

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	<p>This was a federal home health recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 5-16-12, 5-17-12, & 5-18-12</p> <p>Facility #: 008814</p> <p>Medicaid Vendor #: 200060430</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census: 185 skilled patients, 0 home health aide only patients, 0 personal service only patients.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 24, 2012</p>	G0000		

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: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(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
G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure it had provided services in accordance with its own hand hygiene policies in 2 (#s 1 and 2) of 6 home visit observations creating the potential for the spread of disease causing organisms among patients and staff and failed to ensure it had followed its own discharge policy in 1 (# 12) of 2 closed records reviewed creating the potential to affect all of the agency's 26 current patients.</p> <p>The findings include:</p> <p>Regarding hand hygiene:</p> <p>1. The agency's 9-2-04 "Guidelines for Hand Hygiene Policy and Procedure" states, "Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter or when performing any other sterile procedure . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during</p>	G0121	<p>The Administrator will inservice all nursing staff on the Hand Hygiene Policy and procedures. Specifc areas will include: Decontaminating hands piror to donning sterile gloves for any sterile procedures including catheter care, after contact with a patient's intact skin, if moving from a contaminated body site to a clean body site, after contact with inanimate objects, and after removing gloves. All nusing staff will review the policy and perform a competency checklist for handwashing. The competency checklist for handwashing will be performed and reviewed monthly. Documentation will be kept in the Administrator's office.The Administrator will inservice the Home Health Aides on Perineal Care. This will include: review of Perineal Care policy and procedures. The Home Health Aides will demonstrate proper perineal care on a pseudo/patient.The Administrator will make an unscheduled visit with the cited employees within the next 3 months and annually with each employee's performance evaluation to monitor proper hand hygiene and perineal care to ensure</p>	06/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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>patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>2. On 5-16-12 at 10 AM, employee A, a home health aide, was observed to assist patient number 2 bathe.</p> <p>A. The aide assisted the patient to remove the patient's shoes and then picked the shoes up and placed them out into the hallway. The aide then donned clean gloves without cleansing her hands.</p> <p>B. The aide completed bathing the patient's upper body and assisted the patient to remove clothing from the lower body. The aide placed the dirty clothing in another room, removed her gloves, and donned clean gloves without cleansing her hands.</p> <p>C. The aide washed the patient's buttocks and rectal area, rinsed the washcloth, applied more soap, and handed the washcloth to the patient. The patient washed the front perineal area with the same washcloth used to cleanse the buttocks and rectal area. Observation noted the patient had a Foley catheter.</p> <p>D. After the patient completed</p>		<p>compliance and to prevent the deficiency from recurring. The Administrator will inservice the nursing staff on Gibson's Home Health Discharge Policy emphasizing the "Five Day Calendar rule" for notification prior to discharge and providing a list of appropriate community resources. 100% of the discharge charts will be reviewed over the next quarter until 100% compliance is met; then 10% will be monitored quarterly. The Administrator will monitor results to keep the defecency from reccuring. This will be added to the chart audits preformed quarterly by the interdisiplinary team, then will be reported to the Performance Improvement Committee quarterly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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>washing the front perineal area, the aide took the washcloth from the patient and placed it on the sink. The aide removed her gloves and stated, "My hands are sweating like crazy." The aide then donned clean gloves without cleansing her hands.</p> <p>E. The aide applied a cream to the patient's perineal area, removed her gloves, obtained the patient's lower body clothing, and donned clean gloves without cleansing her hands.</p> <p>3. On 5-16-12 at 1:10 PM, employee D, a registered nurse, was observed to perform a PICC line dressing change on patient number 1.</p> <p>A. The registered nurse assisted the patient to remove the patient's arm from the sleeve of a shirt. The registered nurse then donned clean gloves without cleansing her hands.</p> <p>B. The nurse removed the old dressing, removed her gloves, then cleansed her hands. The nurse then obtained the sterile dressing change kit, donned a face mask, opened the dressing change kit and donned the sterile gloves inside the kit without cleansing her hands.</p> <p>4. The administrator, employee C,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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>indicated, on 5-18-12 at 9:45 AM, employees A and D had not provided services in accordance with the agency's hand hygiene policy.</p> <p>Regarding discharge from the agency:</p> <p>1. The agency's 11-6-11 "Discharge / Discharge Summary" policy states, "The nurse will provide notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before services are stopped. The rule does not apply in the following circumstances: A. The health, safety, and/or welfare of the Home Health Agency's employees would be at immediate and significant risk if the Home Health Agency continued to provide services to the patient; B. The patient refuses the Home Health Agency's services; C. The patient's services are no longer reimbursable . . . ; or D. The patient no longer meets applicable regulatory criteria, such as lack of physician's order . . . Provide a list of appropriate community resources to the patient/family. Appropriate referrals are made for the patient's continued care as necessary."</p> <p>2. Clinical record number 12 evidenced services were initiated on 10-11-11. The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>record evidenced a comprehensive assessment had been completed on the start of care date and a home health aide visit had been provided on 10-12-11.</p> <p>A. The record included a "Physician Telephone Order" dated 10-13-11 that states, "Discharge from Home Health Services. Patient has unsafe home environment & refuses all therapies to improve [the patient's] mobility."</p> <p>B. The record failed to evidence agency employees would be at risk if services were continued, that the patient had refused the skilled nursing and home health aide services, that the services were no longer reimbursable, or that the patient no longer met regulatory criteria.</p> <p>C. The record failed to evidence the patient had been given a 5 day notice of discharge or had been provided with a list of available community resources.</p> <p>D. The administrator, employee C, was unable to provide any additional documentation and/or information when asked on 5-17-12 at 1:25 PM.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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			
G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review and interview, the agency failed to ensure patient evaluation and instruction had been completed as ordered by the physician in 5 (#s 1, 4, 5, 8, & 9) of 12 records reviewed creating the potential to affect all of the agency's 26 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 5-10-12 to 7-8-12 that states, "Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose monitoring, medication compliance and disease processes and complications."</p> <p>A. The record included a start of care initial comprehensive assessment dated 5-10-12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage the diabetes.</p> <p>B. Skilled nurse visit notes, dated</p>	G0158	<p>The Administrator will inservice the Home Health Staff to ensure the Physician's Plan of Care is being followed as ordered, and timely initiation/documentation of the Teaching plan. These items will be included: 1. The Initial Comprehensive Assessment form will be expanded to include an assessment of the Patient's understanding and ability to manage their specific disease process ordered on the Physician's Plan of Care.2. All initial and continued patient/family instructions will be documented on the Initial Comprehensive form and ongoing documentation in the progress notes will include all disease management instructions given, and the patient's level of understanding.3. All treatments/procedures i.e. (injections, weights) ordered on the Plan of Care will be charted on the Initial Comprehensive Assessment/Daily progress notes. The Administrator will audit 100% of the charts over the next quarter until 100% compliance is met; then and 10% will be audited quarterly for on-going compliance. This will be added to the chart audits preformed by the Interdisciplinary team quarterly;</p>	06/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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>5-11-12 and 5-14-12, failed to evidence a diabetic management teaching plan had been initiated.</p> <p>2. Clinical record number 4 included a plan of care established by the physician for the certification period 4-21-12 to 6-16-12 that states, "SN [skilled nurse] to give injections. Lovenox 40 mg [milligrams] every 24 hours SQ [subcutaneous] end 042412."</p> <p>The record included a start of care SN visit note dated 4-21-12. The note failed to evidence the SN had administered the injection as ordered.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 4-25-12 to 6-23-12 that states, "Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose monitoring, medication compliance and disease processes and complications."</p> <p>A. The record included a start of care comprehensive assessment dated 4-25-12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage the diabetic diet, foot care, glucose monitoring, and disease process and complications.</p>		which will be reported to the Performance Improvement Committee quarterly.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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 5-1-12, 5-8-12, and 5-15-12, failed to evidence a diabetic management teaching plan had been initiated.</p> <p>4. Clinical record number 8 included a plan of care established by the physician for the certification period 3-23-12 to 5-21-12 that states, "Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose monitoring, medication compliance and disease processes and complications . . . Weight 210 patient to weigh self and report gain of 3 pounds in 24 hours."</p> <p>A. The record included a start of care comprehensive assessment dated 3-23-12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage the diabetes.</p> <p>B. SN visit notes, dated 3-30-12, 4-2-12, 4-9-12, 4-13-12, 4-27-12, 5-1-12, and 5-8-12, failed to evidence the nurse had monitored the patient's compliance with daily weights.</p> <p>5. Clinical record number 9 included a plan of care established by the physician for the certification period 3-31-12 to 5-29-12 that states, ""Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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>monitoring, medication compliance and disease processes and complications . . . Weight: daily by patient - report gain of 3 pounds in 24 hours."</p> <p>A. The record included a SN visit note dated 4-5-12 that states, "Provided teaching guide on Diabetes. Patient very willing to learn. 50% retention. Will review on next H.V. [home visit]."</p> <p>B. The record evidenced the next home visit was made on 4-10-12. The SN visit note for 4-10-12 failed to evidence any diabetic teaching had been completed. Subsequent SN visit notes, dated 4-12-12, and 4-18-12, failed to evidence any diabetic teaching had been completed.</p> <p>C. The record included a start of care comprehensive assessment dated 3-31-12 that failed to evidence the nurse had instructed the patient to weigh daily and report a weight gain of 3 pounds in 24 hours.</p> <p>6. The administrator, employee C, was unable to provide any additional documentation and/or information when asked on 5-17-12 at 4:30 PM.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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			
G0173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had communicated to the physician identified needs for additional services in 4 (#s 1, 5, 6, and 12) of 12 records reviewed creating the potential to affect all of the agency's 26 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a start of care comprehensive assessment dated 5-10-12 that identified the patient had "stiffness", "weakness", "fatigues easily" and is short of breath at rest.</p> <p>A. The record included a "Communication Notes/Report' dated 5-10-12 that states, "I did not put PT [physical therapy] & OT [occupational therapy] in home d/t [due to] patient extremely weak last night - Did not feel [the patient] could tolerate therapy. Perhaps [the patient's] strength will increase & fatigue was from the move home"</p> <p>B. The record failed to evidence the registered nurse had informed the</p>	G0173	<p>The Administrator will inservice the staff on Gibson Home Health's Referral Policy and appropriate usage. The second part of the inservice will include appropriate communication with the ordering physician for potential referrals while in the home health episode, as well as, proper communication for discharge planning. A MSW Screening checklist will be included on the Initial Comprehensive Assessment to assist the nurse in identifying potential reasons/problems for referral to the MSW. The Administrator will review 100% of the charts for 100% compliance over the next quarter/or until compliance is met; then 10% of the charts will be monitored quarterly. The Administrator will monitor results for compliance to prevent any further deficiencies from recurring. This will be added to the chart audits by the Interdisciplinary team preformed quarterly; which will be reported to the Performance Improvement Committee quarterly.</p>	06/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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>physician of the potential need for a referral for PT and OT..</p> <p>C. The registered nurse, employee E, stated, on 5-17-12 at 4:30 PM, "I did talk to the physician about therapy. I just did not document it."</p> <p>2. Clinical record number 5 included a skilled nurse (SN) visit note dated 5-8-12 that states, "Discussion [with] patient & [adult child] in regard to long range planning when HH [home health] services D/C [discontinued]. Will plan to give referral to SWIRCA today."</p> <p>The record failed to evidence the registered nurse had informed the physician of the potential need for a referral to medical social services to assist the patient and family in long range planning.</p> <p>3. Clinical record number 6 evidenced the patient had multiple medical diagnoses that included the need for IV (intravenous) antibiotics, a colostomy, Crohn's Disease, kidney failure, and liver failure.</p> <p>A. The administrator, employee C, indicated, on 5-16-12 at 3:45 PM, the patient was the parent of 2 young children and lived with the patient's parent.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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. A home visit was made to the patient on 5-18-12 at 8:35 AM. The patient indicated there were insurance issues, that the only support available was the patient's mother, and that not being able to attend the patient's child's activities was very hard.</p> <p>C. The record failed to evidence the registered nurse had informed the physician of the potential need for a medical social services</p> <p>4. Clinical record number 12 included an interim physician's order dated 10-13-11 that states, "Discharge from Home Health Services. Patient has unsafe home environment."</p> <p>The record failed to evidence the physician had been informed of the potential need for a referral to medical social services.</p> <p>5. The administrator, employee C, was unable to provide any additional documentation and/or information when asked on 5-17-12 at 4:30 PM.</p> <p>6. The administrator, employee C, stated, on 5-18-12 at 9:45 AM, "I guess we don't use the social worker like we should."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(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. The agency's 11-2-11 "Referral Services" policy states, "Referral services will include Physical therapy, Occupational therapy, Speech therapy, and Medical Social Worker . . . Referral will be initiated by nursing following an assessment visit to the home, or by physician order."</p> <p>8. The agency's 11-6-11 "Medical Plan of Care (POC 485) / Add Orders / Re-Certification" policy states, "The physician is consulted to approve additions or modifications to the original plan."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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	
G0335	<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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure initial assessments included an assessment of the patients' psychosocial status in 12 (#s 1 through 12) of 12 records reviewed creating the potential to affect all of the agency's 26 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included an initial comprehensive assessment dated 5-10-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status. 2. Clinical record number 2 included an initial comprehensive assessment dated 2-14-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status. 3. Clinical record number 3 included an initial comprehensive assessment dated 5-15-12. The assessment failed to include 	G0335	<p>The Initial Comprehensive form will be expanded to include an evaluation and assessment of the patient's psychosocial status. This assessment will include the patient's support systems, patient/family attitude, coping mechanisms, ongoing needs, environmental needs, and financial concerns. The Administrator will inservice the staff on the psychosocial status requirements documentation and assessment on the Initial Comprehensive Assessment form. The Administrator will audit 100% of the Admission/Readmission charts for 100% compliance of proper documentation of the patient's psychosocial status over the next quarter/or until compliance is met; then 10% of the charts will be monitored quarterly. This will be added to the chart audits routinely preformed by the interdisciplinary team quarterly, then will be reported to the Performance Improvement Committee quarterly.</p>	06/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>an evaluation and assessment of the patient's psychosocial status.</p> <p>4. Clinical record number 4 included an initial comprehensive assessment dated 4-21-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>5. Clinical record number 5 included an initial comprehensive assessment dated 4-25-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>6. Clinical record number 6 included an initial comprehensive assessment dated 5-9-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>A. The administrator, employee C, indicated, on 5-16-12 at 3:45 PM, the patient was the parent of 2 young children and lived with the patient's parent.</p> <p>B. A home visit was made to the patient on 5-18-12 at 8:35 AM. The patient indicated there were insurance issues, that the only support available was the patient's mother, and that not being able to attend the patient's child's activities was very hard.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(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. Clinical record number 7 included an initial comprehensive assessment dated 4-16-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>8. Clinical record number 8 included an initial comprehensive assessment dated 3-23-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>9. Clinical record number 9 included an initial comprehensive assessment dated 3-31-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>10. Clinical record number 10 included an initial comprehensive assessment dated 4-13-12. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>11. Clinical record number 11 included an initial comprehensive assessment dated 10-7-11. The assessment failed to include an evaluation and assessment of the patient's psychosocial status.</p> <p>12. Clinical record number 12 included an initial comprehensive assessment dated 10-11-11. The record included an interim physician order dated 10-13-11 that states,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(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>"Discharge from Home Health Services. Patient has unsafe home environment."</p> <p>The initial comprehensive assessment failed to include an evaluation and assessment of the patient's home environment or any other psychosocial factors.</p> <p>13. The administrator, employee C, stated, on 5-18-12 at 9:45 AM, "I am sure the psychosocial assessments were done. They just didn't write it."</p> <p>14. The agency's 11-6-11 "Nursing Admission Assessment/Reassessment" policy states, "The Nursing Admission Assessment will be completed for each patient admitted to Home Health Services . . . On admission/readmission the nurse performs an evaluation of: . . . the patient's psychosocial status."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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	
N0470	<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 clinical record and agency policy review, observation, and interview, the agency failed to ensure it had implemented its own hand hygiene policies in 2 (#s 1 and 2) of 6 home visit observations creating the potential for the spread of disease causing organisms among patients and staff.</p> <p>The findings include:</p> <p>1. The agency's 9-2-04 "Guidelines for Hand Hygiene Policy and Procedure" states, "Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter or when performing any other sterile procedure . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p>	N0470	<p>The Administrator will inservice all nursing staff on the Hand Hygiene Policy and procedures. Specific areas will include: Decontaminating hands prior to donning sterile gloves for any sterile procedures including catheter care, after contact with a patient's intact skin, if moving from a contaminated body site to a clean body site, after contact with inanimate objects, and after removing gloves. All nursing staff will review the policy and perform a competency checklist for handwashing. The competency checklist for handwashing will be performed and reviewed monthly. Documentation will be kept in the Administrator's office. The Administrator will inservice the Home Health Aides on Perineal Care. This will include: review of Perineal Care policy and procedures. The Home Health Aides will demonstrate proper perineal care on a pseudo/patient. The Administrator will also make an unscheduled visit with the cited employees within the next 3 months and annually with each employee's performance evaluation to monitor proper hand</p>	06/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. On 5-16-12 at 10 AM, employee A, a home health aide, was observed to assist patient number 2 bathe.</p> <p>A. The aide assisted the patient to remove the patient's shoes and then picked the shoes up and placed them out into the hallway. The aide then donned clean gloves without cleansing her hands.</p> <p>B. The aide completed bathing the patient's upper body and assisted the patient to remove clothing from the lower body. The aide placed the dirty clothing in another room, removed her gloves, and donned clean gloves without cleansing her hands.</p> <p>C. The aide washed the patient's buttocks and rectal area, rinsed the washcloth, applied more soap, and handed the washcloth to the patient. The patient washed the front perineal area with the same washcloth used to cleanse the buttocks and rectal area. Observation noted the patient had a Foley catheter.</p> <p>D. After the patient completed washing the front perineal area, the aide took the washcloth from the patient and placed it on the sink. The aide removed her gloves and stated, "My hands are sweating like crazy." The aide then donned clean gloves without cleansing</p>		<p>hygiene and perineal care to ensure compliance and to prevent the deficiency from recurring. The Administrator will inservice the nursing staff on Gibson's Home Health Discharge Policy emphasizing the Five Day Calendar rule for notification prior to discharge and providing a list of appropriate community resources. 100% of the discharge charts will be reviewed over the next quarter until 100% compliance is met; then 10% will be monitored quarterly. The Administrator will monitor results to keep the defeciation from reccuring. This will be added to the chart audits performed quarterly by the interdisiplinary team; then will be reported to the Performance Improvement Committee quarterly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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>her hands.</p> <p>E. The aide applied a cream to the patient's perineal area, removed her gloves, obtained the patient's lower body clothing, and donned clean gloves without cleansing her hands.</p> <p>3. On 5-16-12 at 1:10 PM, employee D, a registered nurse, was observed to perform a PICC line dressing change on patient number 1.</p> <p>A. The registered nurse assisted the patient to remove the patient's arm from the sleeve of a shirt. The registered nurse then donned clean gloves without cleansing her hands.</p> <p>B. The nurse removed the old dressing, removed her gloves, then cleansed her hands. The nurse then obtained the sterile dressing change kit, donned a face mask, opened the dressing change kit and donned the sterile gloves inside the kit without cleansing her hands.</p> <p>4. The administrator, employee C, indicated, on 5-18-12 at 9:45 AM, employees A and D had not provided services in accordance with the agency's hand hygiene policy.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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			
N0488	<p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure it had implemented its discharge policy in 1 (# 12) of 2 discharge records reviewed creating the potential to affect all of the agency's 26 current patients.</p> <p>The findings include:</p>	N0488	The Administrator will inservice the nursing staff on Gibson's Home Health Discharge Policy emphasizing the "Five Day Calendar Rule" for notification to be given prior to discharge while, also, providing a list of appropriate community resources to the patient/family. 100% fo the discharge charts will be reviewed over the next quarter until 100%	06/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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 11-6-11 "Discharge / Discharge Summary" policy states, "The nurse will provide notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before services are stopped. The rule does not apply in the following circumstances: A. The health, safety, and/or welfare of the Home Health Agency's employees would be at immediate and significant risk if the Home Health Agency continued to provide services to the patient; B. The patient refuses the Home Health Agency's services; C. The patient's services are no longer reimbursable . . . ; or D. The patient no longer meets applicable regulatory criteria, such as lack of physician's order . . . Provide a list of appropriate community resources to the patient/family. Appropriate referrals are made for the patient's continued care as necessary."</p> <p>2. Clinical record number 12 evidenced services were initiated on 10-11-12. The record evidenced a comprehensive assessment had been completed on the start of care date and a home health aide visit had been provided on 10-12-11.</p> <p>A. The record included a "Physician</p>		<p>or until compliance is met; then 10% will be monitored quarterly. The Adminstrator will monitor results to keep the defeciciency from recurring. This will be added to the chart audits performed quarterly by the interdisiplinary team. The quarterly audit results will then be reported to the Performance Improvement Committee quarterly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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>Telephone Order" dated 10-13-11 that states, "Discharge from Home Health Services. Patient has unsafe home environment & refuses all therapies to improve [the patient's] mobility."</p> <p>B. The record failed to evidence agency employees would be at risk if services were continued, that the patient had refused the skilled nursing and home health aide services, that the services were no longer reimbursable, or that the patient no longer met regulatory criteria.</p> <p>C. The record failed to evidence the patient had been given a 5 day notice of discharge or had been provided with a list of available community resources.</p> <p>D. The administrator, employee C, was unable to provide any additional documentation and/or information when asked on 5-17-12 at 1:25 PM.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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			
N0522	<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:</p> <p>Based on clinical record review and interview, the agency failed to ensure patient evaluation and instruction had been completed as ordered by the physician in 5 (#s 1, 4, 5, 8, & 9 of 12 records reviewed creating the potential to affect all of the agency's 26 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 5-10-12 to 7-8-12 that states, "Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose monitoring, medication compliance and disease processes and complications."</p> <p>A. The record included a start of care initial comprehensive assessment dated 5-10-12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage the diabetes.</p> <p>B. Skilled nurse visit notes, dated</p>	N0522	<p>The Administrator will inservice the Home Health Staff to ensure the Physician's Plan of Care is being followed as ordered. These items will be included: 1. The Initial Comprehensive Assessment form will be expanded to include an assessment of the Patient's understanding and ability to manage their specific disease process ordered on the Physician's Plan of Care. 2. Ongoing documentation in the progress notes will include all disease management instructions given, and the patient's level of understanding. 3. All treatments/procedures i.e. (injections, weights) ordered on the Plan of Care will be charted on the Initial Comprehensive Assessment/Daily progress notes. The Administrator will audit 100% of the charts over the next quarter until 100% compliance is met; then and 10% will be audited quarterly for on-going compliance. This will be added to the chart audits preformed by the Interdisciplinary team quarterly; which will be reported to the Performance Improvement Committee quarterly.</p>	06/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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>5-11-12 and 5-14-12, failed to evidence a diabetic management teaching plan had been initiated.</p> <p>2. Clinical record number 4 included a plan of care established by the physician for the certification period 4-21-12 to 6-16-12 that states, "SN [skilled nurse] to give injections. Lovenox 40 mg [milligrams] every 24 hours SQ [subcutaneous] end 042412."</p> <p>The record included a start of care SN visit note dated 4-21-12. The note failed to evidence the SN had administered the injection as ordered.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 4-25-12 to 6-23-12 that states, "Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose monitoring, medication compliance and disease processes and complications."</p> <p>A. The record included a start of care comprehensive assessment dated 4-25-12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage the diabetic diet, foot care, glucose monitoring, and disease process and complications.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(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 5-1-12, 5-8-12, and 5-15-12, failed to evidence a diabetic management teaching plan had been initiated.</p> <p>4. Clinical record number 8 included a plan of care established by the physician for the certification period 3-23-12 to 5-21-12 that states, "Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose monitoring, medication compliance and disease processes and complications . . . Weight 210 patient to weigh self and report gain of 3 pounds in 24 hours."</p> <p>A. The record included a start of care comprehensive assessment dated 3-23-12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage the diabetes.</p> <p>B. SN visit notes, dated 3-30-12, 4-2-12, 4-9-12, 4-13-12, 4-27-12, 5-1-12, and 5-8-12, failed to evidence the nurse had monitored the patient's compliance with daily weights.</p> <p>5. Clinical record number 9 included a plan of care established by the physician for the certification period 3-31-12 to 5-29-12 that states, ""Diabetic: Instruct/evaluation of diabetic management, foot care, diet, glucose</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012	
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670			
(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>monitoring, medication compliance and disease processes and complications . . . Weight: daily by patient - report gain of 3 pounds in 24 hours."</p> <p>A. The record included a SN visit note dated 4-5-12 that states, "Provided teaching guide on Diabetes. Patient very willing to learn. 50% retention. Will review on next H.V. [home visit]."</p> <p>B. The record evidenced the next home visit was made on 4-10-12. The SN visit note for 4-10-12 failed to evidence any diabetic teaching had been completed. Subsequent SN visit notes, dated 4-12-12, and 4-18-12, failed to evidence any diabetic teaching had been completed.</p> <p>C. The record included a start of care comprehensive assessment dated 3-31-12 that failed to evidence the nurse had instructed the patient to weigh daily and report a weight gain of 3 pounds in 24 hours.</p> <p>6. The administrator, employee C, was unable to provide any additional documentation and/or information when asked on 5-17-12 at 4:30 PM.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2012
NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
(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	
N0542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had communicated to the physician identified needs for additional services in 4 (#s 1, 5, 6, and 12) of 12 records reviewed creating the potential to affect all of the agency's 26 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a start of care comprehensive assessment dated 5-10-12 that identified the patient had "stiffness", "weakness", "fatigues easily" and is short of breath at rest.</p> <p>A. The record included a "Communication Notes/Report' dated 5-10-12 that states, "I did not put PT [physical therapy] & OT [occupational therapy] in home d/t [due to] patient extremely weak last night - Did not feel [the patient] could tolerate therapy. Perhaps [the patient's] strength will increase & fatigue was from the move</p>	N0542	The Administrator will inservice the staff on Gibson Home Health's Referral Policy and appropriate usage. The second part of the inservice will include proper communication with the ordering physician for potential referrals while in the home health episode, as well as, proper communication for discharge planning. A MSW Screening checklist will be included on the Initial Comprehensive Assessment to assist the nurse in identifying potential reasons/problems for referral to the MSW. The Administrator will review 100% of the charts for 100% compliance over the next quarter/or until compliance is met; then 10% of the charts will be monitored quarterly. The Administrator will monitor results for compliance to prevent any further deficiencies from recurring. This will be added to the chart audits by the Interdisciplinary team performed quarterly; which will be reported to the Performance Improvement Committee quarterly.	06/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(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>home"</p> <p>B. The record failed to evidence the registered nurse had informed the physician of the potential need for a referral for PT and OT..</p> <p>C. The registered nurse, employee E, stated, on 5-17-12 at 4:30 PM, "I did talk to the physician about therapy. I just did not document it."</p> <p>2. Clinical record number 5 included a skilled nurse (SN) visit note dated 5-8-12 that states, "Discussion [with] patient & [adult child] in regard to long range planning when HH [home health] services D/C [discontinued]. Will plan to give referral to SWIRCA today."</p> <p>The record failed to evidence the registered nurse had informed the physician of the potential need for a referral to medical social services to assist the patient and family in long range planning.</p> <p>3. Clinical record number 6 evidenced the patient had multiple medical diagnoses that included the need for IV (intravenous) antibiotics, a colostomy, Crohn's Disease, kidney failure, and liver failure.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 administrator, employee C, indicated, on 5-16-12 at 3:45 PM, the patient was the parent of 2 young children and lived with the patient's parent.</p> <p>B. A home visit was made to the patient on 5-18-12 at 8:35 AM. The patient indicated there were insurance issues, that the only support available was the patient's mother, and that not being able to attend the patient's child's activities was very hard.</p> <p>C. The record failed to evidence the registered nurse had informed the physician of the potential need for a medical social services</p> <p>4. Clinical record number 12 included an interim physician's order dated 10-13-11 that states, "Discharge from Home Health Services. Patient has unsafe home environment."</p> <p>The record failed to evidence the physician had been informed of the potential need for a referral to medical social services.</p> <p>5. The administrator, employee C, was unable to provide any additional documentation and/or information when asked on 5-17-12 at 4:30 PM.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GIBSON HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
---	---

(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. The administrator, employee C, stated, on 5-18-12 at 9:45 AM, "I guess we don't use the social worker like we should."</p> <p>7. The agency's 11-2-11 "Referral Services" policy states, "Referral services will include Physical therapy, Occupational therapy, Speech therapy, and Medical Social Worker . . . Referral will be initiated by nursing following an assessment visit to the home, or by physician order."</p> <p>8. The agency's 11-6-11 "Medical Plan of Care (POC 485) / Add Orders / Re-Certification" policy states, "The physician is consulted to approve additions or modifications to the original plan."</p>			