashes, sprays, splatters, or droplets of infectious material in each client's home."</p> <p>B. The agency's 1-27-12 "Transmission-Based Precautions / Universal Standard Precautions &amp; Management &amp; Handling of Infectious &amp; Regulated Wastes / Hazardous Materials / Bloodborne Pathogens" policy number C-165 states, "Place in leak-proof bags and dispose in regular trash . . . bloody dressings, Band-Aids . . . Surgical dressings."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of</p>		<p>April 9, 2013. The Home Care Coordinator will observe and audit each nurses's technique with wound care on their annual supervisory visit, providing the nurse has a patient receiving wound care. The Home Care Coordinator and Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. Observation number 1 was completed during a home visit to patient number 3 on 3-7-13 at 11:35 AM with employee B, a registered nurse (RN). The RN was observed to change the dressings located on the patient's lower extremities.</p> <p>A. The RN cleansed her hands and donned clean gloves and removed a sock and the dressing from the patient's right foot. The RN removed her gloves and failed to cleanse her hands. The RN opened a dressing package and then donned clean gloves without cleansing her hands. The RN applied the dressing and checked the pulses in the lower leg and foot. The RN removed her gloves and failed to cleanse her hands.</p> <p>B. After applying a sock to the right foot, the RN cleansed her hands and touched multiple dressing supplies and personal items on the patient's dresser. The RN then donned clean gloves without cleansing her hands. The RN removed the sock and dressing from the patient's left foot. Open areas were observed on the patient's left lateral heel and left lateral mid-foot. Without changing gloves, the RN then cut the dressing to size and applied the new dressing. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>RN removed her gloves and failed to cleanse her hands. The RN then touched bottles of sterile water and sterile saline located on the patient's dresser. The RN was observed to place the used gloves on the patient's dresser instead of placing them in a trash bag.</p> <p>C. The RN cleansed her hands and donned clean gloves. She soaked 4 x 4 gauze pads with sterile saline solution to cleanse the wounds. The RN completed the dressing change and placed the trash generated as a result of the dressing change on the dresser with the used gloves. The RN placed a sock back on the patient's foot, removed her gloves, and donned new gloves without cleansing her hands.</p> <p>3. Observation number 4 was completed during a home visit to patient number 6 on 3-8-13 at 11:00 AM with employee C, a RN. The employee was observed to change her gloves and cleanse her hands multiple times. When asked what she was using to cleanse her hands, the employee stated, "This is an alcohol-free hand cleanser. I buy it myself."</p> <p>The alternate administrator, employee G, stated, on 3-8-13 at 11:45 AM, [The hand cleanser used by employee C] is not agency approved. We did not issue that</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>to her. She should have checked with us before using it in the home."</p> <p>4. Observation number 9 was completed on 3-12-13 at 10:30 AM during a home visit to patient number 11 with employee D, a RN. The employee was observed to complete a dressing change to the right lower extremity.</p> <p>A. The RN was not observed to change her gloves or cleanse her hands after cleansing the wound and prior to applying a clean dressing.</p> <p>B. After completing the dressing change, the RN was observed to apply a clean stocking and sock to the patient's right foot. The RN then removed her gloves and was observed to gather trash, replace a bottle of normal saline into the patient's own supply, open a new box of supplies, and examine the contents. The RN failed to cleanse her hands after removing her gloves and touching the clean supplies.</p> <p>5. Observation number 10 was completed on 3-12-13 at 1:00 PM during a home visit to patient number 12 with employee E, a RN. The employee was observed to change the dressings to the right and left lower extremities.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>A. The RN cleansed her hands and donned clean gloves. She removed stockings from both of the lower extremities and then cut the Kerlix and Coban off the left lower extremity and then the right. The RN changed her gloves and cleansed her hands. The RN removed the gauze from the left lower extremity and then from the right. Some bloody drainage was observed on the right lower extremity dressing. The RN changed her gloves and cleansed her hands.</p> <p>B. The RN then applied saline soaked gauze to the right leg wound and then the left. The RN then completed the dressing change to both lower extremities.</p> <p>C. The alternate administrator, employee G, indicated, on 3-12-13 at 1:40 PM, the RN should have completed the dressing change in its entirety to one leg and then the other. The alternate administrator agreed the RN's practice created the potential for the spread of disease causing organisms from one wound to the other.</p> <p>6. The home visit observations were discussed with the administrator, employee H, the alternate administrator, employee G, and the supervising nurse, employee A, on 3-12-13 at 2:00 PM.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	They all voiced agreement the observations were not in compliance with agency policy and procedure.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
G000143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure agency staff had coordinated with the physician regarding patient medications in 2 (#s 9 and 15) of 20 records reviewed creating the potential to affect all of the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 9 included a start of care comprehensive assessment completed by the physical therapist, employee I, on 2-18-13. The assessment identified "problems" during the drug regimen review. The assessment indicates the physician was contacted. The assessment failed to identify which medications were identified as "problems."</p> <p>A. The record included a "Clinical Note" dated 2-20-13 that states, "Pt [patient] had follow-up w/PCP [with primary care physician] on Monday and states they talked about [the patient's] meds in detail. This PT received faxed copy of current meds, but illegible. Pt</p>	G000143	G143 - The Manager in-serviced the staff on 3/26/13 and will repeat the in-service on 04/03/13 in order to catch any staff not available on 3/26/13. The Manager also met with the Therapy Coordinator on 3/22/13 regarding education about medication reconciliation and physician communication. The therapy staff will attend the in-services with nursing on 3/26/13 and 4/3/13. The Coordination of Care policy will be reviewed at the in-services that physicians remain informed of the patient's condition. This policy has been updated to indicate that the primary nurse or therapist is responsible for the clinical management of their patients. With the new software system that was implemented on 2/1/13, staff have the opportunity to "task" themselves with reminders. Staff will be educated to utilize this function when they need reminders to follow-up on an unresolved patient issue. 10 random chart audits will be reviewed quarterly to determine if there is appropriate communication with the physician regarding the patient's care including medication clarity until 100% compliant. The Manager will	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>had a copy. Pt continues to take meds that are not on list as [the patient] believes [the patient] is supposed to be taking them . . . Received call back directly from [patient's PCP] . . . states pt could continue medications that [the patient] thought [the patient] was supposed to be taking and should follow-up w/diabetes MD on 2/26 for further clarification."</p> <p>B. The supervising nurse stated, on 3-11-13 at 2:25 PM, "A Novolog pen and the Tylenol dose were the medications in question. The Tylenol dose was resolved. It is unknown if the Novolog pen dose was resolved."</p> <p>C. The record failed to evidence the physical therapist had coordinated with the patient's diabetes physician and/or the patient to clarify the amount of Novolog that had been prescribed.</p> <p>2. Clinical record number 15 evidenced the patient had been admitted on 9-5-12 with a diagnosis of "non healing surgical wound." The record included a skilled nurse visit note, signed and dated by employee E, a registered nurse, on 9-10-12, that states, "Medication notes: According to pt [physician name] office called antibiotic for [the patient] on Friday but [the patient] has not gotten it yet . . . According to spouse, [physician</p>		<p>be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>name] called in antibiotic today and they are getting it today. All medications assessed. Drug regimen review: compliance with all medication is undetermined."</p> <p>A. Skilled nurse visit notes, signed and dated by employee J, a licensed practical nurse, on 9-12-12 and 9-14-12, state, "Medication notes: no medication changes." The record failed to evidence the RN had coordinated with the physician regarding the antibiotic.</p> <p>B. The record included a transfer comprehensive assessment, signed and dated by employee K, a registered nurse, on 9-18-12, that states, "No clinically significant medication issues identified since the previous OASIS assessment . . . Pt went to ER [emergency room] on 9-16-12 due to pain, redness, heat and increased edema in left foot. [Patient] was admitted to the hospital on 9-16-12 with infected left foot."</p> <p>C. The supervising nurse, employee A, indicated, on 3-13-13 at 1:15 PM, the record did not include documentation the registered nurse had coordinated with the physician regarding the prescribed antibiotic. The nurse stated, "I would have expected to see some documentation that the nurse had checked on the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	antibiotic."  3. The agency's 1-27-12 "Coordination of Care" policy number C-28 states, "Coordination of care is the direct responsibility of the Home Care or Hospice coordinator. The coordinator or designee with the cooperation and input from the case managers, referral RN, primary RN, primary Physical Therapist, IDG and Home Care / Hospice staff is responsible for the clinical management of the patients in Home Care / Hospice and reports directly to the Home Services clinical manager."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
G000145	<p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record review and interview, the agency failed to ensure a written summary report had been sent to the physician in 1 (# 12) of 2 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's current patients that have been on service for longer than 60 days.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 12 evidenced a start of care date of 12-8-12 and included plans of care for the certification periods 12-8-12 to 2-5-13 and 2-6-13 to 4-6-13. The plans of care identified the patient had received skilled nursing services during both certification periods. The record failed to evidence a written summary report had been sent to the physician at the end of the first 60 day certification period.</li> <li>2. The supervising nurse, employee A, indicated, on 3-12-13 at 1:55 PM, a written summary report had not been sent to the physician.</li> </ol>	G000145	<p>G145 - In-service to re-educate staff about how to generate the home health 60 day summary for the physician in the new software system that was implemented on 2/1/13. Staff will be re-educated about how to generate and attach the 60 Day Summary to the Recertification that is sent to the physician at the User Group Meeting on 3/27/13. 10 random recertifications will be audited quarterly for the 60 Day Summary. This will continue quarterly until 100% compliant. The Home Care Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	03/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided as ordered by the physician on the plan of care in 5 (#s 3, 12, 14, 18, and 19) of 20 records reviewed creating the potential to affect all of the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 1-21-3 to 3-21-13 that identifies skilled nursing (SN) services were to be provided 3 times per week for 1 week then 2 times per week for 8 weeks. The plan included orders for dressing changes that state, "Lt [left] lateral ankle wound care to be completed two times a week and PRN [as needed] by skilled nurse . . . Cover with Aqua AG . . . Nsg [nursing] wound note: Discontinue Aquacel AG dressing after 2 weeks and charge to Aquacel . . . Lt lateral 4th toe wound . . . Cover with Aquacel AG . . . Nsg wound note: Discontinue Aquacel AG dressing after 2</p>	G000158	G158 - An in-service to re-educate nursing and therapy clinicians about how to check for active patient orders in the new software system on 3/26/13 and 4/3/13. Problem charting in the software system should match the active order and is what the clinician charts against. The wound care documentation should match the current problem that generated the physician order. Additionally, the new software system alerts a clinician if he/she attempts to schedule too many visits for the timeframe of the current physician order. It does not alert the clinician of too few visits; to remedy this the Home Care Scheduler will run a report on Thursdays that will indicate when a patient's visits are "under the frequency limit" and will investigate with the Home Care Coordinator to determine the reason. Further visits will be scheduled to follow the POC or documentation completed to support the reason for unmade visits. 10 patient charts will be audited quarterly for evidence that the physician's plan of care is followed. The Home Care Manager will be responsible for	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>weeks and change to Aquacel." The record included an interim physician order dated 2-22-13 that states, "Santyl ointment BID [2 times per day] to left 4th toe wound."</p> <p>A. The start of care SN admission visit note dated 1-21-13 states, "Lt lat [lateral] 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>B. A SN visit note dated 1-24-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>C. A SN visit note dated 2-8-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG . . . Lt lat ankle wound care . . . Dressing removed from the wound. Wound cleansed with sterile water. Covered with bordered foam dressing as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>D. A SN visit note dated 2-12-13 states, "Lt lat 4th toe wound care</p>		<p>monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>E. A SN visit note dated 2-15-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>F. A SN visit note dated 2-19-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>G. The supervising nurse, employee A, stated, on 3-13-13 at 2:10 PM, "There is no order to continue using the Aquacel AG."</p> <p>2. Clinical record number 12 included a plan of care established by the physician for the certification period 2-6-13 to 4-6-13 that states, "SN 1 x day x 60 days [1 time a day for 60 days] . . . LLE: Q [every] 3 Days, SN to cleanse daily with saline, wrap with Kerlix and Coban for compression."</p> <p>A. SN visit notes, dated 2-6-13,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>2-7-13, 2-8-13, 2-9-13, 2-10-13, 2-11-13, 2-12-13, 2-13-13, 2-14-13, 2-15-13, 2-16-13, 2-17-13, 2-18-13, 2-19-13, 2-20-13, 2-21-13, 2-22-13, 2-23-13, 2-24-13, 2-25-13, 2-26-13, 2-27-13, 2-28-13, 3-1-13, 3-2-13, 3-3-13, 3-4-13, and 3-6-13, failed to evidence any wound care had been completed on the left lower extremity.</p> <p>B. SN visit notes, dated 3-7-13, 3-8-13, 3-9-13, 3-10-13, and 3-11-13, evidenced the SN had performed wound care on the left lower extremity each visit.</p> <p>C. A home visit was made to patient number 12 on 3-12-13 at 1:00 PM with employee E, a registered nurse. The nurse stated, "We have been changing the dressing on both legs every day for about a week now."</p> <p>D. The supervising nurse, employee A, indicated, on 3-12-13 at 1:55 PM, the record did not include an order to discontinue changing the left lower extremity dressing every 3 days or to start changing the dressing daily.</p> <p>3. Clinical record number 14 included SN visit notes, dated 9-27-12, 10-1-12, 10-4-12, 10-9-12, 10-12-12, and 10-15-12, that evidence the left below the knee amputation wound was "covered</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>with Aquacel as a primary dressing."</p> <p>A. The plan of care established by the physician for the certification period 9-27-12 to 11-25-12 states, "Left BKA [below knee amputation] wound care to be completed daily by skilled nurse and [spouse] . . . Remove dressing and cleanse wound with sterile saline solution. Apply Santyl to necrotic areas to wound. Cover with 4 x 4 gauze and apply ABD pad as a second dressing. Secure with kerlix and a 4 inch ace wrap bandage." The plan failed to evidence an order to apply Aquacel to the wound.</p> <p>B. The supervising nurse, employee A, stated, on 3-13-13 at 12:30 PM, "The order for the Aquacel is not on the 485 [plan of care]."</p> <p>4. Clinical record number 18 included an occupational therapy (OT) initial visit note completed by employee N on 2-21-13. The note states, "Modalities: Treatment-Kinesiotape . . . Kinesiotape, as well as wearing schedule / care. Patient may remove tape for any intolerance, but may last up to 5 days. Applied 4 fan taping strips on posterior shoulders and each side of incision for lymphatic drainage and to reduce edema / pain."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>A. The record failed to include an order for the use of the Kinesiotape.</p> <p>B. The supervising nurse, employee A, indicated, on 3-13-13 at 8:45 AM, the record did not include an order for the use of the Kinesiotape.</p> <p>5. Clinical record number 19 included a plan of care established by the physician for the certification period 2-7-13 to 4-7-13 that identified the physician had ordered skilled nurse services to be provided 2 times per week for 5 weeks and 1 time per week for 4 weeks.</p> <p>A. The record evidenced only 1 skilled nurse visit had been provided the week of 3-3-13 (week 5).</p> <p>B. The supervising nurse, employee A, stated, on 3-13-13 at 10:00 AM, "The visit was missed."</p> <p>6. The agency's 1-27-12 "Plan of Care Policy - Home Care" policy number C-14 states, "The primary RN is responsible to ensure that the patient's plan of care is followed."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
G000161	<p><b>484.18(a)</b> <b>PLAN OF CARE</b> Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.</p> <p>Based on clinical record review and interview, the agency failed to ensure orders for therapy services included the specific procedures and modalities to be used in 2 (#s 4 and 18) of 14 records reviewed of patients that received therapy services creating the potential to affect all of the agency's current patients that received therapy services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4 included a plan of care established by the physician for the certification period 2-11-13 to 4-11-13. The plan of care states, "OT [occupational therapy] 3-5 x week x 3 weeks, 1-2 x week x 3 weeks [ 3 to 5 times per week for 3 weeks then 1 to 2 times per week for 3 weeks]." The plan of care failed to evidence the specific procedure and modalities the occupational therapist was to use.</li> </ol> <p>The agency's quality improvement specialist, employee L, indicated, on 3-7-13 at 3:05 PM, the orders for the occupational therapy did not include the specific procedures and modalities to be</p>	G000161	G 161 - The Home Care Manager met with the Therapy Coordinator on 3/22/13 to determine the action plan for the therapists. The therapists will attend the in-service on 3/26/13. An additional in-service will occur 4/3/13 for those on vacation or unable to attend the first in-service. The in-service will include what constitutes a complete therapy order including the procedures and modalities. The Therapy Coordinator assesses two core competencies per year for each therapist. This year she will include proper hand cleansing, medication reconciliation, and that all orders for therapy must include the specific procedures and modalities to be used and the amount, frequency, and duration in the competencies. Therapists will be re-educated about how to generate a physician order in the new software system by creating an appropriate therapy problem that defines the procedure and/or modality. Problems selected generate the physician orders. Therapists will be invited to attend the weekly User Group Meetings that focus on the use and issues with the software system and answer any	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>used. The employee stated, "There are no other orders for OT."</p> <p>2. Clinical record number 18 included an occupational therapy (OT) initial visit note completed by employee N on 2-21-13. The note states, "Modalities: Treatment-Kinesiotape . . . Kinesiotape, as well as wearing schedule / care. Patient may remove tape for any intolerance, but may last up to 5 days. Applied 4 fan taping strips on posterior shoulders and each side of incision for lymphatic drainage and to reduce edema / pain."</p> <p>A. The plan of care failed to include an order for the use of the Kinesiotape.</p> <p>B. The supervising nurse, employee A, indicated, on 3-13-13 at 8:45 AM, the plan of care did not include the use of the Kinesiotape.</p>		<p>questions.10 therapy charts will be audited quarterly for evidence that therapy orders include specific procedures and modalities.The Home Care Manager and Therapy Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
G000170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided as ordered by the physician on the plan of care in 4 (#s 3, 12, 14, and 19) of 19 records reviewed or patients that received skilled nursing services creating the potential to affect all of the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 1-21-3 to 3-21-13 that identifies skilled nursing (SN) services were to be provided 3 times per week for 1 week then 2 times per week for 8 weeks. The plan included orders for dressing changes that state, "Lt [left] lateral ankle wound care to be completed two times a week and PRN [as needed] by skilled nurse . . . Cover with Aqua AG . . . Nsg [nursing] wound note: Discontinue Aquacel AG dressing after 2 weeks and charge to Aquacel . . . Lt lateral 4th toe wound . . . Cover with Aquacel AG . . . Nsg wound note: Discontinue Aquacel AG dressing after 2 weeks and change to Aquacel." The record included an interim physician</p>	G000170	G 170 - An in-service to re-educate nursing clinicians about how to check for active patient orders in the new software system on 3/26/13 and 4/3/13. Problem charting in the software system should match the active order and is what the clinician charts against. The wound care documentation should match the current problem that generated the physician order. Additionally, the new software system alerts a clinician if he/she attempts to schedule too many visits for the timeframe of the current physician order. It does not alert the clinician of too few visits; to remedy this the Home Care Scheduler will run a report on Thursdays that will indicate when a patient's visits are "under the frequency limit" and will investigate with the Home Care Coordinator to determine the reason. Further visits will be scheduled to follow the POC or documentation completed to support the reason for unmade visits. 10 patient charts will be audited quarterly for evidence that the physician's plan of care is followed. The Home Care Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>order dated 2-22-13 that states, "Santyl ointment BID [2 times per day] to left 4th toe wound."</p> <p>A. The start of care SN admission visit note dated 1-21-13 states, "Lt lat [lateral] 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>B. A SN visit note dated 1-24-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>C. A SN visit note dated 2-8-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG . . . Lt lat ankle wound care . . . Dressing removed from the wound. Wound cleansed with sterile water. Covered with bordered foam dressing as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>D. A SN visit note dated 2-12-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>evidence the SN had changed to Aquacel as ordered.</p> <p>E. A SN visit note dated 2-15-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>F. A SN visit note dated 2-19-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>G. The supervising nurse, employee A, stated, on 3-13-13 at 2:10 PM, "There is no order to continue using the Aquacel AG."</p> <p>2. Clinical record number 12 included a plan of care established by the physician for the certification period 2-6-13 to 4-6-13 that states, "SN 1 x day x 60 days [1 time a day for 60 days] . . . LLE: Q [every] 3 Days, SN to cleanse daily with saline, wrap with Kerlix and Coban for compression."</p> <p>A. SN visit notes, dated 2-6-13, 2-7-13, 2-8-13, 2-9-13, 2-10-13, 2-11-13, 2-12-13, 2-13-13, 2-14-13, 2-15-13,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>2-16-13, 2-17-13, 2-18-13, 2-19-13, 2-20-13, 2-21-13, 2-22-13, 2-23-13, 2-24-13, 2-25-13, 2-26-13, 2-27-13, 2-28-13, 3-1-13, 3-2-13, 3-3-13, 3-4-13, and 3-6-13, failed to evidence any wound care had been completed on the left lower extremity.</p> <p>B. SN visit notes, dated 3-7-13, 3-8-13, 3-9-13, 3-10-13, and 3-11-13, evidenced the SN had performed wound care on the left lower extremity each visit.</p> <p>C. A home visit was made to patient number 12 on 3-12-13 at 1:00 PM with employee E, a registered nurse. The nurse stated, "We have been changing the dressing on both legs every day for about a week now."</p> <p>D. The supervising nurse, employee A, indicated, on 3-12-13 at 1:55 PM, the record did not include an order to discontinue changing the left lower extremity dressing every 3 days or to start changing the dressing daily.</p> <p>3. Clinical record number 14 included SN visit notes, dated 9-27-12, 10-1-12, 10-4-12, 10-9-12, 10-12-12, and 10-15-12, that evidence the left below the knee amputation wound was "covered with Aquacel as a primary dressing."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>A. The plan of care established by the physician for the certification period 9-27-12 to 11-25-12 states, "Left BKA [below knee amputation] wound care to be completed daily by skilled nurse and [spouse] . . . Remove dressing and cleanse wound with sterile saline solution. Apply Santyl to necrotic areas to wound. Cover with 4 x 4 gauze and apply ABD pad as a second dressing. Secure with kerlix and a 4 inch ace wrap bandage." The plan failed to evidence an order to apply Aquacel to the wound.</p> <p>B. The supervising nurse, employee A, stated, on 3-13-13 at 12:30 PM, "The order for the Aquacel is not on the 485 [plan of care]."</p> <p>4. Clinical record number 19 included a plan of care established by the physician for the certification period 2-7-13 to 4-7-13 that identified the physician had ordered skilled nurse services to be provided 2 times per week for 5 weeks and 1 time per week for 4 weeks.</p> <p>A. The record evidenced only 1 skilled nurse visit had been provided the week of 3-3-13 (week 5).</p> <p>B. The supervising nurse, employee A, stated, on 3-13-13 at 10:00 AM, "The visit was missed."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	5. The agency's 1-27-12 "Plan of Care Policy - Home Care" policy number C-14 states, "The primary RN is responsible to ensure that the patient's plan of care is followed."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
G000176	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had coordinated with the physician regarding patient medications in 1 (# 15) of 19 records reviewed of patients that received skilled nursing services from the agency creating the potential to affect all of the agency's current patients that receive skilled nursing services.</p> <p>The findings include:</p> <p>1. Clinical record number 15 evidenced the patient had been admitted on 9-5-12 with a diagnosis of "non healing surgical wound." The record included a skilled nurse visit note, signed and dated by employee E, a registered nurse, on 9-10-12, that states, "Medication notes: According to pt [physician name] office called antibiotic for [the patient] on Friday but [the patient] has not gotten it yet . . . According to spouse, [physician name] called in antibiotic today and they are getting it today. All medications assessed. Drug regimen review: compliance with all medication is</p>	G000176	G 176 - The Manager in-serviced the nursing staff on 3/26/13 and will repeat the in-service on 04/03/13 in order to catch any staff not available on 3/26/13. The Coordination of Care policy will be reviewed at the in-services that physicians remain informed of the patient's condition. The policy has been updated to indicate that the primary nurse or therapist is responsible for the clinical management of their patients. With the new software system that was implemented on 2/1/13, staff have the opportunity to "task" themselves with reminders. Staff will be educated to utilize this function when they need reminders to follow-up on an unresolved patient issue. 10 random chart audits will be reviewed quarterly to determine if there is appropriate communication with the physician regarding the patient's care including medication clarity until 100% compliant. The Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>undetermined."</p> <p>A. Skilled nurse visit notes, signed and dated by employee J, a licensed practical nurse, on 9-12-12 and 9-14-12, state, "Medication notes: no medication changes." The record failed to evidence the RN had coordinated with the physician regarding the antibiotic.</p> <p>B. The record included a transfer comprehensive assessment, signed and dated by employee K, a registered nurse, on 9-18-12, that states, "No clinically significant medication issues identified since the previous OASIS assessment . . . Pt went to ER [emergency room] on 9-16-12 due to pain, redness, heat and increased edema in left foot. [Patient] was admitted to the hospital on 9-16-12 with infected left foot."</p> <p>C. The supervising nurse, employee A, indicated, on 3-13-13 at 1:15 PM, the record did not include documentation the registered nurse had coordinated with the physician regarding the prescribed antibiotic. The nurse stated, "I would have expected to see some documentation that the nurse had checked on the antibiotic."</p> <p>2. The agency's 1-27-12 "Coordination of Care" policy number C-28 states,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	"Coordination of care is the direct responsibility of the Home Care or Hospice coordinator. The coordinator or designee with the cooperation and input from the case managers, referral RN, primary RN, primary Physical Therapist, IDG and Home Care / Hospice staff is responsible for the clinical management of the patients in Home Care / Hospice and reports directly to the Home Services clinical manager."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
G000303	<p><b>484.48</b> <b>CLINICAL RECORDS</b> The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure physicians had been informed of the availability of a discharge summary in 3 (#s 2, 15, and 16) of 5 closed records reviewed creating the potential to affect all of the agency's future discharged patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 evidenced the patient had been discharged from services on 3-5-13 per the physical therapist, employee M. The record failed to evidence a discharge summary had been sent to the physician.</li> </ol> <p>Employee L, the agency's quality improvement specialist, indicated, on 3-7-13 at 1:30 PM, the record did not evidence a discharge summary had been sent to the physician.</p> <ol style="list-style-type: none"> <li>2. Clinical record number 15 evidenced the patient had been discharged from services on 9-28-12. The record failed to</li> </ol>	G000303	G 303 - The Home Care Manager in-serviced the staff on 3/26/13 and will repeat on 4/3/13. The LPN chart auditor will monitor that the patient's admission and status screen in the software system is updated by the discharging clinician to a discharged status code, which generates the patient discharge summary, implemented during the survey. The office assistants are automatically tasked (sent a communication) in the software system when the discharge status code is used by the clinician. The office assistants will monitor that each patient task (communication notification) received will have an accompanying discharge summary for mailing. The Home Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	04/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>evidence a discharge summary had been sent to the physician.</p> <p>3. Clinical record number 16 evidenced the patient had been discharged from services on 2-22-13. The record failed to evidence a discharge summary had been sent to the physician.</p> <p>Employee A, the supervising nurse, indicated, on 3-12-13 at 3:00 PM, a discharge summary had not been sent to the physician.</p> <p>4. The agency's 1-24-12 "Discharge Criteria - Home Care" policy number AC-37 states, "The patient's physician will be notified in writing of the patient's condition upon discharge from Home Care by sending the physician a summary of services provided while patient in Home Care."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
N000000	<p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 3-7-13, 3-8-13, 3-11-13, 3-12-13, and 3-13-13</p> <p>Facility #: 005315</p> <p>Medicaid Vendor #: 100264040A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>March 18, 2013</p>	N000000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of documents and agency policy, the agency failed to ensure employees cleansed their hands, used approved cleanser, and changed gloves appropriately in 4 (#s 1, 4, 9, and 10) of 10 home visit observations completed creating the potential for the spread of disease causing organisms among staff and the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. The agency's 1-27-12 "Handwashing/Hand Hygiene" policy number C-207 states, "Hands should be washed for the following: Before providing patient care in the home . . . Before putting on gloves, After glove removal (immediately) . . . Handwashing may occur via soap and running water of via an alcohol based waterless hand rinse."</p> <p>A. The agency's 1-27-12 "Infection Control in the Home" policy number C-85 states, "The Home Care / Hospice Care</p>	N000470	N 470 - A staff in-service was provided by the Manager on 3/26/13 and will again on 4/03/13, in order to include staff on vacation or unavailabe at the time of the first in-service, regarding standards of wound care and appropriate infection control procedures which include standards of gloving, de-gloving, and use of alcohol based hand sanitizer with each glove change, before, and after as well as correct timing of putting on the protective apron. A review of wound care identifying what is considered clean versus what is considered dirty to avoid the transfer of germs will also be included.A Deaconess Hospital Infection Disease nurse will provide an in-service for the clinicians on April 9, 2013.The Home Care Quality Specialist RN will implement a wound care skills checklist and complete a competency review and post test with each nurse twice a year - April and October. An artificial limb borrowed from the hospital will be utilized in this mock wound care competency review. The first skills day is scheduled for April 9, 2013.The Home Care	04/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>staff will follow appropriate infection control procedures while administering patient care in the home setting . . . If the staff cannot, or prefer not, wash their hands in the patient's home, they will use the alcohol-based antiseptic hand cleanser provided . . . General Rules of PPE [personal protective equipment] . . . You must use appropriate protective equipment each time you perform a task . . . Glove Removal . . . Remove gloves when they become contaminated, damaged, or before leaving work area. Wash your hands thoroughly. Aprons. Plastic disposal apron will be used for on-hands, patient care and when tasks or procedures may generate splashes, sprays, splatters, or droplets of infectious material in each client's home."</p> <p>B. The agency's 1-27-12 "Transmission-Based Precautions / Universal Standard Precautions &amp; Management &amp; Handling of Infectious &amp; Regulated Wastes / Hazardous Materials / Bloodborne Pathogens" policy number C-165 states, "Place in leak-proof bags and dispose in regular trash . . . bloody dressings, Band-Aids . . . Surgical dressings."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand</p>		Coordinator will observe and audit each nurses's technique with wound care on their annual supervisory visit, providing the nurse has a patient receiving wound care. The Home Care Coordinator and Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. Observation number 1 was completed during a home visit to patient number 3 on 3-7-13 at 11:35 AM with employee B, a registered nurse (RN). The RN was observed to change the dressings located on the patient's lower extremities.</p> <p>A. The RN cleansed her hands and donned clean gloves and removed a sock and the dressing from the patient's right foot. The RN removed her gloves and failed to cleanse her hands. The RN opened a dressing package and then donned clean gloves without cleansing her hands. The RN applied the dressing and checked the pulses in the lower leg and foot. The RN removed her gloves and failed to cleanse her hands.</p> <p>B. After applying a sock to the right foot, the RN cleansed her hands and touched multiple dressing supplies and personal items on the patient's dresser. The RN then donned clean gloves without cleansing her hands. The RN removed the sock and dressing from the patient's left foot. Open areas were observed on the patient's left lateral heel and left lateral mid-foot. Without changing gloves, the RN then cut the dressing to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>size and applied the new dressing. The RN removed her gloves and failed to cleanse her hands. The RN then touched bottles of sterile water and sterile saline located on the patient's dresser. The RN was observed to place the used gloves on the patient's dresser instead of placing them in a trash bag.</p> <p>C. The RN cleansed her hands and donned clean gloves. She soaked 4 x 4 gauze pads with sterile saline solution to cleanse the wounds. The RN completed the dressing change and placed the trash generated as a result of the dressing change on the dresser with the used gloves. The RN placed a sock back on the patient's foot, removed her gloves, and donned new gloves without cleansing her hands.</p> <p>3. Observation number 4 was completed during a home visit to patient number 6 on 3-8-13 at 11:00 AM with employee C, a RN. The employee was observed to change her gloves and cleanse her hands multiple times. When asked what she was using to cleanse her hands, the employee stated, "This is an alcohol-free hand cleanser. I buy it myself."</p> <p>The alternate administrator, employee G, stated, on 3-8-13 at 11:45 AM, [The hand cleanser used by employee C] is not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>agency approved. We did not issue that to her. She should have checked with us before using it in the home."</p> <p>4. Observation number 9 was completed on 3-12-13 at 10:30 AM during a home visit to patient number 11 with employee D, a RN. The employee was observed to complete a dressing change to the right lower extremity.</p> <p>A. The RN was not observed to change her gloves or cleanse her hands after cleansing the wound and prior to applying a clean dressing.</p> <p>B. After completing the dressing change, the RN was observed to apply a clean stocking and sock to the patient's right foot. The RN then removed her gloves and was observed to gather trash, replace a bottle of normal saline into the patient's own supply, open a new box of supplies, and examine the contents. The RN failed to cleanse her hands after removing her gloves and touching the clean supplies.</p> <p>5. Observation number 10 was completed on 3-12-13 at 1:00 PM during a home visit to patient number 12 with employee E, a RN. The employee was observed to change the dressings to the right and left lower extremities.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>A. The RN cleansed her hands and donned clean gloves. She removed stockings from both of the lower extremities and then cut the Kerlix and Coban off the left lower extremity and then the right. The RN changed her gloves and cleansed her hands. The RN removed the gauze from the left lower extremity and then from the right. Some bloody drainage was observed on the right lower extremity dressing. The RN changed her gloves and cleansed her hands.</p> <p>B. The RN then applied saline soaked gauze to the right leg wound and then the left. The RN then completed the dressing change to both lower extremities.</p> <p>C. The alternate administrator, employee G, indicated, on 3-12-13 at 1:40 PM, the RN should have completed the dressing change in its entirety to one leg and then the other. The alternate administrator agreed the RN's practice created the potential for the spread of disease causing organisms from one wound to the other.</p> <p>6. The home visit observations were discussed with the administrator, employee H, the alternate administrator, employee G, and the supervising nurse,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	employee A, on 3-12-13 at 2:00 PM. They all voiced agreement the observations were not in compliance with agency policy and procedure.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
N000472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on administrative record review and interview, the agency failed to ensure their quality assessment performance improvement program addressed and identified problem areas in 4 (February, June, August, and November 2012) of 4 meeting minutes reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record review audit documentation dated 1-31-12, 6-11-12, 9-03-12, and 12-20-12, evidenced an increasing trend in the number of charts reviewed with physician orders not being followed.</li> </ol> <p>A. The 1-31-12 audit results evidenced 1 record with physician orders</p>	N000472	N 472 - A meeting was held with the administrative team including the Home Care Coordinator, the Manager, and the Nurse QI Specialist on 3/19/2013. The quarterly chart audit results are reviewed at the quarterly PI meeting and will reflect in the minutes that results are analyzed and action taken accordingly. The Nurse QI Specialist chairs the quarterly PI meeting and will ensure the results of the quarterly chart audit are on the agenda. She will analyze, with the attendees, the results of the quarterly audit and the team will develop an action plan. The Nurse QI Specialist will audit the minutes of the quarterly PI meeting to check for minute accuracy and that they reflect the quarterly audit results, the result analysis and the plans for improvement when indicated. The Nurse QI Specialist will be	03/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>not followed.</p> <p>B. The 6-11-12 audit results evidenced 3 records with physician orders not followed.</p> <p>C. The 9-03-12 audit results evidenced 6 records with physician orders not followed.</p> <p>D. The 12-20-12 audit results evidenced 5 records with physician orders not followed.</p> <p>2. The agency's continuous quality improvement (CQI) meeting minutes, dated 2-28-12, 6-13-12, 8-29-12, and 11-20-12, failed to evidence the trend had been identified and a performance improvement plan had been implemented to address the identified problem.</p> <p>3. Five of 20 clinical records reviewed failed to evidence services and treatments had been provided as ordered by the physician on the plan of care. (Refer to G 158).</p> <p>4. The quality assurance specialist, employee L, indicated, on 3-13-13 at 2:05 PM, the CQI meeting minutes did not evidence any action with regards to the identified increasing trend in the number of records with physician orders not being</p>		responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	followed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
N000484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure agency staff had coordinated with the physician regarding patient medications in 2 (#s 9 and 15) of 20 records reviewed creating the potential to affect all of the agency's 232 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 9 included a start of care comprehensive assessment completed by the physical therapist, employee I, on 2-18-13. The assessment identified "problems" during the drug regimen review: The assessment indicates the physician was contacted. The assessment failed to identify which medications were identified as "problems."</li> </ol> <p>A. The record included a "Clinical Note" dated 2-20-13 that states, "Pt [patient] had follow-up w/PCP [with primary care physician] on Monday and</p>	N000484	N 484 - The Manager in-serviced the nursing and therapy staff on 3/26/13 and will repeat the in-service on 04/03/13 in order to catch any staff not available on 3/26/13. The Manager met with the Therapy Coordinator on 3/22/13 regarding education about medication reconciliation and physician communication and the action plan. The Coordination of Care policy will be reviewed at the in-services 'that physicians remain informed of the patient's condition'. This policy has been updated to indicate that the primary nurse or therapist is responsible for the clinical management of their patients. With the new software system that was implemented on 2/1/13, staff have the opportunity to "task" themselves with reminders. Staff will be educated to utilize this function when they need reminders to follow-up on an unresolved patient issue. 10 random chart audits will be reviewed quarterly to determine if there is appropriate communication with the physician regarding the patient's care	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>states they talked about [the patient's] meds in detail. This PT received faxed copy of current meds, but illegible. Pt had a copy. Pt continues to take meds that are not on list as [the patient] believes [the patient] is supposed to be taking them . . . Received call back directly from [patient's PCP] . . . states pt could continue medications that [the patient] thought [the patient] was supposed to be taking and should follow-up w/diabetes MD on 2/26 for further clarification."</p> <p>B. The supervising nurse stated, on 3-11-13 at 2:25 PM, "A Novolog pen and the Tylenol dose were the medications in question. The Tylenol dose was resolved. It is unknown if the Novolog pen dose was resolved."</p> <p>C. The record failed to evidence the physical therapist had coordinated with the patient's diabetes physician and/or the patient to clarify the amount of Novolog that had been prescribed.</p> <p>2. Clinical record number 15 evidenced the patient had been admitted on 9-5-12 with a diagnosis of "non healing surgical wound." The record included a skilled nurse visit note, signed and dated by employee E, a registered nurse, on 9-10-12, that states, "Medication notes: According to pt [physician name] office</p>		including medication clarity. The Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>called antibiotic for [the patient] on Friday but [the patient] has not gotten it yet . . . According to spouse, [physician name] called in antibiotic today and they are getting it today. All medications assessed. Drug regimen review: compliance with all medication is undetermined."</p> <p>A. Skilled nurse visit notes, signed and dated by employee J, a licensed practical nurse, on 9-12-12 and 9-14-12, state, "Medication notes: no medication changes." The record failed to evidence the RN had coordinated with the physician regarding the antibiotic.</p> <p>B. The record included a transfer comprehensive assessment, signed and dated by employee K, a registered nurse, on 9-18-12, that states, "No clinically significant medication issues identified since the previous OASIS assessment . . . Pt went to ER [emergency room] on 9-16-12 due to pain, redness, heat and increased edema in left foot. [Patient] was admitted to the hospital on 9-16-12 with infected left foot."</p> <p>C. The supervising nurse, employee A, indicated, on 3-13-13 at 1:15 PM, the record did not include documentation the registered nurse had coordinated with the physician regarding the prescribed</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>antibiotic. The nurse stated, "I would have expected to see some documentation that the nurse had checked on the antibiotic."</p> <p>3. The agency's 1-27-12 "Coordination of Care" policy number C-28 states, "Coordination of care is the direct responsibility of the Home Care or Hospice coordinator. The coordinator or designee with the cooperation and input from the case managers, referral RN, primary RN, primary Physical Therapist, IDG and Home Care / Hospice staff is responsible for the clinical management of the patients in Home Care / Hospice and reports directly to the Home Services clinical manager."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided as ordered by the physician on the plan of care in 5 (#s 3, 12, 14, 18, and 19) of 20 records reviewed creating the potential to affect all of the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 1-21-3 to 3-21-13 that identifies skilled nursing (SN) services were to be provided 3 times per week for 1 week then 2 times per week for 8 weeks. The plan included orders for dressing changes that state, "Lt [left] lateral ankle wound care to be completed two times a week and PRN [as needed] by skilled nurse . . . Cover with Aqua AG . . . Nsg [nursing] wound note: Discontinue Aquacel AG dressing after 2 weeks and charge to Aquacel . . . Lt lateral 4th toe wound . . . Cover with Aquacel AG . . . Nsg wound note: Discontinue Aquacel AG dressing after 2</p>	N000522	N 522 - An in-service to re-educate nursing and therapy clinicians about how to check for active patient orders in the new software system on 3/26/13 and 4/3/13. Problem charting in the software system should match the active order and is what the clinician charts against. The wound care documentation should match the current problem that generated the physician order. Additionally, the new software system alerts a clinician if he/she attempts to schedule too many visits for the timeframe of the current physician order. It does not alert the clinician of too few visits; to remedy this the Home Care Scheduler will run a report on Thursdays that will indicate when a patient's visits are "under the frequency limit" and will investigate with the Home Care Coordinator to determine the reason. Further visits will be scheduled to follow the POC or documentation completed to support the reason for unmade visits. 10 patient charts will be audited quarterly for evidence that the physician's plan of care is followed. The Home Care Manager will be responsible for	04/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>weeks and change to Aquacel." The record included an interim physician order dated 2-22-13 that states, "Santyl ointment BID [2 times per day] to left 4th toe wound."</p> <p>A. The start of care SN admission visit note dated 1-21-13 states, "Lt lat [lateral] 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>B. A SN visit note dated 1-24-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>C. A SN visit note dated 2-8-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG . . . Lt lat ankle wound care . . . Dressing removed from the wound. Wound cleansed with sterile water. Covered with bordered foam dressing as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>D. A SN visit note dated 2-12-13 states, "Lt lat 4th toe wound care</p>		<p>monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>E. A SN visit note dated 2-15-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>F. A SN visit note dated 2-19-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>G. The supervising nurse, employee A, stated, on 3-13-13 at 2:10 PM, "There is no order to continue using the Aquacel AG."</p> <p>2. Clinical record number 12 included a plan of care established by the physician for the certification period 2-6-13 to 4-6-13 that states, "SN 1 x day x 60 days [1 time a day for 60 days] . . . LLE: Q [every] 3 Days, SN to cleanse daily with saline, wrap with Kerlix and Coban for compression."</p> <p>A. SN visit notes, dated 2-6-13,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>2-7-13, 2-8-13, 2-9-13, 2-10-13, 2-11-13, 2-12-13, 2-13-13, 2-14-13, 2-15-13, 2-16-13, 2-17-13, 2-18-13, 2-19-13, 2-20-13, 2-21-13, 2-22-13, 2-23-13, 2-24-13, 2-25-13, 2-26-13, 2-27-13, 2-28-13, 3-1-13, 3-2-13, 3-3-13, 3-4-13, and 3-6-13, failed to evidence any wound care had been completed on the left lower extremity.</p> <p>B. SN visit notes, dated 3-7-13, 3-8-13, 3-9-13, 3-10-13, and 3-11-13, evidenced the SN had performed wound care on the left lower extremity each visit.</p> <p>C. A home visit was made to patient number 12 on 3-12-13 at 1:00 PM with employee E, a registered nurse. The nurse stated, "We have been changing the dressing on both legs every day for about a week now."</p> <p>D. The supervising nurse, employee A, indicated, on 3-12-13 at 1:55 PM, the record did not include an order to discontinue changing the left lower extremity dressing every 3 days or to start changing the dressing daily.</p> <p>3. Clinical record number 14 included SN visit notes, dated 9-27-12, 10-1-12, 10-4-12, 10-9-12, 10-12-12, and 10-15-12, that evidence the left below the knee amputation wound was "covered</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>with Aquacel as a primary dressing."</p> <p>A. The plan of care established by the physician for the certification period 9-27-12 to 11-25-12 states, "Left BKA [below knee amputation] wound care to be completed daily by skilled nurse and [spouse] . . . Remove dressing and cleanse wound with sterile saline solution. Apply Santyl to necrotic areas to wound. Cover with 4 x 4 gauze and apply ABD pad as a second dressing. Secure with kerlix and a 4 inch ace wrap bandage." The plan failed to evidence an order to apply Aquacel to the wound.</p> <p>B. The supervising nurse, employee A, stated, on 3-13-13 at 12:30 PM, "The order for the Aquacel is not on the 485 [plan of care]."</p> <p>4. Clinical record number 18 included an occupational therapy (OT) initial visit note completed by employee N on 2-21-13. The note states, "Modalities: Treatment-Kinesiotape . . . Kinesiotape, as well as wearing schedule / care. Patient may remove tape for any intolerance, but may last up to 5 days. Applied 4 fan taping strips on posterior shoulders and each side of incision for lymphatic drainage and to reduce edema / pain."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>A. The record failed to include an order for the use of the Kinesiotape.</p> <p>B. The supervising nurse, employee A, indicated, on 3-13-13 at 8:45 AM, the record did not include an order for the use of the Kinesiotape.</p> <p>5. Clinical record number 19 included a plan of care established by the physician for the certification period 2-7-13 to 4-7-13 that identified the physician had ordered skilled nurse services to be provided 2 times per week for 5 weeks and 1 time per week for 4 weeks.</p> <p>A. The record evidenced only 1 skilled nurse visit had been provided the week of 3-3-13 (week 5).</p> <p>B. The supervising nurse, employee A, stated, on 3-13-13 at 10:00 AM, "The visit was missed."</p> <p>6. The agency's 1-27-12 "Plan of Care Policy - Home Care" policy number C-14 states, "The primary RN is responsible to ensure that the patient's plan of care is followed."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record review and interview, the agency failed to ensure orders for therapy services included the specific procedures and modalities to be used in 2 (#s 4 and 18) of 14 records reviewed of patients that received therapy services creating the potential to affect all of the agency's current patients that received therapy services.</p> <p>The findings include:</p>	N000524	N 524 - The Home Care Manager met with the Therapy Coordinator on 3/22/13 to determine the action plan for the therapists. The therapists will attend the in-service on 3/26/13. An additional in-service will occur 4/3/13 for those on vacation or unable to attend the first in-service. The in-service will include what constitutes a complete therapy order including the procedures and modalities. The Therapy Coordinator assesses two core	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>1. Clinical record number 4 included a plan of care established by the physician for the certification period 2-11-13 to 4-11-13. The plan of care states, "OT [occupational therapy] 3-5 x week x 3 weeks, 1-2 x week x 3 weeks [ 3 to 5 times per week for 3 weeks then 1 to 2 times per week for 3 weeks]." The plan of care failed to evidence the specific procedure and modalities the occupational therapist was to use.</p> <p>The agency's quality improvement specialist, employee L, indicated, on 3-7-13 at 3:05 PM, the orders for the occupational therapy did not include the specific procedures and modalities to be used. The employee stated, "There are no other orders for OT."</p> <p>2. Clinical record number 18 included an occupational therapy (OT) initial visit note completed by employee N on 2-21-13. The note states, "Modalities: Treatment-Kinesiotape . . . Kinesiotape, as well as wearing schedule / care. Patient may remove tape for any intolerance, but may last up to 5 days. Applied 4 fan taping strips on posterior shoulders and each side of incision for lymphatic drainage and to reduce edema / pain."</p> <p>A. The plan of care failed to include</p>		<p>competencies per year for each therapist. This year she will include proper hand cleansing, medication reconciliation, and that all orders for therapy must include the specific procedures and modalities to be used and the amount, frequency, and duration in the competencies. Therapists will be re-educated about how to generate a physician order in the new software system by creating an appropriate therapy problem that defines the procedure and/or modality. Problems selected generate the physician orders. Therapists will be invited to attend the weekly User Group Meetings that focus on the use and issues with the software system and answer any questions. 10 therapy charts will be audited quarterly for evidence that therapy orders include specific procedures and modalities. The Home Care Manager and Therapy Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>an order for the use of the Kinesiotape.</p> <p>B. The supervising nurse, employee A, indicated, on 3-13-13 at 8:45 AM, the plan of care did not include the use of the Kinesiotape.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
N000529	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the:</p> <p>(A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on clinical record review and interview, the agency failed to ensure a written summary report had been sent to the physician in 1 (# 12) of 2 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's current patients that have been on service for longer than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record number 12 evidenced a start of care date of 12-8-12 and included plans of care for the certification periods 12-8-12 to 2-5-13 and 2-6-13 to 4-6-13. The plans of care identified the patient had received skilled nursing services during both certification periods. The record failed to evidence a written summary report had been sent to the physician at the end of the first 60 day certification period.</p> <p>2. The supervising nurse, employee A, indicated, on 3-12-13 at 1:55 PM, a</p>	N000529	N 529 - In-service to re-educate staff about how to generate the home health 60 day summary for the physician in the new software system that was implemented on 2/1/13. Staff will be re-educated about how to generate and attach the 60 Day Summary to the Recertification that is sent to the physician at the User Group Meeting on 3/27/13. 10 random recertifications will be audited for the 60 Day Summary for the quarterly compliance meeting. This will continue quarterly until 100% compliant. The Home Care Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	03/27/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	written summary report had not been sent to the physician.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided as ordered by the physician on the plan of care in 4 (#s 3, 12, 14, and 19) of 19 records reviewed or patients that received skilled nursing services creating the potential to affect all of the agency's 232 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 1-21-3 to 3-21-13 that identifies skilled nursing (SN) services were to be provided 3 times per week for 1 week then 2 times per week for 8 weeks. The plan included orders for dressing changes that state, "Lt [left] lateral ankle wound care to be completed two times a week and PRN [as needed] by skilled nurse . . . Cover with Aqua AG . . . Nsg [nursing] wound note: Discontinue Aquacel AG dressing after 2 weeks and charge to Aquacel . . . Lt lateral 4th toe wound . . . Cover with Aquacel AG . . . Nsg wound note:</p>	N000537	N 537 - Re-educate nursing clinicians about how to check for active patient orders in the new software system on 3/26/13 and 4/3/13. Problem charting in the software system matches the active order and is what the clinician charts against. The wound care documentation should match the current problem which generates the physician order. Additionally, the new documentation system alerts a clinician if he/she attempts to schedule too many visits for the timeframe of the current physician order. It does not alert the clinician of too few visits; to remedy this the Home Care Scheduler will run a report on Thursdays that will indicate when a patient's visits are "under the frequency limit" and will investigate with the Home Care Coordinator to determine the reason. Further visits will be scheduled to follow the POC or documentation completed to support the reason for unmade visits. 10 patient charts will be audited quarterly for evidence that the physician's plan of care is followed. The Home Care Manager will be responsible for monitoring these corrective	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>Discontinue Aquacel AG dressing after 2 weeks and change to Aquacel." The record included an interim physician order dated 2-22-13 that states, "Santyl ointment BID [2 times per day] to left 4th toe wound."</p> <p>A. The start of care SN admission visit note dated 1-21-13 states, "Lt lat [lateral] 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>B. A SN visit note dated 1-24-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel . . . Lt lat ankle wound care completed . . . Covered with Aquacel." The note failed to evidence the SN had used Aquacel AG as ordered.</p> <p>C. A SN visit note dated 2-8-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG . . . Lt lat ankle wound care . . . Dressing removed from the wound. Wound cleansed with sterile water. Covered with bordered foam dressing as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>D. A SN visit note dated 2-12-13</p>		actions to ensure that this deficiency is corrected and will not recur.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
	<p>states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>E. A SN visit note dated 2-15-13 states, "Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>F. A SN visit note dated 2-19-13 states, ""Lt lat 4th toe wound care completed . . . Covered with Aquacel AG as a primary dressing." The note failed to evidence the SN had changed to Aquacel as ordered.</p> <p>G. The supervising nurse, employee A, stated, on 3-13-13 at 2:10 PM, "There is no order to continue using the Aquacel AG."</p> <p>2. Clinical record number 12 included a plan of care established by the physician for the certification period 2-6-13 to 4-6-13 that states, "SN 1 x day x 60 days [1 time a day for 60 days] . . . LLE: Q [every] 3 Days, SN to cleanse daily with saline, wrap with Kerlix and Coban for compression."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>A. SN visit notes, dated 2-6-13, 2-7-13, 2-8-13, 2-9-13, 2-10-13, 2-11-13, 2-12-13, 2-13-13, 2-14-13, 2-15-13, 2-16-13, 2-17-13, 2-18-13, 2-19-13, 2-20-13, 2-21-13, 2-22-13, 2-23-13, 2-24-13, 2-25-13, 2-26-13, 2-27-13, 2-28-13, 3-1-13, 3-2-13, 3-3-13, 3-4-13, and 3-6-13, failed to evidence any wound care had been completed on the left lower extremity.</p> <p>B. SN visit notes, dated 3-7-13, 3-8-13, 3-9-13, 3-10-13, and 3-11-13, evidenced the SN had performed wound care on the left lower extremity each visit.</p> <p>C. A home visit was made to patient number 12 on 3-12-13 at 1:00 PM with employee E, a registered nurse. The nurse stated, "We have been changing the dressing on both legs every day for about a week now."</p> <p>D. The supervising nurse, employee A, indicated, on 3-12-13 at 1:55 PM, the record did not include an order to discontinue changing the left lower extremity dressing every 3 days or to start changing the dressing daily.</p> <p>3. Clinical record number 14 included SN visit notes, dated 9-27-12, 10-1-12, 10-4-12, 10-9-12, 10-12-12, and 10-15-12, that evidence the left below the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>knee amputation wound was "covered with Aquacel as a primary dressing."</p> <p>A. The plan of care established by the physician for the certification period 9-27-12 to 11-25-12 states, "Left BKA [below knee amputation] wound care to be completed daily by skilled nurse and [spouse] . . . Remove dressing and cleanse wound with sterile saline solution. Apply Santyl to necrotic areas to wound. Cover with 4 x 4 gauze and apply ABD pad as a second dressing. Secure with kerlix and a 4 inch ace wrap bandage." The plan failed to evidence an order to apply Aquacel to the wound.</p> <p>B. The supervising nurse, employee A, stated, on 3-13-13 at 12:30 PM, "The order for the Aquacel is not on the 485 [plan of care]."</p> <p>4. Clinical record number 19 included a plan of care established by the physician for the certification period 2-7-13 to 4-7-13 that identified the physician had ordered skilled nurse services to be provided 2 times per week for 5 weeks and 1 time per week for 4 weeks.</p> <p>A. The record evidenced only 1 skilled nurse visit had been provided the week of 3-3-13 (week 5).</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>B. The supervising nurse, employee A, stated, on 3-13-13 at 10:00 AM, "The visit was missed."</p> <p>5. The agency's 1-27-12 "Plan of Care Policy - Home Care" policy number C-14 states, "The primary RN is responsible to ensure that the patient's plan of care is followed."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710
---	--

(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
N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had coordinated with the physician regarding patient medications in 1 (# 15) of 19 records reviewed of patients that received skilled nursing services from the agency creating the potential to affect all of the agency's current patients that receive skilled nursing services.</p> <p>The findings include:</p> <p>1. Clinical record number 15 evidenced the patient had been admitted on 9-5-12 with a diagnosis of "non healing surgical wound." The record included a skilled nurse visit note, signed and dated by employee E, a registered nurse, on 9-10-12, that states, "Medication notes: According to pt [physician name] office called antibiotic for [the patient] on Friday but [the patient] has not gotten it yet . . . According to spouse, [physician name] called in antibiotic today and they are getting it today. All medications assessed. Drug regimen review:</p>	N000545	<p>N 545 - The Manager in-serviced the staff on 3/26/13 and will repeat the in-service on 04/03/13 in order to catch any staff not available on 3/26/13. The Coordination of Care policy will be reviewed at the in-services that physicians remain informed of the patient's condition. This policy has been updated to indicate that the primary nurse or therapist is responsible for the clinical management of their patients. With the new software system that was implemented on 2/1/13, staff have the opportunity to "task" themselves with reminders. Staff will be educated to utilize this function when they need reminders to follow-up on an unresolved patient issue. 10 random chart audits will be reviewed quarterly to determine if there is appropriate communication with the physician regarding the patient's care including medication clarity until 100% compliant. The Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	04/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013	
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710			
(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			
	<p>compliance with all medication is undetermined."</p> <p>A. Skilled nurse visit notes, signed and dated by employee J, a licensed practical nurse, on 9-12-12 and 9-14-12, state, "Medication notes: no medication changes." The record failed to evidence the RN had coordinated with the physician regarding the antibiotic.</p> <p>B. The record included a transfer comprehensive assessment, signed and dated by employee K, a registered nurse, on 9-18-12, that states, "No clinically significant medication issues identified since the previous OASIS assessment . . . Pt went to ER [emergency room] on 9-16-12 due to pain, redness, heat and increased edema in left foot. He was admitted to the hospital on 9-16-12 with infected left foot."</p> <p>C. The record included a discharge clinical note, signed and dated by employee F, the alternate supervising nurse, on 10-1-12 that states, "Patient discharged from the Skilled Nurse discipline on September 28, 2012. Reason for discipline discharge as follows: death."</p> <p>D. The supervising nurse, employee A, indicated, on 3-13-13 at 1:15 PM, the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>record did not include documentation the registered nurse had coordinated with the physician regarding the prescribed antibiotic. The nurse stated, "I would have expected to see some documentation that the nurse had checked on the antibiotic."</p> <p>2. The agency's 1-27-12 "Coordination of Care" policy number C-28 states, "Coordination of care is the direct responsibility of the Home Care or Hospice coordinator. The coordinator or designee with the cooperation and input from the case managers, referral RN, primary RN, primary Physical Therapist, IDG and Home Care/Hospice staff is responsible for the clinical management of the patients in Home Care/Hospice and reports directly to the Home Services clinical manager."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure clinical records included a discharge summary in 2 (#s 2 and 16) of 5 closed records reviewed creating the potential to affect all of the agency's future discharged patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient had been discharged from services on 3-5-13 per the physical therapist, employee M. The record failed to evidence a discharge summary had been completed.</p>	N000608	N 608 - The Home Care Manager in-serviced the staff on 3/26/13 and will repeat on 4/3/13. The LPN chart auditor will monitor that the patient's admission and status screen in the software system is updated by the discharging clinician to a discharged status which generates the patient discharge summary; implemented during the survey. The office assistants are automatically tasked (sent a communication) in the software system when the discharge status code is used by the clinician. The office assistants will monitor that each patient task (communication notification) received will have an accompanying discharge	04/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/13/2013
NAME OF PROVIDER OR SUPPLIER  DEACONESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 701 GARFIELD ST EVANSVILLE, IN 47710		
(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	
	<p>Employee L, the agency's quality improvement specialist, indicated, on 3-7-13 at 1:30 PM, the record did not evidence a discharge summary had been completed.</p> <p>2. Clinical record number 16 evidenced the patient had been discharged from services on 2-22-13. The record failed to evidence a discharge summary had been completed.</p> <p>Employee A, the supervising nurse, indicated, on 3-12-13 at 3:00 PM, a discharge summary had not been completed.</p> <p>4. The agency's 1-24-12 "Discharge Criteria - Home Care" policy number AC-37 states, "The patient's physician will be notified in writing of the patient's condition upon discharge from Home Care by sending the physician a summary of services provided while patient in Home Care."</p>		<p>summary for mailing. 10 discharge charts will be audited for the next quarterly compliance meeting scheduled for July 2013. Quarterly monitoring will occur until 100% compliance. The Home Care Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		