

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2012
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NAME OF PROVIDER OR SUPPLIER CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN 46017
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G0000	<p>This was a revisit for a federal home health agency complaint investigation survey that was an extended survey completed December 8, 2011.</p> <p>Survey Dates: January 18, 19, and 20, 2012</p> <p>Facility #: 004091</p> <p>Medicaid Vendor #: 200806840</p> <p>Surveyors: Susan E. Sparks, RN, PHNS, Team Leader</p> <p style="text-align: center;">Bridgett Boston, RN, PHNS, Team Member</p> <p>CJ's Abundant Care is precluded from providing its own training and/or competency evaluation program for a period of two (2) years beginning January 20, 2012, to January 20, 2014, due to being out of compliance with the Conditions of Participation 42 CFR 484.14: Organization, services, and administration and 484.30 Skilled Nursing Services.</p> <p>During this survey, four conditions of participation and twenty eight standards were found corrected. Two conditions and ten standards were recited.</p>	G0000	<p>CJ's Abundant Care hereby submits its Plan of Correction pursuant to the State and Federal rules and regulations governing the licensing and certification of home health care agencies. It is the Indiana State Department of Health's ("ISDH") and the Centers for Medicare and Medicaid Services' ("CMS") stated position that an agency submitting a Plan of Correction ("POC") must respond to each alleged violation, regardless of whether the agency denies or disagrees with a factual or legal allegation contained in the survey. It is ISDH's and CMS's position that even if the agency has requested Informal Dispute Resolution ("IDR") and has set forth specific grounds for its disputes, the agency must still provide a POC for each disputed tag. It is ISDH's position and CMS's position that failure to provide the POC may result in fines, probations, or loss of the Agency's license.</p> <p>In order to comply with these procedural requirements, the Agency has responded to each alleged deficiency below, even those for which IDR is requested. These responses are made only for informational purposes of establishing the Agency's compliance, and do not constitute an admission or agreement with the allegations contained in the</p>	
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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.

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	<p>One new standard was cited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 23, 2012</p>		<p>survey. the Agency denies any and all wrong doing and/or liability arising out of or relating to those factual or legal allegations contained in the survey dated 1/20/2012. The Agency has requested a face to face IDR of certain tags with ISDH, and has stated its grounds for disputing the tags subject to the IDR request where appropriate.</p> <p>It is the Agency's position that the survey contains tags that are not supported by the given factual statements. The Agency also notes for the record that ISDH has taken the position that administrative and legal review is unavailable to home health agencies that disagree with a survey, and routinely denies such requests. Thus the Agency has no ability to challenge the survey before an objective finder of fact and law.</p> <p>This being said, no admission of guilt or concession of agreement should be implied by the lack of administrative or other appeal in this instance by the Agency or by the descriptions of means to correct the alleged and disputed deficiencies. To the extent that such legal or administrative appeal becomes available to the Agency at a later time, the Agency hereby reserves the right to pursue all formal and informal administrative, civil, and legal processes available in contesting</p>		

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			the allegations contained in this survey.	
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G0109	<p>The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p>	G0109	<p>CJ's Abundant Care hereby submits its Plan of Correction pursuant to the State and Federal rules and regulations governing the licensing and certification of home health care agencies. It is the Indiana State Department of Health's ("ISDH") and the Centers for Medicare and Medicaid Services' ("CMS") stated position that an agency submitting a Plan of Correction ("POC") must respond to each alleged violation, regardless of whether the agency denies or disagrees with a factual or legal allegation contained in the survey. It is ISDH's and CMS's position that even if the agency has requested Informal Dispute Resolution ("IDR") and has set forth specific grounds for its disputes, the agency must still provide a POC for each disputed tag. It is ISDH's position and CMS's position that failure to provide the POC may result in fines, probations, or loss of the Agency's license. In order to comply with these procedural requirements, the Agency has responded to each alleged deficiency below, even those for which IDR is requested. These responses are made only for informational purposes of</p>	02/10/2012	

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			<p>establishing the Agency's compliance, and do not constitute an admission or agreement with the allegations contained in the survey. the Agency denies any and all wrong doing and/or liability arising out of or relating to those factual or legal allegations contained in the survey dated 1/20/2012. The Agency has requested a face to face IDR of certain tags with ISDH, and has stated its grounds for disputing the tags subject to the IDR request where appropriate. It is the Agency's position that the survey contains tags that are not supported by the given factual statements. The Agency also notes for the record that ISDH has taken the position that administrative and legal review is unavailable to home health agencies that disagree with a survey, and routinely denies such requests. Thus the Agency has no ability to challenge the survey before an objective finder of fact and law. This being said, no admission of guilt or concession of agreement should be implied by the lack of administrative or other appeal in this instance by the Agency or by the descriptions of means to correct the alleged and disputed deficiencies. To the extent that such legal or administrative appeal becomes available to the Agency at a later time, the Agency hereby reserves the right to pursue all formal and informal administrative, civil, and</p>	

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			<p>legal processes available in contesting the allegations contained in this survey. Administrator and Director of Nursing have reviewed the federal and state regulations as well as the company policies on patient rights. On 1/26/2012 in-serviced all nurses, therapist, and office staff to document telephone calls from patients and families before an order to hold services. Office will speak to families or patients for communications, such as requests, not home health aide. Any change in PT/PTA schedule will be telephoned or texted to office and office will then notify patient. All patients notified to report to office any changes in therapy schedule. Patient handbooks to be left in home with each admission/re-admission (No specific changes have been made to the client handbook). Administrator/DON, Alternate Administrator/ Alternate DON to be notified weekly of any therapy schedule change or missed visit to ensure coordination of care. DON will monitor 100% of therapy cases every 14 days during supervisory completed by RN to ensure therapist is showing up as scheduled. From this date forward, the RN will provide care coordination with nonskilled patients every 30 days to ensure that the patient is involved with the plan of care. The RN will begin this with the next 14 or 30</p>	

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	<p>Based on clinical record review and interview, the agency failed to ensure the patient had been involved in the planning of care when the services were placed on hold on 12/29/11 in 1 of 7 records reviewed of patients. (16)</p> <p>Findings:</p> <p>1. Clinical record 16, start of care 9/29/11, evidenced a plan of care for the certification period 11/28/11 through 1/26/12 with orders for physical therapy (PT), home health aide, and attendant care services. The clinical record evidenced a telephone order dated 12/29/11 written by employee FF that states, "Hold all services week of 1/2/12 due to client moving. Resume all previous services week of 1/9/12. Read back and verified."</p> <p>2. During a telephone interview on January 20, 2012, at 11:45 AM, the caregiver for patient #16 indicated that after services had not been provided during the week beginning January 2, 2012, the caregiver called the agency to find out why there were no services provided. The caregiver indicated that employee BB, the agency scheduler,</p>				<p>day supervisory visit. The DON will maintain a supervisory/care coordination book to ensure that this deficiency is corrected and will not reoccur.</p>		

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	<p>informed the caregiver the patient's services had been placed on hold on 12/29/11. The caregiver indicated that the caregiver was not involved with nor requested a hold on the patient's services. During the same telephone interview, the patient indicated that employee M, a home health aide, was the individual who called the agency and notified the agency of the patients move and to place all services on hold. The caregiver also indicated that when the physical therapist, employee A is in the home, he schedules the following visit but frequently fails to show and stated, "He never calls" to notify that he is running late, or not coming as scheduled. The caregiver indicated that a PT visit was scheduled for 1/19/12 and the therapist did not arrive nor did the patient / family receive a telephone call from the therapist or the agency regarding the missed visit or when the therapist may next arrive. The caregiver stated that all phone calls from the caregiver and patient to the agency are routed through to the scheduler and the information booklet given to the patient was dated from the patient's 2008 admission to the agency. When the patient was last admitted on 9/29/11 for skilled services, the patient was not provided with a new admission booklet and notification as to who was in charge of the agency and who to contact with</p>			
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G0122	<p>problems or concerns.</p> <p>Based on administrative document review and interview, it was determined the agency failed to ensure the administrator addressed a suspected problem which could have affected patient safety 1 of 1 agencies which had the potential to affect all the agency's patients (See G 133) and failed to ensure the registered nurse, licensed practical nurse, and physician coordinated efforts in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients (See G 143 and G 144).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.14: Organization, services, and administration potentially affecting all 60 patients of the agency.</p>	G0122	<p>The administrator and director of nursing have reviewed state and federal guidelines. On 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor any change with patients condition. ex: new wound, surigical procedure, ect. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC.</p>	02/10/2012	

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G0133	<p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p> <p>Based on administrative document review and interview, the administrator failed to address a suspected problem which could have affected patient safety 1 of 1 agencies which had the potential to affect all the agency's patients.</p> <p>Findings:</p> <p>1. On January 19, 2012, at 2 PM the Administrator, Employee DD, indicated she was suspicious of the documentation of Employee E, RN, and was concerned that the RN had not been making the visits, just documenting they had been completed. She indicated the employee began calling in sick a lot the last couple weeks of December. She indicated Licensed Practical Nurse, employee EE, and Registered Nurse Clinical Manager, employee FF, called RN E into the office and accepted the RN's resignation. She indicated she did not send another registered nurse to the patient's homes to check on the welfare of the patients or the accuracy of Employee E's documentation.</p>	G0133	All skilled time sheets will be checked weekly against patient visit notes and assessments for patient signatures, and matching time. Any discrepancies will followed up with phone call to patient and/or follow up visit by RN. To be ensured by Administrator/DON/Clinical Coordinator. On 1/10/2012 Employee E RN, was brought into office for termination and employee resigned before terminated.	01/30/2012			

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	2. An administrative document dated 1/10/12 states, "[Name of employee E] RN, Upon bringing employee into office for termination due to poor documentation on 1/10/12, employee resigned before terminated." Witnesses were employees EE and FF. The document was signed by employees EE and FF.			
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G0143	<p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record, hospital record, and policy review and interview, the agency failed to ensure the registered nurse, licensed practical nurse, and physician coordinated efforts in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (# 14 and 17)</p> <p>Findings Include:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel and was seen in wound clinic. The clinical record indicated the patient had a wound for the past 8 months and failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily.</p> <p>A. On January 18, 2012, at 11 AM,</p>	G0143	<p>on 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect.</p> <p>2/2/2012 In-serviced all nurses on comprehensive assessments, Braden Scale, and policy on Pressure Ulcer Prevention. On 2/2/2012, In-serviced all nurses on comprehensive assessments.</p> <p>On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC.</p>	02/10/2012			

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	<p>the caregiver of patient number 14 identified self as the primary caregiver for the patient and indicated the patient has had multiple chronic wounds for years while on service with this home health agency. The patient had not been assessed by any nurse in months. The caregiver indicated the patient had been to the emergency room at Community Hospital in Anderson around December 29, 2011, and identified the wound care clinic was the same location as the hospital.</p> <p>B. On January 18, 2012, at 2:10 PM, an onsite visit was conducted at Community Hospital in Anderson. During a confidential interview with the wound care nurse and a review of the patient's wound clinic clinical record, the nurse indicated the patient was treated at the wound clinic on November 11 and 18, 2011, for a blister to the left heel and a blister on the right great toe. The nurse indicated the patient's wounds were healed on November 18, 2011, the patient was clear of any further skin breakdown and that the patient was not seen again until December 30, 2011, when the patient arrived with a 5 centimeter black blister on the left heel. The nurse indicated the patient began treatments at the wound clinic on May 6, 2010, for ulcers on bilateral ankles and feet and had</p>				

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	<p>been seen weekly up through May 9, 2011, at which time all ulcers were healed. The patient next returned for treatment on October 4, 2011, and was also treated on October 7 and 11 and November 11 and 18, 2011. The nurse stated, "The patient was a podiatry patient and should have been seen weekly but would cancel."</p> <p>1.) The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>2.) The hospital emergency room "Patient Abstract" dated 12/26/11 for patient 14 states, "Reason for Visit Skin Lesion ... 682.3 Cellulitis of Arm." The document titled "Department of Emergency Medicine Medical Record - Physician's Report" dated 12/26/11 states, "Cellulitis of Left Shoulder ... 58 year old patient complaint of pain / redness and drainage from having biopsy site 2 weeks ago. ... Biopsy site ... open draining yellow drainage."</p>						

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	<p>C. The record failed to evidence the nurse had consulted with the patient's physician regarding the skin lesions.</p> <p>2. Clinical record 17, start of care 6/10/09, evidenced a plan of care for the certification period 11/27/11 through 1/25/12 with principle diagnosis of pressure lower back with onset date 11/23/11 and orders that stated, " SN [skilled nurse]: 2 - 3 X [times] W [week] X [times] 9 W [weeks] for: ... SN to perform wound care of sacral wound three times weekly SN to record wound dimensions once a week. ... Goal Wound will decrease from 1.0 cm to 0.7 cm with in 5 weeks. Skin integrity will be maintained without further s/s [signs and symptoms] of skin breakdown within cert [certification] period."</p> <p>A. The clinical record evidenced a document titled "Nursing Visit Note" documented by employee E dated 12/21/11 that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p> <p>B. The clinical record evidenced documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed</p>						

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	<p>by employee D, a licensed practical nurse. The notes failed to evidence the nurse had measured the wound and a description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note" dated 12/31/11, completed by employee D, that failed to evidence the dimensions and an assessment of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>E. The record failed to evidence the LPN communicated with the registered nurse regarding the deteriorating status of the wound.</p>			
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	<p>F. The policy titled "Assessment / Staging of Pressure Ulcers # G - 150" states, "Home Care should use a risk assessment tool to determine risk and plan accordingly. ... APPLIES TO - registered nurses, licensed practical nurses, ... In assessing the pressure ulcer, the following parameters should be addressed consistently, site, stage of ulcer, and size of ulcer (include length, width, and depth). Presence of tunneling or undermining. Presence of necrotic tissue. Drainage amount, color, and odor. Granulation. Pain. Condition of surrounding tissue."</p> <p>G. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>H. On January 19, 2012 at 12 PM</p>						

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	<p>the administrator indicated wounds are to be measured weekly by the registered nurses not the licensed practical nurses (LPNs). The agency did not want the LPNs to complete this documentation at this time.</p> <p>3. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated they do not feel it is the agency's responsibility for the healthcare for all of their home health aide only patients. The agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service. The administrator and director of nursing indicated employee E was terminated on January 10, 2012, due to poor work performance.</p>			
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G0144	<p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on clinical record, hospital record, and policy review and interview, the agency failed to ensure the registered nurse, licensed practical nurse, and physician coordinated efforts in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (# 14 and 17)</p> <p>Findings Include:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel and was seen in wound clinic. The clinical record indicated the patient had a wound for the past 8 months and failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily.</p> <p>A. On January 18, 2012, at 11 AM,</p>	G0144	<p>on 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect. On 2/2/2012, In-serviced all nurses on comprehensive assessments, Braden Scale, and policy on Pressure Ulcer Prevention. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC.</p>	02/10/2012			

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	<p>the caregiver of patient number 14 identified self as the primary caregiver for the patient and indicated the patient has had multiple chronic wounds for years while on service with this home health agency. The patient had not been assessed by any nurse in months. The caregiver indicated the patient had been to the emergency room at Community Hospital in Anderson around December 29, 2011, and identified the wound care clinic was the same location as the hospital.</p> <p>B. On January 18, 2012, at 2:10 PM, an onsite visit was conducted at Community Hospital in Anderson. During a confidential interview with the wound care nurse and a review of the patient's wound clinic clinical record, the nurse indicated the patient was treated at the wound clinic on November 11 and 18, 2011, for a blister to the left heel and a blister on the right great toe. The nurse indicated the patient's wounds were healed on November 18, 2011, the patient was clear of any further skin breakdown and that the patient was not seen again until December 30, 2011, when the patient arrived with a 5 centimeter black blister on the left heel. The nurse indicated the patient began treatments at the wound clinic on May 6, 2010, for ulcers on bilateral ankles and feet and had</p>				

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	<p>been seen weekly up through May 9, 2011, at which time all ulcers were healed. The patient next returned for treatment on October 4, 2011, and was also treated on October 7 and 11 and November 11 and 18, 2011. The nurse stated, "The patient was a podiatry patient and should have been seen weekly but would cancel."</p> <p>1.) The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>2.) The hospital emergency room "Patient Abstract" dated 12/26/11 for patient 14 states, "Reason for Visit Skin Lesion ... 682.3 Cellulitis of Arm." The document titled "Department of Emergency Medicine Medical Record - Physician's Report" dated 12/26/11 states, "Cellulitis of Left Shoulder ... 58 year old patient complaint of pain / redness and drainage from having biopsy site 2 weeks ago. ... Biopsy site ... open draining yellow drainage."</p>						

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	<p>C. The record failed to evidence the nurse had consulted with the patient's physician regarding the skin lesions.</p> <p>2. Clinical record 17, start of care 6/10/09, evidenced a plan of care for the certification period 11/27/11 through 1/25/12 with principle diagnosis of pressure lower back with onset date 11/23/11 and orders that stated, " SN [skilled nurse]: 2 - 3 X [times] W [week] X [times] 9 W [weeks] for: ... SN to perform wound care of sacral wound three times weekly SN to record wound dimensions once a week. ... Goal Wound will decrease from 1.0 cm to 0.7 cm with in 5 weeks. Skin integrity will be maintained without further s/s [signs and symptoms] of skin breakdown within cert [certification] period."</p> <p>A. The clinical record evidenced a document titled "Nursing Visit Note" documented by employee E dated 12/21/11 that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p> <p>B. The clinical record evidenced documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed</p>						

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	<p>by employee D, a licensed practical nurse. The notes failed to evidence the nurse had measured the wound and a description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note" dated 12/31/11, completed by employee D, that failed to evidence the dimensions and an assessment of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>E. The record failed to evidence the LPN communicated with the registered nurse regarding the deteriorating status of the wound.</p>			
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	<p>F. The policy titled "Assessment / Staging of Pressure Ulcers # G - 150" states, "Home Care should use a risk assessment tool to determine risk and plan accordingly. ... APPLIES TO - registered nurses, licensed practical nurses, ... In assessing the pressure ulcer, the following parameters should be addressed consistently, site, stage of ulcer, and size of ulcer (include length, width, and depth). Presence of tunneling or undermining. Presence of necrotic tissue. Drainage amount, color, and odor. Granulation. Pain. Condition of surrounding tissue."</p> <p>G. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>H. On January 19, 2012 at 12 PM</p>						

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	<p>the administrator indicated wounds are to be measured weekly by the registered nurses not the licensed practical nurses (LPNs). The agency did not want the LPNs to complete this documentation at this time.</p> <p>3. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated they do not feel it is the agency's responsibility for the healthcare for all of their home health aide only patients. The agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service. The administrator and director of nursing indicated employee E was terminated on January 10, 2012, due to poor work performance.</p>			
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	<p>week as ordered in 1 of 5 clinical records reviewed of patients with skilled nursing services which resulted in no documentation to reflect the deterioration of the wound. (17)</p> <p>Findings:</p> <p>1. Clinical record 17, start of care 6/10/09, evidenced a plan of care for the certification period 11/27/11 through 1/25/12 with principle diagnosis of pressure lower back with onset date 11/23/11 and orders that stated, "SN [skilled nurse]: 2 - 3 X [times] W [week] X [times] 9 W [weeks] for: ... SN to perform wound care of sacral wound three times weekly SN to record wound dimensions once a week. ... Goal Wound will decrease from 1.0 cm to 0.7 cm with in 5 weeks. Skin integrity will be maintained without further s/s [signs and symptoms] of skin breakdown within cert [certification] period."</p> <p>A. The clinical record evidenced a document titled "Nursing Visit Note" signed by employee E, dated 12/21/11, that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p> <p>B. The clinical record evidenced</p>						

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	<p>documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed by employee D, a licensed practical nurse (LPN) that failed to evidence the wound had been measured and a clinical description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note" dated 12/31/11 and completed by employee D that failed to evidence the wound had been measured and a clinical description of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>2. The policy titled "Assessment / Staging of Pressure Ulcers # G - 150" states, "</p>				

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	<p>Home Care should use a risk assessment tool to determine risk and plan accordingly. ... APPLIES TO - registered nurses, licensed practical nurses, ... In assessing the pressure ulcer, the following parameters should be addressed consistently, site, stage of ulcer, and size of ulcer (include length, width, and depth). Presence of tunneling or undermining. Presence of necrotic tissue. Drainage amount, color, and odor. Granulation. Pain. Condition of surrounding tissue. "</p> <p>3. The policy titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>4. On January 19, 2012, at 12 PM the administrator indicated that wounds are to be measured weekly by the registered nurses, not the LPN; the agency did not want the LPNs to complete this documentation at this time.</p> <p>5. Employee D was in-serviced on "Oasis, Admit Packs, implemented new skilled visit note, vital sign Parameter</p>			
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	<p>Policy" as presented by the Administrator on 12/12/11.</p> <p>Employee D was in-serviced on "5. Documentation 6. Read and sign policies a. Wound care ... c. Documentation d. Case Conference ..." as presented by the Administrator on 12/22/11.</p>			
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G0159	<p>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 policy review, the agency failed to ensure all patients had an individualized plan of care that included all of the required items in 1 (# 16) of 7 clinical records reviewed creating the potential for treatment omission and patient harm.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #16, start of care 9/29/11, included a plan of care established by the physician for the certification period 11/28/11 through 1/26/12 with orders for physical therapy (PT) 1 week 1, 1 - 2 times a week for weeks 2 through 8, home health aide services 2 - 3 times a week for nine weeks under the medicare benefit, and home health aide services for 1-2 hours, one to three times a day, four to seven times a week for seven weeks under the medicaid benefit for assistance with the activities of daily living, and for attendant care services 1 - 2 hours a day, one time a 	G0159	<p>D/C planning on POC to be written when short term and long term goals met, when higher level of care needed. PT evals with treatment plan, goals, and D/C planning is faxed to and signed by physician on intial evaluation, thereafter for recertification, the orders and goals will be written upon the recertification POC for PT. To be ensured by Administrator overseeing fax compliance book weekly.</p>	02/03/2012			

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	<p>week for nine weeks to assist with bathing, dressing, skin and hair care, nutrition, and light housekeeping duties. The Plan of Care states, "Goals: PT Please see PT eval. ... Discharge Plans: When goals met or when pt [patient] states services are no longer needed." On 1/20/12 at 11 AM, the clinical record was reviewed and failed to evidence instructions for a timely discharge specific for this patient.</p> <p>2. The policy titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p>			
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G0168	<p>Based on clinical record, wound clinic record, and policy review and interview, it was determined the agency failed to ensure the registered nurse assessed the patient's wound as part of the comprehensive recertification assessment in 1 of 5 clinical records reviewed of patients receiving services over 60 days with the potential to affect all the agency's patients who receive services longer than 60 days (See G 172), failed to ensure the registered nurse initiated preventative nursing procedures in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients (See G 175), and failed to ensure the registered nurse coordinated with the licensed practical nurse and physician in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.30 Skilled Nurse Services potentiality affecting all 60 patients of the agency.</p>	G0168	<p>on 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect. 2/2/2012 In-serviced all nurses on comprehensive assessments, Braden Scale, and policy on Pressure Ulcer Prevention. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC.</p>	02/10/2012			

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	<p>assessment in 1 of 5 clinical records reviewed of patients receiving services over 60 days with the potential to affect all the agency's patients who receive services longer than 60 days. (# 14)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel was seen in wound clinic. The assessment failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily. 2. On January 18, 2012 at 11 AM, the caregiver of patient number 14 indicated the patient has had multiple chronic wounds for years while on service with this home health agency and the patient was not assessed by any nurse in months. 3. The wound center clinical record evidenced documentation dated December 30, 2011, which states, 			
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	<p>"Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>4. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated the agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment for their home health aide only patients and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service.</p> <p>5. The policy titled "Client Reassessment / Update of the Comprehensive Assessment" states, The comprehensive assessment will be updated and revised as often as the clients condition warrants due to a major decline ... Within 48 hours of or knowledge of client return from a hospital admission of more than 24 hours, ... or other changes representing a SCIC (significant change in condition). PURPOSE To identify decline or improvement in health status, modify the plan of care and document changes that</p>						

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	may affect care and reimbursement."			

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G0175	<p>The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>Based on clinical record, hospital record, and policy review and interview, the agency failed to ensure the registered nurse initiated preventative nursing procedures in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (# 14 and 17)</p> <p>Findings Include:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel and was seen in wound clinic. The clinical record indicated the patient had a wound for the past 8 months and failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily.</p>	G0175	<p>on 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect. 2/2/2012 In-serviced all nurses on comprehensive assessments, Braden Scale, and policy on Pressure Ulcer Prevention. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC.</p>	02/10/2012	

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	<p>A. On January 18, 2012, at 11 AM, the caregiver of patient number 14 identified self as the primary caregiver for the patient and indicated the patient has had multiple chronic wounds for years while on service with this home health agency. The patient had not been assessed by any nurse in months. The caregiver indicated the patient had been to the emergency room at Community Hospital in Anderson around December 29, 2011, and identified the wound care clinic was the same location as the hospital.</p> <p>B. On January 18, 2012, at 2:10 PM, an onsite visit was conducted at Community Hospital in Anderson. During a confidential interview with the wound care nurse and a review of the patient's wound clinic clinical record, the nurse indicated the patient was treated at the wound clinic on November 11 and 18, 2011, for a blister to the left heel and a blister on the right great toe. The nurse indicated the patient's wounds were healed on November 18, 2011, the patient was clear of any further skin breakdown and that the patient was not seen again until December 30, 2011, when the patient arrived with a 5 centimeter black blister on the left heel. The nurse indicated the patient began treatments at the wound clinic on May 6, 2010, for</p>			
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	<p>ulcers on bilateral ankles and feet and had been seen weekly up through May 9, 2011, at which time all ulcers were healed. The patient next returned for treatment on October 4, 2011, and was also treated on October 7 and 11 and November 11 and 18, 2011. The nurse stated, "The patient was a podiatry patient and should have been seen weekly but would cancel."</p> <p>1.) The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>2.) The hospital emergency room "Patient Abstract" dated 12/26/11 for patient 14 states, "Reason for Visit Skin Lesion ... 682.3 Cellulitis of Arm." The document titled "Department of Emergency Medicine Medical Record - Physician's Report" dated 12/26/11 states, "Cellulitis of Left Shoulder ... 58 year old patient complaint of pain / redness and drainage from having biopsy site 2 weeks ago. ... Biopsy site ... open draining</p>			
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	<p>yellow drainage."</p> <p>C. The record failed to evidence the nurse had initiated preventative nursing procedures to address the patient's skin lesions.</p> <p>2. Clinical record 17, start of care 6/10/09, evidenced a plan of care for the certification period 11/27/11 through 1/25/12 with principle diagnosis of pressure lower back with onset date 11/23/11 and orders that stated, " SN [skilled nurse]: 2 - 3 X [times] W [week] X [times] 9 W [weeks] for: ... SN to perform wound care of sacral wound three times weekly SN to record wound dimensions once a week. ... Goal Wound will decrease from 1.0 cm to 0.7 cm with in 5 weeks. Skin integrity will be maintained without further s/s [signs and symptoms] of skin breakdown within cert [certification] period."</p> <p>A. The clinical record evidenced a document titled "Nursing Visit Note" documented by employee E dated 12/21/11 that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p> <p>B. The clinical record evidenced</p>			
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	<p>documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed by employee D, a licensed practical nurse. The notes failed to evidence the nurse had measured the wound and a description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note" dated 12/31/11, completed by employee D, that failed to evidence the dimensions and an assessment of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>E. The record failed to evidence the nurse had initiated preventative nursing procedures to address the patient's</p>			
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	<p>wounds.</p> <p>F. The policy titled "Assessment / Staging of Pressure Ulcers # G - 150" states, "Home Care should use a risk assessment tool to determine risk and plan accordingly. ... APPLIES TO - registered nurses, licensed practical nurses, ... In assessing the pressure ulcer, the following parameters should be addressed consistently, site, stage of ulcer, and size of ulcer (include length, width, and depth). Presence of tunneling or undermining. Presence of necrotic tissue. Drainage amount, color, and odor. Granulation. Pain. Condition of surrounding tissue."</p> <p>G. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p>			
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	<p>H. On January 19, 2012 at 12 PM the administrator indicated wounds are to be measured weekly by the registered nurses not the licensed practical nurses (LPNs). The agency did not want the LPNs to complete this documentation at this time.</p> <p>3. Employee D was in-serviced on "Oasis, Admit Packs, implemented new skilled visit note, vital sign Parameter Policy" as presented by the Administrator on 12/12/11.</p> <p>Employee D was in-serviced on "5. Documentation 6. Read and sign policies a. Wound care ... c. Documentation d. Case Conference ..." as presented by the Administrator on 12/22/11.</p>			
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G0176	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, hospital record, and policy review and interview, the agency failed to ensure the registered nurse coordinated with the licensed	G0176	on 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect. 2/2/2012 In-serviced all nurses on comprehensive assessments, Braden Scale, and policy on Pressure Ulcer Prevention. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC.	02/10/2012	

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	<p>practical nurse and physician in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (# 14 and 17)</p> <p>Findings Include:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel and was seen in wound clinic. The clinical record indicated the patient had a wound for the past 8 months and failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily.</p> <p>A. On January 18, 2012, at 11 AM, the caregiver of patient number 14 identified self as the primary caregiver for the patient and indicated the patient has had multiple chronic wounds for years while on service with this home health agency. The patient had not been assessed by any nurse in months. The</p>				

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	<p>caregiver indicated the patient had been to the emergency room at Community Hospital in Anderson around December 29, 2011, and identified the wound care clinic was the same location as the hospital.</p> <p>B. On January 18, 2012, at 2:10 PM, an onsite visit was conducted at Community Hospital in Anderson. During a confidential interview with the wound care nurse and a review of the patient's wound clinic clinical record, the nurse indicated the patient was treated at the wound clinic on November 11 and 18, 2011, for a blister to the left heel and a blister on the right great toe. The nurse indicated the patient's wounds were healed on November 18, 2011, the patient was clear of any further skin breakdown and that the patient was not seen again until December 30, 2011, when the patient arrived with a 5 centimeter black blister on the left heel. The nurse indicated the patient began treatments at the wound clinic on May 6, 2010, for ulcers on bilateral ankles and feet and had been seen weekly up through May 9, 2011, at which time all ulcers were healed. The patient next returned for treatment on October 4, 2011, and was also treated on October 7 and 11 and November 11 and 18, 2011. The nurse stated, "The patient was a podiatry patient</p>				

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	<p>and should have been seen weekly but would cancel."</p> <p>1.) The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>2.) The hospital emergency room "Patient Abstract" dated 12/26/11 for patient 14 states, "Reason for Visit Skin Lesion ... 682.3 Cellulitis of Arm." The document titled "Department of Emergency Medicine Medical Record - Physician's Report" dated 12/26/11 states, "Cellulitis of Left Shoulder ... 58 year old patient complaint of pain / redness and drainage from having biopsy site 2 weeks ago. ... Biopsy site ... open draining yellow drainage."</p> <p>C. The record failed to evidence the nurse had consulted with the patient's physician regarding the skin lesions.</p> <p>2. Clinical record 17, start of care 6/10/09, evidenced a plan of care for the</p>			
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	<p>certification period 11/27/11 through 1/25/12 with principle diagnosis of pressure lower back with onset date 11/23/11 and orders that stated, " SN [skilled nurse]: 2 - 3 X [times] W [week] X [times] 9 W [weeks] for: ... SN to perform wound care of sacral wound three times weekly SN to record wound dimensions once a week. ... Goal Wound will decrease from 1.0 cm to 0.7 cm with in 5 weeks. Skin integrity will be maintained without further s/s [signs and symptoms] of skin breakdown within cert [certification] period."</p> <p>A. The clinical record evidenced a document titled "Nursing Visit Note" documented by employee E dated 12/21/11 that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p> <p>B. The clinical record evidenced documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed by employee D, a licensed practical nurse. The notes failed to evidence the nurse had measured the wound and a description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note"</p>						

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	<p>dated 12/31/11, completed by employee D, that failed to evidence the dimensions and an assessment of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>E. The record failed to evidence the LPN communicated with the registered nurse regarding the deteriorating status of the wound.</p> <p>F. The policy titled "Assessment / Staging of Pressure Ulcers # G - 150" states, "Home Care should use a risk assessment tool to determine risk and plan accordingly. ... APPLIES TO - registered nurses, licensed practical nurses, ... In assessing the pressure ulcer, the following</p>						

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	<p>parameters should be addressed consistently, site, stage of ulcer, and size of ulcer (include length, width, and depth). Presence of tunneling or undermining. Presence of necrotic tissue. Drainage amount, color, and odor. Granulation. Pain. Condition of surrounding tissue."</p> <p>G. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>H. On January 19, 2012 at 12 PM the administrator indicated wounds are to be measured weekly by the registered nurses not the licensed practical nurses (LPNs). The agency did not want the LPNs to complete this documentation at this time.</p>			
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	<p>3. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated they do not feel it is the agency's responsibility for the healthcare for all of their home health aide only patients. The agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service. The administrator and director of nursing indicated employee E was terminated on January 10, 2012, due to poor work performance.</p>			
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G0225	<p>The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the home health aides furnished care only as identified on the aide care plan in 1 of 5 records reviewed of patients with orders for home health aide services with the potential to affect all the patients of the agency who receive home health aide services. (16)</p> <p>Findings:</p> <p>1. On January 20, 2012 at 11:45 AM, the caregiver of patient # 16 indicated employees M and U, home health aides, had soaked the patient's feet daily in an</p>	G0225	<p>Employ U terminated by Administrator on 2/01/2012 for not following Home Health Aide care plan and in-serviced 100% of Home Health Aides on importance of not performing tasks asked by patient/caregiver without consulting Adminnistrator/DON. If this action is not followed, disciplinary actions will be taken upon Home Health Aide not following instructions. RN case manager to first update care plan. 100% of Home Health Aide notes reviewed weekly by scheduler to ensure they match what is on Home Health Aide Care Plan.</p>	02/03/2012			

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	<p>Epson salts. Employee U had provided aide services for the past 2 weeks, Monday through Thursday, since approximately January 10, 2012, and, during these aide visits, employee U daily removed the dressing from an area on the patient's right foot, 2nd toe, and performed an Epson salt foot soak, then reapplied the dressing only.</p> <p>2. Clinical record 16, start of care 9/29/11, evidenced a plan of care for the certification period 11/28/11 through 1/26/12 with orders for home health aide and physical therapy services. The clinical record evidenced an order to discontinue the skilled nurse services on 1/11/12. The "Aide Care Plan" dated 12/26/11 failed to evidence the aide was to perform Epsom foot soaks or to remove the patient's dressings.</p> <p>3. The policy titled "Home Health Aide Services" states, "Services will be provided to appropriate clients ... under the direct supervision of an agency registered nurse / therapist in accordance with a medically approved plan of care. ... The aide will follow the care plan and will not initiate new services ... without contacting the supervising nurse. ... Delegated nursing tasks performed by home health aides must be properly delegated and documented according to</p>						

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	specific state / federal and agency policies."			
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G0339	<p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>BBased on clinical record, wound clinic record, and policy review and interview, the agency failed to ensure the registered nurse assessed the patient's wound as part of the comprehensive recertification assessment in 1 of 5 clinical records reviewed of patients receiving services over 60 days with the potential to affect all the agency's patients who receive services longer than 60 days. (# 14)</p> <p>Findings:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel was seen in wound clinic. The assessment failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current</p>	G0339	<p>on 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect. 2/2/2012 In-serviced all nurses on comprehensive assessments, Braden Scale, and policy on Pressure Ulcer Prevention. On 2/2/2012, In-serviced all nurses on comprehensive assessments. Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC.</p>	02/10/2012			

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	<p>treatment for the wound, and who was caring for the wound daily.</p> <p>2. On January 18, 2012 at 11 AM, the caregiver of patient number 14 indicated the patient has had multiple chronic wounds for years while on service with this home health agency and the patient was not assessed by any nurse in months.</p> <p>3. The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>4. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated the agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment for their home health aide only patients and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service.</p>						

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	<p>5. The policy titled "Client Reassessment / Update of the Comprehensive Assessment" states, The comprehensive assessment will be updated and revised as often as the clients condition warrants due to a major decline ... Within 48 hours of or knowledge of client return from a hospital admission of more than 24 hours, ... or other changes representing a SCIC (significant change in condition). PURPOSE To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement."</p>			

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N0444	<p>Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following:</p> <p>(1) Organize and direct the home health agency's ongoing functions.</p> <p>Based on administrative document review and interview, the administrator failed to address a suspected problem which could have affected patient safety 1 of 1 agencies which had the potential to affect all the agency's patients.</p> <p>Findings:</p> <p>1. On January 19, 2012, at 2 PM the Administrator, Employee DD, indicated she was suspicious of the documentation of Employee E, RN, and was concerned that the RN had not been making the visits, just documenting they had been completed. She indicated the employee began calling in sick a lot the last couple weeks of December. She indicated Licensed Practical Nurse, employee EE, and Registered Nurse Clinical Manager, employee FF, called RN E into the office and accepted the RN's resignation. She indicated she did not send another registered nurse to the patient's homes to check on the welfare of the patients or the</p>	N0444	<p>CJ's Abundant Care hereby submits its Plan of Correction pursuant to the State and Federal rules and regulations governing the licensing and certification of home health care agencies. It is the Indiana State Department of Health's ("ISDH") and the Centers for Medicare and Medicaid Services' ("CMS") stated position that an agency submitting a Plan of Correction ("POC") must respond to each alleged violation, regardless of whether the agency denies or disagrees with a factual or legal allegation contained in the survey. It is ISDH's and CMS's position that even if the agency has requested Informal Dispute Resolution ("IDR") and has set forth specific grounds for its disputes, the agency must still provide a POC for each disputed tag. It is ISDH's position and CMS's position that failure to provide the POC may result in fines, probations, or loss of the Agency's license. In order to comply with these procedural requirements, the Agency has responded to each alleged deficiency below, even those for</p>	02/10/2012			

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	accuracy of Employee E's documentation. 2. An administrative document dated 1/10/12 states, "[Name of employee E] RN, Upon bringing employee into office for termination due to poor documentation on 1/10/12, employee resigned before terminated." Witnesses were employees EE and FF. The document was signed by employees EE and FF.		which IDR is requested. These responses are made only for informational purposes of establishing the Agency's compliance, and do not constitute an admission or agreement with the allegations contained in the survey. the Agency denies any and all wrong doing and/or liability arising out of or relating to those factual or legal allegations contained in the survey dated 1/20/2012. The Agency has requested a face to face IDR of certain tags with ISDH, and has stated its grounds for disputing the tags subject to the IDR request where appropriate. It is the Agency's position that the survey contains tags that are not supported by the given factual statements. The Agency also notes for the record that ISDH has taken the position that administrative and legal review is unavailable to home health agencies that disagree with a survey, and routinely denies such requests. Thus the Agency has no ability to challenge the survey before an objective finder of fact and law. This being said, no admission of guilt or concession of agreement should be implied by the lack of administrative or other appeal in this instance by the Agency or by the descriptions of means to correct the alleged and disputed deficiencies. To the extent that such legal or administrative appeal becomes available to the Agency at a later		

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			time, the Agency hereby reserves the right to pursue all formal and informal administrative, civil, and legal processes available in contesting the allegations contained in this survey. All skilled time sheets will be checked weekly against patient visit notes and assessments for patient signatures, and matching time. Any discrepancies will followed up with phone call to patient and/or follow up visit by RN. To be ensured by Administrator/DON/Clinical Coordinator. On 1/10/2012 Employee E RN, was brought into office for termination and employee resigned before terminated. On 2/9/2012, there was a change in administration. The board appointed a new administrator, alternate administrator, director of nursing, and alternate director of nursing to ensure that management will be in the building to ensure the company remains compliant with federal/state regulations as well as company policies. The new administrator/alt. administrator, director of nursing/alt. director of nursing has reviewed state and federal guidelines as well as the organizations policies to ensure quality of care, patient safety, and all care plans are followed as directed. 100% of staff inserviced on reporting any suspected problems which could affect patient care/safety by 2/10/2012.	

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NAME OF PROVIDER OR SUPPLIER CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN 46017		
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			All reports of concerns will be addressed by the administrator as soon as they are reported. The DON will monitor all reports of concerns on a daily basis to ensure this deficiency is corrected and does not reoccur.		

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N0484	Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.	N0484	.The administrator and director of nursing have reviewed state and federal guidelines. On 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor any change with patients condition. ex: new wound, surigical procedure, ect. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC. The administrator and director of nursing have reviewed state and	02/10/2012	

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			federal guidelines and agency's organization policy on maintaining and following up on QA and PIP. Additionally, the Administrator and DON will review the QA topics and address any trends or identified issues. For example, if there are 10 UTI's in a month, the DON will ensure that the staff will be inserviced on proper technique/policy and/or skills checked to ensure that the clients are receiving quality care. By 2/10/2012, the QA completed in January, 2012, will be reviewed, and the plan of action revised to focus on improving agency's quality performance and ensuring patient's safety and optimal care. Upon admission, the RN will speak with the client/caregiver/physician to see if there are any other outside entities providing care for the patient. The Rn will continue to complete coordination of care every 30 days per company policy. The DON will review 100% of all charts for the next 6 month to ensure that coordination of care is being completed every 30 days per policy and that this deficiency is corrected and does not occur again.	

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N0486	<p>Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on hospital record and clinical record review and interview, the agency failed to ensure the registered nurse and the wound clinic coordinated efforts in 1 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (# 14)</p> <p>Findings Include:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel and was seen in wound clinic. The clinical record indicated the patient had a wound for the past 8 months and failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily.</p> <p>A. On January 18, 2012, at 11 AM,</p>	N0486	<p>on 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor any change with patients condition. ex: new wound, surigical procedure, ect. 2/2/2012 In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC. The administrator and director of nursing have reviewed state and federal guidelines and agency's organization policy on maintaining and following up on QA and PIP. Additionally, the administrator and DON will review the QA topics and address any trends or identified issues. For example, if</p>	02/10/2012			

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	<p>the caregiver of patient number 14 identified self as the primary caregiver for the patient and indicated the patient has had multiple chronic wounds for years while on service with this home health agency. The patient had not been assessed by any nurse in months. The caregiver indicated the patient had been to the emergency room at Community Hospital in Anderson around December 29, 2011, and identified the wound care clinic was the same location as the hospital.</p> <p>B. On January 18, 2012, at 2:10 PM, an onsite visit was conducted at Community Hospital in Anderson. During a confidential interview with the wound care nurse and a review of the patient's wound clinic clinical record, the nurse indicated the patient was treated at the wound clinic on November 11 and 18, 2011, for a blister to the left heel and a blister on the right great toe. The nurse indicated the patient's wounds were healed on November 18, 2011, the patient was clear of any further skin breakdown and that the patient was not seen again until December 30, 2011, when the patient arrived with a 5 centimeter black blister on the left heel. The nurse indicated the patient began treatments at the wound clinic on May 6, 2010, for ulcers on bilateral ankles and feet and had</p>		<p>there are 10 UTI's in a month, the DON will ensure that the staff will be inserviced on proper technique/policy and/or skills checked to ensure that the clients are receiving quality care. By 2/10/2012, the QA completed in January, 2012, will be reviewed, and the plan of action revised to focus on improving agency's quality performance and ensuring patient's safety and optimal care. Upon admission, the RN will speak with the client/caregiver/physician to see if there are any other outside entities providing care for the patient. The Rn will continue to complete coordination of care every 30 days per company policy. The DON will review 100% of all charts for the next 6 month to ensure that coordination of care is being completed every 30 days per policy and that this deficiency is corrected and does not occur again.</p>		

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	<p>been seen weekly up through May 9, 2011, at which time all ulcers were healed. The patient next returned for treatment on October 4, 2011, and was also treated on October 7 and 11 and November 11 and 18, 2011. The nurse stated, "The patient was a podiatry patient and should have been seen weekly but would cancel."</p> <p>1.) The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>2.) The hospital emergency room "Patient Abstract" dated 12/26/11 for patient 14 states, "Reason for Visit Skin Lesion ... 682.3 Cellulitis of Arm." The document titled "Department of Emergency Medicine Medical Record - Physician's Report" dated 12/26/11 states, "Cellulitis of Left Shoulder ... 58 year old patient complaint of pain / redness and drainage from having biopsy site 2 weeks ago. ... Biopsy site ... open draining yellow drainage."</p>						

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	<p>C. The record failed to evidence the nurse had consulted with the wound clinic regarding the skin lesions.</p> <p>2. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated they do not feel it is the agency's responsibility for the healthcare for all of their home health aide only patients. The agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service. The administrator and director of nursing indicated employee E was terminated on January 10, 2012, due to poor work performance.</p>						

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N0505	<p>Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:</p> <p>(2) The patient has the right to the following:</p> <p>(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:</p> <p>(ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following:</p> <p>(AA) The care or treatment.</p> <p>(BB) Changes in the care or treatment.</p>	N0505	<p>Administrator and Director of Nursing have reviewed the federal and state regulations as well as the company policies on patient rights. On 1/26/2012 in-serviced all nurses, therapist, and office staff to document telephone calls from patients and families before an order to hold services. Office will speak to families or patients for communications, such as requests, not home health aide. Any change in PT/PTA schedule will be telephoned or texted to office and office will then notify patient. All patients notified to report to office any changes in therapy schedule. Patient handbooks to be left in home with each admission/re-admission (No specific changes have been made to the client handbook). Administrator/DON, Alternate Administrator/ Alternate DON to be notified weekly of any therapy schedule change or missed visit</p>	02/10/2012
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	<p>Based on clinical record review and interview, the agency failed to ensure the patient had been involved in the planning of care when the services were placed on hold on 12/29/11 in 1 of 7 records reviewed of patients. (16)</p> <p>Findings:</p> <p>1. Clinical record 16, start of care 9/29/11, evidenced a plan of care for the certification period 11/28/11 through 1/26/12 with orders for physical therapy (PT), home health aide, and attendant care services. The clinical record evidenced a telephone order dated 12/29/11 written by employee FF that states, "Hold all services week of 1/2/12 due to client moving. Resume all previous services</p>		<p>to ensure coordination of care. DON will monitor 100% of therapy cases every 14 days during supervisory completed by RN to ensure therapist is showing up as scheduled. From this date forward, the RN will provide care coordination with nonskilled patients every 30 days to ensure that the patient is involved with the plan of care. The RN will begin this with the next 14 or 30 day supervisory visit. The DON will maintain a supervisory/care coordination book to ensure that this deficiency is corrected and will not reoccur.</p>		

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	<p>week of 1/9/12. Read back and verified."</p> <p>2. During a telephone interview on January 20, 2012, at 11:45 AM, the caregiver for patient #16 indicated that after services had not been provided during the week beginning January 2, 2012, the caregiver called the agency to find out why there were no services provided. The caregiver indicated that employee BB, the agency scheduler, informed the caregiver the patient's services had been placed on hold on 12/29/11. The caregiver indicated that the caregiver was not involved with nor requested a hold on the patient's services. During the same telephone interview, the patient indicated that employee M, a home health aide, was the individual who called the agency and notified the agency of the patients move and to place all services on hold. The caregiver also indicated that when the physical therapist, employee A is in the home, he schedules the following visit but frequently fails to show and stated, "He never calls" to notify that he is running late, or not coming as scheduled. The caregiver indicated that a PT visit was scheduled for 1/19/12 and the therapist did not arrive nor did the patient / family receive a telephone call from the therapist or the agency regarding the missed visit or when the therapist may next arrive. The</p>				

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	caregiver stated that all phone calls from the caregiver and patient to the agency are routed through to the scheduler and the information booklet given to the patient was dated from the patient's 2008 admission to the agency. When the patient was last admitted on 9/29/11 for skilled services, the patient was not provided with a new admission booklet and notification as to who was in charge of the agency and who to contact with problems or concerns.			
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N0522	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:	N0522	Administrator/DON reviewed state and federal regulations as well as company policy regarding plan of care. On 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor any change with patients condition. ex: new wound, surigical procedure, ect. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC. Administrator will inservice nurses on following physician's orders. All nurses will be give a copy of current 485/plan of care and all	02/10/2012
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	<p>A. The clinical record evidenced a document titled "Nursing Visit Note" signed by employee E, dated 12/21/11, that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p> <p>B. The clinical record evidenced documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed by employee D, a licensed practical nurse (LPN) that failed to evidence the wound had been measured and a clinical description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note" dated 12/31/11 and completed by employee D that failed to evidence the wound had been measured and a clinical description of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for</p>			
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	<p>Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>2. The policy titled "Assessment / Staging of Pressure Ulcers # G - 150" states, " Home Care should use a risk assessment tool to determine risk and plan accordingly. ... APPLIES TO - registered nurses, licensed practical nurses, ... In assessing the pressure ulcer, the following parameters should be addressed consistently, site, stage of ulcer, and size of ulcer (include length, width, and depth). Presence of tunneling or undermining. Presence of necrotic tissue. Drainage amount, color, and odor. Granulation. Pain. Condition of surrounding tissue. "</p> <p>3. The policy titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p>			
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	<p>4. On January 19, 2012, at 12 PM the administrator indicated that wounds are to be measured weekly by the registered nurses, not the LPN; the agency did not want the LPNs to complete this documentation at this time.</p> <p>5. Employee D was in-serviced on "Oasis, Admit Packs, implemented new skilled visit note, vital sign Parameter Policy" as presented by the Administrator on 12/12/11.</p> <p>Employee D was in-serviced on "5. Documentation 6. Read and sign policies a. Wound care ... c. Documentation d. Case Conference ..." as presented by the Administrator on 12/22/11.</p>			
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N0524	<p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record and agency policy review, the agency failed to ensure all patients had an individualized plan of care that included all of the required items in 1 (# 16) of 7 clinical records reviewed creating the potential for treatment omission and patient harm.</p> <p>The findings include:</p> <p>1. Clinical record #16, start of care 9/29/11, included a plan of care established by the physician for the</p>	N0524	Administrator and Director of Nursing reviewed state and federal regulations as well as company policy regarding patient care. D/C planning on POC to be written when short term and long term goals met, when higher level of care needed. PT evals with treatment plan, goals, and D/C planning is faxed to and signed by physician on intial evaluation, thereafter for recertification, the orders and goals will be written upon the recertification POC for PT. To be ensured by Administrator overseeing fax compliance book weekly.	02/10/2012			

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	<p>certification period 11/28/11 through 1/26/12 with orders for physical therapy (PT) 1 week 1, 1 - 2 times a week for weeks 2 through 8, home health aide services 2 - 3 times a week for nine weeks under the medicare benefit, and home health aide services for 1-2 hours, one to three times a day, four to seven times a week for seven weeks under the medicaid benefit for assistance with the activities of daily living, and for attendant care services 1 - 2 hours a day, one time a week for nine weeks to assist with bathing, dressing, skin and hair care, nutrition, and light housekeeping duties. The Plan of Care states, "Goals: PT Please see PT eval. ... Discharge Plans: When goals met or when pt [patient] states services are no longer needed." On 1/20/12 at 11 AM, the clinical record was reviewed and failed to evidence instructions for a timely discharge specific for this patient.</p> <p>2. The policy titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p>		<p>Administrator/DON has reviewed with therapist and nurses to ensure that all patient's have an individualized plan of care and that all required elements are completed to ensure that this deficiency is corrected and does not reoccur. The DON/ADON will review all medical plans of care to ensure that all required elements are present.</p>				

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N0541	Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.	N0541	Administrator/DON reviewed state and federal regulations as well as company policy on scope of services. On 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surgical procedure, ect. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC. DON/ADON will ensure that this is being completed in order to	02/10/2012	

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	<p>Based on clinical record, wound clinic record, and policy review and interview, the agency failed to ensure the registered nurse assessed the patient's wound as part of the comprehensive recertification assessment in 1 of 5 clinical records reviewed of patients receiving services over 60 days with the potential to affect all the agency's patients who receive services longer than 60 days. (# 14)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel was seen in wound clinic. The assessment failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily. 2. On January 18, 2012 at 11 AM, the caregiver of patient number 14 indicated 		correct this deficiency and keep it from reoccurring by keeping log book of supervisory visits (including SCIC).		

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	<p>the patient has had multiple chronic wounds for years while on service with this home health agency and the patient was not assessed by any nurse in months.</p> <p>3. The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>4. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated the agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment for their home health aide only patients and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service.</p> <p>5. The policy titled "Client Reassessment / Update of the Comprehensive Assessment" states, The comprehensive assessment will be updated and revised as often as the clients condition warrants due</p>			
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	to a major decline ... Within 48 hours of or knowledge of client return from a hospital admission of more than 24 hours, ... or other changes representing a SCIC (significant change in condition). PURPOSE To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement."			
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N0543	<p>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.</p> <p>Based on clinical record, hospital record, and policy review and interview, the agency failed to ensure the registered nurse initiated preventative nursing procedures in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (# 14 and 17)</p> <p>Findings Include:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel and was seen in wound clinic. The clinical record indicated the patient had a wound for the past 8 months and failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the wound daily.</p>	N0543	<p>Administrator/DON reviewed state and federal regulations as well as company policy to ensure compliance with scope of services. On 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect. On 2/10/2012, inserviced all nurses that Upon every recert, start of care, resumption of care, and comprehensive adult assessment Braden scale will be completed. On 2/2/2012,In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of</p>	02/10/2012			

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	<p>A. On January 18, 2012, at 11 AM, the caregiver of patient number 14 identified self as the primary caregiver for the patient and indicated the patient has had multiple chronic wounds for years while on service with this home health agency. The patient had not been assessed by any nurse in months. The caregiver indicated the patient had been to the emergency room at Community Hospital in Anderson around December 29, 2011, and identified the wound care clinic was the same location as the hospital.</p> <p>B. On January 18, 2012, at 2:10 PM, an onsite visit was conducted at Community Hospital in Anderson. During a confidential interview with the wound care nurse and a review of the patient's wound clinic clinical record, the nurse indicated the patient was treated at the wound clinic on November 11 and 18, 2011, for a blister to the left heel and a blister on the right great toe. The nurse indicated the patient's wounds were healed on November 18, 2011, the patient was clear of any further skin breakdown and that the patient was not seen again until December 30, 2011, when the patient arrived with a 5 centimeter black blister on the left heel. The nurse indicated the patient began treatments at</p>		<p>same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC. The DON or ADON will initial all above listed assessments in order to ensure completion of braden scale as well as any other necessary nursing measures in order to correct this deficiency and prevent it from reoccurring.</p>				

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	<p>the wound clinic on May 6, 2010, for ulcers on bilateral ankles and feet and had been seen weekly up through May 9, 2011, at which time all ulcers were healed. The patient next returned for treatment on October 4, 2011, and was also treated on October 7 and 11 and November 11 and 18, 2011. The nurse stated, "The patient was a podiatry patient and should have been seen weekly but would cancel."</p> <p>1.) The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>2.) The hospital emergency room "Patient Abstract" dated 12/26/11 for patient 14 states, "Reason for Visit Skin Lesion ... 682.3 Cellulitis of Arm." The document titled "Department of Emergency Medicine Medical Record - Physician's Report" dated 12/26/11 states, "Cellulitis of Left Shoulder ... 58 year old patient complaint of pain / redness and drainage from having biopsy site 2 weeks</p>			
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	<p>ago. ... Biopsy site ... open draining yellow drainage."</p> <p>C. The record failed to evidence the nurse had initiated preventative nursing procedures to address the patient's skin lesions.</p> <p>2. Clinical record 17, start of care 6/10/09, evidenced a plan of care for the certification period 11/27/11 through 1/25/12 with principle diagnosis of pressure lower back with onset date 11/23/11 and orders that stated, " SN [skilled nurse]: 2 - 3 X [times] W [week] X [times] 9 W [weeks] for: ... SN to perform wound care of sacral wound three times weekly SN to record wound dimensions once a week. ... Goal Wound will decrease from 1.0 cm to 0.7 cm with in 5 weeks. Skin integrity will be maintained without further s/s [signs and symptoms] of skin breakdown within cert [certification] period."</p> <p>A. The clinical record evidenced a document titled "Nursing Visit Note" documented by employee E dated 12/21/11 that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p>			
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	<p>B. The clinical record evidenced documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed by employee D, a licensed practical nurse. The notes failed to evidence the nurse had measured the wound and a description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note" dated 12/31/11, completed by employee D, that failed to evidence the dimensions and an assessment of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>E. The record failed to evidence the nurse had initiated preventative</p>			
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	<p>nursing procedures to address the patient's wounds.</p> <p>F. The policy titled "Assessment / Staging of Pressure Ulcers # G - 150" states, "Home Care should use a risk assessment tool to determine risk and plan accordingly. ... APPLIES TO - registered nurses, licensed practical nurses, ... In assessing the pressure ulcer, the following parameters should be addressed consistently, site, stage of ulcer, and size of ulcer (include length, width, and depth). Presence of tunneling or undermining. Presence of necrotic tissue. Drainage amount, color, and odor. Granulation. Pain. Condition of surrounding tissue."</p> <p>G. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing</p>						

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	<p>devices."</p> <p>H. On January 19, 2012 at 12 PM the administrator indicated wounds are to be measured weekly by the registered nurses not the licensed practical nurses (LPNs). The agency did not want the LPNs to complete this documentation at this time.</p> <p>3. Employee D was in-serviced on "Oasis, Admit Packs, implemented new skilled visit note, vital sign Parameter Policy" as presented by the Administrator on 12/12/11.</p> <p>Employee D was in-serviced on "5. Documentation 6. Read and sign policies a. Wound care ... c. Documentation d. Case Conference ..." as presented by the Administrator on 12/22/11.</p>				

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N0545	<p>Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record, hospital record, and policy review and interview, the agency failed to ensure the registered nurse coordinated with the licensed practical nurse and physician in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (# 14 and 17)</p> <p>Findings Include:</p> <p>1. Clinical record 14, start of care 9/3/09, evidenced a plan of care for the certification period 12/22/11 through 2/19/12 with orders for home health aide services. The clinical record evidenced a document titled "COMPREHENSIVE ASSESSMENT" dated 12/16/11, completed by employee E, that identified the patient had one wound located on the left heel and was seen in wound clinic. The clinical record indicated the patient had a wound for the past 8 months and failed to evidence an assessment of the wound, the name of the indicated wound clinic, the current treatment for the wound, and who was caring for the</p>	N0545	<p>Administrator/DON have reviewed state and federal regulations as well as company policy regarding coordination of care. On 2/3/2012 In-serviced 100% of home health aides on reporting to supervisor and change with patients condition. ex: new wound, surigical procedure, ect. On 2/2/2012, In-serviced all nurses on comprehensive assessments. On 2/10/2012, In-serviced all nurses on Non skilled patients with and existing wound who are being seen by an outside entity will be measured upon recertification. Non skilled patients with a new wound will be evaluated by a skilled nurse and MD notified and appropriate referral made. Must measure all wounds of skilled patients weekly and upon recertification or notification of new wound unless specific order from physician stating Home Health Care Agency not to remove dressing and assess wound, or communication of same with Wound Clinic. Supervising RN to question patient upon supervisory visit of any SCIC and follow up with physician as to the SCIC. Upon admission, the RN will speak with the client/caregiver/physician to</p>	02/10/2012	

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	<p>wound daily.</p> <p>A. On January 18, 2012, at 11 AM, the caregiver of patient number 14 identified self as the primary caregiver for the patient and indicated the patient has had multiple chronic wounds for years while on service with this home health agency. The patient had not been assessed by any nurse in months. The caregiver indicated the patient had been to the emergency room at Community Hospital in Anderson around December 29, 2011, and identified the wound care clinic was the same location as the hospital.</p> <p>B. On January 18, 2012, at 2:10 PM, an onsite visit was conducted at Community Hospital in Anderson. During a confidential interview with the wound care nurse and a review of the patient's wound clinic clinical record, the nurse indicated the patient was treated at the wound clinic on November 11 and 18, 2011, for a blister to the left heel and a blister on the right great toe. The nurse indicated the patient's wounds were healed on November 18, 2011, the patient was clear of any further skin breakdown and that the patient was not seen again until December 30, 2011, when the patient arrived with a 5 centimeter black blister on the left heel. The nurse</p>		<p>see if there are any other outside entities providing care for the patient. The Rn will continue to complete coordination of care every 30 days per company policy. The DON will review 100% of all charts for the next 6 month to ensure that coordination of care is being completed every 30 days per policy and that this deficiency is corrected and does not occur again.</p>		

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	<p>indicated the patient began treatments at the wound clinic on May 6, 2010, for ulcers on bilateral ankles and feet and had been seen weekly up through May 9, 2011, at which time all ulcers were healed. The patient next returned for treatment on October 4, 2011, and was also treated on October 7 and 11 and November 11 and 18, 2011. The nurse stated, "The patient was a podiatry patient and should have been seen weekly but would cancel."</p> <p>1.) The wound center clinical record evidenced documentation dated December 30, 2011, which states, "Wound number 14, left heel, pressure ulcer, acquired 12/27/11 ... Wound Measurements 5 centimeters in length, 3.5 centimeters in width, depth 0.1 centimeter, ... stage necrotic tissue unstageable, exudate amount scant, exudate - serous, odor none, pain -5, ... dry black eschar 76 - 100 %."</p> <p>2.) The hospital emergency room "Patient Abstract" dated 12/26/11 for patient 14 states, "Reason for Visit Skin Lesion ... 682.3 Cellulitis of Arm." The document titled "Department of Emergency Medicine Medical Record - Physician's Report" dated 12/26/11 states, "Cellulitis of Left Shoulder ... 58 year old patient complaint of pain / redness and</p>						

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	<p>drainage from having biopsy site 2 weeks ago. ... Biopsy site ... open draining yellow drainage."</p> <p>C. The record failed to evidence the nurse had consulted with the patient's physician regarding the skin lesions.</p> <p>2. Clinical record 17, start of care 6/10/09, evidenced a plan of care for the certification period 11/27/11 through 1/25/12 with principle diagnosis of pressure lower back with onset date 11/23/11 and orders that stated, " SN [skilled nurse]: 2 - 3 X [times] W [week] X [times] 9 W [weeks] for: ... SN to perform wound care of sacral wound three times weekly SN to record wound dimensions once a week. ... Goal Wound will decrease from 1.0 cm to 0.7 cm with in 5 weeks. Skin integrity will be maintained without further s/s [signs and symptoms] of skin breakdown within cert [certification] period."</p> <p>A. The clinical record evidenced a document titled "Nursing Visit Note" documented by employee E dated 12/21/11 that stated, "Wound Care Provided ... length 1.2 cm [centimeters] width 0.6 cm depth 0.2 cm, drainage scant, sur. tis. [surrounding tissue] gray, red, white."</p>			

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	<p>B. The clinical record evidenced documents titled "Nursing Visit Note" dated 12/26/11 and 12/28/11 completed by employee D, a licensed practical nurse. The notes failed to evidence the nurse had measured the wound and a description of the wound.</p> <p>C. The clinical record evidenced document titled "Nursing Visit Note" dated 12/31/11, completed by employee D, that failed to evidence the dimensions and an assessment of the wound.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 1/2/12 completed by employee EE that states, "Reason for visit Dressing Change ... Wound Care Provided ... length 1.4 cm, width 0.8 cm, depth 0.5 cm, drainage 0, tunneling 12 o'clock 0.5 cm 5 o'clock 0.5 cm. ... Patient states has canceled several appointments with wound clinic. Notified Center for Advanced Wound Healing, spoke with [name], pt. [patient] needs referral to wound clinic. Notified [name of employee FF] LPN (licensed practical nurse at office of CJ's) to notify Dr [name] office to request wound clinic referral."</p> <p>E. The record failed to evidence the LPN communicated with the</p>			
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	<p>devices."</p> <p>H. On January 19, 2012 at 12 PM the administrator indicated wounds are to be measured weekly by the registered nurses not the licensed practical nurses (LPNs). The agency did not want the LPNs to complete this documentation at this time.</p> <p>3. On January 20, 2012, at 12:45 PM, the administrator and director of nursing indicated they do not feel it is the agency's responsibility for the healthcare for all of their home health aide only patients. The agency is only required to complete supervisory visits to make sure the aide is following and completing the assignment and they would not undress and assess a wound if the patient did not have an order for skilled services or know how they were going to be reimbursed for the service. The administrator and director of nursing indicated employee E was terminated on January 10, 2012, due to poor work performance.</p>			
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