

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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 Federal home health recertification survey. This was an extended survey.</p> <p>Survey Dates: 3-12-14, 3-13-14, 3-14-14, and 3-17-14 Partial extended 3-12-13 Extended 3-14-14</p> <p>Facility #: 005354</p> <p>Medicaid Vendor #: 100264920A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Daviess Community Hospital Home Health is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 3-24-14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30 Skilled Nursing Services.</p> <p>The Administrator and the Supervising Nurse were informed of the above-stated preclusions at the exit conference held on 3-17-14 at 2:15 PM</p>	G000000	No response required.	
---------	--	---------	-----------------------	--

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: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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>Quality Review: Joyce Elder, MSN, BSN, RN March 24, 2014</p> <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 review and interview, the agency failed to ensure patients had been informed of the hours of operations of the toll-free hotline number established by the State and that the number could be used to lodge complaints regarding the implementation of the advanced directives requirements in 12 (#s 1 through 12) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical records numbered 1 through</p>	G000116	G116-The "Davieess Community Hospital Home Health Admission Agreement" has been updated to include the toll free Home Health agency hotline for the State of Indiana, the hours of ISDH operation, and that the purpose of the hotline is to recieve complaints or questions about local home care agencies. The form also states the patient has the right to use this hotline to lodge complaints concerning the implementation of the Advance Directives requirements. The Home Health Care Director or her designee will be responsible for monitoring to ensure compliance.	04/03/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>12 evidenced the patient or the caregiver had been provided with the agency's "Daviess Community Hospital Home Health Admissions Agreement" at the start of care. By signing the agreement, the patient or caregiver had acknowledged receipt of the agency's patient rights statement that included the toll-free hotline number established by the State.</p> <p>2. The agency's "Client/Family Rights and Responsibilities" statement failed to inform the patients of the hours of operation of the toll-free hotline number established by the State or that the hotline number could be used to lodge complaints regarding the implementation of the advance directives requirements.</p> <p>3. The Administrator stated, on 3-12-14 at 12:20 PM, "The hours of operation and the part about the advance directives is not there."</p> <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 agency policy review, observation, and interview, the agency</p>	G000121	G 121 - Infection Control Policies and Procedures will be reviewed and will reflect	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>failed to ensure its staff had followed the agency's own infection control policies while providing care to patients in 4 (patients # 2, 4, 5, and 6) of 6 home visit observations creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The agency's 08-09 "Infection Control" policy number 5 states, "Home health services staff members implement infection control procedure with regard to clients, staff, and their environment. Client infection control procedures include, but are not limited to, the following: . . . following universal precautions." The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand 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 . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, 		<p>cleaning and disinfection of multi-use electronic equipment. An inservice will be conducted by the Infection Control Manager to nursing staff on the agencies current infection control policies including, but not limited to, proper hand hygiene, proper use of sterile and nonsterile gloves, proper cleansing of equipment, and proper bathing of patients. This inservice will be completed by 4/15/14. Monitoring will be done by the infection control manager by evaluating five employees per month on an ongoing bases until 100% compliance is achieved for 90 days. The Director of Home Health Care Services and/or the Infection Control Manager or their designee will be responsible for monitoring for ongoing compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>mucous membranes, nonintact skin, or wound dressings. 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). 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, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>3. A home visit was completed on 3-13-14 at 9:25 AM to patient number 2 with employee E, a registered nurse (RN). The RN was observed to perform a sterile dressing change to a peripherally inserted central catheter</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>(PICC) on the patient's left lower arm. The RN cleaned her hands, opened dressing change packages, applied a face mask, and the donned sterile gloves without cleansing her hands. The RN removed the old dressing and her gloves and cleaned her hands. The RN was observed to don the right glove and touch the right glove with her bare left hand by intertwining the fingers of the left hand with the right hand in order to help don the right glove thus creating the potential for the transfer of disease causing organisms from the bare left hand to the sterile right glove.</p> <p>A. After completing the dressing change, the RN was observed to removed her gloves and cleanse her hands. The RN retrieved alcohol pads from the supply in the patient's home and donned clean gloves without cleansing her hands. The RN then changed the caps on the catheter limbs.</p> <p>B. The RN was observed to place a plastic sheath on a thermometer and insert it into the patient's mouth. The RN was observed to remove the thermometer from the patient's mouth and remove and discard the sheath from the thermometer without donning gloves.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>4. A home visit was completed on 3-13-14 at 10:15 AM to patient number 4 with employee G, a home health aide. The aide was observed to provide a shower bath to the patient. The aide was observed to place a plastic sheath on a thermometer and insert it into the patient's mouth. The aide was observed to remove the thermometer from the patient's mouth and remove and discard the sheath from the thermometer without donning gloves.</p> <p>A. The aide was observed to clean the thermometer, the blood pressure cuff, and a stethoscope with the same disinfectant wipe. The aide was observed to only partially clean the equipment, missing some surfaces of the equipment.</p> <p>B. The aide was observed to shave the patient and then remove the socks and shoes. Without cleansing her hands or donning clean gloves, the aide was observed to assist the patient to stand from the wheelchair and removed the pants and assist the patient to transfer to a shower bench.</p> <p>C. After assisting the patient to complete the shower down to the perineal area, the aide assisted the patient to stand in the shower. The aide</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>washed and rinsed the patient's buttocks and anal area. The aide then handed the same washcloth to the patient and the patient washed the front perineal area.</p> <p>D. The aide assisted the patient out of the shower and into the chair and assisted the patient to dry. The aide changed gloves without cleansing her hands. The aide then applied deodorant and lotion to the patient and assisted the patient to don a clean shirt and socks. The aide changed her gloves and failed to cleanse her hands after assisting the patient to complete the dressing process.</p> <p>5. A home visit was completed on 3-14-14 at 9:40 AM to patient number 5 with employee L, an RN. The RN was observed to complete a dressing change to the patient's right lower extremity. The RN was observed to reach into her pocket, after removing potentially contaminated gloves, 6 times to retrieve hand gel to cleanse her hands.</p> <p>A. The RN was observed to draw sterile water into syringes to irrigate the wound. The RN poured the sterile water and donned clean gloves without cleansing her hands.</p> <p>B. The RN was observed to apply Sencicare around the wound with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>un-gloved hands. The agency's undated "Topical Skin Drug Application" policy states, "Apply the medication to the affected area with long, smooth strokes that follow the direction of hair growth using your gloved hands."</p> <p>6. A home visit was completed on 3-14-14 at 12:05 PM to patient number 6 with employee D, an RN. The RN was observed to complete a dressing change to the patient's left lower extremity. The RN was observed to reach into her pocket 12 times to retrieve hand gel to cleanse her hands after removing potentially contaminated gloves.</p> <p>A. The RN was observed to retrieve syringes to prepare normal saline to irrigate the wound and open the packages. The RN donned clean gloves without cleansing her hands.</p> <p>B. The RN was observed to open packages of gauze and don clean gloves without cleansing her hands.</p> <p>C. The RN was observed to place a plastic sheath on a thermometer and insert it into the patient's mouth. The RN was observed to remove the thermometer from the patient's mouth and remove and discard the sheath from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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
G000153	<p>the thermometer without donning gloves.</p> <p>7. The above-stated observations were discussed with the administrator and the supervising nurse on 3-14-14 at 1:30 PM. The administrator and the supervising nurse agreed the observed practices were not in compliance with the agency's infection control policies.</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. Based on administrative record and agency policy review and interview, the agency failed to ensure the professional advisory group (PAG) had reviewed all of the required policies at least annually in 1 (2013) of 2 years reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p>	G000153	G-153 This policy will be reviewed by members of the Professional Advisory Group and any recommended changes will be made and approved at the 4/23/14 meeting. The Home Health Care Director or her designee will be responsible for monitoring to ensure all required policies are reviewed at least annually.	04/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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. The agency's administrative records failed to evidence the PAG had reviewed the agency's "Medical Supervision" policy during 2013. PAG meeting minutes, dated 1-15-13, 4-23-13, 10-15-13, and 1-28-14, failed to evidence the policy had been reviewed.</p> <p>2. The agency's PAG binder included a "Yearly Evaluation of Policies and Procedures PAC [professional advisory committee] List." The list included all of the policies the PAG is required to review on an annual basis. The list failed to evidence the "Medical Supervision" policy had been reviewed in 2013.</p> <p>3. The office manager, employee N, indicated, on 3-17-14 at 12:40 PM, the PAG meeting minutes did not evidence the "Medical Supervision" policy had been reviewed in 2013.</p> <p>4. The agency's 01/13 "Professional Advisory" policy number 10 states, "The Daviess Community Hospital Home Health maintains a professional advisory committee . . . The Committee: . . . establishes and annually reviews the policies and procedures governing: . . . medical supervision."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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	
G000156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to maintain compliance with this condition by failing to to ensure services and treatments had been provided in accordance with physician orders in 6 of 12 records reviewed creating the potential to affect all of the agency's 56 current patients (See G 158); by failing to ensure plans of care included all medications and services in 3 of 12 records reviewed creating the potential to affect all of the agency's 56 current patients (See G 159); by failing to ensure staff had alerted the physician to changes that suggested a need to alter the plan of care in 2 of 12 records reviewed creating the potential to affect all of the agency's 56 current patients (See G 164); and by failing to ensure treatments had been provided in accordance with physician orders in 5 of 12 records reviewed creating the potential to affect all of the agency's 56 current patients (See G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.18 Acceptance</p>	G000156	G156 - An in-service will be conducted by the Home health Care Director or her designee for all nursing staff to ensure the patient's plan of care will include all medications and services being provided to the patient. Will also in-service on the the need to notify the physician to changes that suggest a need to alter the plan of care for the patient. The in-service will also include that nursing will ensure treatments have been provided in accordance with physician orders. This in-service will be completed by 4/15/14. Ramdom chart audists will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>of Patients, Plan of Care, and Medical Supervision.</p> <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. Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician orders in 6 (#s 2, 4, 5, 9, 10, & 12) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient had a peripherally inserted central catheter (PICC) and included a supplemental order dated 2-25-14 that states, "SN [skilled nurse] Change occlusive dressing and injection caps weekly and PRN [as needed] if soiled or loose."</p> <p>A. The record included SN visit</p>	G000158	<p>G158 - An inservice will be conducted for the nursing staff by the Home Health Care Director or her designee on the provision of ensuring a written plan of care is established and periodically reviewed by the physician so that services and treatments have been provided in accordance with physician orders and documented accordingly.</p> <p>This inservice will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>notes that evidenced the PICC dressing change had been completed 2 times the week of 2-23-14, on 2-25-14 by employee B, a registered nurse (RN), and on 2-27-14 by employee E, a RN.</p> <p>B. The supervising nurse stated, on 3-14-14 at 3 PM, "The dressing was changed again on 2-27-14 because it was soiled. The visit note does not indicate the dressing needed to be changed."</p> <p>C. The agency's undated "Peripherally Inserted Central Catheter (PICC) Dressing Change" procedure states, "A peripherally inserted central catheter (PICC) dressing should be changed at least every 7 days if a transparent semipermeable dressing is used."</p> <p>2. Clinical record number 4 included a plan of care established by the physician for the certification period 2-28-14 to 4-28-14 that included diagnoses of "Abdominal pain . . . gastritis . . . abnormal weight loss." The plan of care states, "SN . . . weigh 1 X [one time per] week if patient able to stand safely."</p> <p>A. The record included a start of care comprehensive assessment dated 2-28-14 that identified "pt [patient] has right epigastric pain on and off and does</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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 eat well due to pain . . . pt has difficulty having bowel movements does go 1-2 weekly small amounts . . . appetite: poor . . . Hydration: Poor. Nutrition/Hydration Within Patient's Normal Limits: No . . . Meal Pattern: Bites only . . .Nutrition: Probably inadequate - Rarely eats a complete meal and generally only eats about 1/2 of any food offered." The assessment identifies the patient does walk "occasionally . . . but for very short distances, with or without assistance."</p> <p>The start of care comprehensive assessment failed to evidence the SN had obtained the patient's weight.</p> <p>B. SN visit notes, dated 3-3-14 and 3-10-14, failed to evidence the SN had obtained the patient's weight. The visit notes did not evidence the patient was unable to stand safely.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 1-30-14 to 3-30-14. The plan of care identified a wound on the right lower extremity. The plan of care states, "SN . . . Measure wounds for depth, width, length weekly."</p> <p>A. The record failed to evidence the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>SN had measured the wound since 2-19-14. The record evidenced SN visits had been made on 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14.</p> <p>The visit notes dated 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14 all state, "type: venous stasis ulcer, healing: healing by secondary intent . . . Incision / wound tissue observed: beefy red, surrounding tissue: intact . . . drainage: serous, drainage amount: moderate."</p> <p>B. The alternate supervising nurse stated, on 3-14-14 at 2:55 PM, "There are no measurements [after 2-19-14]. It [the plan of care] does say weekly."</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 1-23-14 to 3-23-14 that identified a diagnosis of congestive heart failure. The plan of care states, "SN . . . Weigh weekly."</p> <p>A. The record failed to evidence a weight had been obtained at start of care or the weeks of 1-27-14 or 2-7-14.</p> <p>B. The record included a transfer comprehensive assessment that states, "Patient was sent to hospital by [name]"</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>at Wound Care Clinic."</p> <p>5. Clinical record number 10 included a SN visit note dated 2-3-14 that states, "cup left for pcg [patient care giver] to acquire urine sample, will pick up when done." The record included urine culture laboratory results dated 2-3-14.</p> <p>A. The record failed to evidence an order for the urine culture.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 3:10 PM.</p> <p>6. Clinical record number 12, start of care 10-31-13, included home health aide visit notes dated 2-28-14, 3-3-14, 3-5-14, and 3-7-14. The record failed to evidence orders for the home health aide services.</p> <p>The supervising nurse indicated, on 3-14-14 at 3:55 PM, the record did not include orders for the home health aide services. The nurse stated, "There are no verbal recertification orders in the record."</p> <p>7. The agency's 01/10 "Physician Orders Cert./Re-certification" policy number 9 states, "Daviss Community</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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	
G000159	<p>Hospital Home Health is furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the client's condition and to ensure that services are medically required . . . When using verbal orders for re-certification, document the physician contact in the record, noting that the entire plan was reviewed with the physician."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all medications and services in 3 (#s 1, 6, and 11) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a</p>	G000159	<p>G159 - Nursing staff will be in-serviced by the Home Health Care director or her designee to ensure the patient's plan of care will include all medications and services being provided to the patient.</p> <p>This inservice will be completed by 4/15/14 Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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>physical therapy assistant note dated 3-6-14 that states, "Pt [patient] stated had an anxiety attack [sic] last night. Had to take mild medication to calm down." The plan of care failed to include any anti-anxiety medications.</p> <p>The supervising nurse indicated, on 3-14-14 at 3 PM, the plan of care did not include any anti-anxiety medications.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 1-15-14 to 3-15-15. The plan of care states, "Open Wound Knee/Leg Complicat [complications] Open Wound of Foot." The plan of care included orders for the wound care but failed to specify on which leg/knee/foot the wound care had been ordered.</p> <p>3. Clinical record number 11 included a plan of care established by the physician for the certification period 3-8-14 to 5-6-14 that states, "SN [skilled nurse] Assess for side effects of medications and eval [evaluate] for polypharmacy along with high risk and use and S/S [signs and symptoms] of complications to report @ [at] SOC [start of care]."</p> <p>A. The plan of care failed to include frequency of visits for the SN services.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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 stated, on 3-14-14 at 3:30 PM, "It [the SN services] is not supposed to be on there, no need for SN services.</p> <p>C. The record included a recertification comprehensive assessment dated 3-11-14 that states, "Patient receives HH [home health] & Private OT [occupational therapy] & PT [physical therapy] as well as homemaker services from another company."</p> <p>1.) The plan of care failed to include the other services being provided from another company.</p> <p>2.) The supervising nurse stated, on 3-14-14 at 3:30 PM, "They are not there [on the plan of care]."</p> <p>4. The agency's 01/10 "Physician Orders Cert./Re-certification" policy number 9 states, "The client plan of care: . . . includes the following: . . . Medications: dose / frequency /route / (N) new / (C) changed . . . orders for discipline and treatments (specify amount / frequency / duration)."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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			
G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure staff had alerted the physician to changes that suggested a need to alter the plan of care in 2 (#s 1 and 4) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 included a physical therapy assistant (PTA) note, co-signed by the physical therapist, employee K, dated 3-6-14. The note states, "Pt [patient] stated had an anxiety attack [sic] last night. Had to take mild medication to calm down." <ul style="list-style-type: none"> A. The clinical record failed to evidence the physical therapist had informed the physician of the patient's anxiety and need for medication. B. The plan of care for the certification period 2-25-14 to 4-25-14 did not include any anxiety medications. Clinical record number 4 included a 	G000164	<p>G164 - Nursing staff will be in-serviced by the Home Health Care Director or her designee on the need to notify the physician to changes that suggest a need to alter the plan of care for the patient. This inservice will be completed by 4/15/14. Random Chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>physical therapy assistant note dated 3-12-14 that states, "Pt [patient] refused Rx [treatment] this date due to [not] feeling well. c/o [complaint of] upset stomach & passing out frequently. Family reports pt fell this AM coming out of BR [bathroom]. Also states hands & arms have began tremoring @ times. Will report this to HH [home health] nurse."</p> <p>A. The record included a "Charts/Clinical Note", signed and dated by employee E, a registered nurse (RN), on 3-12-14 that states, "1500 Received a message from [employee J, the PTA] that pt had fallen this am and struck his head, was in bed asleep all yesterday and did not do therapy today. Instructed [PTA] RN will call pcg [patient care giver]. 1600 Pcg called and inquired about fall. Fell on the way to the bathroom, struck back of head has a goose egg, and a bruise. Asked how pt's pain level is was instructed pain is bad, instructed pcg to take pt to ER for further evaluation. Pcg refused stating, 'They never help him.' Instructed if pt gets worse to please take to ER and keep Home Health informed."</p> <p>B. The record failed to evidence the RN had informed the physician of the patient's fall, the "bad" pain level, the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>"goose egg and bruise" and the "tremoring" reported by the PTA.</p> <p>C. Employee E, the RN, stated, on 3-13-14 at 2:40 PM, "I did not call the physician. I called the family & requested they take him to the ER. They refused."</p> <p>D. A home visit was made to patient number 4 on 3-13-14 at 1 PM with employee M, the occupational therapist (OT). Upon arrival the therapist assisted the patient to sit on the side of the bed. The patient was observed to begin shaking uncontrollably with seizure-like activity. The OT assisted the patient to lie down and the shaking stopped.</p> <p>E. The administrator indicated, on 3-13-14 at 3 PM, the patient's family had transported the patient to the hospital and the patient had been admitted.</p> <p>3. The agency's 03/06 "Client/Home Health Care Visit Protocol for Staff Nurses" policy number 2 states, "Staff Nurse: . . . notifies physician of change in condition."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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	
G000165	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and agency policy review and interview, the agency failed to ensure treatments had been provided in accordance with physician orders in 5 (#s 2, 4, 5, 9, & 10) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 evidenced the patient had a peripherally inserted central catheter (PICC) and included a supplemental order dated 2-25-14 that states, "SN [skilled nurse] Change occlusive dressing and injection caps weekly and PRN [as needed] if soiled or loose." <ul style="list-style-type: none"> A. The record included SN visit notes that evidenced the PICC dressing change had been completed 2 times the week of 2-23-14, on 2-25-14 by employee B, a registered nurse (RN), and on 2-27-14 by employee E, a RN. B. The supervising nurse stated, on 3-14-14 at 3 PM, "The dressing was 	G000165	<p>G165 - An inservice for nursing staff will be completed by the Home Health Director or her designee on the follow-up of the medical plan of care to ensure nursing services and treatments provided by a RN or LPN have been provided in accordance with physician orders.</p> <p>This inservice will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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>changed again on 2-27-14 because it was soiled. The visit note does not indicate the dressing needed to be changed."</p> <p>C. The agency's undated "Peripherally Inserted Central Catheter (PICC) Dressing Change" procedure states, "A peripherally inserted central catheter (PICC) dressing should be changed at least every 7 days if a transparent semipermeable dressing is used."</p> <p>2. Clinical record number 4 included a plan of care established by the physician for the certification period 2-28-14 to 4-28-14 that included diagnoses of "Abdominal pain . . . gastritis . . . abnormal weight loss." The plan of care states, "SN . . . weigh 1 X [one time per] week if patient able to stand safely."</p> <p>A. The record included a start of care comprehensive assessment dated 2-28-14 that identified "pt [patient] has right epigastric pain on and off and does not eat well due to pain . . . pt has difficulty having bowel movements does go 1-2 weekly small amounts . . . appetite: poor . . . Hydration: Poor. Nutrition/Hydration Within Patient's Normal Limits: No . . . Meal Pattern: Bites only . . . Nutrition: Probably inadequate - Rarely eats a complete meal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>and generally only eats about 1/2 of any food offered." The assessment identifies the patient does walk "occasionally . . . but for very short distances, with or without assistance."</p> <p>The start of care comprehensive assessment failed to evidence the SN had obtained the patient's weight.</p> <p>B. SN visit notes, dated 3-3-14 and 3-10-14, failed to evidence the SN had obtained the patient's weight. The visit notes did not evidence the patient was unable to stand safely.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 1-30-14 to 3-30-14. The plan of care identified a wound on the right lower extremity. The plan of care states, "SN . . . Measure wounds for depth, width, length weekly."</p> <p>A. The record failed to evidence the SN had measured the wound since 2-19-14. The record evidenced SN visits had been made on 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14.</p> <p>The visit notes dated 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>3-5-14, and 3-9-14 all state, "type: venous stasis ulcer, healing: healing by secondary intent . . . Incision / wound tissue observed: beefy red, surrounding tissue: intact . . . drainage: serous, drainage amount: moderate."</p> <p>B. The alternate supervising nurse stated, on 3-14-14 at 2:55 PM, "There are no measurements [after 2-19-14]. It [the plan of care] does say weekly."</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 1-23-14 to 3-23-14 that identified a diagnosis of congestive heart failure. The plan of care states, "SN . . . Weigh weekly."</p> <p>A. The record failed to evidence a weight had been obtained at start of care or the weeks of 1-27-14 or 2-7-14.</p> <p>B. The record included a transfer comprehensive assessment that states, "Patient was sent to hospital by [name] at Wound Care Clinic."</p> <p>5. Clinical record number 10 included a SN visit note dated 2-3-14 that states, "cup left for ppg [patient care giver] to acquire urine sample, will pick up when done." The record included urine culture laboratory results dated 2-3-14.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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			
G000168	<p>A. The record failed to evidence an order for the urine culture.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 3:10 PM.</p> <p>6. The agency's 01/10 "Physician Orders Cert./Re-certification" policy number 9 states, "Davieess Community Hospital Home Health is furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the client's condition and to ensure that services are medically required . . . When using verbal orders for re-certification, document the physician contact in the record, noting that the entire plan was reviewed with the physician."</p> <p>484.30 SKILLED NURSING SERVICES Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure nursing services and treatments had been</p>	G000168	<p>G168 - An inservice for nursing staff will be completed by the Home Health Director or her designee on the follow-up of the medical plan of care to ensure nursing services and treatments provided by a RN or LPN have been provided in accordance with physician orders.</p>	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>provided in accordance with physician orders in 5 of 12 records reviewed creating the potential to affect all of the agency's 56 current patients (See G 170); by failing to ensure the registered nurse had initiated interventions to address identified nursing needs in 1 of 12 records reviewed creating the potential to affect all of the agency's 56 current patients; and by failing to ensure the registered nurse had alerted the physician to changes that suggested a need to alter the plan of care in 1 of 12 records reviewed creating the potential to affect all of the agency's 56 current patients (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this conditions, 42 CFR 484.30 Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES 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 nursing services and treatments had been provided in</p>	G000170	<p>This inservice will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p> <p>G170 - An in-service for nursing staff will be completed by the Home Health Director or her designee on the follow-up of the medical plan of care to ensure nursing services and treatments provided by a RN</p>	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>accordance with physician orders in 5 (#s 2, 4, 5, 9, & 10) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient had a peripherally inserted central catheter (PICC) and included a supplemental order dated 2-25-14 that states, "SN [skilled nurse] Change occlusive dressing and injection caps weekly and PRN [as needed] if soiled or loose."</p> <p>A. The record included SN visit notes that evidenced the PICC dressing change had been completed 2 times the week of 2-23-14, on 2-25-14 by employee B, a registered nurse (RN), and on 2-27-14 by employee E, a RN.</p> <p>B. The supervising nurse stated, on 3-14-14 at 3 PM, "The dressing was changed again on 2-27-14 because it was soiled. The visit note does not indicate the dressing needed to be changed."</p> <p>C. The agency's undated "Peripherally Inserted Central Catheter (PICC) Dressing Change" procedure states, "A peripherally inserted central catheter (PICC) dressing should be</p>		<p>or LPN have been provided in accordance with physician orders.</p> <p>This inservice will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>changed at least every 7 days if a transparent semipermeable dressing is used."</p> <p>2. Clinical record number 4 included a plan of care established by the physician for the certification period 2-28-14 to 4-28-14 that included diagnoses of "Abdominal pain . . . gastritis . . . abnormal weight loss." The plan of care states, "SN . . . weigh 1 X [one time per] week if patient able to stand safely."</p> <p>A. The record included a start of care comprehensive assessment dated 2-28-14 that identified "pt [patient] has right epigastric pain on and off and does not eat well due to pain . . . pt has difficulty having bowel movements does go 1-2 weekly small amounts . . . appetite: poor . . . Hydration: Poor. Nutrition/Hydration Within Patient's Normal Limits: No . . . Meal Pattern: Bites only . . . Nutrition: Probably inadequate - Rarely eats a complete meal and generally only eats about 1/2 of any food offered." The assessment identifies the patient does walk "occasionally . . . but for very short distances, with or without assistance."</p> <p>The start of care comprehensive assessment failed to evidence the SN had obtained the patient's weight.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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. SN visit notes, dated 3-3-14 and 3-10-14, failed to evidence the SN had obtained the patient's weight. The visit notes did not evidence the patient was unable to stand safely.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 1-30-14 to 3-30-14. The plan of care identified a wound on the right lower extremity. The plan of care states, "SN . . . Measure wounds for depth, width, length weekly."</p> <p>A. The record failed to evidence the SN had measured the wound since 2-19-14. The record evidenced SN visits had been made on 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14.</p> <p>The visit notes dated 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14 all state, "type: venous stasis ulcer, healing: healing by secondary intent . . . Incision / wound tissue observed: beefy red, surrounding tissue: intact . . . drainage: serous, drainage amount: moderate."</p> <p>B. The alternate supervising nurse stated, on 3-14-14 at 2:55 PM, "There</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>are no measurements [after 2-19-14]. It [the plan of care] does say weekly."</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 1-23-14 to 3-23-14 that identified a diagnosis of congestive heart failure. The plan of care states, "SN . . . Weigh weekly."</p> <p>A. The record failed to evidence a weight had been obtained at start of care or the weeks of 1-27-14 or 2-7-14.</p> <p>B. The record included a transfer comprehensive assessment that states, "Patient was sent to hospital by [name] at Wound Care Clinic."</p> <p>5. Clinical record number 10 included a SN visit note dated 2-3-14 that states, "cup left for pcg [patient care giver] to acquire urine sample, will pick up when done." The record included urine culture laboratory results dated 2-3-14.</p> <p>A. The record failed to evidence an order for the urine culture.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 3:10 PM.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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			
G000175	<p>6. The agency's 02/06 "Skilled Nursing Services" policy number 13A states, "Skilled Nursing services are provided by or under the supervision of a registered nurse and in accordance with the physician's plan of treatment outlining client's plan of care."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified nursing needs in 1 (# 7) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 7 included a start of care comprehensive assessment dated 10-24-13 that identified a diagnosis of "Digestive Neoplasm." The assessment evidenced the patient had a "poor appetite", "fair hydration", ate "small frequent meals" and used nutritional supplements two times per day. The assessment states, "Nutrition / hydration within patient's normal limits: No."</p>	G000175	<p>G175 - An in-service will be provided for all nursing staff by the Home Health Care Director or her designee to ensure appropriate preventive and rehabilitative nursing interventions have been initiated for all patients.</p> <p>This inservice will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>The record failed to evidence the RN had initiated any nursing interventions or procedures to address the identified alteration in nutritional status.</p> <p>2. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 2 PM.</p> <p>3. The agency's 02/06 "Skilled Nursing Services" policy number 13A states, "The duties of the registered nurse include the following, but may not be limited to: . . . Initiating appropriate preventative and rehabilitative nursing procedures."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE 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. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure the registered nurse (RN) had alerted the physician to changes that suggested a need to alter the plan of care in 1 (# 4) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p>	G000176	<p>G176 - An in-service will be provided for all nursing staff by the Home Health Care Director or her designee on the need to inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs and supervise and teach other nursing personnel.</p> <p>This in-service will be completed by 4/15/14.</p>	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>The findings include:</p> <p>1. Clinical record number 4 included a physical therapy assistant (PTA) note dated 3-12-14 that states, "Pt [patient] refused Rx [treatment] this date due to [not] feeling well. c/o [complaint of] upset stomach & passing out frequently. Family reports pt fell this AM coming out of BR [bathroom]. Also states hands & arms have began tremoring @ times. Will report this to HH [home health] nurse."</p> <p>A. The record included a "Charts / Clinical Note", signed and dated by employee E, a registered nurse (RN), on 3-12-14 that states, "1500 Received a message from [employee J, the PTA] that pt had fallen this am and struck his head, was in bed asleep all yesterday and did not do therapy today. Instructed [PTA] RN will call pcg [patient care giver]. 1600 Pcg called and inquired about fall. Fell on the way to the bathroom, struck back of head has a goose egg, and a bruise. Asked how pt's pain level is was instructed pain is bad, instructed pcg to take pt to ER for further evaluation. Pcg refused stating, 'They never help him.' Instructed if pt gets worse to please take to ER and keep Home Health informed."</p>		<p>Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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 record failed to evidence the RN had informed the physician of the patient's fall, the "bad" pain level, the "goose egg and bruise" and the "tremoring" reported by the PTA.</p> <p>C. Employee E, the RN, stated, on 3-13-14 at 2:40 PM, "I did not call the physician. I called the family & requested they take him to the ER. They refused."</p> <p>D. A home visit was made to patient number 4 on 3-13-14 at 1 PM with employee M, the occupational therapist (OT). Upon arrival the therapist assisted the patient to sit on the side of the bed. The patient was observed to begin shaking uncontrollably with seizure-like activity. The OT assisted the patient to lie down and the shaking stopped.</p> <p>E. The administrator indicated, on 3-13-14 at 3 PM, the patient's family had transported the patient to the hospital and the patient had been admitted.</p> <p>2. The agency's 02/06 "Skilled Nursing Services" policy number 13A states, "The duties of the registered nurse include the following, but may not be limited to: . . . Informing physicians and home health care staff and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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
G000186	<p>interdisciplinary team members of changes in client condition and needs."</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on clinical record and agency policy review and interview, the agency failed to ensure the qualified physical therapist had consulted with the physician regarding the discontinuation of therapy services in 1 (#10) of 6 records reviewed of patients that received physical therapy (PT) services creating the potential to affect all of the agency's 33 current patients that receive PT services.</p> <p>The findings include:</p> <p>1. Clinical record number 10 included a plan of care established by the physician for the certification period 1-16-14 to 3-16-14 that identified physical therapy services were to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, and 1 time per week for 2 weeks. The record failed to evidence the physical therapist had assessed the patient and consulted with the physician</p>			G000186	<p>G186 - An in-service will be conducted with therapy staff by the Home Health Care Director or her designee. This inservice will address that the appropriate therapist will consult with the physician in evaluating the patient's level of function as related to the need for the continuing or discontinuing of therapy services.</p> <p>This in-service will be completed by 4/15/14 Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance</p>		04/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>regarding discharge from physical therapy services.</p> <p>A. The record included a visit note, signed and dated by the physical therapy assistant, employee J, on 2-11-14, that states, "Client's status discussed with [employee K], PT, per phone/direct contact. Plan: Continue home-based PT interventions as established within initial PT plan of care." The note was co-signed by the physical therapist, employee K.</p> <p>B. The record included a "Progress Notes Addendum", signed and dated by the physical therapist, employee K, on 2-11-14, that states, "D/C [discharge] summary: S: See subjective from daily note 2-11-14 O: See objective from daily note 2-11-14 A: All Goals met. P: D/C HH [at] this time."</p> <p>2. The Supervising Nurse stated, on 3-17-14 at 11:05 AM, "The physical therapist did not make a visit to the patient on 2-11-14.</p> <p>3. The agency's 02-06 "Physical Therapy Services" policy number 13C states, "The duties of the physical therapist includes the following but are not limited to: Assisting the physician in evaluating the client's functional</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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	
G000335	<p>status."</p> <p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments were complete and accurately reflected the patient's status in 3 (#s 4, 7, & 9) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included a start of care comprehensive assessment completed by employee E, a registered nurse (RN), on 2-28-14. The assessment failed to evidence the patient's ability to perform activities of daily living (bathing, dressing, toileting, etc) and instrumental activities of daily living (meal preparation, laundry, cleaning,</p>	G000335	G335 - An in-service will be conducted with the nursing staff by the Home Health Care Director or her designee to ensure registered nurses are completeing the full comprehensive assessment which includes Daily Living and Instrumental Activities of Daily Living Assesment on every pateint. For Medicare patients the registered nurse will complete full comprehensive assessment which includes Daily Living and Instrumental Activities of Daily Living Assessment as well as determine eligibility for the Medicare Home Health benefit, including homebound status. This in-service will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>etc.).</p> <p>2. Clinical record number 7 included a start of care comprehensive assessment completed by employee E, a RN, on 10-24-13. The assessment identified a diagnosis of "Digestive Neoplasm", that the patient had a "poor" appetite, "fair" hydration, and "Nutrition/hydration within patient's normal limits: No." The assessment identified the patient uses nutritional supplements two times per day.</p> <p>The assessment failed to include the patient's weight or if the patient had any weight loss.</p> <p>3. Clinical record number 9 included a start of care comprehensive assessment completed by employee D, a RN, on 1-23-14. The assessment included a diagnosis of congestive heart failure. The assessment failed to include nursing interventions related to fluid volume excess. The assessment failed to include the patient's weight.</p> <p>4. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 1:40 PM.</p> <p>5. The agency's 01/10 "Comprehensive</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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
G000339	<p>Assessment" policy number 13 states, "The comprehensive assessment includes screening criteria related to but not limited to: nutrition . . . functional ability . . . Assessment data includes but not limited to . . . the patient's functional status (for example, current level of functioning, self-care, independence) . . . any other relevant information that may affect the patient's goals."</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record and agency policy review and interview, the agency failed to ensure the comprehensive assessment had been updated the last 5 days of every 60 days in 2 (#s 11 and 12) of 4 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 11, start of</p>	G000339	G339 - An in-service will be conducted by the Home Health Care Director or her designee covering information that the comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer, or significant change in condition resulting in a new case mix assessment; or discharge and return to the same Home Health Agency during the 60 day episode. This in-service will be	04/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPITAL WASHINGTON, IN 47501		
(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>care 1-7-14, evidenced the physician had ordered that speech language pathology services be continued through the 2nd certification period, 3-8-14 to 5-6-14. The record evidenced the comprehensive assessment had not been updated until 3-11-14, 3 days after the start of the 2nd recertification period.</p> <p>2. Clinical record number 12, start of care 10-31-13, evidenced home health aide services were to be continued through the certification period 12-30-13 to 2-27-14. The record evidenced the comprehensive assessment had not been updated until 12-31-13, 1 day after the start of the recertification period.</p> <p>3. The supervising nurse was unable to provide any additional documentation when asked on 3-14-14 at 4 PM.</p> <p>4. The agency's 01/10 "Comprehensive Assessment" policy number 13 states, "The periodic comprehensive assessment will [be completed] within 5 days prior to through date of PPOT [physician's plan of treatment] for re-certification."</p> <p>This was a State home health re-licensure survey.</p>	N000000	<p>completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p> <p>No response required.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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>Survey Dates: 3-12-14, 3-13-14, 3-14-14, and 3-17-14</p> <p>Facility #: 005354</p> <p>Medicaid Vendor #: 100264920A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 24, 2014</p> <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 agency policy review, observation, and interview, the agency failed to ensure its staff had followed the agency's own infection control policies while providing care to patients in 4 (patients # 2, 4, 5, and 6) of 6 home visit observations creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. The agency's 08-09 "Infection Control" policy number 5 states, "Home</p>	N000470	<p>N 470 – An in-service will be conducted by the Infection Control Manager to nursing staff on the agencies current infection control policies including, but not limited to, proper hand hygiene, proper use of sterile and non-sterile gloves, proper cleansing of equipment, and proper bathing of patients.</p> <p>This in-service will be completed by 4/15/14.</p> <p>Monitoring will be done by the infection control manager by evaluating five employees per month on an ongoing basis until 100% compliance is achieved for 90 days.</p> <p>The Director of Home Health</p>	04/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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>health services staff members implement infection control procedure with regard to clients, staff, and their environment. Client infection control procedures include, but are not limited to, the following: . . . following universal precautions."</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 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 . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. 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). 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</p>		<p>Care Services and/or the Infection Control Manager or their designee will be responsible for monitoring for ongoing compliance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>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, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>3. A home visit was completed on 3-13-14 at 9:25 AM to patient number 2 with employee E, a registered nurse (RN). The RN was observed to perform a sterile dressing change to a peripherally inserted central catheter (PICC) on the patient's left lower arm. The RN cleaned her hands, opened dressing change packages, applied a face mask, and the donned sterile gloves without cleansing her hands. The RN removed the old dressing and her gloves and cleaned her hands. The RN was observed to don the right glove and touch the right glove with her bare left hand by intertwining the fingers of the left hand with the right hand in order to help don the right glove thus creating the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>potential for the transfer of disease causing organisms from the bare left hand to the sterile right glove.</p> <p>A. After completing the dressing change, the RN was observed to removed her gloves and cleanse her hands. The RN retrieved alcohol pads from the supply in the patient's home and donned clean gloves without cleansing her hands. The RN then changed the caps on the catheter limbs.</p> <p>B. The RN was observed to place a plastic sheath on a thermometer and insert it into the patient's mouth. The RN was observed to remove the thermometer from the patient's mouth and remove and discard the sheath from the thermometer without donning gloves.</p> <p>4. A home visit was completed on 3-13-14 at 10:15 AM to patient number 4 with employee G, a home health aide. The aide was observed to provide a shower bath to the patient. The aide was observed to place a plastic sheath on a thermometer and insert it into the patient's mouth. The aide was observed to remove the thermometer from the patient's mouth and remove and discard the sheath from the thermometer without donning gloves.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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 aide was observed to clean the thermometer, the blood pressure cuff, and a stethoscope with the same disinfectant wipe. The aide was observed to only partially clean the equipment, missing some surfaces of the equipment.</p> <p>B. The aide was observed to shave the patient and then remove the socks and shoes. Without cleansing her hands or donning clean gloves, the aide was observed to assist the patient to stand from the wheelchair and removed the pants and assist the patient to transfer to a shower bench.</p> <p>C. After assisting the patient to complete the shower down to the perineal area, the aide assisted the patient to stand in the shower. The aide washed and rinsed the patient's buttocks and anal area. The aide then handed the same washcloth to the patient and the patient washed the front perineal area.</p> <p>D. The aide assisted the patient out of the shower and into the chair and assisted the patient to dry. The aide changed gloves without cleansing her hands. The aide then applied deodorant and lotion to the patient and assisted the patient to don a clean shirt and socks.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>The aide changed her gloves and failed to cleanse her hands after assisting the patient to complete the dressing process.</p> <p>5. A home visit was completed on 3-14-14 at 9:40 AM to patient number 5 with employee L, an RN. The RN was observed to complete a dressing change to the patient's right lower extremity. The RN was observed to reach into her pocket, after removing potentially contaminated gloves, 6 times to retrieve hand gel to cleanse her hands.</p> <p>A. The RN was observed to draw sterile water into syringes to irrigate the wound. The RN poured the sterile water and donned clean gloves without cleansing her hands.</p> <p>B. The RN was observed to apply Senticare around the wound with un-gloved hands. The agency's undated "Topical Skin Drug Application" policy states, "Apply the medication to the affected area with long, smooth strokes that follow the direction of hair growth using your gloved hands."</p> <p>6. A home visit was completed on 3-14-14 at 12:05 PM to patient number 6 with employee D, an RN. The RN was observed to complete a dressing change to the patient's left lower</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>extremity. The RN was observed to reach into her pocket 12 times to retrieve hand gel to cleanse her hands after removing potentially contaminated gloves.</p> <p>A. The RN was observed to retrieve syringes to prepare normal saline to irrigate the wound and open the packages. The RN donned clean gloves without cleansing her hands.</p> <p>B. The RN was observed to open packages of gauze and don clean gloves without cleansing her hands.</p> <p>C. The RN was observed to place a plastic sheath on a thermometer and insert it into the patient's mouth. The RN was observed to remove the thermometer from the patient's mouth and remove and discard the sheath from the thermometer without donning gloves.</p> <p>7. The above-stated observations were discussed with the administrator and the supervising nurse on 3-14-14 at 1:30 PM. The administrator and the supervising nurse agreed the observed practices were not in compliance with the agency's infection control policies.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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 in accordance with physician orders in 6 (#s 2, 4, 5, 9, 10, & 12) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient had a peripherally inserted central catheter (PICC) and included a supplemental order dated 2-25-14 that states, "SN [skilled nurse] Change occlusive dressing and injection caps weekly and PRN [as needed] if soiled or loose."</p> <p>A. The record included SN visit notes that evidenced the PICC dressing change had been completed 2 times the week of 2-23-14, on 2-25-14 by employee B, a registered nurse (RN), and on 2-27-14 by employee E, a RN.</p>	N000522	<p>N 522 – An in-service will be conducted for the nursing staff by the Home Health Care Director or her designee on the provision of ensuring a written plan of care is established and periodically reviewed by the physician so that services and treatments have been provided in accordance with physician orders and documented accordingly.</p> <p>This in-service will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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 stated, on 3-14-14 at 3 PM, "The dressing was changed again on 2-27-14 because it was soiled. The visit note does not indicate the dressing needed to be changed."</p> <p>C. The agency's undated "Peripherally Inserted Central Catheter (PICC) Dressing Change" procedure states, "A peripherally inserted central catheter (PICC) dressing should be changed at least every 7 days if a transparent semipermeable dressing is used."</p> <p>2. Clinical record number 4 included a plan of care established by the physician for the certification period 2-28-14 to 4-28-14 that included diagnoses of "Abdominal pain . . . gastritis . . . abnormal weight loss." The plan of care states, "SN . . . weigh 1 X [one time per] week if patient able to stand safely."</p> <p>A. The record included a start of care comprehensive assessment dated 2-28-14 that identified "pt [patient] has right epigastric pain on and off and does not eat well due to pain . . . pt has difficulty having bowel movements does go 1-2 weekly small amounts . . . appetite: poor . . . Hydration: Poor. Nutrition/Hydration Within Patient's Normal Limits: No . . . Meal Pattern:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>Bites only . . .Nutrition: Probably inadequate - Rarely eats a complete meal and generally only eats about 1/2 of any food offered." The assessment identifies the patient does walk "occasionally . . . but for very short distances, with or without assistance."</p> <p>The start of care comprehensive assessment failed to evidence the SN had obtained the patient's weight.</p> <p>B. SN visit notes, dated 3-3-14 and 3-10-14, failed to evidence the SN had obtained the patient's weight. The visit notes did not evidence the patient was unable to stand safely.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 1-30-14 to 3-30-14. The plan of care identified a wound on the right lower extremity. The plan of care states, "SN . . . Measure wounds for depth, width, length weekly."</p> <p>A. The record failed to evidence the SN had measured the wound since 2-19-14. The record evidenced SN visits had been made on 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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>The visit notes dated 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14 all state, "type: venous stasis ulcer, healing: healing by secondary intent . . . Incision / wound tissue observed: beefy red, surrounding tissue: intact . . . drainage: serous, drainage amount: moderate."</p> <p>B. The alternate supervising nurse stated, on 3-14-14 at 2:55 PM, "There are no measurements [after 2-19-14]. It [the plan of care] does say weekly."</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 1-23-14 to 3-23-14 that identified a diagnosis of congestive heart failure. The plan of care states, "SN . . . Weigh weekly."</p> <p>A. The record failed to evidence a weight had been obtained at start of care or the weeks of 1-27-14 or 2-7-14.</p> <p>B. The record included a transfer comprehensive assessment that states, "Patient was sent to hospital by [name] at Wound Care Clinic."</p> <p>5. Clinical record number 10 included a SN visit note dated 2-3-14 that states, "cup left for pcg [patient care giver] to acquire urine sample, will pick up when</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>done." The record included urine culture laboratory results dated 2-3-14.</p> <p>A. The record failed to evidence an order for the urine culture.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 3:10 PM.</p> <p>6. Clinical record number 12, start of care 10-31-13, included home health aide visit notes dated 2-28-14, 3-3-14, 3-5-14, and 3-7-14. The record failed to evidence orders for the home health aide services.</p> <p>The supervising nurse indicated, on 3-14-14 at 3:55 PM, the record did not include orders for the home health aide services. The nurse stated, "There are no verbal recertification orders in the record."</p> <p>7. The agency's 01/10 "Physician Orders Cert./Re-certification" policy number 9 states, "Daviess Community Hospital Home Health is furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the services to the client's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>condition and to ensure that services are medically required . . . When using verbal orders for re-certification, document the physician contact in the record, noting that the entire plan was reviewed with the physician."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all medications and services in 3 (#s 1,</p>	N000524	N524 – Nursing staff will be in-serviced by the Home Health Care director or her designee to ensure the patient’s plan of care will include all medications and services being provided to the patient.	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>6, and 11) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a physical therapy assistant note dated 3-6-14 that states, "Pt [patient] stated had an anxiety attack [sic] last night. Had to take mild medication to calm down." The plan of care failed to include any anti-anxiety medications. The supervising nurse indicated, on 3-14-14 at 3 PM, the plan of care did not include any anti-anxiety medications. 2. Clinical record number 6 included a plan of care established by the physician for the certification period 1-15-14 to 3-15-15. The plan of care states, "Open Wound Knee/Leg Complicat [complications] . . . Open Wound of Foot." The plan of care included orders for the wound care but failed to specify on which leg/knee/foot the wound care had been ordered. 3. Clinical record number 11 included a plan of care established by the physician for the certification period 3-8-14 to 5-6-14 that states, "SN [skilled nurse] Assess for side effects of medications 		<p>This in-service will be completed by 4/15/14</p> <p>Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>and eval [evaluate] for polypharmacy along with high risk and use and S/S [signs and symptoms] of complications to report @ [at] SOC [start of care]."</p> <p>A. The plan of care failed to include frequency of visits for the SN services.</p> <p>B. The supervising nurse stated, on 3-14-14 at 3:30 PM, "It [the SN services] is not supposed to be on there, no need for SN services.</p> <p>C. The record included a recertification comprehensive assessment dated 3-11-14 that states, "Patient receives HH [home health] & Private OT [occupational therapy] & PT [physical therapy] as well as homemaker services from another company."</p> <p>1.) The plan of care failed to include the other services being provided from another company.</p> <p>2.) The supervising nurse stated, on 3-14-14 at 3:30 PM, "They are not there [on the plan of care]."</p> <p>4. The agency's 01/10 "Physician Orders Cert./Re-certification" policy number 9 states, "The client plan of care: . . . includes the following: . . . Medications: dose / frequency /route /</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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			
N000527	<p>(N) new / (C) changed . . . orders for discipline and treatments (specify amount / frequency / duration)."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure staff had alerted the physician to changes that suggested a need to alter the plan of care in 2 (#s 1 and 4) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a physical therapy assistant (PTA) note, co-signed by the physical therapist, employee K, dated 3-6-14. The note states, "Pt [patient] stated had an anxiety attack [sic] last night. Had to take mild medication to calm down."</p> <p>A. The clinical record failed to evidence the physical therapist had informed the physician of the patient's</p>	N000527	<p>N527 – Nursing staff will be in-serviced by the Home Health Care Director or her designee on the need to notify the physician to changes that suggest a need to alter the plan of care for the patient. This in-service will be completed by 4/15/14. Random Chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>anxiety and need for medication.</p> <p>B. The plan of care for the certification period 2-25-14 to 4-25-14 did not include any anxiety medications.</p> <p>2. Clinical record number 4 included a PTA note dated 3-12-14 that states, "Pt [patient] refused Rx [treatment] this date due to [not] feeling well. c/o [complaint of] upset stomach & passing out frequently. Family reports pt fell this AM coming out of BR [bathroom]. Also states hands & arms have began tremoring @ times. Will report this to HH [home health] nurse."</p> <p>A. The record included a "Charts/Clinical Note", signed and dated by employee E, a registered nurse (RN), on 3-12-14 that states, "1500 Received a message from [employee J, the PTA] that pt had fallen this am and struck his head, was in bed asleep all yesterday and did not do therapy today. Instructed [PTA] RN will call pcg [patient care giver]. 1600 Pcg called and inquired about fall. Fell on the way to the bathroom, struck back of head has a goose egg, and a bruise. Asked how pt's pain level is was instructed pain is bad, instructed pcg to take pt to ER for further evaluation. Pcg refused stating, 'They never help him.' Instructed if pt</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>gets worse to please take to ER and keep Home Health informed."</p> <p>B. The record failed to evidence the RN had informed the physician of the patient's fall, the "bad" pain level, the "goose egg and bruise" and the "tremoring" reported by the PTA.</p> <p>C. Employee E, the RN, stated, on 3-13-14 at 2:40 PM, "I did not call the physician. I called the family & requested they take him to the ER. They refused."</p> <p>D. A home visit was made to patient number 4 on 3-13-14 at 1 PM with employee M, the occupational therapist (OT). Upon arrival the therapist assisted the patient to sit on the side of the bed. The patient was observed to begin shaking uncontrollably with seizure-like activity. The OT assisted the patient to lie down and the shaking stopped.</p> <p>E. The administrator indicated, on 3-13-14 at 3 PM, the patient's family had transported the patient to the hospital and the patient had been admitted.</p> <p>3. The agency's 03/06 "Client/Home Health Care Visit Protocol for Staff Nurses" policy number 2 states, "Staff Nurse: . . . notifies physician of change</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>in condition."</p> <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 nursing services and treatments had been provided in accordance with physician orders in 5 (#s 2, 4, 5, 9, & 10) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient had a peripherally inserted central catheter (PICC) and included a supplemental order dated 2-25-14 that states, "SN [skilled nurse] Change occlusive dressing and injection caps weekly and PRN [as needed] if soiled or loose."</p> <p>A. The record included SN visit notes that evidenced the PICC dressing change had been completed 2 times the week of 2-23-14, on 2-25-14 by employee B, a registered nurse (RN),</p>	N000537	<p>N537 – An in-service for nursing staff will be completed by the Home Health Director or her designee on the follow-up of the medical plan of care to ensure nursing services and treatments provided by a SN has a physician order, and is provided in accordance with those physician orders, or if the SN is unable to complete the service appropriate documentation is made in the medical record.</p> <p>This in-service will be completed by 4/15/14.</p> <p>Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014
---------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
--	--

(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>and on 2-27-14 by employee E, a RN.</p> <p>B. The supervising nurse stated, on 3-14-14 at 3 PM, "The dressing was changed again on 2-27-14 because it was soiled. The visit note does not indicate the dressing needed to be changed."</p> <p>C. The agency's undated "Peripherally Inserted Central Catheter (PICC) Dressing Change" procedure states, "A peripherally inserted central catheter (PICC) dressing should be changed at least every 7 days if a transparent semipermeable dressing is used."</p> <p>2. Clinical record number 4 included a plan of care established by the physician for the certification period 2-28-14 to 4-28-14 that included diagnoses of "Abdominal pain . . . gastritis . . . abnormal weight loss." The plan of care states, "SN . . . weigh 1 X [one time per] week if patient able to stand safely."</p> <p>A. The record included a start of care comprehensive assessment dated 2-28-14 that identified "pt [patient] has right epigastric pain on and off and does not eat well due to pain . . . pt has difficulty having bowel movements does go 1-2 weekly small amounts . . . appetite: poor . . . Hydration: Poor.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>Nutrition/Hydration Within Patient's Normal Limits: No . . . Meal Pattern: Bites only . . . Nutrition: Probably inadequate - Rarely eats a complete meal and generally only eats about 1/2 of any food offered." The assessment identifies the patient does walk "occasionally . . . but for very short distances, with or without assistance."</p> <p>The start of care comprehensive assessment failed to evidence the SN had obtained the patient's weight.</p> <p>B. SN visit notes, dated 3-3-14 and 3-10-14, failed to evidence the SN had obtained the patient's weight. The visit notes did not evidence the patient was unable to stand safely.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 1-30-14 to 3-30-14. The plan of care identified a wound on the right lower extremity. The plan of care states, "SN . . . Measure wounds for depth, width, length weekly."</p> <p>A. The record failed to evidence the SN had measured the wound since 2-19-14. The record evidenced SN visits had been made on 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501
---	--

(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>3-5-14, and 3-9-14.</p> <p>The visit notes dated 2-21-14, 2-23-14, 2-26-14, 2-28-14, 3-2-14, 3-5-14, and 3-9-14 all state, "type: venous stasis ulcer, healing: healing by secondary intent . . . Incision / wound tissue observed: beefy red, surrounding tissue: intact . . . drainage: serous, drainage amount: moderate."</p> <p>B. The alternate supervising nurse stated, on 3-14-14 at 2:55 PM, "There are no measurements [after 2-19-14]. It [the plan of care] does say weekly."</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 1-23-14 to 3-23-14 that identified a diagnosis of congestive heart failure. The plan of care states, "SN . . . Weigh weekly."</p> <p>A. The record failed to evidence a weight had been obtained at start of care or the weeks of 1-27-14 or 2-7-14.</p> <p>B. The record included a transfer comprehensive assessment that states, "Patient was sent to hospital by [name] at Wound Care Clinic."</p> <p>5. Clinical record number 10 included a SN visit note dated 2-3-14 that states,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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			
N000543	<p>"cup left for pcg [patient care giver] to acquire urine sample, will pick up when done." The record included urine culture laboratory results dated 2-3-14.</p> <p>A. The record failed to evidence an order for the urine culture.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 3:10 PM.</p> <p>6. The agency's 02/06 "Skilled Nursing Services" policy number 13A states, "Skilled Nursing services are provided by or under the supervision of a registered nurse and in accordance with the physician's plan of treatment outlining client's plan of care."</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified nursing needs in 1 (#</p>	N000543	N543 – An in-service will be provided for all nursing staff by the Home Health Care Director or her designee to ensure appropriate preventive and rehabilitative nursing interventions have been initiated for all patients.	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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>7) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 7 included a start of care comprehensive assessment dated 10-24-13 that identified a diagnosis of "Digestive Neoplasm." The assessment evidenced the patient had a "poor appetite", "fair hydration", ate "small frequent meals" and used nutritional supplements two times per day. The assessment states, "Nutrition / hydration within patient's normal limits: No." The record failed to evidence the RN had initiated any nursing interventions or procedures to address the identified alteration in nutritional status. 2. The supervising nurse was unable to provide any additional documentation and/or information when asked on 3-14-14 at 2 PM. 3. The agency's 02/06 "Skilled Nursing Services" policy number 13A states, "The duties of the registered nurse include the following, but may not be limited to: . . . Initiating appropriate preventative and rehabilitative nursing 		<p>This in-service will be completed by 4/15/14.</p> <p>Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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			
N000546	<p>procedures."</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure the registered nurse (RN) had alerted the physician to changes that suggested a need to alter the plan of care in 1 (# 4) of 12 records reviewed creating the potential to affect all of the agency's 56 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included a physical therapy assistant (PTA) note dated 3-12-14 that states, "Pt [patient] refused Rx [treatment] this date due to [not] feeling well. c/o [complaint of] upset stomach & passing out frequently. Family reports pt fell this AM coming out of BR [bathroom]. Also states</p>	N000546	<p>N546 – An in-service will be provided for all nursing, physical therapy and occupational therapy staff by the Home Health Care Director or her designee on the need to inform the physician and other appropriate medical personnel of changes in the patient’s condition and needs, counsel the patient and family in meeting nursing and related needs, participate in in-service programs and supervise and teach other nursing personnel. This in-service will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>	04/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPITAL WASHINGTON, IN 47501			
(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>hands & arms have began tremoring @ times. Will report this to HH [home health] nurse."</p> <p>A. The record included a "Charts / Clinical Note", signed and dated by employee E, a registered nurse (RN), on 3-12-14 that states, "1500 Received a message from [employee J, the PTA] that pt had fallen this am and struck his head, was in bed asleep all yesterday and did not do therapy today. Instructed [PTA] RN will call pcg [patient care giver]. 1600 Pcg called and inquired about fall. Fell on the way to the bathroom, struck back of head has a goose egg, and a bruise. Asked how pt's pain level is was instructed pain is bad, instructed pcg to take pt to ER for further evaluation. Pcg refused stating, 'They never help him.' Instructed if pt gets worse to please take to ER and keep Home Health informed."</p> <p>B. The record failed to evidence the RN had informed the physician of the patient's fall, the "bad" pain level, the "goose egg and bruise" and the "tremoring" reported by the PTA.</p> <p>C. Employee E, the RN, stated, on 3-13-14 at 2:40 PM, "I did not call the physician. I called the family & requested they take him to the ER. They</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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	
N000564	<p>refused."</p> <p>D. A home visit was made to patient number 4 on 3-13-14 at 1 PM with employee M, the occupational therapist (OT). Upon arrival the therapist assisted the patient to sit on the side of the bed. The patient was observed to begin shaking uncontrollably with seizure-like activity. The OT assisted the patient to lie down and the shaking stopped.</p> <p>E. The administrator indicated, on 3-13-14 at 3 PM, the patient's family had transported the patient to the hospital and the patient had been admitted.</p> <p>2. The agency's 02/06 "Skilled Nursing Services" policy number 13A states, "The duties of the registered nurse include the following, but may not be limited to: . . . Informing physicians and home health care staff and interdisciplinary team members of changes in client condition and needs."</p> <p>410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function; Based on clinical record and agency policy review and interview, the agency</p>	N000564	N564 – An in-service will be conducted	04/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501			
(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>failed to ensure the qualified physical therapist had consulted with the physician regarding the discontinuation of therapy services in 1 (#10) of 6 records reviewed of patients that received physical therapy (PT) services creating the potential to affect all of the agency's 33 current patients that receive PT services.</p> <p>The findings include:</p> <p>1. Clinical record number 10 included a plan of care established by the physician for the certification period 1-16-14 to 3-16-14 that identified physical therapy services were to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, and 1 time per week for 2 weeks. The record failed to evidence the physical therapist had assessed the patient and consulted with the physician regarding discharge from physical therapy services.</p> <p>A. The record included a visit note, signed and dated by the physical therapy assistant, employee J, on 2-11-14, that states, "Client's status discussed with [employee K], PT, per phone/direct contact. Plan: Continue home-based PT interventions as established within initial PT plan of care." The note was co-signed by the physical therapist,</p>		<p>with therapy staff by the Home Health Care Director or her designee. This inservice will address that the appropriate therapist will consult with the physician in evaluating the patient's level of function as related to the need for the continuing or discontinuing of therapy services. This inservice will be completed by 4/15/14. Random chart audits will be conducted on 10 charts per month by the Home Health Care Director or her designee to ensure ongoing compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157189	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER DAVISS COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPI WASHINGTON, IN 47501		
(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 K.</p> <p>B. The record included a "Progress Notes Addendum", signed and dated by the physical therapist, employee K, on 2-11-14, that states, "D/C [discharge] summary: S: See subjective from daily note 2-11-14 O: See objective from daily note 2-11-14 A: All Goals met. P: D/C HH [at] this time."</p> <p>2. The Supervising Nurse stated, on 3-17-14 at 11:05 AM, "The physical therapist did not make a visit to the patient on 2-11-14.</p> <p>3. The agency's 02-06 "Physical Therapy Services" policy number 13C states, "The duties of the physical therapist includes the following but are not limited to: Assisting the physician in evaluating the client's functional status."</p>				