STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151518	A. BUILDING 00 B. WING	02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEACONESS VNA	611 HARRIETT STREET P O BOX 3487 EVANSVILLE, IN 47734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.113. Survey Dates: 2/8/21-2/10/21 Facility Number: 005939 Census = 28 active At this Focused Infection Control Emergency Preparedness survey, in regards to staffing and implementation of staffing, Deaconess VNA was found to be in compliance with 42 CFR 418.113 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Hospice. Quality Review completed on 2/11/2021 A4	E 0000		
L 0000 Bldg. 00	This visit was for a Federal/State complaint investigation in conjunction with a Covid-19 focused survey. Complaint IN00345828: Unsubstantiated, lack of sufficient evidence Survey Dates: 2/8/21-2/10/21 Facility ID: 005939 Unduplicated last 12 month census: 399	L 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total Active Census: 28 Inpatient: 1 ALF: 1 SNF: 3			
L 0549 Bldg. 00	418.56(c)(4) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (4) Drugs and treatment necessary to meet the needs of the patient. Based on observation, record review, and interview, the agency failed to ensure the plan of care included a treatment order for 1 of 2 home visit observations. (Patient 2) Findings include: A revised 11/22/19 policy titled Hospice Plan of Care was provided by the CHI Manager Area Director B on 2/8/21 at 1:45 p.m. The policy indicated, but was not limited to, "Hospice services are furnished in accordance with a written Plan of Care (POC) ... " A revised 7/8/15 policy titled Medication Administration was provided by the CHI Manager Area Director B on 2/8/21 at 1:45. The policy indicated, but was not limited to, "All nurses may administer medications by ... transdermal, topical ... when following physician orders." During a home visit on 2/9/21 at 10:30 a.m. RN (registered nurse) C was observed assessing patient 2's abdominal folds and under both breast for redness. RN C indicated Interdry (anti-microbial moisture wicking) dressing was in place to patient 2's abdominal folds and under	L 0549	L549 Mandatory in-service for all field staff regarding: Hospice services are furnished in accordance with a written Plan of Care and all nurses administering medications must be following physician orders was completed by the Director of Clinical Services and designee on 02/10/21 and 02/26/21. Education provided included the following policies: 82.82 IDH Coordination of Care Hospice Education included following education sheet: "Why do we follow a plan of care" Staff unable to attend the in-service will be provided an educational packet on the above education no later than 03/04/2021. After discussion with IDG Patient	03/05/2021

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	right breast. RN C cut Interdry dressing and placed the dressing under patient 2's left breast. RN C indicated the family changes the dressings when the nurse was not there. The complete clinical record for patient 2 was reviewed on 2/9/21, start of care date 7/16/20 for the election period 1/12/21 to 3/12/21. A review of the updated plan of care failed to evidence a treatment order for Interdry dressing. A review of the electronic medical record failed to evidence a physician order for Interdry dressing. During an interview on 2/10/21 at 9:00 a.m. the Administrator agreed there should have been an order for Interdry.		# 2 orders were updated to include Interdry on 02/19/21. To ensure compliance with the above policies, the Director of Clinical Services or designee will complete 4 chart reviews for 3 months, to ensure physician orders are in place for all interventions. On-going monitoring will be completed as part of the quarterly quality improvement process to include clinical record reviews by Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Administrator/Director of Operations with oversight by the Governing Body.	
L 0578 Bldg. 00	418.60 INFECTION CONTROL The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases. Based on observation, record review, and interview, the agency failed to follow agency policy regarding bag technique for 1 of 2 home visit observations (Patient 2); and failed to screen visitors for Covid-19 upon entry to the agency for 2 of 3 survey visit dates.	L 0578	L578 Mandatory in-service for all field staff regarding: infection control/bag technique was completed by the Director of Clinical Services and designee on 02/09/21 and 02/25/21.	03/05/2021

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	Findings include: 1. A 2/14/17 policy titled Bag Technique was provided by the CHI Manager Area Director B on 2/8/21 at 1:45 p.m. The policy indicated, but was not limited to, " ... keep the bag closed during the visit ... " 2. A 10/23/20 policy titled Pandemic Regulatory Guidance was provided by the CHI Manager Area Director B on 2/8/21 at 4:05 p.m. The policy indicated, but was not limited to, "Visitor restriction are to follow recommended infection control guidance from the CDC and State Health Departments." 3. A 10/24/19 policy titled Infection Control Surveillance was provided by the CHI Manager Area Director B on 2/8/21 at 4:05 p.m. The policy indicated, but was not limited to, "2. The Company takes reasonable efforts to protect the patient and the associate from infectious and communicable disease". 4. During a home visit on 2/9/21 at 10:30 a.m. RN (registered nurse) C was observed removing vital sign equipment from his/her supply bag. RN C failed to zip the bag closed before providing patient care. 5. Upon entering the agency's office, no Covid-19 (virus) screening process including temperature checks, symptom check or questions about travel was conducted for either of the State Health Surveyors on 2 of 3 days (2/8/21, 2/9/21). 6. During an interview on 2/9/21 at 12:40 p.m. the Administrator was asked if the agency had a Covid-19 screening process for those entering the agency. The Administrator stated the agency		Education provided included the following policy: 33.83 Bag Technique One on one education with RN C was completed on 02/10/21. Staff unable to attend the in-service will be provided an educational packet on the above education no later than 03/04/2021. On-going monitoring will be completed as part of quarterly quality improvement process that includes 2 shared visits (in person or remote) for observation of care by Director of Clinical Services or designee for 3 months. L578 Mandatory in-service for all staff that work the reception desk screening regarding: Pandemic regulatory requirements and infection control guidance for visitors was completed by the Director of Clinical Services and designee on 02/09/21 and 02/10/21. Additional signage was added to the front desk notifying all visitors to stop for screening on 02/09/21 Education provided included the following: Deaconess Linda E. White Hospice House Visitor Screening Process	

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	followed the same policy the hospital did and the hospital was currently taking visitor's temperatures and asking questions about travel and Covid exposure.		To ensure compliance with the above process the Director of Clinical Services or designee will do rounds daily of the reception entrance, inpatient unit, and office areas to monitor process compliance. This compliance process will be under the direct supervision of the Administrator/Director of Operations with oversight by the Governing Body.	