

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157124		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/12/2013	
NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HOME HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1415 SALEM ST STE 202 W LAFAYETTE, IN 47904			
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N000000	<p>This visit was for a state home health agency relicensure survey.</p> <p>Survey Dates: April 11 and 12, 2013.</p> <p>Facility #: 005313</p> <p>Medicaid Vendor # 100263950A</p> <p>Surveyor: Bridget Boston, RN PHNS</p> <p>Census Service Type:</p> <p>Skilled: 890</p> <p>Home Health Aide Only: 0</p> <p>Personal Care Only: 0</p> <p>Total: 890</p> <p>Sample:</p> <p>RR w/HV: 3</p> <p>RR w/o HV: 2</p> <p>Total: 5</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>April 18, 2013</p>			N000000			

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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N000440	<p>410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.</p> <p>Based on interview and review of agency documents, the agency failed to ensure all personnel providing services for the agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the organizational chart failed to identify the lines of authority down to the patient level. The administrative document "Home Hospital Home Health Care - St. Clare Home Health Care (branch office) St. Elizabeth Hospice" dated July 2010 was a corporate organizational document and did not include a clear line of authority for the home health agency. 2. On 4/11/13 at 11 AM, employee I indicated the organization chart was not up to date. 	N000440	<p>Organizational chart has been updates as of 4/12/13. Administrator is responsible to ensure that the organizational chart remains current.</p>	04/12/2013			

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N000460	<p>410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall:</p> <p>(1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.</p> <p>Based on personnel file review and interview, the agency failed to ensure personnel files included a criminal history obtained from the Indiana central repository for criminal history information as required by IC 16-27-2 for 1 (File D) of 4 files reviewed of staff hired since the last survey 7/15/10.</p> <p>The findings include:</p> <p>1. Personnel file D failed to evidence a criminal history was obtained from the Indiana central repository. The file evidenced the criminal history search of only Frankfort and Mulberry in Clinton County Indiana dated July 26, 2011.</p> <p>2. On 4/12/13 at 4:15 PM, employee J indicated the file did not evidence of a</p>	N000460	All elements required under this rule have been added to the orientation checklist for all new home health employees. In addition to relying on our hospital Human Resources Dept. to obtain the required information and screening, at the home health department level, we will obtain a copy of each document and ensure that it is in the personnel chart prior to allowing a new employee to have patient contact. The education coordinator is to ensure this procedure is followed.	04/12/2013

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	criminal history search from the Indiana central repository.				

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N000470	<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 clinical record and policy review, observation, and interview, the agency failed to ensure it had implemented its own infection control - hand hygiene policy in 1 (patient #4) of 3 home visit observations creating the potential for the spread of disease causing organisms among patients and staff.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The policy dated October 20, 2010 and titled "Hand Hygiene Procedure for Home Healthcare and Hospice" states, "Hand hygiene should be performed: ... Before and after removing gloves. Any time hands have come in contact with body secretions or contaminated equipment." 2. On 4/12/13 at 8:30 AM, employee E, a home health aide, was observed to assist patient number 4 to bathe. Prior to the bath, the patient identified self to be bed bound and indicated had 3 recent episodes of "C-diff" [Clostridium difficile] and had taken the last antibiotic a few days earlier. The patient indicated experiencing another episode of loose 	N000470	<p>All clinical staff will be reeducated on current infection control policy by May 17, 2013. The education coordinator is responsible to ensure that this education takes place. Clinical supervisor will put special emphasis on evaluating compliance with infection control policy during the ride along supervision. Home Health supervisor is responsible for ride along supervision.</p>	05/17/2013			

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	<p>stool prior to the aide visit of the same day - 4/12/13.</p> <p>A. The aide had prepared two basins of water for a bed bath, one used for washing and one was used for rinse water. After bathing the patient's face, upper body and legs, the aide positioned the patient on their right side in the bed and washed the patient's back and then the buttocks and perianal area with a washcloth. The patient had a Foley catheter. Visible soft stool was present on a disposable pad underneath the patient's buttocks. After cleansing, the aide carried the bath basins, one at a time, to the bathroom where the water was disposed of, then walked to a laundry room and obtained a spray bottle containing a clear solution labeled "10 % bleach" and sprayed into the basins. She then carried the basins to the kitchen sink where she immediately disposed of the "10 % bleach" solution from the basin and then began to fill the basins with more water.</p> <p>B. She carried the same basins back into the patient area, one for washing and one for rinsing. She donned gloves, wet a clean cloth, cleansed the patient's perineum, then dipped the wash cloth into the rinse basin and rinsed the perineum. Then, while wearing the same gloves, she</p>						

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	<p>applied soap again to the same wash cloth and handed the wash cloth to the patient and indicated the wash cloth was for the patient to wash their hands.</p> <p>C. After completing the bath, without changing her gloves, the aide carried the two basins, one at a time, to a bathroom and disposed of the bath water. Then she walked to the laundry room, picked up a spray bottle labeled "10 % bleach" and sprayed the basins. She carried the basins to the kitchen and immediately disposed the solution.</p> <p>D. While continuing to wear the same gloves as worn while bathing the patient, the aide was observed in the kitchen holding two cups which the patient had used for oral hygiene. One of the cups contained the patient's toothbrush. The aide confirmed, when asked, the gloves she was wearing were not changed after she completed the bed bath and before she picked up the patients belongings.</p> <p>The aide indicated she was not aware how long the bleach solution she used to decontaminate the basins was to remain in contact with the basin and the procedures to be used to decontaminate the surfaces due to the Clostridium difficile when asked.</p>						

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	3. On 4/12/13 at 9:30 AM, employee I indicated the aide did not follow appropriate infection control standards during the bath.				

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N000522	<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 interview, observation, and review of clinical records, the agency failed to ensure physician orders were obtained for all services and treatments provided by the agency staff in 1 of (# 1) 5 clinical records reviewed with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record #1, start if care (SOC) 1/5/13, included a physician ordered plan of care for the certification period 3/6/13 through 5/4/13 with orders for skilled nurse services twice a week for nine weeks to administer 1 liter normal saline intravenously on Wednesdays and Fridays of every week. Skilled nurse visit note dated 3/13/13 stated, "Wound Location R [right] outer ankle ... length cm [centimeter] 0.8 ... width ... 0.6 ... depth 0.1 ... PT [patient] developed a pressure sore on right lateral ankle. Stage II. The area is red and has a thick callous to the area. ... Applied duoderm dressing to area." The record failed to evidence a physician order for the wound care provided.</p>	N000522	<p>Nursing and therapy staff will be reeducated on the requirement to notify the physician and obtain orders for all care provided and for all changes in patient condition. They will also be provided reminder about appropriate computer entry of orders by May 17, 2013. The education coordinator is responsible to ensure education takes place within the time frame. Additionally, notifying the physician and obtaining order for all documented care will be added to quarterly chart audit tool to monitor compliance. The informatics nurse is responsible to ensure audits include this indicator.</p>	05/17/2013			

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	<p>A. A skilled nurse visit note dated 3/15/13 stated, "PT has duoderm in place over wound.</p> <p>B. Skilled nurse visit note dated 3/20/13 stated, "Wound Location R outer ankle ... length cm [centimeter] 1 ... width ... 0.6 depth 0.3 ... Duoderm placed over wound." The record failed to evidence a physician order for the wound care provided.</p> <p>C. A skilled nurse visit note dated 3/22/13 stated, "Patient's duoderm has come off of R lateral ankle. replaced by this nurse. PT has not yet received shipment of foam dressings." The record failed to evidence a physician order for the wound care provided.</p> <p>D. Skilled nurse visit note dated 3/27/13 which stated, "Wound Location Right Lateral ankle ... length cm [centimeter] 1 ... width ... 0.6 depth unknown - type pressure ... Appearance of wound bed ... Hard clear scab present. ... Wound dressing applied. Optifoam Adhesive." The record failed to evidence a physician order for the wound care provided.</p> <p>E. Skilled nurse visit note dated 4/5/13 stated, "Optifoam in place over R outer ankle wound. No drainage visible on</p>			

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	<p>Optifoam." The record failed to evidence a physician order for the wound care provided.</p> <p>F. Skilled nurse visit note dated 4/10/13 stated, "Wound on R outer ankle ... with clear scab in place and redness has diminished. Area healing well with Optifoam and Optifoam placed today." The record failed to evidence a physician order for the wound care provided.</p> <p>2. On 4/11/13 at 5:10 PM, employee H, indicated the record failed to evidence physician orders for the wound care provided.</p> <p>3. During a home visit on 4/12/13 at 9:50 AM, the patient was observed with a dressing on right outer ankle and employee D provided wound care, measured the wound, and applied an Optifoam dressing.</p>				

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on interview, observation, and review of clinical records, the agency failed to ensure the physician was notified regarding changes in the patient's condition in 1 of (# 1) 5 clinical records reviewed with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) 1/5/13, included a physician ordered plan of care for the certification period 3/6/13 through 5/4/13 with orders for skilled nurse services twice a week for nine weeks to administer 1 liter normal saline intravenously on Wednesdays and Fridays of every week. Skilled nurse visit note dated 3/13/13 stated, "Wound Location R [right] outer ankle ... length cm [centimeter] 0.8 ... width ... 0.6 depth 0.1 ... PT [patient] developed a pressure sore on right lateral ankle. Stage II. The area is red and has a thick callous to the area. ... Applied duoderm dressing to area." The record failed to evidence</p>	N000527	<p>Nursing and therapy staff will be reeducated on the requirement to notify the physician and obtain orders for all care provided and for all changes in patient condition. They will also be provided reminder about appropriate computer entry of orders by May 17, 2013. The education coordinator is responsible to ensure education takes place within the time frame. Additionally, notifying the physician and obtaining order for all documented care will be added to quarterly chart audit tool to monitor compliance. The informatics nurse is responsible to ensure audits include this indicator.</p>	05/17/2013			

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	<p>the physician was notified of the wound and an order for the wound care obtained.</p> <p>A. A skilled nurse visit note dated 3/15/13 stated, "PT has duoderm in place over wound.</p> <p>B. Skilled nurse visit note dated 3/20/13 stated, "Wound Location R outer ankle ... length cm [centimeter] 1 ... width ... 0.6 depth 0.3 ... Duoderm placed over wound."</p> <p>C. A skilled nurse visit note dated 3/22/13 stated, "Patient's duoderm has come off of R lateral ankle. replaced by this nurse. PT has not yet received shipment of foam dressings."</p> <p>D. Skilled nurse visit note dated 3/27/13 which stated, "Wound Location Right Lateral ankle ... length cm [centimeter] 1 ... width ... 0.6 depth unknown - type pressure ... Appearance of wound bed ... Hard clear scab present. ... Wound dressing applied. Optifoam Adhesive."</p> <p>E. Skilled nurse visit note dated 4/5/13 stated, "Optifoam in place over R outer ankle wound. No drainage visible on Optifoam."</p> <p>F. Skilled nurse visit note dated 4/10/13 stated, "Wound on R outer ankle ... with</p>			

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	<p>clear scab in place and redness has diminished. Area healing well with Optifoam and Optifoam placed today."</p> <p>2. On 4/11/13 at 5:10 PM, employee H, indicated the record failed to evidence the physician was notified of the wound.</p> <p>3. During a home visit on 4/12/13 at 9:50 AM, the patient was observed with a dressing on right outer ankle and employee D provided wound care, measured the wound, and applied an Optifoam dressing.</p>			

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N000532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on interview, observation, and review of clinical records, the agency failed to ensure the physician was notified regarding changes in the patient's condition in 1 of (# 1) 5 clinical records reviewed with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record #1, start if care (SOC) 1/5/13, included a physician ordered plan of care for the certification period 3/6/13 through 5/4/13 with orders for skilled nurse services twice a week for nine weeks to administer 1 liter normal saline intravenously on Wednesdays and Fridays of every week. Skilled nurse visit note dated 3/13/13 stated, "Wound Location R [right] outer ankle ... length cm [centimeter] 0.8 ... width ... 0.6 depth 0.1 ... PT [patient] developed a pressure sore on right lateral ankle. Stage II. The area is red and has a thick callous</p>	N000532	<p>Nursing and therapy staff will be reeducated on the requirement to notify the physician and obtain orders for all care provided and for all changes in patient condition. They will also be provided reminder about appropriate computer entry of orders by May 17, 2013. The education coordinator is responsible to ensure education takes place within the time frame. Additionally, notifying the physician and obtaining order for all documented care will be added to quarterly chart audit tool to monitor compliance. The informatics nurse is responsible to ensure audits include this indicator.</p>	05/17/2013			

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	<p>to the area. ... Applied duoderm dressing to area." The record failed to evidence the physician was notified of the wound and an order for the wound care obtained.</p> <p>A. A skilled nurse visit note dated 3/15/13 stated, "PT has duoderm in place over wound.</p> <p>B. Skilled nurse visit note dated 3/20/13 stated, "Wound Location R outer ankle ... length cm [centimeter] 1 ... width ... 0.6 depth 0.3 ... Duoderm placed over wound."</p> <p>C. A skilled nurse visit note dated 3/22/13 stated, "Patient's duoderm has come off of R lateral ankle. replaced by this nurse. PT has not yet received shipment of foam dressings."</p> <p>D. Skilled nurse visit note dated 3/27/13 which stated, "Wound Location Right Lateral ankle ... length cm [centimeter] 1 ... width ... 0.6 depth unknown - type pressure ... Appearance of wound bed ... Hard clear scab present. ... Wound dressing applied. Optifoam Adhesive."</p> <p>E. Skilled nurse visit note dated 4/5/13 stated, "Optifoam in place over R outer ankle wound. No drainage visible on Optifoam."</p>			

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	<p>F. Skilled nurse visit note dated 4/10/13 stated, "Wound on R outer ankle ... with clear scab in place and redness has diminished. Area healing well with Optifoam and Optifoam placed today."</p> <p>2. On 4/11/13 at 5:10 PM, employee H, indicated the record failed to evidence the physician was notified of the wound.</p> <p>3. During a home visit on 4/12/13 at 9:50 AM, the patient was observed with a dressing on right outer ankle and employee D provided wound care, measured the wound, and applied an Optifoam dressing.</p>				

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N000540	<p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse assessed the patient's wound when the patient was admitted to home care for 1 of 1 clinical record reviewed of patients admitted for wound care with the potential to affect all patients admitted with wounds. (patient # 3)</p> <p>The findings included:</p> <p>1. The policy titled "Wound Care Protocol," revision date March 10, 2010 stated, "Prevention and / or Admission (initial patient contact) phase 1. Assessment: The RN or appropriate professional should: ... j. Assess wound including the following key criteria: Length, width, depth, appearance of wound including color, presence of granulation, moisture. Appearance of surrounding area including signs and symptoms of inflammation. Drainage including type, color, consistency, odor, amount."</p>	N000540	Our policy requires measurement once a week. In order to avoid any confusion as to when weekly measurements are due, nursing staff will be instructed to document wound measurements with every dressing change. Education coordinator is responsible to ensure that education takes place as scheduled. Informatics coordinator is responsible to ensure that quarterly audits measure compliance with this requirement.	05/17/2013			

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	<p>2. Clinical record # 3, start of care 2/28/13, included a plan of care with the admission diagnosis of a Cellulitis and abscess of foot. The comprehensive assessment dated 3/1/13 evidenced the patient had a wound on the right plantar surface of the foot and had a wound vacuum. The comprehensive assessment failed to evidence an assessment of the wound.</p> <p>A. The skilled nurse visit note dated 3/2/13 evidenced the patient's wound was assessed and care was provided. The documentation failed to include the wound measurements.</p> <p>B. The skilled nurse visit note dated 3/4/13 evidenced the patient's wound was assessed and care was provided. The documentation failed to include measurements of the patient's wound.</p> <p>3. On 4/11/13 at 5:25 PM, employees H and I confirmed the record did not evidence a measurement of the wound until 3/6/13 and the agency policy was to complete a wound assessment as part of the comprehensive assessment.</p>						

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N000542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on interview and review of clinical records, the agency failed to ensure the registered nurse updated the plan of care by obtaining physician orders for wound care in 1 of (# 1) 5 clinical records reviewed with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) 1/5/13, included a physician ordered plan of care for the certification period 3/6/13 through 5/4/13 with orders for skilled nurse services twice a week for nine weeks to administer 1 liter normal saline intravenously on Wednesdays and Fridays of every week. Skilled nurse visit note dated 3/13/13 stated, "Wound Location R [right] outer ankle ... length cm [centimeter] 0.8 ... width ... 0.6 depth 0.1 ... PT [patient] developed a pressure sore on right lateral ankle. Stage II. The area is red and has a thick callous to the area. ... Applied duoderm dressing</p>	N000542	<p>Nursing and therapy staff will be reeducated on the requirement to notify the physician and obtain orders for all care provided and for all changes in patient condition. They will also be provided reminder about appropriate computer entry of orders by May 17, 2013. The education coordinator is responsible to ensure education takes place within the time frame. Additionally, notifying the physician and obtaining order for all documented care will be added to quarterly chart audit tool to monitor compliance. The informatics nurse is responsible to ensure audits include this indicator.</p>	05/17/2013	

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	<p>to area." The record failed to evidence the physician was notified of the wound and an order for the wound care obtained.</p> <p>A. A skilled nurse visit note dated 3/15/13 stated, "PT has duoderm in place over wound.</p> <p>B. Skilled nurse visit note dated 3/20/13 stated, "Wound Location R outer ankle ... length cm [centimeter] 1 ... width ... 0.6 depth 0.3 ... Duoderm placed over wound." The record failed to evidence the physician was notified of the wound and an order for the wound care obtained.</p> <p>C. A skilled nurse visit note dated 3/22/13 stated, "Patient's duoderm has come off of R lateral ankle. replaced by this nurse. PT has not yet received shipment of foam dressings." The record failed to evidence the physician was notified of the wound and an order for the wound care obtained.</p> <p>D. Skilled nurse visit note dated 3/27/13 which stated, "Wound Location Right Lateral ankle ... length cm [centimeter] 1 ... width ... 0.6 depth unknown - type pressure ... Appearance of wound bed ... Hard clear scab present. ... Wound dressing applied. Optifoam Adhesive." The record failed to evidence the physician was notified of the wound and</p>						

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	<p>an order for the wound care obtained.</p> <p>E. Skilled nurse visit note dated 4/5/13 stated, "Optifoam in place over R outer ankle wound. No drainage visible on Optifoam." The record failed to evidence the physician was notified of the wound and an order for the wound care obtained.</p> <p>F. Skilled nurse visit note dated 4/10/13 stated, "Wound on R outer ankle ... with clear scab in place and redness has diminished. Area healing well with Optifoam and Optifoam placed today." The record failed to evidence the physician was notified of the wound and an order for the wound care obtained.</p> <p>2. On 4/11/13 at 5:10 PM, employee H, indicated the record failed to evidence the physician was notified of the wound.</p>			

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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on interview, observation, and review of clinical records, the agency failed to ensure the registered nurse notified the physician regarding changes in the patient's condition in 1 of (# 1) 5 clinical records reviewed with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record #1, start if care (SOC) 1/5/13, included a physician ordered plan of care for the certification period 3/6/13 through 5/4/13 with orders for skilled nurse services twice a week for nine weeks to administer 1 liter normal saline intravenously on Wednesdays and Fridays of every week. Skilled nurse visit note dated 3/13/13 stated, "Wound Location R [right] outer ankle ... length cm [centimeter] 0.8 ... width ... 0.6</p>	N000546	Nursing and therapy staff will be reeducated on the requirement to notify the physician and obtain orders for all care provided and for all changes in patient condition. They will also be provided reminder about appropriate computer entry of orders by May 17, 2013. The education coordinator is responsible to ensure education takes place within the time frame. Additionally, notifying the physician and obtaining order for all documented care will be added to quarterly chart audit tool to monitor compliance. The informatics nurse is responsible to ensure audits include this indicator.	05/17/2013			

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	<p>depth 0.1 ... PT [patient] developed a pressure sore on right lateral ankle. Stage II. The area is red and has a thick callous to the area. ... Applied duoderm dressing to area." The record failed to evidence the physician was notified of the wound and an order for the wound care obtained.</p> <p>A. A skilled nurse visit note dated 3/15/13 stated, "PT has duoderm in place over wound.</p> <p>B. Skilled nurse visit note dated 3/20/13 stated, "Wound Location R outer ankle ... length cm [centimeter] 1 ... width ... 0.6 depth 0.3 ... Duoderm placed over wound."</p> <p>C. A skilled nurse visit note dated 3/22/13 stated, "Patient's duoderm has come off of R lateral ankle. replaced by this nurse. PT has not yet received shipment of foam dressings."</p> <p>D. Skilled nurse visit note dated 3/27/13 which stated, "Wound Location Right Lateral ankle ... length cm [centimeter] 1 ... width ... 0.6 depth unknown - type pressure ... Appearance of wound bed ... Hard clear scab present. ... Wound dressing applied. Optifoam Adhesive."</p> <p>E. Skilled nurse visit note dated 4/5/13 stated, "Optifoam in place over R outer</p>			

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	<p>ankle wound. No drainage visible on Optifoam."</p> <p>F. Skilled nurse visit note dated 4/10/13 stated, "Wound on R outer ankle ... with clear scab in place and redness has diminished. Area healing well with Optifoam and Optifoam placed today."</p> <p>2. On 4/11/13 at 5:10 PM, employee H, indicated the record failed to evidence the physician was notified of the wound.</p> <p>3. During a home visit on 4/12/13 at 9:50 AM, the patient was observed with a dressing on right outer ankle and employee D provided wound care, measured the wound, and applied an Optifoam dressing.</p>				