

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
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NAME OF PROVIDER OR SUPPLIER SERENITY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2809 W GODMAN AVE STE 4 MUNCIE, IN 47304
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G0000	<p>This was a federal home health complaint investigation conducted 4/5/2012.</p> <p>Complaint number: IN00105313, Unsubstantiated: Lack of sufficient evidence. Unrelated deficiencies are cited.</p> <p>Survey dates: April 4 and 5, 2012.</p> <p>Facility Number: 012415</p> <p>Medicaid #: 201017550</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">April 11, 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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G0144	<p>484.14(g) COORDINATION OF PATIENT SERVICES 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 review, policy review, and interview, the agency failed to ensure the Registered Nurse documented care coordination per policy for 4 of 4 records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, and 4).</p> <p>Findings include:</p> <p>1. Clinical record #1, SOC (start of care) date 11/11/2011, contained a Nurse Visit Note dated 2/22/12 stated, "Patient reports recent productive cough at night able to cough up medium amount of thick yellow mucus. Lung sounds clear throughout bases diminished." Care coordination section indicated Physician and HHA (home health aide) were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>The record contains a Nurse Visit Note dated 2/28/12 that states, "Patient reports occasional nausea and fair appetite." Care coordination section indicated Physician and HHA were</p>	G0144	<p>G 0144 The Administrator will In-Service skilled nursing staff on the proper documentation of care coordination as per policy. All care coordination between physician, home health aides and other personnel involved in the patient's care coordination will be documented in the patient's care conference /clinical progress notes. Skilled nurses will discontinue the practice of not documenting the care coordination with the physician, home health aides and other personnel involved in the patient's care coordination. 10% of all clinical records will be audited quarterly by the agency for evidence of documentation of care coordination with the physician, home health aides and other personnel involved in the patient's care coordination.. The Administrator of Serenity Homecare will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not occur.</p>	05/18/2012			

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	<p>involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>2. Clinical Record #2, SOC 9/14/11, contained seven Nursing Visit Notes dated 2/13/12, 1/23/12, 1/4/12, 12/29/11, 12/21/11, 11/4/11, and 10/21/11 that indicated care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>3. Clinical Record #3, SOC 2/13/12, contained a Nursing Visit Note dated 3/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>4. Clinical Record #4, SOC 6/4/11, contained a Nursing Visit Note dated 9/8/11 indicating an update of medications effective 9/1/11. The note states, "Patient reports feeling nauseated and having hallucinations after only 2 doses; these side effects called / reported to [the doctor's] nurse [name]. (left message)" No evidence of written physician orders in record. Care Coordination section has Physician and</p>				

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	<p>HHA checked. The record failed to evidence any further documentation of coordination with the physician and home health aide.</p> <p>The record also contained ten Nursing Visit Notes dated 9/1/3/11, 10/5/11, 10/21/11, 11/3/11, 1/25/12, 1/29/12, 2/2/12, 2/6/12, 2/13/12, and 2/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>5. The agency's policy titled "Clinical Documentation, #C-680, not dated, states under "Special Instructions", "3. Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet. 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication form."</p> <p>6. During interview on 4/4/12 at 12:05 PM, employee A indicated they do not document physician phone calls in the client charts, but rather they keep track of them in their head.</p>						

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G0166	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to follow its own policies for writing physician's orders for 3 of 4 clinical records reviewed with the potential to affect all the agency's patients. (#2, 3, and 4).</p> <p>Findings include:</p> <p>1. Medical record #2, SOC date 9/14/11, contained a Nursing Visit Note dated 12/29/11 that identified the patient's medication was changed effective 12/28/11 for "Hydrocodone/APAP 5/500 1 tab PO [by mouth] q [every] 4-6 hours prn [as needed] pain" and to discontinue Percocet. The record failed to evidence any written physician orders for these medication changes.</p> <p>a. A Nursing Visit Note dated 10/21/11 indicated a medication update for "Ciprofloxacin 250 mg [milligrams] 1 tab PO BID [twice a day] x [times] 5 days." The record failed to evidence any written physician order for this</p>	G0166	<p>G 0166 The Administrator will In-Service the skilled nursing staff on the agency's policy for written physician orders including written physician orders for all medication changes a patient might have. Skilled nurses will discontinue the practice of not obtaining written physician orders from the physicians for medication changes to the patient. 10% of all clinical records will be audited quarterly by the agency for evidence of documentation of care coordination with the physician, home health aides and other personnel that is involved in the patient's care coordination. The Administrator of Serenity Homecare will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not occur.</p>	05/18/2012			

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	<p>medication change.</p> <p>b. A Nursing Visit Note dated 11/4/11 indicated a medication decrease for "Metoprolol Succinate ER 50 mg PO Daily, and Megace 40 mg/mL [milliliter] 20 mg - 1/2 mL PO Daily, Orders Obtained." The record failed to evidence any written physician order for this medication change.</p> <p>c. A Nursing Visit Note dated 2/13/12 indicated a medication update for "Levofloxacin 500 mg 1 tab PO daily x 10 days started 2/6/12, end 2/16/12, Orders Obtained." The record failed to evidence any written physician order for the medication change.</p> <p>2. Medical Record #3, SOC date 2/13/12, contained a Nurse Visit Note dated 3/20/12 indicating an update of medications for "Toresemide increase dose to 40 mg PO daily (2) 20 mg tabs q AM." The record failed to evidence any written physician order for this medication change.</p> <p>3. Medical Record #4, SOC date 6/4/11, contained a Nursing Visit Note dated 9/8/11 indicating an update of medications for "Tramadol 50 mg 1 tab PO 4x Day PRN effective 9/1/11." The record failed to evidence any written</p>						

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	<p>physician order for this medication change.</p> <p>a. Nursing Visit Note dated 9/13/11 indicated an update of medications to "DC [discontinue] Tramadol 50 mg resume Norco 5/325 1 tab PO q 6 hours PRN." The record failed to evidence any written physician order for these medication changes.</p> <p>b. Nursing Visit Note dated 10/5/11 indicated an update of medications for "Promethazine 25 mg 1 tab PO q 6 hours PRN Nausea" and "Diphenhydramine 25 mg 1 cap PO q HS [bedtime] prn insomnia." The record failed to evidence any written physician order for these medication changes.</p> <p>c. Nursing Visit Note dated 10/21/11 indicated an update of medications for "Lantus 25 u [units] sub q [subcutaneous] q HS" and "Novolog 8 u sub q tid [3 times a day] with meals" and "Rantidine [sic] 150 mg 1 tab PO bid [twice a day]" and "Nitrostat 0.4 mg 1 tab SL [sublingual] q 5 min [minutes] x 3 doses prn." The record failed to evidence any written physician order for these medication changes.</p> <p>d. Nursing Visit Note dated 11/3/11 indicated an update of medications for</p>			
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	<p>"[increase] Lantus 35 u 100 u/mL sub q q HS, [increase] Novolog 11 u 100 mL sub q TID with meals." The record failed to evidence any written physician order for these medication changes.</p> <p>e. Nursing Visit Note dated 1/25/12 indicated an update of medications for "Bactrim DS 800-1600 mg 2 tabs BID x 10 Days, Cephalexin 500 mg 1 cap QID [four times a day] x 10 days, orders obtained Start 1/23/12, stop 2/01/12." The record failed to evidence any written physician order for these medication changes.</p> <p>f. Nursing Visit Note dated 1/29/12 indicated an update of medications for "Famotidine 40 mg 1 tab PO BID started 1/26 and orders obtained." The record failed to evidence any written physician order for this medication change.</p> <p>g. Nursing Visit Note dated 2/2/12 indicated and update of medication to include "[increase] Lantus to 45 u q HS, and [decrease] Hydralazine 50 mg to TID, started 1/26/12." The record failed to evidence any written physician order for these medication changes.</p> <p>4. The agency's policy titled Physician Orders, #C-635, not dated, states, "All medication, treatments, and services</p>						

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	<p>provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner." This policy's purpose is "To document verification that orders for services have been obtained from the physician." Under the section "Special Instructions" the policy states, "2. All orders for medications must contain the name of the drug, dosage, route of administration, and directions for use. Orders must be written completely and not contain any of the dangerous abbreviations, acronyms or signals that may contribute to medication or treatment errors. ... 6. If the client or caregiver initiates changes that have been communicated to them by the physician, the nurse or therapist will write and date the order the day he/she is informed of the change, but shall indicate on the order the actual day the change was made."</p> <p>5. The agency's policy titled "Medication Management," #C-705, not dated, states under the section "Program Specifics", "Medication storage areas will be inspected at least every 60 days and more often if medication changes occur or if the agency is managing and/or setting up the medications. If medications are being set up by the nurse for self administration or administration by family or other</p>			

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	<p>caregivers, a chart or other form of direction should be left in the home to assure medications are taken at the times ordered, and to assess client compliance with the schedule." Under the section "Medication Orders" the policy states, "1. Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug (no abbreviations), b. Dose and time drug is to be given and any time limitations (no unacceptable abbreviations), c. Indication for the drug, d. Special instructions for the use of the drug and nay taper or titrating orders, e. Parameters for using PRN medications including amount and frequency and any other time limitations."</p> <p>6. During interview on 4/4/12 at 12:05 PM, employee A indicated they do not document physician phone calls in the client charts, but rather they keep track of them in their head.</p> <p>7. During phone interview on 4/5/12 at 4:20 PM, employee A indicated new medication orders from clients are taken from the prescription bottles once the client receives the medication from the pharmacy. They do not write the medications as a physician order since they have the prescription label, but document any changes on the Nurse Visit</p>				

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	Notes. Employee A was not sure if this is what the agency policy states.				

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse documented care coordination per policy for 4 of 4 records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, and 4).</p> <p>Findings include:</p> <p>1. Clinical record #1, SOC (start of care) date 11/11/2011, contained a Nurse Visit Note dated 2/22/12 stated, "Patient reports recent productive cough at night able to cough up medium amount of thick yellow mucus. Lung sounds clear throughout bases diminished." Care coordination section indicated Physician and HHA (home health aide) were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>The record contains a Nurse Visit Note dated 2/28/12 that states, "Patient reports occasional nausea and fair appetite." Care coordination section indicated Physician and HHA were</p>	G0176	<p>G 0176 The Administrator will In-Service skilled nursing staff on the proper documentation of care coordination as per policy. All care coordination between physicians, home health aides and personnel needing to know of the changes will be documented in the patient's care conference /clinical progress notes. Skilled nurses will discontinue the practice of not documenting the care coordination with the physician, home health aides and other agency personnel that is involved in the patient's care coordination. 10% of all clinical records will be audited quarterly by the agency for evidence of documentation of care coordination with the physician, home health aides and other personnel that is involved in the patient's care coordination. The Administrator of Serenity Homecare will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not occur.</p>	05/18/2012			

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	<p>involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>2. Clinical Record #2, SOC 9/14/11, contained seven Nursing Visit Notes dated 2/13/12, 1/23/12, 1/4/12, 12/29/11, 12/21/11, 11/4/11, and 10/21/11 that indicated care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>3. Clinical Record #3, SOC 2/13/12, contained a Nursing Visit Note dated 3/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>4. Clinical Record #4, SOC 6/4/11, contained a Nursing Visit Note dated 9/8/11 indicating an update of medications effective 9/1/11. The note states, "Patient reports feeling nauseated and having hallucinations after only 2 doses; these side effects called / reported to [the doctor's] nurse [name]. (left message)" No evidence of written physician orders in record. Care Coordination section has Physician and</p>				

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	<p>HHA checked. The record failed to evidence any further documentation of coordination with the physician and home health aide.</p> <p>The record also contained ten Nursing Visit Notes dated 9/1/3/11, 10/5/11, 10/21/11, 11/3/11, 1/25/12, 1/29/12, 2/2/12, 2/6/12, 2/13/12, and 2/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>5. The agency's policy titled "Clinical Documentation, #C-680, not dated, states under "Special Instructions", "3. Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet. 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication form."</p> <p>6. During interview on 4/4/12 at 12:05 PM, employee A indicated they do not document physician phone calls in the client charts, but rather they keep track of them in their head.</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012
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N0484	<p>410 IAC 17-12-2(g) Q A and performance improvement 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.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse documented care coordination per policy for 4 of 4 records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, and 4).</p> <p>Findings include:</p> <p>1. Clinical record #1, SOC (start of care) date 11/11/2011, contained a Nurse Visit Note dated 2/22/12 stated, "Patient reports recent productive cough at night able to cough up medium amount of thick yellow mucus. Lung sounds clear throughout bases diminished." Care coordination section indicated Physician and HHA (home health aide) were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>The record contains a Nurse Visit Note dated 2/28/12 that states, "Patient</p>	N0484	<p>N 0484 The Administrator will In-Service skilled nursing staff on the proper documentation of care coordination as per policy. All care coordination between physician and home health aides will be documented in the patient's care conference /clinical progress notes. Skilled nurses will discontinue the practice of not documenting the care coordination with the physician and home health aides. 10% of all clinical records will be audited quarterly by the agency for evidence of documentation of care coordination with the physician and home health aides. The Administrator of Serenity Homecare will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not occur.</p>	05/18/2012	

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	<p>reports occasional nausea and fair appetite." Care coordination section indicated Physician and HHA were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>2. Clinical Record #2, SOC 9/14/11, contained seven Nursing Visit Notes dated 2/13/12, 1/23/12, 1/4/12, 12/29/11, 12/21/11, 11/4/11, and 10/21/11 that indicated care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>3. Clinical Record #3, SOC 2/13/12, contained a Nursing Visit Note dated 3/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>4. Clinical Record #4, SOC 6/4/11, contained a Nursing Visit Note dated 9/8/11 indicating an update of medications effective 9/1/11. The note states, "Patient reports feeling nauseated and having hallucinations after only 2 doses; these side effects called / reported to [the doctor's] nurse [name]. (left</p>			

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	<p>message)" No evidence of written physician orders in record. Care Coordination section has Physician and HHA checked. The record failed to evidence any further documentation of coordination with the physician and home health aide.</p> <p>The record also contained ten Nursing Visit Notes dated 9/1/3/11, 10/5/11, 10/21/11, 11/3/11, 1/25/12, 1/29/12, 2/2/12, 2/6/12, 2/13/12, and 2/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>5. The agency's policy titled "Clinical Documentation, #C-680, not dated, states under "Special Instructions", "3. Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet. 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication form."</p> <p>6. During interview on 4/4/12 at 12:05 PM, employee A indicated they do not document physician phone calls in the</p>				

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	client charts, but rather they keep track of them in their head.				

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N0544	<p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse documented care coordination per policy for 4 of 4 records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, and 4).</p> <p>Findings include:</p> <p>1. Clinical record #1, SOC (start of care) date 11/11/2011, contained a Nurse Visit Note dated 2/22/12 stated, "Patient reports recent productive cough at night able to cough up medium amount of thick yellow mucus. Lung sounds clear throughout bases diminished." Care coordination section indicated Physician and HHA (home health aide) were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>The record contains a Nurse Visit Note dated 2/28/12 that states, "Patient reports occasional nausea and fair</p>	N0544	<p>N 0544 The Administrator will In-Service skilled nursing staff on the proper documentation of care coordination as per policy. All care coordination between physician and home health aides will be documented in the patient's care conference /clinical progress notes. Skilled nurses will discontinue the practice of not documenting the care coordination with the physician and home health aides. 10% of all clinical records will be audited quarterly by the agency for evidence of documentation of care coordination with the physician and home health aides. The Administrator of Serenity Homecare will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not occur.</p>	05/18/2012			

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	<p>appetite." Care coordination section indicated Physician and HHA were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>2. Clinical Record #2, SOC 9/14/11, contained seven Nursing Visit Notes dated 2/13/12, 1/23/12, 1/4/12, 12/29/11, 12/21/11, 11/4/11, and 10/21/11 that indicated care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>3. Clinical Record #3, SOC 2/13/12, contained a Nursing Visit Note dated 3/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>4. Clinical Record #4, SOC 6/4/11, contained a Nursing Visit Note dated 9/8/11 indicating an update of medications effective 9/1/11. The note states, "Patient reports feeling nauseated and having hallucinations after only 2 doses; these side effects called / reported to [the doctor's] nurse [name]. (left message)" No evidence of written</p>			

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	<p>physician orders in record. Care Coordination section has Physician and HHA checked. The record failed to evidence any further documentation of coordination with the physician and home health aide.</p> <p>The record also contained ten Nursing Visit Notes dated 9/1/3/11, 10/5/11, 10/21/11, 11/3/11, 1/25/12, 1/29/12, 2/2/12, 2/6/12, 2/13/12, and 2/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>5. The agency's policy titled "Clinical Documentation, #C-680, not dated, states under "Special Instructions", "3. Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet. 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication form."</p> <p>6. During interview on 4/4/12 at 12:05 PM, employee A indicated they do not document physician phone calls in the client charts, but rather they keep track of</p>						

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services 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 review, policy review, and interview, the agency failed to ensure the Registered Nurse documented care coordination per policy for 4 of 4 records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, and 4).</p> <p>Findings include:</p> <p>1. Clinical record #1, SOC (start of care) date 11/11/2011, contained a Nurse Visit Note dated 2/22/12 stated, "Patient reports recent productive cough at night able to cough up medium amount of thick yellow mucus. Lung sounds clear throughout bases diminished." Care coordination section indicated Physician and HHA (home health aide) were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>The record contains a Nurse Visit Note dated 2/28/12 that states, "Patient</p>	N0545	<p>N 0545 The Administrator will In-Service skilled nursing staff on the proper documentation of care coordination as per policy. All care coordination between physician and home health aides will be documented in the patient's care conference /clinical progress notes. Skilled nurses will discontinue the practice of not documenting the care coordination with the physician and home health aides. 10% of all clinical records will be audited quarterly by the agency for evidence of documentation of care coordination with the physician and home health aides. The Administrator of Serenity Homecare will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not occur.</p>	05/18/2012	

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	<p>reports occasional nausea and fair appetite." Care coordination section indicated Physician and HHA were involved in coordination of care. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>2. Clinical Record #2, SOC 9/14/11, contained seven Nursing Visit Notes dated 2/13/12, 1/23/12, 1/4/12, 12/29/11, 12/21/11, 11/4/11, and 10/21/11 that indicated care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>3. Clinical Record #3, SOC 2/13/12, contained a Nursing Visit Note dated 3/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>4. Clinical Record #4, SOC 6/4/11, contained a Nursing Visit Note dated 9/8/11 indicating an update of medications effective 9/1/11. The note states, "Patient reports feeling nauseated and having hallucinations after only 2 doses; these side effects called / reported to [the doctor's] nurse [name]. (left</p>			

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	<p>message)" No evidence of written physician orders in record. Care Coordination section has Physician and HHA checked. The record failed to evidence any further documentation of coordination with the physician and home health aide.</p> <p>The record also contained ten Nursing Visit Notes dated 9/1/3/11, 10/5/11, 10/21/11, 11/3/11, 1/25/12, 1/29/12, 2/2/12, 2/6/12, 2/13/12, and 2/20/12 indicating care was coordinated with the Physician and HHA. The record failed to evidence any documentation of coordination with the physician and home health aide.</p> <p>5. The agency's policy titled "Clinical Documentation, #C-680, not dated, states under "Special Instructions", "3. Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet. 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication form."</p> <p>6. During interview on 4/4/12 at 12:05 PM, employee A indicated they do not document physician phone calls in the</p>				

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N0547	<p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written).</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse followed its own policies for writing physician's orders for 3 of 4 clinical records reviewed with the potential to affect all the agency's patients. (#2, 3, and 4).</p> <p>Findings include:</p> <p>1. Medical record #2, SOC date 9/14/11, contained a Nursing Visit Note dated 12/29/11 that identified the patient's medication was changed effective 12/28/11 for "Hydrocodone/APAP 5/500 1 tab PO [by mouth] q [every] 4-6 hours prn [as needed] pain" and to discontinue Percocet. The record failed to evidence any written physician orders for these medication changes.</p> <p>a. A Nursing Visit Note dated 10/21/11 indicated a medication update for "Ciprofloxacin 250 mg [milligrams] 1 tab PO BID [twice a day] x [times] 5</p>	N0547	<p>N 0547 The Administrator will In-Service the nursing staff on the agency's policy for written physician orders including written physician orders for all medication changes a patient might have. Skilled nurses will discontinue the practice of not obtaining written physician orders from the physicians for medication changes to the patient.</p> <p>10% of all clinical records will be audited quarterly by the agency for evidence of documentation that written physician orders were obtained for all medication changes.</p> <p>The Administrator of Serenity</p>	05/18/2012	

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	<p>days." The record failed to evidence any written physician order for this medication change.</p> <p>b. A Nursing Visit Note dated 11/4/11 indicated a medication decrease for "Metroprolol Succinate ER 50 mg PO Daily, and Megace 40 mg/mL [milliliter] 20 mg - 1/2 mL PO Daily, Orders Obtained." The record failed to evidence any written physician order for this medication change.</p> <p>c. A Nursing Visit Note dated 2/13/12 indicated a medication update for "Levofloxacin 500 mg 1 tab PO daily x 10 days started 2/6/12, end 2/16/12, Orders Obtained." The record failed to evidence any written physician order for the medication change.</p> <p>2. Medical Record #3, SOC date 2/13/12, contained a Nurse Visit Note dated 3/20/12 indicating an update of medications for "Toresemide increase dose to 40 mg PO daily (2) 20 mg tabs q AM." The record failed to evidence any written physician order for this medication change.</p> <p>3. Medical Record #4, SOC date 6/4/11, contained a Nursing Visit Note dated 9/8/11 indicating an update of medications for "Tramadol 50 mg 1 tab</p>		<p>Homecare will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not occur.</p>		

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	<p>PO 4x Day PRN effective 9/1/11." The record failed to evidence any written physician order for this medication change.</p> <p>a. Nursing Visit Note dated 9/13/11 indicated an update of medications to "DC [discontinue] Tramadol 50 mg resume Norco 5/325 1 tab PO q 6 hours PRN." The record failed to evidence any written physician order for these medication changes.</p> <p>b. Nursing Visit Note dated 10/5/11 indicated an update of medications for "Promethazine 25 mg 1 tab PO q 6 hours PRN Nausea" and "Diphenhydramine 25 mg 1 cap PO q HS [bedtime] prn insomnia." The record failed to evidence any written physician order for these medication changes.</p> <p>c. Nursing Visit Note dated 10/21/11 indicated an update of medications for "Lantus 25 u [units] sub q [subcutaneous] q HS" and "Novolog 8 u sub q tid [3 times a day] with meals" and "Rantidine [sic] 150 mg 1 tab PO bid [twice a day]" and "Nitrostat 0.4 mg 1 tab SL [sublingual] q 5 min [minutes] x 3 doses prn." The record failed to evidence any written physician order for these medication changes.</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>d. Nursing Visit Note dated 11/3/11 indicated an update of medications for "[increase] Lantus 35 u 100 u/mL sub q q HS, [increase] Novolog 11 u 100 mL sub q TID with meals." The record failed to evidence any written physician order for these medication changes.</p> <p>e. Nursing Visit Note dated 1/25/12 indicated an update of medications for "Bactrim DS 800-1600 mg 2 tabs BID x 10 Days, Cephalexin 500 mg 1 cap QID [four times a day] x 10 days, orders obtained Start 1/23/12, stop 2/01/12." The record failed to evidence any written physician order for these medication changes.</p> <p>f. Nursing Visit Note dated 1/29/12 indicated an update of medications for "Famotidine 40 mg 1 tab PO BID started 1/26 and orders obtained." The record failed to evidence any written physician order for this medication change.</p> <p>g. Nursing Visit Note dated 2/2/12 indicated and update of medication to include "[increase] Lantus to 45 u q HS, and [decrease] Hydralazine 50 mg to TID, started 1/26/12." The record failed to evidence any written physician order for these medication changes.</p> <p>4. The agency's policy titled Physician</p>						

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	<p>Orders, #C-635, not dated, states, "All medication, treatments, and services provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner." This policy's purpose is "To document verification that orders for services have been obtained from the physician." Under the section "Special Instructions" the policy states, "2. All orders for medications must contain the name of the drug, dosage, route of administration, and directions for use. Orders must be written completely and not contain any of the dangerous abbreviations, acronyms or signals that may contribute to medication or treatment errors. ... 6. If the client or caregiver initiates changes that have been communicated to them by the physician, the nurse or therapist will write and date the order the day he/she is informed of the change, but shall indicate on the order the actual day the change was made."</p> <p>5. The agency's policy titled "Medication Management," #C-705, not dated, states under the section "Program Specifics", "Medication storage areas will be inspected at least every 60 days and more often if medication changes occur or if the agency is managing and/or setting up the medications. If medications are being set</p>						

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	<p>up by the nurse for self administration or administration by family or other caregivers, a chart or other form of direction should be left in the home to assure medications are taken at the times ordered, and to assess client compliance with the schedule." Under the section "Medication Orders" the policy states, "1. Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug (no abbreviations), b. Dose and time drug is to be given and any time limitations (no unacceptable abbreviations), c. Indication for the drug, d. Special instructions for the use of the drug and nay taper or titrating orders, e. Parameters for using PRN medications including amount and frequency and any other time limitations."</p> <p>6. During interview on 4/4/12 at 12:05 PM, employee A indicated they do not document physician phone calls in the client charts, but rather they keep track of them in their head.</p> <p>7. During phone interview on 4/5/12 at 4:20 PM, employee A indicated new medication orders from clients are taken from the prescription bottles once the client receives the medication from the pharmacy. They do not write the medications as a physician order since</p>				

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	they have the prescription label, but document any changes on the Nurse Visit Notes. Employee A was not sure if this is what the agency policy states.			