

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/22/2012
NAME OF PROVIDER OR SUPPLIER  SPECIALTY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715		
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G0000	<p>This was a home health federal recertification survey.</p> <p>Facility #: 002416</p> <p>Survey Dates: 8-14-12, 8-15-12, 8-16-12, 8-21-12, and 8-22-12</p> <p>Medicaid Vendor #; 200252140</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>August 27, 2012</p>	G0000			

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

TITLE

(X6) DATE

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

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G0121	<p><b>484.12(c)</b> <b>COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, interview, and review of agency policy, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures in 4 (#s 1, 2, 3, &amp; 4) of 6 home visit observations completed creating the potential for the spread of disease causing organisms among staff and all of the agency's 118 current patients.</p> <p>The findings include:</p> <p>1. The agency's 1999 "Standards of Practice Policy" number AO6-1 states, "The acceptable standards of practice for staff to implement with patient care and services, include, but are not limited to . . . The agency's own policies and procedures based on standards of practice and agency expectations."</p> <p>A. The agency's 8-5-11 "Infection Control Policy" number AO15-1 states, "This program is based on using current standards of practice in reducing and preventing infections. The standards we will use include: Standard and Universal</p>	G0121	The Administrator and Director of Clinical Services will be conducting an infection control inservice with all clinicians on 9/11/12. This inservice will review the agency's following policies and procedures: Infection Control Policy AO15-1(Including the Centers for Disease Control Standard Precautions), Hand Washing Procedure, Bag Technique Procedure, and Maintaining Medical Supplies and Equipment in the Home Procedure. We will also review Federal Regulation 484.12 (c) with all clinicians. The Director of Clinical Services will focus on infection control with all clinician supervisory visits beginning 9/4/12. The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	09/11/2012

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	<p>Precautions."</p> <p>B. The agency's undated "Handwashing" procedure states, "Wash the hands before and after the care of patients and before entering the nursing bag."</p> <p>C. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies</p>				

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	<p>and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. On 8-15-12 at 8:20 AM, a home visit was made to patient number 1 with employee J, a registered nurse (RN). The RN was observed to perform dressing changes to the patient's lower extremities. The RN was observed to cleanse her hands and bandage scissors and then open supplies to be used to perform the dressing change that included ABD pads and "Acticoat", an antimicrobial wound dressing. The RN donned clean gloves without cleansing her hands after touching the supply packages that were stored in the patient's home. The RN then completed the dressing change to the patient's left lower extremity.</p> <p>A. After completing the dressing change to the patient's left lower</p>				

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	<p>extremity, the RN removed her gloves, gathered up the trash, and then cleansed her hands. The RN then gathered and opened the packages of supplies needed to complete the dressing change to the patient's right lower extremity. The RN donned clean gloves without cleansing her hands. After the dressing change had been completed the RN removed her gloves, gathered up the trash, and, without cleansing her hands, applied stockings to both of the patient's lower extremities.</p> <p>B. After completing the dressing changes, the RN took the patient's temperature, pulse, and a pulse oximetry reading using an oximeter removed from the nurse's bag. After obtaining the reading, the RN removed the oximeter from the patient's right forefinger and placed it on a barrier at the patient's side. After taking the patient's blood pressure and listening to the patient's lungs, the RN then placed the pulse oximeter into her nursing bag without first cleansing it.</p> <p>3. On 8-15-12 at 10:40 AM, a home visit was made to patient number 2 with employee K, a RN. During the course of a dressing change to the patient's upper left chest area, the RN obtained an ABD pad in the package from her nursing bag. The RN donned gloves without cleansing her hands after reaching into her nursing</p>						

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	<p>bag and completed the dressing change.</p> <p>4. On 8-15-12 at 11:35 AM, a home visit was made to patient number 3 with employee L, a RN. The RN was observed to complete a dressing change to a surgical wound on the patient's right upper abdomen. Upon entering the patient's bedroom where the dressing change would be completed, the RN was observed to place her computer on the foot of the patient's bed without a barrier. The RN then gathered supplies to complete the dressing change and then donned clean gloves without cleansing her hands.</p> <p>A. After removing the old dressing, the RN removed her gloves and cleansed her hands. The RN then reached into her nursing bag and obtained a small ruler to measure the wound. The RN then reached into her pocket and obtained a cell phone. Without cleansing her hands and donning clean gloves the RN placed the ruler just under the wound and photographed the wound using the cell phone. After the measurement had been completed the RN donned clean gloves without cleansing her hands and measured the depth of the wound using a sterile cotton applicator.</p> <p>B. After the dressing change had been</p>			

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	<p>completed, the RN removed her gloves, gathered the trash, and cleansed her hands. The RN then touched the patient's lower legs, cleaned her bandage scissors, and reached into her nursing bag to obtain a blood pressure cuff. The RN took the patient's blood pressure and placed the cuff back into her nursing bag without cleansing the cuff. The RN took the patient's pulse and temperature and placed a pulse oximeter on the patient's finger. After the reading had been obtained, the RN placed the pulse oximeter back into her nursing bag without cleansing it.</p> <p>5. A home visit was made to patient number 4 on 8-16-12 at 8:55 AM with employee H, an occupational therapist (OT). Upon arrival the OT took the patient's blood pressure. After obtaining the blood pressure reading, the OT placed the blood pressure cuff back into her bag without cleansing it.</p> <p>The OT checked the patient's pulse oximetry reading after the patient had performed standing exercise. The OT then placed the pulse oximetry into her pocket. The OT then checked the patient's oxygen saturation with the pulse oximetry after the patient had performed some sitting exercises, removing the pulse oximetry from her pocket.</p>			

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	6. The above-stated observations were discussed with the administrator, employee C, and the supervising nurse, employee D, on 8-16-12 at 2:15 PM. The administrator and the supervising nurse did not comment on the observations.			

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure treatments had been provided as ordered by the physician on the written plan of care in 6 (#s 5, 8, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 118 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to evidence orders for wound care performed by the skilled nurse (SN) and taught to the patient's caregiver had been obtained from the physician.</p> <p>A. The record included a start of care comprehensive assessment completed by employee N, a registered nurse, on 6-22-12. The visit note states, "Suture to R [right] rib area intact with no redness or drainage. Patient is to leave open to air . . . patient has suture on R side of lower ribs from drainage tube that was inserted from biopsy. No redness or drainage." The visit note identified the wound bed was "clean and dry", the wound edges were</p>	G0158	An inservice will be conducted on 9/11/12 by the Quality Assurance Specialist which will review policy SD9-1 Physicians Plan of Care, SD9-5 Patient Care Plan Policy, and Federal Regulation 484.18 with all clinicians. The Quality Assurance Specialist will also educate the clinical staff on the process of appropriate care planning. The Quality Assurance Specialist will audit 10% of all clinical records every quarter for evidence that treatments have been provided as ordered on the plan of care. The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	09/11/2012	

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	<p>"WNL [within normal limits]", there was no drainage from the wound, and it measured 1.5 centimeters in length.</p> <p>B. A SN visit note dated 7-27-12 evidenced the SN had performed wound care on the patient and had taught the patient's caregiver how to do the wound care. The note states, "Area is about 1/4 inch depth and dime size circle opening with red wound edges. slough is in the bottom and sides with little pink see. attempted to clean out area with saline pat dried then covered with dressing. instructed pt [patient] and [spouse] on all steps of wound care and sign of infection or increasing drainage requiring more than 2 x [times] in a day to change dressing then call staff. Cg [caregiver] to change daily and prn [as needed] if noticed increase drainage to keep area clean and dry."</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 3-24-12 to 5-22-12 that identified the patient's diagnoses as chronic diastolic heart failure and atrial fibrillation. The record evidenced a start of care date of 3-24-12 and a discharge date of 5-22-12.</p> <p>A. The plan of care identified the SN was to monitor the patient's daily weight</p>				

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	<p>log. The plan states, ""Teach pt/cg [patient/caregiver] to weight self weekly . . . 'Teach Back' Daily Wt. log - call for 2# - 1 day or 3-5 # in 5 days . . . Teach / reinforce rationale for daily weights, keeping log, noting trends . . . Monitor daily weight log."</p> <p>B. The record evidenced the SN had made visits on 3-24-12, 3-30-12, 4-4-12, and 4-11-12 before the patient was transferred to the hospital on 4-16-12 due to a fall with injury. The SN visit notes failed to evidence the nurse had monitored the patient's daily weight log.</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 6-29-12 to 8-27-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. The agency's undated "Blood Pressure" procedure states, "Take the patient's blood pressure while the patient is sitting and again while he or she is standing to evaluate for orthostatic hypotension [a form of low blood pressure that occurs in a standing position]."</p> <p>B. SN visit notes, dated 7-6-12, 7-9-12, and 8-7-12, failed to evidence the</p>			

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	<p>nurse had taken both a sitting and standing blood pressure reading.</p> <p>C. The administrator, employee C, stated, on 8-22-12 at 1:19 PM, "We found readings on 7-19 and 8-1 but none on the rest of the visits."</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 8-11-12 to 10-9-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 8-13-12 and 8-16-12 failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The administrator, employee C, indicated, on 8-22-12 at 1:20 PM, the visit notes did not evidence documentation the SN had taken both sitting and standing blood pressure readings at the visit. The administrator stated, "It's not there."</p> <p>5. Clinical record number 11 included a plan of care established by the physician for the certification period 7-21-12 to 9-9-12. The plan of care states, "SN: Notify MD of irregular HR [heart rate], pulse &lt; 60 or &gt; 120 . . . SN: Perform</p>						

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	<p>wound measurements per protocol: q [every] weekly."</p> <p>A. The agency's undated "Wound Assessment and Documentation" procedure states, "Document the following on the visit report: . . . Wound measurement (at least weekly) including the length, depth, and width of the wound in centimeters."</p> <p>B. The "Wound Flowsheet" identified the patient had a wound on the "left head neckline half graft site / half open area / graft site." SN visit notes failed to evidence the wound had been measured the weeks of 7-15-12, 7-22-12, and 8-5-12.</p> <p>C. SN visit notes identified the patient's pulse rate had been measured at less than 60. The record failed to evidence the physician had been notified per the plan of care.</p> <p>1.) A SN visit note dated 7-16 12 evidenced the patient's pulse rate had been measured at 54 beats per minutes.</p> <p>2.) A SN visit note dated 7-20-12 failed to evidence the patient's pulse rate had been measured at all.</p> <p>3.) A SN visit note dated 7-23-12</p>				

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	<p>evidenced the patient's pulse rate had been measured at 51 beats per minute.</p> <p>4.) A SN visit note dated 8-14-12 evidenced the patient's pulse rate had been measured at 58 beats per minute.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 7-3-12 to 8-31-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 7-9-12, 7-19-12, 7-26-12, 8-14-12, and 8-21-12, failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The supervising nurse, employee D, indicated, on 8-22-12 at 1:35 PM, the nurse had not performed the orthostatic blood pressure readings as ordered on the plan of care.</p> <p>7. The supervising nurse, employee D, and the administrator, employee C, were unable to provide any additional documentation and/or information when asked on 8-22-12 at 10:50 AM.</p> <p>8. The agency's 5-25-2009 ""Physician's Plan of Care" policy number SD9-1</p>			

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	states, "Plan of care is a written plan developed with the participation of professional staff and the patient, in consultation with and authorized by the physician, that supports the patient's medical, nursing and social needs in the home setting and services as the basis of care delivery . . . Care delivery follows the plan of care."			

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G0161	<p><b>484.18(a)</b> <b>PLAN OF CARE</b> Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure orders for therapy services included all modalities and procedures to be used in 1 (#5) of 8 record reviewed of patients that received physical therapy services from the agency creating the potential to affect all of the facility's 118 current patients.</p> <p>The findings include:</p> <p>1. A home visit was made to patient number 5 on 8-16-12 at 10:10 AM with employee G, a physical therapist. The therapist was observed to perform percussion and postural drainage, an exercise used to loosen and remove mucus from the lungs, on the patient.</p> <p>A. Physical therapy visit notes, dated 7-6-12, 7-20-12, 7-24-12, 7-27-12, 7-30-12, 8-2-12, 8-6-12, 8-13-12, and 8-16-12 evidenced the therapist, employee G, had performed percussion and/or postural drainage or "pulmonary physical therapy."</p> <p>B. A. The plan of care, established by</p>	G0161	An inservice will be conducted on 9/11/12 by the Quality Assurance Specialist which will review policy SD9-1 Physicians Plan of Care and SD9-5 Patient Care Plan Policy with all clinicians. We will also review Federal Regulation 484.18 (a). The Quality Assurance Specialist will also educate the therapists on the process of appropriate care planning and orders with specifics on procedures and therapy modalities with the amount, frequency, and duration. The Quality Assurance Specialist will audit 10% of all clinical records every quarter to ensure all orders for therapy treatments include specific procedures and modalities with the amount, frequency, and duration. The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	09/11/2012	

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	<p>the physician for the certification period 6-22-12 to 8-20-12, failed to include percussion and postural drainage in the physical therapy orders.</p> <p>2. The administrator, employee C, indicated, on 8-22-12 at 1:13 PM, the orders for the physical therapy services did not include the percussion and postural drainage.</p> <p>3. The agency's 5-2009 "Physician's Plan of Care" policy number SD9-1 states, "The agency obtains complete orders for care . . . Specific procedures and treatments, including frequency and duration. Specific modalities and amount for therapy services."</p>			

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G0170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure the skilled nurse had provided treatments as ordered by the physician on the written plan of care in 6 (#s 5, 8, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 118 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 5 failed to evidence orders for wound care performed by the skilled nurse (SN) and taught to the patient's caregiver had been obtained from the physician.</li> </ol> <p>A. The record included a start of care comprehensive assessment completed by employee N, a registered nurse, on 6-22-12. The visit note states, "Suture to R [right] rib area intact with no redness or drainage. Patient is to leave open to air . . . patient has suture on R side of lower ribs from drainage tube that was inserted from biopsy. No redness or drainage." The visit note identified the wound bed was "clean and dry", the wound edges were "WNL [within normal limits]", there was no drainage from the wound, and it measured 1.5 centimeters in length.</p>	G0170	<p>An inservice will be conducted on 9/11/12 by the Quality Assurance Specialist which will review policy SD9-1 Physicians Plan of Care and SD9-5 Patient Care Plan Policy with all skilled nursing staff. We will also review Federal Regulation 484.30. The Quality Assurance Specialist will also educate the skilled nursing staff on the process of appropriate care planning.</p> <p>The Quality Assurance Specialist will audit 10% of all clinical records every quarter for evidence the skilled nurse provided treatments as ordered on the plan of care.</p> <p>The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>	09/11/2012			

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	<p>B. A SN visit note dated 7-27-12 evidenced the SN had performed wound care on the patient and had taught the patient's caregiver how to do the wound care. The note states, "Area is about 1/4 inch depth and dime size circle opening with red wound edges. slough is in the bottom and sides with little pink see. attempted to clean out area with saline pat dried then covered with dressing. instructed pt [patient] and [spouse] on all steps of wound care and sign of infection or increasing drainage requiring more than 2 x [times] in a day to change dressing then call staff. Cg [caregiver] to change daily and prn [as needed] if noticed increase drainage to keep area clean and dry."</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 3-24-12 to 5-22-12 that identified the patient's diagnoses as chronic diastolic heart failure and atrial fibrillation. The record evidenced a start of care date of 3-24-12 and a discharge date of 5-22-12.</p> <p>A. The plan of care identified the SN was to monitor the patient's daily weight log. The plan states, ""Teach pt/cg [patient/caregiver] to weight self weekly . . . 'Teach Back' Daily Wt. log - call for 2#</p>			

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	<p>- 1 day or 3-5 # in 5 days . . . Teach / reinforce rationale for daily weights, keeping log, noting trends . . . Monitor daily weight log."</p> <p>B. The record evidenced the SN had made visits on 3-24-12, 3-30-12, 4-4-12, and 4-11-12 before the patient was transferred to the hospital on 4-16-12 due to a fall with injury. The SN visit notes failed to evidence the nurse had monitored the patient's daily weight log.</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 6-29-12 to 8-27-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. The agency's undated "Blood Pressure" procedure states, "Take the patient's blood pressure while the patient is sitting and again while he or she is standing to evaluate for orthostatic hypotension [a form of low blood pressure that occurs in a standing position]."</p> <p>B. SN visit notes, dated 7-6-12, 7-9-12, and 8-7-12, failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p>			

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	<p>C. The administrator, employee C, stated, on 8-22-12 at 1:19 PM, "We found readings on 7-19 and 8-1 but none on the rest of the visits."</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 8-11-12 to 10-9-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 8-13-12 and 8-16-12 failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The administrator, employee C, indicated, on 8-22-12 at 1:20 PM, the visit notes did not evidence documentation the SN had taken both sitting and standing blood pressure readings at the visit. The administrator stated, "It's not there."</p> <p>5. Clinical record number 11 included a plan of care established by the physician for the certification period 7-21-12 to 9-9-12. The plan of care states, "SN: Notify MD of irregular HR [heart rate], pulse &lt; 60 or &gt; 120 . . . SN: Perform wound measurements per protocol: q [every] weekly."</p>			

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	<p>A. The agency's undated "Wound Assessment and Documentation" procedure states, "Document the following on the visit report: . . . Wound measurement (at least weekly) including the length, depth, and width of the wound in centimeters."</p> <p>B. The "Wound Flowsheet" identified the patient had a wound on the "left head neckline half graft site / half open area / graft site." SN visit notes failed to evidence the wound had been measured the weeks of 7-15-12, 7-22-12, and 8-5-12.</p> <p>C. SN visit notes identified the patient's pulse rate had been measured at less than 60. The record failed to evidence the physician had been notified per the plan of care.</p> <p>1.) A SN visit note dated 7-16 12 evidenced the patient's pulse rate had been measured at 54 beats per minutes.</p> <p>2.) A SN visit note dated 7-20-12 failed to evidence the patient's pulse rate had been measured at all.</p> <p>3.) A SN visit note dated 7-23-12 evidenced the patient's pulse rate had been measured at 51 beats per minute.</p>				

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	<p>4.) A SN visit note dated 8-14-12 evidenced the patient's pulse rate had been measured at 58 beats per minute.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 7-3-12 to 8-31-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 7-9-12, 7-19-12, 7-26-12, 8-14-12, and 8-21-12, failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The supervising nurse, employee D, indicated, on 8-22-12 at 1:35 PM, the nurse had not performed the orthostatic blood pressure readings as ordered on the plan of care.</p> <p>7. The supervising nurse, employee D, and the administrator, employee C, were unable to provide any additional documentation and/or information when asked on 8-22-12 at 10:50 AM.</p> <p>8. The agency's 5-25-2009 ""Physician's Plan of Care" policy number SD9-1 states, "Plan of care is a written plan developed with the participation of professional staff and the patient, in</p>				

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N0000	<p>consultation with and authorized by the physician, that supports the patient's medical, nursing and social needs in the home setting and services as the basis of care delivery . . . Care delivery follows the plan of care."</p> <p>This was a home health state re-licensure survey.</p> <p>Facility #: 002416</p> <p>Survey Dates: 8-14-12, 8-15-12, 8-16-12, 8-21-12, and 8-22-12</p> <p>Medicaid Vendor #; 200252140</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>August 27, 2012</p>	N0000					

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of agency policy, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures in 4 (#s 1, 2, 3, &amp; 4) of 6 home visit observations completed creating the potential for the spread of disease causing organisms among staff and all of the agency's 118 current patients.</p> <p>The findings include:</p> <p>1. The agency's 1999 "Standards of Practice Policy" number AO6-1 states, "The acceptable standards of practice for staff to implement with patient care and services, include, but are not limited to . . . The agency's own policies and procedures based on standards of practice and agency expectations."</p> <p>A. The agency's 8-5-11 "Infection Control Policy" number AO15-1 states, "This program is based on using current standards of practice in reducing and preventing infections. The standards we</p>	N0470	<p>The Administrator and Director of Clinical Services will be conducting an infection control inservice with all clinicians on 9/11/12. This inservice will review the agency's following policies and procedures: Infection Control Policy AO15-1(Including the Centers for Disease Control Standard Precautions), Hand Washing Procedure, Bag Technique Procedure, and Maintaining Medical Supplies and Equipment in the Home Procedure. We will also review State Regulation 410 IAC 17-12-1 (m) with all clinicians.</p> <p>The Director of Clinical Services will focus on infection control with all clinician supervisory visits beginning 9/04/12.</p> <p>The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>	09/11/2012			

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	<p>will use include: Standard and Universal Precautions."</p> <p>B. The agency's undated "Handwashing" procedure states, "Wash the hands before and after the care of patients and before entering the nursing bag."</p> <p>C. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include</p>						

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	<p>multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. On 8-15-12 at 8:20 AM, a home visit was made to patient number 1 with employee J, a registered nurse (RN). The RN was observed to perform dressing changes to the patient's lower extremities. The RN was observed to cleanse her hands and bandage scissors and then open supplies to be used to perform the dressing change that included ABD pads and "Acticoat", an antimicrobial wound dressing. The RN donned clean gloves without cleansing her hands after touching the supply packages that were stored in the patient's home. The RN then completed the dressing change to the patient's left lower extremity.</p> <p>A. After completing the dressing</p>			

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	<p>change to the patient's left lower extremity, the RN removed her gloves, gathered up the trash, and then cleansed her hands. The RN then gathered and opened the packages of supplies needed to complete the dressing change to the patient's right lower extremity. The RN donned clean gloves without cleansing her hands. After the dressing change had been completed the RN removed her gloves, gathered up the trash, and, without cleansing her hands, applied stockings to both of the patient's lower extremities.</p> <p>B. After completing the dressing changes, the RN took the patient's temperature, pulse, and a pulse oximetry reading using an oximeter removed from the nurse's bag. After obtaining the reading, the RN removed the oximeter from the patient's right forefinger and placed it on a barrier at the patient's side. After taking the patient's blood pressure and listening to the patient's lungs, the RN then placed the pulse oximeter into her nursing bag without first cleansing it.</p> <p>3. On 8-15-12 at 10:40 AM, a home visit was made to patient number 2 with employee K, a RN. During the course of a dressing change to the patient's upper left chest area, the RN obtained an ABD pad in the package from her nursing bag. The RN donned gloves without cleansing</p>			

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	<p>her hands after reaching into her nursing bag and completed the dressing change.</p> <p>4. On 8-15-12 at 11:35 AM, a home visit was made to patient number 3 with employee L, a RN. The RN was observed to complete a dressing change to a surgical wound on the patient's right upper abdomen. Upon entering the patient's bedroom where the dressing change would be completed, the RN was observed to place her computer on the foot of the patient's bed without a barrier. The RN then gathered supplies to complete the dressing change and then donned clean gloves without cleansing her hands.</p> <p>A. After removing the old dressing, the RN removed her gloves and cleansed her hands. The RN then reached into her nursing bag and obtained a small ruler to measure the wound. The RN then reached into her pocket and obtained a cell phone. Without cleansing her hands and donning clean gloves the RN placed the ruler just under the wound and photographed the wound using the cell phone. After the measurement had been completed the RN donned clean gloves without cleansing her hands and measured the depth of the wound using a sterile cotton applicator.</p>			

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	<p>B. After the dressing change had been completed, the RN removed her gloves, gathered the trash, and cleansed her hands. The RN then touched the patient's lower legs, cleaned her bandage scissors, and reached into her nursing bag to obtain a blood pressure cuff. The RN took the patient's blood pressure and placed the cuff back into her nursing bag without cleansing the cuff. The RN took the patient's pulse and temperature and placed a pulse oximeter on the patient's finger. After the reading had been obtained, the RN placed the pulse oximeter back into her nursing bag without cleansing it.</p> <p>5. A home visit was made to patient number 4 on 8-16-12 at 8:55 AM with employee H, an occupational therapist (OT). Upon arrival the OT took the patient's blood pressure. After obtaining the blood pressure reading, the OT placed the blood pressure cuff back into her bag without cleansing it.</p> <p>The OT checked the patient's pulse oximetry reading after the patient had performed standing exercise. The OT then placed the pulse oximetry into her pocket. The OT then checked the patient's oxygen saturation with the pulse oximetry after the patient had performed some sitting exercises, removing the pulse oximetry from her pocket.</p>						

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	<p>6. The above-stated observations were discussed with the administrator, employee C, and the supervising nurse, employee D, on 8-16-12 at 2:15 PM. The administrator and the supervising nurse did not comment on the observations.</p>			

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure treatments had been provided as ordered by the physician on the written plan of care in 6 (#s 5, 8, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 118 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to evidence orders for wound care performed by the skilled nurse (SN) and taught to the patient's caregiver had been obtained from the physician.</p> <p>A. The record included a start of care comprehensive assessment completed by employee N, a registered nurse, on 6-22-12. The visit note states, "Suture to R [right] rib area intact with no redness or drainage. Patient is to leave open to air . . . patient has suture on R side of lower ribs from drainage tube that was inserted from biopsy. No redness or drainage." The visit note identified the wound bed was "clean and dry", the wound edges were</p>	N0522	<p>An inservice will be conducted on 9/11/12 by the Quality Assurance Specialist which will review policy SD9-1 Physicians Plan of Care and SD9-5 Patient Care Plan Policy and State Regulation 410 IAC 17-13-1 (a) with all clinicians. The Quality Assurance Specialist will also educate the clinical staff on the process of appropriate care planning.</p> <p>The Quality Assurance Specialist will audit 10% of all clinical records every quarter for evidence that treatments have been provided as ordered on the plan of care.</p> <p>The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>	09/11/2012			

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	<p>"WNL [within normal limits]", there was no drainage from the wound, and it measured 1.5 centimeters in length.</p> <p>B. A SN visit note dated 7-27-12 evidenced the SN had performed wound care on the patient and had taught the patient's caregiver how to do the wound care. The note states, "Area is about 1/4 inch depth and dime size circle opening with red wound edges. slough is in the bottom and sides with little pink see. attempted to clean out area with saline pat dried then covered with dressing. instructed pt [patient] and [spouse] on all steps of wound care and sign of infection or increasing drainage requiring more than 2 x [times] in a day to change dressing then call staff. Cg [caregiver] to change daily and prn [as needed] if noticed increase drainage to keep area clean and dry."</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 3-24-12 to 5-22-12 that identified the patient's diagnoses as chronic diastolic heart failure and atrial fibrillation. The record evidenced a start of care date of 3-24-12 and a discharge date of 5-22-12.</p> <p>A. The plan of care identified the SN was to monitor the patient's daily weight</p>				

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	<p>log. The plan states, ""Teach pt/cg [patient/caregiver] to weight self weekly . . . 'Teach Back' Daily Wt. log - call for 2# - 1 day or 3-5 # in 5 days . . . Teach / reinforce rationale for daily weights, keeping log, noting trends . . . Monitor daily weight log."</p> <p>B. The record evidenced the SN had made visits on 3-24-12, 3-30-12, 4-4-12, and 4-11-12 before the patient was transferred to the hospital on 4-16-12 due to a fall with injury. The SN visit notes failed to evidence the nurse had monitored the patient's daily weight log.</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 6-29-12 to 8-27-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. The agency's undated "Blood Pressure" procedure states, "Take the patient's blood pressure while the patient is sitting and again while he or she is standing to evaluate for orthostatic hypotension [a form of low blood pressure that occurs in a standing position]."</p> <p>B. SN visit notes, dated 7-6-12, 7-9-12, and 8-7-12, failed to evidence the</p>						

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	<p>nurse had taken both a sitting and standing blood pressure reading.</p> <p>C. The administrator, employee C, stated, on 8-22-12 at 1:19 PM, "We found readings on 7-19 and 8-1 but none on the rest of the visits."</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 8-11-12 to 10-9-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 8-13-12 and 8-16-12 failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The administrator, employee C, indicated, on 8-22-12 at 1:20 PM, the visit notes did not evidence documentation the SN had taken both sitting and standing blood pressure readings at the visit. The administrator stated, "It's not there."</p> <p>5. Clinical record number 11 included a plan of care established by the physician for the certification period 7-21-12 to 9-9-12. The plan of care states, "SN: Notify MD of irregular HR [heart rate], pulse &lt; 60 or &gt; 120 . . . SN: Perform</p>						

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	<p>wound measurements per protocol: q [every] weekly."</p> <p>A. The agency's undated "Wound Assessment and Documentation" procedure states, "Document the following on the visit report: . . . Wound measurement (at least weekly) including the length, depth, and width of the wound in centimeters."</p> <p>B. The "Wound Flowsheet" identified the patient had a wound on the "left head neckline half graft site / half open area / graft site." SN visit notes failed to evidence the wound had been measured the weeks of 7-15-12, 7-22-12, and 8-5-12.</p> <p>C. SN visit notes identified the patient's pulse rate had been measured at less than 60. The record failed to evidence the physician had been notified per the plan of care.</p> <p>1.) A SN visit note dated 7-16 12 evidenced the patient's pulse rate had been measured at 54 beats per minutes.</p> <p>2.) A SN visit note dated 7-20-12 failed to evidence the patient's pulse rate had been measured at all.</p> <p>3.) A SN visit note dated 7-23-12</p>				

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	<p>evidenced the patient's pulse rate had been measured at 51 beats per minute.</p> <p>4.) A SN visit note dated 8-14-12 evidenced the patient's pulse rate had been measured at 58 beats per minute.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 7-3-12 to 8-31-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 7-9-12, 7-19-12, 7-26-12, 8-14-12, and 8-21-12, failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The supervising nurse, employee D, indicated, on 8-22-12 at 1:35 PM, the nurse had not performed the orthostatic blood pressure readings as ordered on the plan of care.</p> <p>7. The supervising nurse, employee D, and the administrator, employee C, were unable to provide any additional documentation and/or information when asked on 8-22-12 at 10:50 AM.</p> <p>8. The agency's 5-25-2009 ""Physician's Plan of Care" policy number SD9-1</p>			

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	states, "Plan of care is a written plan developed with the participation of professional staff and the patient, in consultation with and authorized by the physician, that supports the patient's medical, nursing and social needs in the home setting and services as the basis of care delivery . . . Care delivery follows the plan of care."			

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure orders for therapy services included all modalities and procedures to be used in 1 (#5) of 8 record reviewed of patients that received physical therapy services from the agency creating the potential to affect all of the facility's 118 current patients.</p> <p>The findings include:</p>	N0524	An inservice will be conducted on 9/11/12 by the Quality Assurance Specialist which will review policy SD9-1 Physicians Plan of Care and SD9-5 Patient Care Plan Policy with all clinicians. We will also review State Regulation 410 IAC 17-13-1 (a) (1). The Quality Assurance Specialist will also educate the therapists on the process of appropriate care planning and orders with specifics on procedures and therapy modalities with the amount,	09/11/2012			

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	<p>1. A home visit was made to patient number 5 on 8-16-12 at 10:10 AM with employee G, a physical therapist. The therapist was observed to perform percussion and postural drainage, an exercise used to loosen and remove mucus from the lungs, on the patient.</p> <p>A. Physical therapy visit notes, dated 7-6-12, 7-20-12, 7-24-12, 7-27-12, 7-30-12, 8-2-12, 8-6-12, 8-13-12, and 8-16-12 evidenced the therapist, employee G, had performed percussion and/or postural drainage or "pulmonary physical therapy."</p> <p>B. A. The plan of care, established by the physician for the certification period 6-22-12 to 8-20-12, failed to include percussion and postural drainage in the physical therapy orders.</p> <p>2. The administrator, employee C, indicated, on 8-22-12 at 1:13 PM, the orders for the physical therapy services did not include the percussion and postural drainage.</p> <p>3. The agency's 5-2009 "Physician's Plan of Care" policy number SD9-1 states, "The agency obtains complete orders for care . . . Specific procedures and treatments, including frequency and duration. Specific modalities and amount</p>		<p>frequency, and duration.</p> <p>The Quality Assurance Specialist will audit 10% of all clinical records every quarter to ensure all orders for therapy treatments include specific procedures and modalities with the amount, frequency, and duration.</p> <p>The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure the skilled nurse had provided treatments as ordered by the physician on the written plan of care in 6 (#s 5, 8, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 118 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to evidence orders for wound care performed by the skilled nurse (SN) and taught to the patient's caregiver had been obtained from the physician.</p> <p>A. The record included a start of care comprehensive assessment completed by employee N, a registered nurse, on 6-22-12. The visit note states, "Suture to R [right] rib area intact with no redness or drainage. Patient is to leave open to air . . . patient has suture on R side of lower ribs from drainage tube that was inserted from biopsy. No redness or drainage." The visit note identified the wound bed was "clean and dry", the wound edges were</p>	N0537	<p>An inservice will be conducted on 9/11/12 by the Quality Assurance Specialist which will review policy SD9-1 Physicians Plan of Care and SD9-5 Patient Care Plan Policy with all skilled nursing staff. We will also review State Regulation 410 IAC 17-14-1 (a). The Quality Assurance Specialist will also educate the skilled nursing staff on the process of appropriate care planning.</p> <p>The Quality Assurance Specialist will audit 10% of all clinical records every quarter for evidence the skilled nurse provided treatments as ordered on the plan of care.</p> <p>The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>	09/11/2012			

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	<p>"WNL [within normal limits]", there was no drainage from the wound, and it measured 1.5 centimeters in length.</p> <p>B. A SN visit note dated 7-27-12 evidenced the SN had performed wound care on the patient and had taught the patient's caregiver how to do the wound care. The note states, "Area is about 1/4 inch depth and dime size circle opening with red wound edges. slough is in the bottom and sides with little pink see. attempted to clean out area with saline pat dried then covered with dressing. instructed pt [patient] and [spouse] on all steps of wound care and sign of infection or increasing drainage requiring more than 2 x [times] in a day to change dressing then call staff. Cg [caregiver] to change daily and prn [as needed] if noticed increase drainage to keep area clean and dry."</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 3-24-12 to 5-22-12 that identified the patient's diagnoses as chronic diastolic heart failure and atrial fibrillation. The record evidenced a start of care date of 3-24-12 and a discharge date of 5-22-12.</p> <p>A. The plan of care identified the SN was to monitor the patient's daily weight</p>				

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	<p>log. The plan states, ""Teach pt/cg [patient/caregiver] to weight self weekly . . . 'Teach Back' Daily Wt. log - call for 2# - 1 day or 3-5 # in 5 days . . . Teach / reinforce rationale for daily weights, keeping log, noting trends . . . Monitor daily weight log."</p> <p>B. The record evidenced the SN had made visits on 3-24-12, 3-30-12, 4-4-12, and 4-11-12 before the patient was transferred to the hospital on 4-16-12 due to a fall with injury. The SN visit notes failed to evidence the nurse had monitored the patient's daily weight log.</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 6-29-12 to 8-27-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. The agency's undated "Blood Pressure" procedure states, "Take the patient's blood pressure while the patient is sitting and again while he or she is standing to evaluate for orthostatic hypotension [a form of low blood pressure that occurs in a standing position]."</p> <p>B. SN visit notes, dated 7-6-12, 7-9-12, and 8-7-12, failed to evidence the</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>nurse had taken both a sitting and standing blood pressure reading.</p> <p>C. The administrator, employee C, stated, on 8-22-12 at 1:19 PM, "We found readings on 7-19 and 8-1 but none on the rest of the visits."</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 8-11-12 to 10-9-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 8-13-12 and 8-16-12 failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The administrator, employee C, indicated, on 8-22-12 at 1:20 PM, the visit notes did not evidence documentation the SN had taken both sitting and standing blood pressure readings at the visit. The administrator stated, "It's not there."</p> <p>5. Clinical record number 11 included a plan of care established by the physician for the certification period 7-21-12 to 9-9-12. The plan of care states, "SN: Notify MD of irregular HR [heart rate], pulse &lt; 60 or &gt; 120 . . . SN: Perform</p>						

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	<p>wound measurements per protocol: q [every] weekly."</p> <p>A. The agency's undated "Wound Assessment and Documentation" procedure states, "Document the following on the visit report: . . . Wound measurement (at least weekly) including the length, depth, and width of the wound in centimeters."</p> <p>B. The "Wound Flowsheet" identified the patient had a wound on the "left head neckline half graft site / half open area / graft site." SN visit notes failed to evidence the wound had been measured the weeks of 7-15-12, 7-22-12, and 8-5-12.</p> <p>C. SN visit notes identified the patient's pulse rate had been measured at less than 60. The record failed to evidence the physician had been notified per the plan of care.</p> <p>1.) A SN visit note dated 7-16 12 evidenced the patient's pulse rate had been measured at 54 beats per minutes.</p> <p>2.) A SN visit note dated 7-20-12 failed to evidence the patient's pulse rate had been measured at all.</p> <p>3.) A SN visit note dated 7-23-12</p>				

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	<p>evidenced the patient's pulse rate had been measured at 51 beats per minute.</p> <p>4.) A SN visit note dated 8-14-12 evidenced the patient's pulse rate had been measured at 58 beats per minute.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 7-3-12 to 8-31-12. The plan of care states, "SN: Assess Orthostatic Blood Pressure at each visit."</p> <p>A. SN visit notes, dated 7-9-12, 7-19-12, 7-26-12, 8-14-12, and 8-21-12, failed to evidence the nurse had taken both a sitting and standing blood pressure reading.</p> <p>B. The supervising nurse, employee D, indicated, on 8-22-12 at 1:35 PM, the nurse had not performed the orthostatic blood pressure readings as ordered on the plan of care.</p> <p>7. The supervising nurse, employee D, and the administrator, employee C, were unable to provide any additional documentation and/or information when asked on 8-22-12 at 10:50 AM.</p> <p>8. The agency's 5-25-2009 ""Physician's Plan of Care" policy number SD9-1</p>				

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	states, "Plan of care is a written plan developed with the participation of professional staff and the patient, in consultation with and authorized by the physician, that supports the patient's medical, nursing and social needs in the home setting and services as the basis of care delivery . . . Care delivery follows the plan of care."			