

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 01/09/2015
--	---	--	---

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
G000000	<p>This was a Federal home health recertification survey.</p> <p>Survey Dates: 1-6-15, 1-7-15, 1-8-15, and 1-9-15</p> <p>Facility #: 008814</p> <p>Medicaid Vendor #: 200060430</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Gibson Home Health was found to be out of compliance with 42 CFR 484.18 Acceptance of Patients, Plan of Care and Medical Supervision; 42 CFR 484.30 Skilled Nursing Services; and 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>Gibson Home Health Services is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 1-9-15 due to being found out of compliance with 42 CFR 484.18 Acceptance of Patients, Plan of Care and Medical Supervision; 42 CFR 484.30 Skilled Nursing Services; and 42 CFR 484.55 Comprehensive Assessment of Patients.</p>	G000000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2015
--	---	--	---

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
G000156	<p>Quality Review: Joyce Elder, MSN, BSN, RN January 14, 2015</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure services had been provided in accordance with physician orders in 5 of 12 records reviewed creating the potential to affect all of the agency's 36 current patients (See G 158); by failing to ensure plans of care included all required items in 3 of 12 records reviewed creating the potential to affect all of the agency's 36 current patients (See G 159); and by failing to ensure the physician had been alerted to changes in the patient's condition in 1 of 12 records reviewed creating the potential to affect all of the agency's 36 current patients (See G 164).</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 of Patients, Plan of Care and Medical Supervision.</p>	G000156	<p>The Administrator will in-service all staff on the Plan of Care and additional Physician orders which are required for all patient care, and will include the citations of 1. Frequency of visits 2. Orders for treatments which includes: dressings, venipunctures, cold packs, etc. 3. Notification of changes in the patient condition to the physician. Administrator will review the Medical Plan of Care policy with the staff. All inservice education will be completed by 1/30/2015</p> <p>100% of Physician orders and Plans of Care will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audit for at least one corrective actions will be reviewed at the monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these</p>	01/30/2015

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 01/09/2015
--	---	--	---

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
G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and agency policy review and interview, the agency failed to ensure services had been provided in accordance with physician orders in 5 (#s 2, 6, 9, 10, and 12) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a physician telephone order dated 12-20-14 that identified occupational therapy (OT) was to be provided 1 time a week for 1 week, 3 times per week for 1 week, 1 time per week for 1 week, and 2 times per week for 5 weeks.</p> <p>A. The record evidenced only 1 OT visit had been provided the week of 12-28-14.</p>	G000158	<p>corrective actions to ensure that the Plan of Care and Physician Orders deficiency has been corrected and will not recur.</p> <p>The Administrator will in-service all staff on the Plan of Care and additional Physician orders which are required for all patient care, and will include the citations of 1. Frequency of visits 2. Orders for treatments which includes: dressings, venipunctures, cold packs, etc. 3. Notification of changes in the patient condition to the physician. Administrator will review the Medical Plan of Care policy with the staff. All in-service education will be completed by 01/30/2015.</p> <p>100% of Physician orders and Plans of Care will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective actions will be reviewed with the monthly staff meeting.</p>	01/30/2015

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 01/09/2015	
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. The administrator indicated, on 1-6-15 at 3 PM, the OT visits had not been provided as ordered the week of 12-28-14. The administrator stated, "They had the flu in the department and they had no one to send."</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 12-1-14 to 1-29-15. The plan of care identified home health aide services were to be provided 4 times per week for 8 weeks.</p> <p>A. The record evidenced home health aide services had been provided only 3 times per week the weeks of 12-1-14, 12-7-14, 12-14-14, 12-21-14, and 12-28-14.</p> <p>B. The administrator stated, on 1-7-15 at 2:45 PM, "The patient originally wanted home health aide services 4 times per week but then decided 3 times was enough. There was no order to change the plan of care."</p> <p>3. Clinical record number 9 included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports that [the patient] was moving from the wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend</p>		The Administrator will be responsible for monitoring these corrective actions to ensure that the Plan of Care and Physician Orders deficiency has been corrected and will not recur.				

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 01/09/2015
--	---	--	---

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>and therapist will check next week."</p> <p>A. A SN visit note dated 11-28-14 identifies 2 + edema in the upper arm. The note states, "pt rates should [shoulder] pain # 3, no pain meds taken. Instructed On: Use of breakthrough medication, Cold therapy."</p> <p>B. The record failed to include an order for the use of ice to the right shoulder.</p> <p>C. The registered nurse (RN), employee H, indicated, on 1-8-15 at 3:35 PM, the record did not include an order for the application of ice to the right shoulder.</p> <p>4. Clinical record number 10 included a physician verbal order dated 12-22-14 that states, "SN [skilled nurse] Venipuncture for CBC [complete blood count] 12262014." The record failed to evidence the Venipuncture had been completed.</p> <p>A. The administrator was unable to provide any additional documentation and/or information when asked regarding the ordered Venipuncture on 1-9-15 at 11:10 AM.</p> <p>B. The record included a PT visit note</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 01/09/2015
--	---	--	---

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>dated 1-2-15 that identified the therapist applied Mepilex border to wounds on the patient's bilateral lower extremities. The record failed to include an order for the therapist to apply the Mepilex to the wounds.</p> <p>C. The administrator indicated, on 1-8-15 at 10:55 AM, the record did not include an order for the physical therapist to apply the Mepilex to the wounds.</p> <p>5. Clinical record number 12 included physician verbal orders dated 5-30-14 that identified a Venipuncture was to be performed for a PT/INR (blood test for clotting time) on 6-1-14. The record failed to evidence the Venipuncture had been completed as ordered.</p> <p>A. The record included a physician verbal order dated 6-10-14 that identified a Venipuncture was to be performed for a PT/INR on 6-11-14. The record failed to evidence the Venipuncture had been performed as ordered.</p> <p>B. The administrator indicated, on 1-9-15 at 9:45 AM, the Venipunctures on 6-1-14 and 6-11-14 had not been completed per the physician's orders.</p> <p>6. The agency's 11-27-12 "Medical Plan of Care (POC 485) / Add Orders /</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 01/09/2015
--	---	--	---

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
G000159	<p>Re-Certification" policy states, "All patients admitted to home health services will have a POC . . . To ensure current orders for services and provide effective care, treatment, and services for the patient."</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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all required items in 3 (#s 2, 8, and 11) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care for the certification period 12-5-14 to 2-2-15 that states, "Change negative pressure wound therapy dressing 3 times/week and PRN MWF [as needed on Monday, Wednesday, Friday]."</p>	G000159	The Administrator will in-service all staff on the Plan of Care Policy/Re-certification Policy which covers all pertinent diagnoses, including mental status, type of services and equipment required, frequency of visits, prognosis, rehabilitation potential, function limitations, activities permitted, nutritional requirement, medications and treatments any safety measures to protect against injury instructions for timely discharge or referral, and any other appropriated items. The Administrator will, also, review the citations of Wound Vac orders, nutritional supplements, and	01/30/2015

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 01/09/2015
--	---	--	---

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>Therapy setting: continuous Therapy setting: intermittent. Negative Pressure Setting (mmHg [millimeters of mercury]) 125 mmHg." The orders failed to specify the type of dressing to be used and if the pressure was continuous or intermittent."</p> <p>A. The administrator indicated, on 1-6-15 at 3 PM, the agency uses KCI for the negative pressure wound therapy and uses their instructions as the agency's policy and procedure.</p> <p>B. The KCI "V.A.C. [vacuum assisted closure] Clinical Guidelines" states, "Physician Order: All V.A.C. Therapy systems require a physician's order. The following information should be included: . . . Therapy settings (i.e.: Intermittent or Continuous) . . . Dressing to be used (i.e. V.A.C. GranuFoam or V.A.C. Vers-foam Dressings."</p> <p>2. Clinical record number 8 included a plan of care for the certification period 11-7-14 to 1-5-15 that states, "Change negative pressure wound therapy dressing 3 times/week and PRN MWF. Therapy setting: continuous. Negative pressure Setting (mmHg) 125." The order failed to specify the type of dressing to be used.</p> <p>A. The administrator indicated, on 1-9-15 at 9:50 AM, the agency uses KCI</p>		<p>frequency of visits. All in-service education will be completed by 1/30/2015.</p> <p>100% of Physician orders and Plan of Care will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the Plan of Care and Physician Orders deficiency has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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>for the negative pressure wound therapy and uses their instructions as the agency's policy and procedure.</p> <p>B. The KCI "V.A.C. [vacuum assisted closure] Clinical Guidelines" states, "Physician Order: All V.A.C. Therapy systems require a physician's order. The following information should be included: . . . Therapy settings (i.e.: Intermittent or Continuous) . . . Dressing to be used (i.e. V.A.C. GranuFoam or V.A.C. Vers-foam Dressings."</p> <p>3. Clinical record number 11 included a physician verbal order dated 4-22-14 that states, "AID Provide personal care and assistance with ADLs [activities of daily living]." The order failed to specify the frequency and duration of the aide visits. The record evidenced aide services had been provided by the registered nurse 1 to 2 times per week.</p> <p>A. The record included skilled nurse (SN) visit notes, dated 4-15-14, 4-17-14, 4-22-14, 4-24-14, 4-29-14, and 5-7-14, that identified the patient used Glucerna, a nutritional supplement used to help stabilize blood sugars. The plan of care, for the certification period 4-11-14 to 6-9-14, failed to include the nutritional supplement.</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 01/09/2015
--	---	--	---

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
G000164	<p>B. The administrator was unable to provide any additional information / documentation regarding the inclusion of the Glucerna on the plan of care when asked on 1-9-15 at 11 AM.</p> <p>4. The agency's 11-27-12 "Medical Plan of Care (POC 485)/Add Orders/Re-Certification" policy states, "The POC includes, but is not limited to the following: . . . e. frequency of visits f. Duration of visits . . . l. Nutritional requirements."</p> <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 and interview, the agency failed to ensure the physician had been alerted to changes in the patient's condition in 1 (# 9) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients</p> <p>The findings include:</p> <p>1. Clinical record number 9 failed to evidence the registered nurse (RN) or the physical therapist had reported the patient's right shoulder pain to the physician and failed to evidence the RN</p>	G000164	The Administrator will in-service the staff on the Communication with the Physician policy, and review the specifications of occurrences when the physician was not notified. All in-service education will be completed by 1/30/2015. 100% of the clinical notes from all patients charts will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings. The	01/30/2015

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 01/09/2015	
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>reported a change in the patient's respiratory status and complaints of severe pain to the physician.</p> <p>A. The record included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports that [the patient] was moving from wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend and therapist will check next week. A SN visit note dated 11-28-14 identifies swelling in the right upper arm and that the patient continued to have pain in the right shoulder.</p> <p>B. A communication note, signed and dated by employee K, a physical therapist, on 11-10-14 states, "Pt's caregiver called to cancel PT [physical therapy] for the week d/t [due to] pt falling and 'spraining' [the patient's] shoulder. MD recommended 'taking it easy with PT' for a while."</p> <p>C. A "Home Health Therapy Note", dated 11-25-14, states, "Pt c/o [complained of] [right] shoulder 'popping out.' Denies pain in shoulder but states [the patient's] shoulder really hurts from the back all around the front when it 'pops' out . . . possible [right] RTC [rotator cuff] tear."</p>		<p>Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of physician notification of all changes in the patient's condition has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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>D. A "Home Health Therapy Note", dated 11-28-14, states, "Pt reports [right] shoulder is still sore. Caregiver reports [the caregiver] will call MD Monday unless [the patient] has pain [the caregiver] will take [the patient] to ER [emergency room]."</p> <p>E. A SN visit note dated 1-2-15 identifies the patient had a new onset of an intermittent, productive cough with thick white sputum and was congested. The note states, "Pt complaining of abd [abdominal] discomfort, reporting feels like kidneys. pt rates pain # 10. pt reports more on the rt middle side of abdomen."</p> <p>F. The record included a transfer comprehensive assessment dated 1-6-15 that identified the patient had been admitted to the hospital for a "respiratory infection (e.g., pneumonia, bronchitis."</p> <p>2. The RN, employee H, indicated, on 1-8-15, she had reported the patient's shoulder problem to the physician but had not documented it. The nurse stated, regarding the respiratory change, "The patient had seen the doctor at the Tulip Tree the day before." The physician that established the plan of care for this patient was not at the clinic the patient</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 01/09/2015
--	---	--	---

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
G000168	<p>had been to the day before.</p> <p>3. The agency's 2-2-12 "Communication with Physician" policy states, "The professional staff will call for additional orders as the patient condition changes . . . Verbal communication will take place at the discretion of the professional staff as condition warrants . . . All communication will be documented in the medical record."</p> <p>484.30 SKILLED NURSING SERVICES Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure skilled nursing services had been provided in accordance with physician orders in 4 of 12 records reviewed creating the potential to affect all of the agency's 36 current patients (See G 170); by failing to ensure the registered nurse had initiated preventative nursing procedures in 4 of 12 records reviewed creating the potential to affect all of the agency's 36 current patients (See G 175); and by failing to ensure the registered nurse had alerted the physician to changes in the patient's condition in 1 of 12 records reviewed creating the potential to affect all of the agency's 36</p>	G000168	<p>The Administrator will in-service all staff on the Plan of Care and additional Physician orders which are required for all patient care, and will include the citations of 1. Frequency of visits 2. Orders for treatments which includes: dressings, venipunctures, cold packs, etc. 3. Notification of changes in the patient condition to the physician. The Administrator will review the specific citations with the in-service that includes preventative nursing procedures. All in-service education will be completed by 1/30/2015.</p> <p>100% of the Physician Orders, Plan of Care and clinical notes from all patients charts will be monitored for no less than three months until</p>	01/30/2015

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 01/09/2015
--	---	--	---

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
G000170	<p>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 condition, 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 skilled nursing services had been provided in accordance with physician orders in 3 (#s 9, 10, and 12) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 9 included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports</p>	G000170	<p>compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of physician notification of all changes in the patient's condition and correct physician orders has been corrected and will not recur.</p> <p>The Administrator will in-service all staff on the Plan of Care and additional Physician orders which are required for all patient care, and will include the citations of 1. Frequency of visits 2. Orders for treatments which includes: dressings, venipunctures, cold packs, etc. 3. Notification of changes in the patient condition to the physician. Administrator will review the Medical Plan of Care policy with the staff. All in-service education will be completed by 01/30/2015.</p>	01/30/2015

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 01/09/2015
--	---	--	---

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>that [the patient] was moving from the wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend and therapist will check next week."</p> <p>A. A skilled nurse (SN) visit note dated 11-28-14 identifies 2 + edema in the upper arm. The note states, "pt rates should [shoulder] pain # 3, no pain meds [medications] taken. Instructed On: Use of breakthrough medication, Cold therapy."</p> <p>B. The record failed to include an order for the use of ice to the right shoulder.</p> <p>C. The registered nurse (RN), employee H, indicated, on 1-8-15 at 3:35 PM, the record did not include an order for the application of ice to the right shoulder.</p> <p>2. Clinical record number 10 included a physician verbal order dated 12-22-14 that states, "SN Venipuncture for CBC [complete blood count] 12262014." The record failed to evidence the Venipuncture had been completed.</p> <p>The administrator was unable to provide any additional documentation and/or information when asked regarding</p>		<p>100% of Physician orders and Plans of Care will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective actions will be reviewed with the monthly staff meeting.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the Plan of Care and Physician Orders deficiency has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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
G000175	<p>484.30(a)</p> <p>the ordered Venipuncture on 1-9-15 at 11:10 AM.</p> <p>3. Clinical record number 12 included physician verbal orders dated 5-30-14 that identified a Venipuncture was to be performed for a PT/INR (blood test for clotting time) on 6-1-14. The record failed to evidence the Venipuncture had been completed as ordered.</p> <p>A. The record included a physician verbal order dated 6-10-14 that identified a Venipuncture was to be performed for a PT/INR on 6-11-14. The record failed to evidence the Venipuncture had been performed as ordered.</p> <p>B. The administrator indicated, on 1-9-15 at 9:45 AM, the Venipunctures on 6-1-14 and 6-11-14 had not been completed per the physician's orders.</p> <p>4. The agency's 11-27-12 "Medical Plan of Care (POC 485)/Add Orders/ Re-Certification" policy states, "All patients admitted to home health services will have a POC . . . To ensure current orders for services and provide effective care, treatment, and services for the patient."</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 01/09/2015	
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>DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had initiated preventative nursing procedures in 4 (#s 8, 9, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 8 included a resumption of care after an inpatient stay comprehensive assessment dated 11-19-14. The assessment identified the patient had a "fair" appetite and "required more instruction" regarding the prescribed diet." The record failed to evidence the RN had initiated a plan to address the identified need for further dietary instruction. Clinical record number 9 included a start of care comprehensive assessment dated 9-16-14 and a recertification comprehensive assessment dated 11-14-14 that identified the patient had an arteriovenous graft in the left arm. The record failed to evidence the RN had initiated a plan for the care and maintenance of the dialysis access. 	G000175	<p>The Administrator will in-service the nursing staff regarding duties of the Registered Nurse, initiating appropriate, preventative, and rehabilitative procedures. Specific citations that will be reviewed are Nutrition/Diet Needs, Plans of Care for Dialysis patients, and CHF monitoring. All in-service education will be completed by 1/30/2015. 100% of the Physician Orders, Plan of Care and clinical notes from all patients charts will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of nursing initiating appropriate, preventative and rehabilitative nursing procedures has been corrected and will not recur.</p>	01/30/2015			

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 01/09/2015
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	
G000176	<p>3. Clinical record number 11 included a plan of care for the certification period 4-11-14 to 6-9-14 that identified the patient had a secondary diagnosis of congestive heart failure and the patient or caregiver was to "record patient's weight daily and report weight gain of 2 pounds in 24 hours or 5 pounds in 1 week." The record failed to evidence the RN had initiated a plan of check for compliance with regards to the daily weights and to monitor the patient's weight.</p> <p>4. Clinical record number 12 included a start of care comprehensive assessment dated 5-24-14 that identified the patient had a dialysis access in the right arm. The record failed to evidence the RN had initiated a plan for the care and maintenance of the dialysis access.</p> <p>5. The administrator indicated, on 1-9-15 at 10:30 AM., records numbered 8, 9, 11, and 12 did not evidence the RN had initiated plans to address the identified problems.</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</p>	G000176		01/30/2015	

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 01/09/2015
--	---	--	---

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>policy review and interview, the agency failed to ensure the registered nurse (RN) had alerted the physician to changes in the patient's condition in 1 (# 9) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients</p> <p>The findings include:</p> <p>1. Clinical record number 9 failed to evidence the registered nurse (RN) or the physical therapist had reported the patient's right shoulder pain to the physician and failed to evidence the RN reported a change in the patient's respiratory status and complaints of severe pain to the physician.</p> <p>A. The record included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports that [the patient] was moving from wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend and therapist will check next week. A SN visit note dated 11-28-14 identifies swelling in the right upper arm and that the patient continued to have pain in the right shoulder.</p> <p>B. A communication note, signed and dated by employee K, a physical</p>		<p>The Administrator will in-service the staff regarding duties of the Registered Nurse preparing clinical and progress notes, coordinating services, informing the physician and other personnel of changes in the patient's condition and needs. The Administrator will review the Communication Physician policy with the nursing staff. All in-service education will be completed by 1/30/2015.</p> <p>100% of the Physician Orders, Plan of Care and clinical notes from all patients charts will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of the nurse preparing the clinical and progress notes, coordinating services, and informing the physician and other personnel of changes in the patient's condition and needs has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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>therapist, on 11-10-14 states, "Pt's caregiver called to cancel PT [physical therapy] for the week d/t [due to] pt falling and 'spraining' [the patient's] shoulder. MD recommended 'taking it easy with PT' for a while."</p> <p>C. A "Home Health Therapy Note", dated 11-25-14, states, "Pt c/o [complained of] [right] shoulder 'popping out.' Denies pain in shoulder but states [the patient's] shoulder really hurts from the back all around the front when it 'pops' out . . . possible [right] RTC [rotator cuff] tear."</p> <p>D. A "Home Health Therapy Note", dated 11-28-14, states, "Pt reports [right] shoulder is still sore. Caregiver reports [the caregiver] will call MD Monday unless [the patient] has pain [the caregiver] will take [the patient] to ER [emergency room]."</p> <p>E. A SN visit note dated 1-2-15 identifies the patient had a new onset of an intermittent, productive cough with thick white sputum and was congested. The note states, "Pt complaining of abd [abdominal] discomfort, reporting feels like kidneys. pt rates pain # 10. pt reports more on the rt middle side of abdomen."</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 01/09/2015	
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			
G000330	<p>F. The record included a transfer comprehensive assessment dated 1-6-15 that identified the patient had been admitted to the hospital for a "respiratory infection (e.g., pneumonia, bronchitis."</p> <p>2. The RN, employee H, indicated, on 1-8-15, she had reported the patient's shoulder problem to the physician but had not documented it. The nurse stated, regarding the respiratory change, "The patient had seen the doctor at the Tulip Tree the day before." The physician that established the plan of care for this patient was not at the clinic the patient had been to the day before.</p> <p>3. The agency's 2-2-12 "Communication with Physician" policy states, "The professional staff will call for additional orders as the patient condition changes . . . Verbal communication will take place at the discretion of the professional staff as condition warrants . . . All communication will be documented in the medical record."</p> <p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately</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 01/09/2015
--	---	--	---

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>reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure all current medications had been reviewed in 4 of 12 records reviewed creating the potential to affect all of the agency's 36 current patients (See G 337); by failing to ensure the comprehensive assessment had been updated to reflect the patient's current condition in 1 of 4 records reviewed of patients on service for greater than 60 days creating the potential to affect all of the agency's 36 current patients (See G 338); and by failing to ensure the comprehensive assessment had been updated at the time of transfer to an</p>	G000330	The Administrator will in-service the staff on the Comprehensive assessment of the patients. The comprehensive assessment must accurately reflect the patient's current health status and progress toward achievement of designated outcomes. It must address continuing needs and homebound status and must use the current version of the OASIS. The in-service will review all continued OASIS assessments Admission, Transfer, Resumption, and Discharge. The in-service will review the citation of the missing Transfer OASIS and wound documentation at assessments. The in-service will, also, include the agency's OASIS policy. All in-service education will	01/30/2015

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 01/09/2015
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	
G000337	<p>inpatient facility in 1 of 3 records reviewed of patients that had been transferred to the hospital creating the potential to affect all of the agency's patients that are transferred (See G 340).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record and agency policy review and interview, the agency failed to ensure all current medications had been reviewed in 4 (9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 36</p>	G000337	<p>be completed by 1/30/2015.</p> <p>100% of the OASIS assessments will be monitored for no less than three months until compliance is achieved, then 10% of all OASIS will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of the Comprehensive Assessments has been completed correctly and will not recur.</p> <p>The Administrator will in-service the nursing staff on completing the Drug regimen and sending to pharmacy for review at admission, recertification, resumption and when new medications are added,</p>	01/30/2015	

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 01/09/2015	
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>current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 9 evidenced the patient received dialysis 3 times per week. The record included a start of care comprehensive assessment dated 9-16-14 and a follow-up comprehensive assessment dated 11-14-14. The assessments failed to evidence the medications the patient received at the dialysis facility had been included in the drug regimen review.</p> <p>A. A telephone call was placed to the dialysis facility on 1-8-15 at 3:35 PM and a list of medications the patient received at the facility was received. The medications include Epogen (red blood cell stimulating agent), Iron, and Hectorol (Vitamin D).</p> <p>B. The registered nurse, employee H, stated, on 1-8-15 at 3:35 PM, "I did not check with the dialysis facility for medications the patient received there."</p> <p>2. Clinical record number 10 included a start of care comprehensive assessment dated 11-14-14. The assessment failed to evidence a review of all medications had been completed.</p>		<p>looking for any potential adverse effects and drug reactions, side effects, drug interactions, duplicate drug therapy and non compliance. The in-service will include Dialysis medications being obtained from the dialysis center and a list sent to pharmacy to review with current medication regimen. The dialysis medications will be added to the chart either on the plan of care or on a subsequent order for the physician. The Administrator will review the Drug Regimen policy. All in-service education will be completed by 1/30/2015.</p> <p>100% of the Drug Regimen's will be monitored for compliance with dialysis medications documentation and for completion of all drug reviews, no less than three months until compliance is achieved, then 10% of all Drug profiles will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of the Drug Regimen review, and the Dialysis drug review has been completed correctly and will not recur.</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 01/09/2015
--	---	--	---

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>A. The plan of care, for the certification period 11-14-14 to 01-12-15, included 17 different medications had been ordered by the physician.</p> <p>B. The administrator indicated, on on 1-8-15 at 10:55 AM, the comprehensive assessment did not evidence a drug review had been completed.</p> <p>3. Clinical record number 11 included skilled nurse visit notes, dated 4-15-14, 4-17-14, 4-22-14, 4-24-14, 4-29-14, and 5-7-14, that identified the patient used Glucerna, a nutritional supplement used to help stabilize blood sugars. The 4-11-14 start of care comprehensive assessment failed to evidence the Glucerna had been included in the drug regimen review.</p> <p>The administrator was unable to provide any additional documentation and/or information when asked on 1-9-15 at 11 AM.</p> <p>4. Clinical record number 12 evidenced the patient received dialysis treatment 3 times per week. The record included a start of care comprehensive assessment dated 5-24-14. The assessment failed to evidence the medications the patient received at the dialysis facility had been included in the drug regimen review.</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 01/09/2015
--	---	--	---

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
--------------------	--	---------------	---	----------------------

G000338	<p>A. A telephone call was placed to the dialysis facility on 1-7-15 at 4:15 PM and a list of medications the patient received at the facility was subsequently received. The medications included Epogen, Venofer (Iron), Vancomycin (antibiotic), and Hectorol.</p> <p>B. The registered nurse, employee H, stated, on 1-7-15 at 4:15 PM, " I did not call the dialysis facility to get the list of medications.</p> <p>5. The agency's 11-18-14 "Patient Drug Regimen" policy states, "Upon admission the home care nurse will identify all medications the patient is currently taking . . . The case manager will review each patient's drug regimen, medical chart contents, nurse's notes and other associated documentation in sufficient detail to determine if irregularities exist. This will be done upon admission and each time a new medications is added . . . Review of patient drug regimen on medication profile will be reviewed with recertification or no less than often than every 60 days."</p> <p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be</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 01/09/2015
--	---	--	---

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>updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the comprehensive assessment had been updated to reflect the patient's current condition in 1 (# 8) of 4 records reviewed of patients on service for greater than 60 days creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 8 included a follow-up comprehensive assessment dated 1-2-15 that identified the patient had a surgical wound on the rectum. The assessment failed to include a measurement of the wound. The record evidenced wound care had been provided to the patient since the start of care on 9-5-14 and had been ordered on the subsequent plan of care. 2. The administrator indicated, on 1-9-15 at 9:50 AM, the assessment did not evidence a measurement of the wound. 3. The agency's 11-7-13 "OASIS" policy states, "The comprehensive assessment must be updated and revised as 	G000338	<p>The Administrator will in-service the staff on the Comprehensive assessment of the patients. The comprehensive assessment must accurately reflect the patient's current health status and progress toward achievement of designated outcomes. It must address continuing needs and homebound status and must use the current version of the OASIS. The in-service will review all continued OASIS assessments Admission, Transfer, Resumption, and Discharge. The in-service will review the citation of the missing Transfer OASIS and wound documentation at assessments. The in-service will, also, include the agency's OASIS policy. All in-service education will be completed by 1/30/2015.</p> <p>100% of the OASIS assessments will be monitored for no less than three months until compliance is achieved, then 10% of all OASIS will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p>	01/30/2015

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 01/09/2015
--	---	--	---

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
G000341	<p>frequently as the patient's condition requires, but not less frequency than every 55-60 days."</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record and agency policy review and interview, the agency failed to ensure the comprehensive assessment had been updated at the time of transfer to an inpatient facility in 1 (# 12) of 3 records reviewed of patients that had been transferred to the hospital creating the potential to affect all of the agency's patients that are transferred.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 12 included a nurse's note dated 6-24-14 that identified the patient had been transferred to the hospital for stabilization of the bleeding time, PT/INR. The record failed to evidence a transfer comprehensive assessment had been completed. 2. The administrator indicated, on 1-7-15 	G000341	<p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of the Comprehensive Assessments has been completed correctly and will not recur.</p> <p>The Administrator will in-service the staff on the Comprehensive assessment of the patients. The comprehensive assessment must accurately reflect the patient's current health status and progress toward achievement of designated outcomes. It must address continuing needs and homebound status and must use the current version of the OASIS. The in-service will review all continued OASIS assessments Admission, Transfer, Resumption, and Discharge. The in-service will review the citation of the missing Transfer OASIS and wound documentation at assessments. The in-service will, also, include the agency's OASIS policy. All in-service education will be completed by 1/30/2015. 100% of the OASIS assessments will be monitored for no less than three months until compliance is achieved, then 10% of all OASIS</p>	01/30/2015

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 01/09/2015
--	---	--	---

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
N000000	<p>at 4 PM, the record did not include a transfer comprehensive assessment.</p> <p>3. The agency's 11-7-13 "OASIS" policy states, "The comprehensive assessment, which includes the OASIS data set items, must be updated and revised as follows: . . . At transfer to another facility."</p>		<p>will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of the Comprehensive Assessments has been completed correctly and will not recur.</p>	
	<p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 1-6-15, 1-7-15, 1-8-15, and 1-9-15</p> <p>Facility #: 008814</p> <p>Medicaid Vendor #: 200060430</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 14, 2015</p>	N000000		
N000464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff</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 01/09/2015
--	---	--	---

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>members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with:</p> <p>(A) a documented:</p> <p>(i) history of tuberculosis;</p> <p>(ii) previously positive test result for tuberculosis; or</p> <p>(iii) completion of treatment for tuberculosis; or</p> <p>(B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must:</p> <p>(A) be completed annually; and</p> <p>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain</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 01/09/2015
--	---	--	---

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>documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure all direct care employees had an annual tuberculosis (TB) skin test in 5 (files K, P, Q, R, and T) of 5 personnel files reviewed of employees eligible to receive the TB skin test creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file K evidenced the individual had been hired on 8-10-12 to provide physical therapy (PT) services to patients on behalf of the agency. The file evidenced the most recent TB skin test had been administered on 10-23-13. 2. Personnel file P evidenced the individual had been hired on 7-25-96 to provide home health aide services to patients on behalf of the agency. The file evidenced the most recent TB skin test had been administered on 10-11-13. 3. Personnel file Q evidenced the individual had been hired on 8-14-06 as 	N000464	<p>The Administrator will have all expired employees with Tuberculin testing receive the tuberculin skin test . Documentation will be placed in the employee files after completion. The Tuberculin testing will be added to the Infection Prevention/ Control Plan for Home Health and will be preformed annually. 100% of all employee files will be reviewed annually for competency. 100% of all current files will be reviewed for current documentation. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	01/30/2015

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 01/09/2015
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>the agency's administrator and to provide skilled nursing services on behalf of the agency. The file evidenced the most recent TB skin test had been administered on 10-18-13.</p> <p>4. Personnel file R evidenced the individual had been hired on 4-14-99 to provide skilled nursing services to patients on behalf of the agency. The file evidenced the most recent TB skin test had been administered on 10-21-13.</p> <p>5. Personnel file T evidenced the individual had been hired on 10-4-95 to provide PT assistant services to patients on behalf of the agency. The file evidenced the most recent TB skin test had been administered on 10-21-13.</p> <p>6. The administrator indicated, on 1-9-15 at 12:30 PM, the hospital had "changed their policy" and that "no one has had a TB test since October 2013." The administrator indicated risk assessments were to be completed annually.</p> <p>7. The hospital's 10-8-14 "Tuberculosis (TB) Control Plan" states, "Appendix B. Tuberculosis (TB) risk assessment worksheet. This model worksheet is for use in performing TB risk assessments for Gibson General Hospital (inpatient, outpatient services including 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 01/09/2015
--	---	--	---

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
N000522	<p>emergency room and physician offices), Home Health, and the skilled nursing facility."</p> <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 had been provided in accordance with physician orders in 5 (#s 2, 6, 9, 10, and 12) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a physician telephone order dated 12-20-14 that identified occupational therapy (OT) was to be provided 1 time a week for 1 week, 3 times per week for 1 week, 1 time per week for 1 week, and 2 times per week for 5 weeks.</p> <p>A. The record evidenced only 1 OT visit had been provided the week of 12-28-14.</p> <p>B. The administrator indicated, on</p>	N000522	The Administrator will in-service all staff on the Plan of Care and additional Physician orders which are required for all patient care, and will include the citations of 1. Frequency of visits 2. Orders for treatments which includes: dressings, venipunctures, cold packs, etc. 3. Notification of changes in the patient condition to the physician. Administrator will review the Medical Plan of Care policy with the staff. All in-service education will be completed by 01/30/2015. 100% of Physician orders and Plans of Care will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective actions will be reviewed with the monthly staff meeting. The Administrator will be responsible for monitoring these corrective actions to ensure	01/30/2015

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 01/09/2015
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>1-6-15 at 3 PM, the OT visits had not been provided as ordered the week of 12-28-14. The administrator stated, "They had the flu in the department and they had no one to send."</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 12-1-14 to 1-29-15. The plan of care identified home health aide services were to be provided 4 times per week for 8 weeks.</p> <p>A. The record evidenced home health aide services had been provided only 3 times per week the weeks of 12-1-14, 12-7-14, 12-14-14, 12-21-14, and 12-28-14.</p> <p>B. The administrator stated, on 1-7-15 at 2:45 PM, "The patient originally wanted home health aide services 4 times per week but then decided 3 times was enough. There was no order to change the plan of care."</p> <p>3. Clinical record number 9 included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports that [the patient] was moving from the wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend and therapist will check next week."</p>		that the Plan of Care and Physician Orders deficiency has been corrected and will not recur.		

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 01/09/2015
--	---	--	---

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>A. A SN visit note dated 11-28-14 identifies 2 + edema in the upper arm. The note states, "pt rates should [shoulder] pain # 3, no pain meds taken. Instructed On: Use of breakthrough medication, Cold therapy."</p> <p>B. The record failed to include an order for the use of ice to the right shoulder.</p> <p>C. The registered nurse (RN), employee H, indicated, on 1-8-15 at 3:35 PM, the record did not include an order for the application of ice to the right shoulder.</p> <p>4. Clinical record number 10 included a physician verbal order dated 12-22-14 that states, "SN [skilled nurse] Venipuncture for CBC [complete blood count] 12262014." The record failed to evidence the Venipuncture had been completed.</p> <p>A. The administrator was unable to provide any additional documentation and/or information when asked regarding the ordered Venipuncture on 1-9-15 at 11:10 AM.</p> <p>B. The record included a PT visit note dated 1-2-15 that identified the therapist</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 01/09/2015
--	---	--	---

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>applied Mepilex border to wounds on the patient's bilateral lower extremities. The record failed to include an order for the therapist to apply the Mepilex to the wounds.</p> <p>C. The administrator indicated, on 1-8-15 at 10:55 AM, the record did not include an order for the physical therapist to apply the Mepilex to the wounds.</p> <p>5. Clinical record number 12 included physician verbal orders dated 5-30-14 that identified a Venipuncture was to be performed for a PT/INR (blood test for clotting time) on 6-1-14. The record failed to evidence the Venipuncture had been completed as ordered.</p> <p>A. The record included a physician verbal order dated 6-10-14 that identified a Venipuncture was to be performed for a PT/INR on 6-11-14. The record failed to evidence the Venipuncture had been performed as ordered.</p> <p>B. The administrator indicated, on 1-9-15 at 9:45 AM, the Venipunctures on 6-1-14 and 6-11-14 had not been completed per the physician's orders.</p> <p>6. The agency's 11-27-12 "Medical Plan of Care (POC 485) / Add Orders / Re-Certification" policy states, "All</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 01/09/2015
--	---	--	---

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
N000524	<p>patients admitted to home health services will have a POC . . . To ensure current orders for services and provide effective care, treatment, and services for the patient."</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 required items in 3 (#s 2, 8, and 11) of 12 records reviewed creating the potential to</p>	N000524	The Administrator will in-service all staff on the Plan of Care Policy/Re-certification Policy which covers all pertinent diagnoses, including mental status, type of	01/30/2015

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 01/09/2015
--	---	--	---

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>affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care for the certification period 12-5-14 to 2-2-15 that states, "Change negative pressure wound therapy dressing 3 times/week and PRN MWF [as needed on Monday, Wednesday, Friday]. Therapy setting: continuous Therapy setting: intermittent. Negative Pressure Setting (mmHg [millimeters of mercury]) 125 mmHg." The orders failed to specify the type of dressing to be used and if the pressure was continuous or intermittent."</p> <p>A. The administrator indicated, on 1-6-15 at 3 PM, the agency uses KCI for the negative pressure wound therapy and uses their instructions as the agency's policy and procedure.</p> <p>B. The KCI "V.A.C. [vacuum assisted closure] Clinical Guidelines" states, "Physician Order: All V.A.C. Therapy systems require a physician's order. The following information should be included: . . . Therapy settings (i.e.: Intermittent or Continuous) . . . Dressing to be used (i.e. V.A.C. GranuFoam or V.A.C. Vers-foam Dressings."</p>		<p>services and equipment required, frequency of visits, prognosis, rehabilitation potential, function limitations, activities permitted, nutritional requirement, medications and treatments any safety measures to protect against injury instructions for timely discharge or referral, and any other appropriated items. The Administrator will, also, review the citations of Wound Vac orders, nutritional supplements, and frequency of visits. All in-service education will be completed by 1/30/2015.</p> <p>100% of Physician orders and Plan of Care will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the Plan of Care and Physician Orders deficiency has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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. Clinical record number 8 included a plan of care for the certification period 11-7-14 to 1-5-15 that states, "Change negative pressure wound therapy dressing 3 times/week and PRN MWF. Therapy setting: continuous. Negative pressure Setting (mmHg) 125." The order failed to specify the type of dressing to be used.</p> <p>A. The administrator indicated, on 1-9-15 at 9:50 AM, the agency uses KCI for the negative pressure wound therapy and uses their instructions as the agency's policy and procedure.</p> <p>B. The KCI "V.A.C. [vacuum assisted closure] Clinical Guidelines" states, "Physician Order: All V.A.C. Therapy systems require a physician's order. The following information should be included: . . . Therapy settings (i.e.: Intermittent or Continuous) . . . Dressing to be used (i.e. V.A.C. GranuFoam or V.A.C. Vers-foam Dressings."</p> <p>3. Clinical record number 11 included a physician verbal order dated 4-22-14 that states, "AID Provide personal care and assistance with ADLs [activities of daily living]." The order failed to specify the frequency and duration of the aide visits. The record evidenced aide services had been provided by the registered nurse 1 to 2 times per week.</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 01/09/2015
--	---	--	---

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
N000527	<p>A. The record included skilled nurse (SN) visit notes, dated 4-15-14, 4-17-14, 4-22-14, 4-24-14, 4-29-14, and 5-7-14, that identified the patient used Glucerna, a nutritional supplement used to help stabilize blood sugars. The plan of care, for the certification period 4-11-14 to 6-9-14, failed to include the nutritional supplement.</p> <p>B. The administrator was unable to provide any additional information / documentation regarding the inclusion of the Glucerna on the plan of care when asked on 1-9-15 at 11 AM.</p> <p>4. The agency's 11-27-12 "Medical Plan of Care (POC 485)/Add Orders/Re-Certification" policy states, "The POC includes, but is not limited to the following: . . . e. frequency of visits f. Duration of visits . . . l. Nutritional requirements."</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</p>	N000527		01/30/2015

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 01/09/2015
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>policy review and interview, the agency failed to ensure the physician had been alerted to changes in the patient's condition in 1 (# 9) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients</p> <p>The findings include:</p> <p>1. Clinical record number 9 failed to evidence the registered nurse (RN) or the physical therapist had reported the patient's right shoulder pain to the physician and failed to evidence the RN reported a change in the patient's respiratory status and complaints of severe pain to the physician.</p> <p>A. The record included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports that [the patient] was moving from wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend and therapist will check next week. A SN visit note dated 11-28-14 identifies swelling in the right upper arm and that the patient continued to have pain in the right shoulder.</p> <p>B. A communication note, signed and dated by employee K, a physical therapist, on 11-10-14 states, "Pt's</p>		<p>The Administrator will in-service the staff on the Communication with the Physician policy, and review the specifications of occurrences when the physician was not notified. All in-service education will be completed by 1/30/2015.</p> <p>100% of the clinical notes from all patients charts will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of physician notification of all changes in the patient's condition has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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>caregiver called to cancel PT [physical therapy] for the week d/t [due to] pt falling and 'spraining' [the patient's] shoulder. MD recommended 'taking it easy with PT' for a while."</p> <p>C. A "Home Health Therapy Note", dated 11-25-14, states, "Pt c/o [complained of] [right] shoulder 'popping out.' Denies pain in shoulder but states [the patient's] shoulder really hurts from the back all around the front when it 'pops' out . . . possible [right] RTC [rotator cuff] tear."</p> <p>D. A "Home Health Therapy Note", dated 11-28-14, states, "Pt reports [right] shoulder is still sore. Caregiver reports [the caregiver] will call MD Monday unless [the patient] has pain [the caregiver] will take [the patient] to ER [emergency room]."</p> <p>E. A SN visit note dated 1-2-15 identifies the patient had a new onset of an intermittent, productive cough with thick white sputum and was congested. The note states, "Pt complaining of abd [abdominal] discomfort, reporting feels like kidneys. pt rates pain # 10. pt reports more on the rt middle side of abdomen."</p> <p>F. The record included a transfer</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 01/09/2015
--	---	--	---

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
N000537	<p>comprehensive assessment dated 1-6-15 that identified the patient had been admitted to the hospital for a "respiratory infection (e.g., pneumonia, bronchitis."</p> <p>2. The RN, employee H, indicated, on 1-8-15, she had reported the patient's shoulder problem to the physician but had not documented it. The nurse stated, regarding the respiratory change, "The patient had seen the doctor at the Tulip Tree the day before." The physician that established the plan of care for this patient was not at the clinic the patient had been to the day before.</p> <p>3. The agency's 2-2-12 "Communication with Physician" policy states, "The professional staff will call for additional orders as the patient condition changes . . . Verbal communication will take place at the discretion of the professional staff as condition warrants . . . All communication will be documented in the medical record."</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</p>	N000537		01/30/2015

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 01/09/2015	
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>policy review and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 3 (#s 9, 10, and 12) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 9 included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports that [the patient] was moving from the wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend and therapist will check next week."</p> <p>A. A skilled nurse (SN) visit note dated 11-28-14 identifies 2 + edema in the upper arm. The note states, "pt rates should [shoulder] pain # 3, no pain meds [medications] taken. Instructed On: Use of breakthrough medication, Cold therapy."</p> <p>B. The record failed to include an order for the use of ice to the right shoulder.</p> <p>C. The registered nurse (RN), employee H, indicated, on 1-8-15 at 3:35 PM, the record did not include an order</p>		<p>The Administrator will in-service the staff on the Communication with the Physician policy, and review the specifications of occurrences when the physician was not notified. All in-service education will be completed by 1/30/2015.</p> <p>100% of the clinical notes from all patients charts will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of physician notification of all changes in the patient's condition has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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>for the application of ice to the right shoulder.</p> <p>2. Clinical record number 10 included a physician verbal order dated 12-22-14 that states, "SN Venipuncture for CBC [complete blood count] 12262014." The record failed to evidence the Venipuncture had been completed.</p> <p>The administrator was unable to provide any additional documentation and/or information when asked regarding the ordered Venipuncture on 1-9-15 at 11:10 AM.</p> <p>3. Clinical record number 12 included physician verbal orders dated 5-30-14 that identified a Venipuncture was to be performed for a PT/INR (blood test for clotting time) on 6-1-14. The record failed to evidence the Venipuncture had been completed as ordered.</p> <p>A. The record included a physician verbal order dated 6-10-14 that identified a Venipuncture was to be performed for a PT/INR on 6-11-14. The record failed to evidence the Venipuncture had been performed as ordered.</p> <p>B. The administrator indicated, on 1-9-15 at 9:45 AM, the Venipunctures on 6-1-14 and 6-11-14 had not been</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 01/09/2015
--	---	--	---

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
N000543	<p>completed per the physician's orders.</p> <p>4. The agency's 11-27-12 "Medical Plan of Care (POC 485)/Add Orders/ Re-Certification" policy states, "All patients admitted to home health services will have a POC . . . To ensure current orders for services and provide effective care, treatment, and services for the patient."</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 review and interview, the agency failed to ensure the registered nurse (RN) had initiated preventative nursing procedures in 4 (#s 8, 9, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 8 included a resumption of care after an inpatient stay comprehensive assessment dated</p>	N000543	<p>The Administrator will in-service the nursing staff regarding duties of the Registered Nurse, initiating appropriate, preventative, and rehabilitative procedures. Specific citations that will be reviewed are Nutrition/Diet Needs, Plans of Care for Dialysis patients, and CHF monitoring. All in-service education will be completed by 1/30/2015.</p> <p>100% of the Physician Orders, Plan of Care and clinical notes from all patients charts will be monitored for no less than three months until</p>	01/30/2015

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 01/09/2015
--	---	--	---

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>11-19-14. The assessment identified the patient had a "fair" appetite and "required more instruction" regarding the prescribed diet." The record failed to evidence the RN had initiated a plan to address the identified need for further dietary instruction.</p> <p>2. Clinical record number 9 included a start of care comprehensive assessment dated 9-16-14 and a recertification comprehensive assessment dated 11-14-14 that identified the patient had an arteriovenous graft in the left arm. The record failed to evidence the RN had initiated a plan for the care and maintenance of the dialysis access.</p> <p>3. Clinical record number 11 included a plan of care for the certification period 4-11-14 to 6-9-14 that identified the patient had a secondary diagnosis of congestive heart failure and the patient or caregiver was to "record patient's weight daily and report weight gain of 2 pounds in 24 hours or 5 pounds in 1 week." The record failed to evidence the RN had initiated a plan of check for compliance with regards to the daily weights and to monitor the patient's weight.</p> <p>4. Clinical record number 12 included a start of care comprehensive assessment dated 5-24-14 that identified the patient</p>		<p>compliance is achieved, then 10% of all clinical records will be reviewed quarterly and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of nursing initiating appropriate, preventative and rehabilitative nursing procedures has been corrected and will not recur.</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 01/09/2015
--	---	--	---

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
N000546	<p>had a dialysis access in the right arm. The record failed to evidence the RN had initiated a plan for the care and maintenance of the dialysis access.</p> <p>5. The administrator indicated, on 1-9-15 at 10:30 AM., records numbered 8, 9, 11, and 12 did not evidence the RN had initiated plans to address the identified problems.</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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had alerted the physician to changes in the patient's condition in 1 (# 9) of 12 records reviewed creating the potential to affect all of the agency's 36 current patients</p> <p>The findings include:</p>	N000546	The Administrator will in-service the staff on the Communication with the Physician policy, and review the specifications of occurrences when the physician was not notified. All in-service education will be completed by 1/30/2015. 100% of the clinical notes from all patients charts will be monitored for no less than three months until compliance is achieved, then 10% of all clinical records will be reviewed quarterly	01/30/2015

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 01/09/2015
--	---	--	---

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. Clinical record number 9 failed to evidence the registered nurse (RN) or the physical therapist had reported the patient's right shoulder pain to the physician and failed to evidence the RN reported a change in the patient's respiratory status and complaints of severe pain to the physician.</p> <p>A. The record included a skilled nurse (SN) visit note dated 11-21-14 that states, "Pt [patient] reports that [the patient] was moving from wheelchair and heard [the patient's] rt [right] shoulder pop, rt shoulder has some swelling, instructed to ice over weekend and therapist will check next week. A SN visit note dated 11-28-14 identifies swelling in the right upper arm and that the patient continued to have pain in the right shoulder.</p> <p>B. A communication note, signed and dated by employee K, a physical therapist, on 11-10-14 states, "Pt's caregiver called to cancel PT [physical therapy] for the week d/t [due to] pt falling and 'spraining' [the patient's] shoulder. MD recommended 'taking it easy with PT' for a while."</p> <p>C. A "Home Health Therapy Note", dated 11-25-14, states, "Pt c/o</p>		and reported to the Performance Improvement Committee for no less than one year. Results of audits for at least one corrective action will be reviewed with monthly staff meetings. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency of physician notification of all changes in the patient's condition has been corrected and will not recur.	

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 01/09/2015	
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>[complained of] [right] shoulder 'popping out.' Denies pain in shoulder but states [the patient's] shoulder really hurts from the back all around the front when it 'pops' out . . . possible [right] RTC [rotator cuff] tear."</p> <p>D. A "Home Health Therapy Note", dated 11-28-14, states, "Pt reports [right] shoulder is still sore. Caregiver reports [the caregiver] will call MD Monday unless [the patient] has pain [the caregiver] will take [the patient] to ER [emergency room]."</p> <p>E. A SN visit note dated 1-2-15 identifies the patient had a new onset of an intermittent, productive cough with thick white sputum and was congested. The note states, "Pt complaining of abd [abdominal] discomfort, reporting feels like kidneys. pt rates pain # 10. pt reports more on the rt middle side of abdomen."</p> <p>F. The record included a transfer comprehensive assessment dated 1-6-15 that identified the patient had been admitted to the hospital for a "respiratory infection (e.g., pneumonia, bronchitis."</p> <p>2. The RN, employee H, indicated, on 1-8-15, she had reported the patient's shoulder problem to the physician but</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 01/09/2015	
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>had not documented it. The nurse stated, regarding the respiratory change, "The patient had seen the doctor at the Tulip Tree the day before." The physician that established the plan of care for this patient was not at the clinic the patient had been to the day before.</p> <p>3. The agency's 2-2-12 "Communication with Physician" policy states, "The professional staff will call for additional orders as the patient condition changes . . . Verbal communication will take place at the discretion of the professional staff as condition warrants . . . All communication will be documented in the medical record."</p>						