

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2014
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NAME OF PROVIDER OR SUPPLIER  AMERICAN NURSING CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2504 WATERBRIDGE WAY EVANSVILLE, IN 47710
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G000000	<p>This was a federal home health recertification survey.</p> <p>Survey Dates: 4-2-14, 4-3-14, 4-4-14, 4-7-14, and 4-8-14 Partial extended 4-2-14 Extended 4-7-14</p> <p>Facility #: 004372</p> <p>Medicaid Vendor #: 200272600A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>American Nursing Care is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 4-14-14 due to being found out of compliance with Conditions of Participation 484.18 Acceptance of Patients, Plans of Care, and Medical Supervision; 484.30 Skilled Nursing Services; and 484.55 Comprehensive Assessment of Patients.</p> <p>The administrator and the supervising nurse were informed of the above-stated preclusion at the exit conference held at this agency on 4-8-14 at 11:00 AM.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 14, 2014 484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals</p>	G000000		
G000121	<p>COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals</p>			

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

TITLE

(X6) DATE

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

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	<p>furnishing services in an HHA.</p> <p>Based on observation, interview, and review of agency policy, the agency failed to ensure its staff had provided services in accordance with its own infection control policies and procedures in 4 (Employees B, E, I, and O) of 6 home visit observations completed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The agency's undated "Infection Control Plan" policy number 33.28 states, "The Infection Control Plan will comply with applicable local, state and/or federal regulations, OSHA regulations, and CDC guidelines and currently accepted standards of practice . . . Activities to be performed by the company to prevent and control the spread of infection include but are not limited to: . . . Observe universal precautions."</li> <li>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.</li> </ol>	G000121	G121 Mandatory inservices for all Professional/Paraprofessional staff held on 4/16/14, 4/21/14, 4/22/14,4/23/14, and 4/25/14 by the Director of Clinical Services(DCS) and/or Clinical Educator regarding Policy # 33.39 Standard (Universal) Precautions, Policy #33.900 Hand Hygiene and Policy 33.28 Infection Control Plan. Return demonstration of appropriate hand hygiene technique demonstration was included. Education packets to be mailed to all Professional and Paraprofessional staff that were unable to attend the inservice on 4/28/14. Return demonstration of hand hygiene is being individually scheduled with staff unable to attend. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 home visits per month for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly quality monitoring. This compliance process will be under the direct supervision of the Director of Operations with oversight by Regional Clinical Manager and Regional Vice President.	05/07/2014

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	<p>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 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>3. A home visit was made to patient number 4 with employee I, a home health aide, on 4-3-14 at 8:00 AM. The aide was observed to provide the patient with assistance with a shower bath. The aide was observed to wash her hands and don a clean pair of gloves. The aide assisted the patient to wash the patient's face. The aide then assisted the patient to undress and enter the shower and be seated on a shower bench. The aide washed and rinsed the patient's back and handed the washcloth to the patient and the patient completed the bath. The patient washed the front and rear perineal area. The patient handed the soiled washcloth to the aide and the aide placed it on the faucet.</p> <p>Without changing her gloves or cleansing her hands, the aide then applied lotion to the patient's body, assisted the patient to dress</p>			

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	<p>the lower part of the body, retrieved a garment from the patient's drawer, and then applied the patient's socks.</p> <p>4. A home visit was made to patient number 6 with employee B, a registered nurse (RN), on 4-3-14 at 10:00 AM. The RN was observed to change the dressings to the patient's feet. The RN prepared the supplies for the dressing change and reached into her pocket, retrieved a pen, charted, and then placed the pen back into her pocket. The RN soaked a gauze pad with normal saline and donned clean gloves without cleansing her hands.</p> <p>A. After the RN had completed the dressing change to the right foot, she removed her gloves, and, without cleansing her hands, reached into her pocket to retrieve her pen. The RN marked the dressing with the date.</p> <p>B. After completing the dressing change to the right foot, the RN removed the old dressing from the left foot. Without changing her gloves or cleansing her hands, the RN then soaked a gauze with normal saline and cleaned wounds on the toes of the right foot. The RN applied a medicated ointment, removed her gloves, cleansed her hands, retrieved the Mepilex dressing from the patient's supplies, and completed the dressing change to the patient's right toes.</p> <p>5. A home visit was made to patient number 8 with employee O, a RN, on 4-4-14 at 9:15 AM. The RN was observed to assess the patient and provide medication teaching. Without cleansing her hands or donning gloves, the RN was observed to open a bottle of pills, pour one out into her hand and show</p>			

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G000143	<p>the patient the pill. The RN then replaced the pill back into the bottle. The RN repeated these actions with a second medication.</p> <p>The nurse's failure to cleanse her hands and don clean gloves prior to touching the patient's medication was discussed with employee BB, the RN branch manager, on 4-4-14 at 10:15 AM. The RN branch manager indicated the RN had not complied with agency procedure.</p> <p>6. A home visit was made to patient number 9 with employee E, a RN, on 4-4-14 at 1:10 PM. The RN was observed to change the dressing to the patient's left foot. The RN was observed to obtain saline and gauze from supplies in the patient's home. The RN soaked a gauze with saline and donned clean gloves without cleansing her hands. The RN was observed to repeat the actions a second time.</p> <p>7. The above-stated home visit observations were discussed with the administrator and the supervising nurse on 4-7-14 at 8:45 AM. The administrator and the supervising nurse indicated agency staff had not provided services in accordance with the agency's infection control policies and procedures. 484.14(g)</p> <p>COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure all personnel communicated and coordinated services to support the plan of</p>	G000143	G143 Mandatory inservices 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and the Clinical Educator regarding policy #33.20 Case	

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	<p>care in 2 (#s 5 and 10) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to evidence the director of clinical services had communicated with the physician and coordinated with the skilled nurse (SN) to obtain supplies needed to flush and deaccess a patient's intravenous access.</p> <p>A. The record included a verbal order dated 2-27-14 that states, "SN [skilled nurse] to deaccess port per protocol."</p> <p>B. The record included a SN visit note dated 2-28-14 that states, "SN [employee E] called DCS [director of clinical services] as pt [patient] does not have needed supplies to flush and remove port access. SN informed by [director of clinical services] that she will order the supplies and have them sent to pts home so SN can do the flush the next visit."</p> <p>C. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, and 3-12-14 by employee E. The SN visit notes failed to evidence the port had been flushed and deaccessed.</p> <p>D. The record included a faxed order signed and dated by employee E on 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>E. The record evidenced SN visits had been completed on 3-18-14 and 3-26-14 by employee E. The SN visit notes failed to evidence the port had been deaccessed per</p>		<p>Conference-Interdisciplinary Group Meeting/Coordination of Service. Information regarding coordination of services among agency staff and other healthcare providers was included. Education was provided regarding Policy #33.24 Plan of Care and Physician orders. The inservice included appropriate documentation and physician notification if services are provided elsewhere or refused. Education packets to be mailed to all professional staff that were unable to attend the inservice 4/28/14. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. Patient # 10- Physician notified on 4/22/14 of patient experiencing pain, no new orders received from the physician. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, coordination of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice</p>				

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G000156	<p>the physician's order.</p> <p>F. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p> <p>2. During a home visit to patient number 10, on 4-3-14 at 1:55 PM, with employee FF, a physical therapy assistant, the patient indicated severe pain in the lower back, buttocks, and upper legs. The patient stated, "This is the worst it's ever been. I've never hurt like this before."</p> <p>The record failed to evidence the physical therapy assistant had communicated and coordinated with the supervising physical therapist or the registered nurse to inform them of the patient's pain.</p> <p>3. The agency's "Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" policy number 33.20 states, "Agency staff regularly communicate to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure services and treatments had been provided in</p>	G000156	<p>President.</p> <p>G156See G158, G159, G164, G165, and G166 to address this condition.</p>	

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G000158	<p>accordance with physician orders in 8 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 158); by failing to ensure plans of care included all of the required items in 4 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 159); by failing to ensure ensure professional staff alerted the physician to changes in the patients' conditions in 3 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 164); by failing to ensure treatments had been provided in accordance with physician orders in 8 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 165); and by failing to ensure verbal orders included signatures and dates in 1 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 166).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.18 Acceptance of Patients, Plans of Care, and Medical Supervision.</p> <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 services and treatments had been provided in accordance with physician orders in 8 (#s 1, 2, 5, 6, 9, 10, 11, and 12) of 12</p>	G000158	G158 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders,	

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	<p>records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a resumption of care after an inpatient stay comprehensive assessment dated 11-26-14 completed by employee CC, a physical therapist. The assessment states, "Pt [patient] has 3 skin tears on [left] forearm and 1 on right. Pt has bandages on all of them. Pt did not want bandages removed so unable to assess. RN order obtained. RN to assess."</p> <p>A. The record included a verbal order dated 11-26-13 that states, "SN [skilled nurse] 1 day 1. SN to eval [evaluate] and treat patient assess for wound care and medication management."</p> <p>B. The record failed to evidence any SN visits had been completed until 12-11-13.</p> <p>C. The supervising nurse indicated, on 4-7-11 at 2:35 PM, a SN visit had not been completed on 11-26-13.</p> <p>2. Clinical record number 2 included plans of care established by the physician for the certification periods 1-14-14 to 3-14-14 and 3-15-14 to 5-13-14. The plans of care identify SN visits were to be provided 1 time per week for 9 weeks. The plans state, "Monitor for S/S [signs and symptoms] of depression . . . SN to assess/observe stoma/skin integrity."</p> <p>A. SN visit notes, dated 2-5-14, 3-4-14, 3-10-14, and 3-18-14, failed to evidence the SN had assessed the stoma or had</p>		<p>Policy #33.43 Assessment of Patient and Policy #33.87 Education for Blood Glucose Monitoring in the Home. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient # 1- Discharged on 2/4/14. Patient #2- Depression, stoma and skin integrity assessment completed on 4/22/14. No significant findings noted. Patient #5 -Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. Patient #6-Lesion assessment completed on 4/14/14, order received from physician for wound care of lesion. Patient #9-Lower legs and right and left foot assessment completed on 4/21/14, no significant findings noted. Patient #10-Nursing services was discharged on 3/25/14. Patient #11- Late entry on 4/22/14 to SN note for 3/17/14 stating PT/INR was obtained on 3/17/14 and Physician was notified. SN documented ordered medication changes and assistance given to patient to implement dose changes. Patient #12- Discharged on 4/1/14. To ensure compliance with the above policies and</p>	

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	<p>monitored the patient for signs and symptoms of depression.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:10 PM, the SN visit notes did not evidence assessments of the stoma or that the patient had been monitored for signs and symptoms of depression." The nurse stated, "It's not there."</p> <p>3. Clinical record number 5 included a verbal order dated 2-27-14 that states, "SN to deaccess port per protocol." The record included a faxed order dated 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>A. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, 3-12-14, 3-18-14, and 3-26-14. The SN visit notes failed to evidence the port had been deaccessed per the physician's order.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p> <p>4. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that identifies SN services are to be provided 2 times per week for 2 weeks, 1 time per week for 2 weeks, and 1 every other week for 5 weeks. The plan of care states, "Monitor for S/S depression, monitor effectiveness of depression medication, refer to physician of</p>		<p>procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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	<p>client experiencing signs of depression . . . Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 2-17-14 (the start of care comprehensive assessment) identified "lesions on RLE". The visit note failed to evidence an assessment of the lesions. The note states, "Flat affect noted; wife verbalizes understanding of S/S of depression and who to contact."</p> <p>B. A SN visit note dated 2-21-14 failed to evidence the SN (employee A) had addressed the lesions on the right lower extremity or signs and symptoms of depression.</p> <p>C. A SN visit note dated 2-28-14 identified the patient had been hospitalized and "now has a dermatologist and was diagnosed with a disease that is causing blisters and itching, still has blisters on legs that the patient picks and itches and pops the blisters."</p> <p>D. A SN visit note dated 3-7-14 failed to evidence any mention of the lesions/blisters on the patient's lower extremities.</p> <p>E. A SN visit note dated 3-18-14 identified the patient's "right leg from knee down is red, wrm [sic] . . . is warm to touch" and that the physician had been notified. A SN visit note dated 3-21-14 identified the patient had been admitted to the hospital.</p> <p>F. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the visit notes did not evidence the SN had focused care on the lesions on the right lower extremity during the</p>			

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	<p>SN visits."</p> <p>5. Clinical record number 9 included a plan of care established by the physician for the certification period 3-21-14 to 5-19-14 that identified a secondary diagnosis of diabetes mellitus type II uncontrolled. The plan of care states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury or new/increased sensations of numbness/tingling." The plan of care evidenced orders for dressing changes to the left foot great toe amputation site.</p> <p>A. SN visit notes, dated 3-21-14 ( start of care comprehensive assessment), 3-24-14, 3-26-14, 3-28-14, 3-31-14, 4-2-14, and 4-4-14, included an assessment of the amputation wound of the left great toe with the dressing change, but failed to evidence an assessment of the patient's lower legs and right foot.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>6. Clinical record number 10 included a plan of care established by the physician for the certification period 2-26-14 to 4-26-14 that evidenced a secondary diagnosis of diabetes mellitus uncontrolled. The plan of care included orders for the SN to "focus on . . . blood glucose control, skin integrity, blood glucose testing and evaluation" with a goal to "demonstrate blood glucose levels within normal limits for patient by 3-28-14."</p> <p>A. A SN visit note dated 2-26-14 (start of care comprehensive assessment) states, "Glucometer reading: did not do today." The</p>			

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	<p>note failed to evidence the SN had assessed the patient's past performance of blood glucose testing and how often, the results, the type of glucometer used, if the patient knew how to use it properly, and if the patient kept a log of the blood glucose readings.</p> <p>B. A SN visit note dated 3-4-14 states, "FBS [fasting blood sugar] = 155." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>C. The record included a SN discharge visit note dated 3-25-14 that states, "Pt feels is managing DM well with diet and does not need to test all the time."</p> <p>D. A SN visit note dated 3-7-14 states, "FBS [fasting blood sugar] = 160." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>E. A SN visit note dated 3-11-14 states, "FBS [fasting blood sugar] = 182 after eating." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>F. A SN visit note dated 3-19-14 failed to evidence the SN had assessed the patient's blood glucose control, how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings. The blood sugar</p>			

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	<p>reading portion of the note was blank.</p> <p>G. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 1:10 PM.</p> <p>7. Clinical record number 11 failed to evidence blood samples were obtained and medication changes had been implemented per the physician's orders. The record included a plan of care for the certification period 3-7-14 to 5-5-14 that states, "SN to instruct on . . . medications including purpose, S/E [side effects], and interactions . . . SN to perform INR/Protime as ordered and report results via fax to MD for further orders."</p> <p>A. The record included a verbal order dated 3-14-14 that states, "SN to obtain INR/Protime 3-17-14." A SN visit note dated 3-17-14 failed to evidence the SN had obtained the ordered laboratory blood test.</p> <p>The supervising nurse stated, on 4-8-14 at 3:10 PM, "The blood draw was done but it is not documented."</p> <p>B. The record included a start of care comprehensive assessment dated 3-7-14 that identified the patient had "blindness of both eyes", vision "severely impaired", and that the patient was "able to take medications at the correct times if individual dosages are prepared in advance by another person."</p> <p>1). The record included a verbal order dated 3-17-14 that states, "effective 3-17-14 . . . change Coumadin to 7 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the</p>			

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	<p>Coumadin dose.</p> <p>2.) The record included a verbal order effective 3-21-14 that states, "change Coumadin to 6.5 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>C. The supervising nurse stated, on 4-8-14 at 3-10-14, "The SN calls the MD from the patient's home and reports the PT/INR results. She gets orders for medication changes at that time and makes the changes then. She did not document this."</p> <p>8. Clinical record number 12 included a plan of care established by the physician for the certification period 2-14-14 to 4-14-14. The plan of care states, "OT [occupational therapy] 1 week 1 OT to eval [evaluate] and treat. PT [physical therapy] 1 week 1 PT to eval and treat."</p> <p>A. The record failed to evidence the OT and PT evaluations had been completed.</p> <p>B. The supervising nurse stated, on 4-8-14 at 10:30 AM, "There is no PT or OT evaluation done."</p> <p>C. The record included a verbal order dated 2-14-14 that states, "Skilled nurse to collect UA/C&amp;S [urine sample for analysis and culture and sensitivity]." SN visit notes, dated 2-14-14, 2-18-14, 2-21-14, 2-26-14, 2-28-14, and 3-3-14, failed to evidence the SN had obtained the urine sample.</p> <p>The record included a verbal order dated 3-3-14 that states, "SN to obtain UA C &amp; S in one week." SN visit notes, dated</p>			

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G000159	<p>3-6-14, 3-18-14, 3-19-14, 3-25-14, and 4-1-14 (SN discharge visit) failed to evidence the SN had obtained the urine sample for testing.</p> <p>D. The supervising nurse stated, on 4-8-14 at 10:30 AM, "The urine samples were not obtained."</p> <p>9. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for every client in conjunction with their attending/treating physician and to provide our clients with services and care consistent with their plan of care . . . All care and services provided is according to current physician orders." 484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all required items in 4 (#s 5, 6, 11, &amp; 12) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p>	G000159	G159 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.04 Medication Management and #33.20 Case Conference -Interdisciplinary Group				

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	<p>1. Clinical record number 5 included a plan of care for the certification period 2-23-14 to 4-23-14. The plan of care states, "SN [skilled nurse] 3 week 1; 2 week 1; 1 week 2; 1 every other week 6; 2 as needed." The plan of care failed to include specific orders and interventions for the SN services.</p> <p>2. Clinical record number 6 included resumption of care verbal orders dated 3-18-14. The orders state, "SN to perform wound care as follows to bilateral feet blisters . . . apply ointment and cover." The orders failed to specify the name of the ointment to be used.</p> <p>3. Clinical record number 11 included a start of care comprehensive assessment dated 3-7-14 that identifies homemaker/attendant care is provided to the patient through another agency.</p> <p>The plan of care for the certification period 3-7-14 to 5-5-14 failed to include the homemaker/attendant care provided by the other agency.</p> <p>4. Clinical record number 12 included a plan of care for the certification period 2-14-14 to 4-14-14 that evidenced orders for wound care to be performed by the skilled nurse to a pressure ulcer on the coccyx. The orders included 2 different frequencies for the wound care to be completed, "2 time(s) a week" and "Change every 5-7 days and prn [when necessary] for non-secure dressing."</p> <p>The supervising nurse indicated, on 4-8-14 at 10:30 AM, the wound care orders did include 2 conflicting frequencies for the dressing change to be completed.</p>		<p>Meeting/Coordination of Services. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #5- Physician clarification order was obtained 4/21/14 for specific orders and interventions for SN services. Patient #6-Physician clarification order obtained for specific ointment on 4/14/14. Patient #11- The agency providing homemaker/attendant care services was notified 4/22/14 that we are also providing care to coordinate services. Physician notified on 4/22/14 regarding other agency providing homemaker/attendant care. Patient #12- Discharged on 4/1/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, coordination of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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G000164	<p>5. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM and at 2:25 PM.</p> <p>6. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "The plan of care should be based upon a current assessment of the client's needs for care. The plan of care must include: . . . types of services . . . all treatments." 484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure professional staff alerted the physician to changes in the patients' conditions in 3 (#s 5, 6, and 10 ) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included skilled nurse (SN) visit notes, dated 3-12-14 and 3-26-14, that identify the patient had experienced angina (chest pain) and had taken medication for relief. SN visit notes, dated 3-6-14 and 3-18-14 note the patient "denies angina."</p> <p>A. The record failed to evidence the SN had informed the physician of the episodes of chest pain.</p>	G000164	G164 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.17 Medical Supervision and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #5-Physician was notified of angina on 4/7/14, new orders received from physician on 4/8/14. Patient #6-Physician was notified of blisters on right and left foot on 3/28/14 and treatment orders for the blisters were received by the physician. Patient	

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	<p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the record did not evidence the SN had informed the physician of the chest pain episodes.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that states, "Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 3-13-14 states, "Patient blisters on legs and feet are called bollous. They are putting a cream on it and they look better but has new ones popping up on left and right foot. Goes to dermatologist in April."</p> <p>The record failed to evidence the SN had informed the physician of the "new" blisters "popping up on left and right foot."</p> <p>B. The record evidenced the patient had been admitted to the hospital on 3-21-14. During a home visit to the patient with employee B, a registered nurse (RN), on 4-3-14 at 10:00 AM, to observe dressing changes to the patient's bilateral feet, the RN stated, "[The patient] did not have the blisters on the feet before [the patient] went into the hospital. [The patient] came home with these blisters on the feet."</p> <p>3. During a home visit to patient number 10, on 4-3-14 at 1:55 PM, with employee FF, a physical therapy assistant, the patient indicated severe pain in the lower back, buttocks, and upper legs. The patient stated, "This is the worst it's ever been. I've never hurt like this before."</p>		# 10- Physician notified on 4/22/14 of patient experiencing pain, no new orders received. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President	

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G000165	<p>The record failed to evidence agency professional staff had notified the physician of the patient's increased, severe pain.</p> <p>4. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM and 1:10 PM.</p> <p>5. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "Clinicians are responsible for alerting the physician to any changes in client care or condition that suggest a need to alter the plan of care." 484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician orders in 8 (#s 1, 2, 5, 6, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a resumption of care after an inpatient stay comprehensive assessment dated 11-26-14 completed by employee CC, a physical therapist. The assessment states, "Pt [patient] has 3 skin tears on [left] forearm and 1 on right. Pt has bandages on all of them. Pt did not want bandages removed so unable</p>	G000165	G165 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, 33.09 Physical Therapy Services, #33.11 Occupational Therapy Services and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient # 1- Discharged on 2/4/14. Patient #2-	

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	<p>to assess. RN order obtained. RN to assess."</p> <p>A. The record included a verbal order dated 11-26-13 that states, "SN [skilled nurse] 1 day 1. SN to eval [evaluate] and treat patient assess for wound care and medication management."</p> <p>B. The record failed to evidence any SN visits had been completed until 12-11-13.</p> <p>C. The supervising nurse indicated, on 4-7-11 at 2:35 PM, a SN visit had not been completed on 11-26-13.</p> <p>2. Clinical record number 2 included plans of care established by the physician for the certification periods 1-14-14 to 3-14-14 and 3-15-14 to 5-13-14. The plans of care identify SN visits were to be provided 1 time per week for 9 weeks. The plans state, "Monitor for S/S [signs and symptoms] of depression . . . SN to assess/observe stoma/skin integrity."</p> <p>A. SN visit notes, dated 2-5-14, 3-4-14, 3-10-14, and 3-18-14, failed to evidence the SN had assessed the stoma or had monitored the patient for signs and symptoms of depression.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:10 PM, the SN visit notes did not evidence assessments of the stoma or that the patient had been monitored for signs and symptoms of depression." The nurse stated, "It's not there."</p> <p>3. Clinical record number 5 included a verbal order dated 2-27-14 that states, "SN to deaccess port per protocol." The record</p>		<p>Depression, stoma and skin integrity assessment completed on 4/22/14 no significant finding were noted. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. Patient #6-Lesion assessment completed on 4/14/14, order received from physician for wound care of lesion. Patient #9-Lower legs and right and left foot assessment completed on 4/21/14 no significant findings noted. Patient #10-Nursing was discharged on 3/25/14. Patient #11- Late entry on 4/22/14 to SN note for 3/17/14 stating PT/INR was obtained on 3/17/14 and Physician was notified. SN documented ordered medication changes and assistance given to patient to implement dose changes. Patient #12 - Discharged 4/1/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and</p>				

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	<p>included a faxed order dated 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>A. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, 3-12-14, 3-18-14, and 3-26-14. The SN visit notes failed to evidence the port had been deaccessed per the physician's order.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p> <p>4. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that identifies SN services are to be provided 2 times per week for 2 weeks, 1 time per week for 2 weeks, and 1 every other week for 5 weeks. The plan of care states, "Monitor for S/S depression, monitor effectiveness of depression medication, refer to physician of client experiencing signs of depression . . . Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 2-17-14 (the start of care comprehensive assessment) identified "lesions on RLE". The visit note failed to evidence an assessment of the lesions. The note states, "Flat affect noted; wife verbalizes understanding of S/S of depression and who to contact."</p>		Regional Vice President.	

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	<p>B. A SN visit note dated 2-21-14 failed to evidence the SN (employee A) had addressed the lesions on the right lower extremity or signs and symptoms of depression.</p> <p>C. A SN visit note dated 2-28-14 identified the patient had been hospitalized and "now has a dermatologist and was diagnosed with a disease that is causing blisters and itching, still has blisters on legs that the patient picks and itches and pops the blisters."</p> <p>D. A SN visit note dated 3-7-14 failed to evidence any mention of the lesions/blisters on the patient's lower extremities.</p> <p>E. A SN visit note dated 3-18-14 identified the patient's "right leg from knee down is red, wrm [sic] . . . is warm to touch" and that the physician had been notified. A SN visit note dated 3-21-14 identified the patient had been admitted to the hospital.</p> <p>F. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the visit notes did not evidence the SN had focused care on the lesions on the right lower extremity during the SN visits."</p> <p>5. Clinical record number 9 included a plan of care established by the physician for the certification period 3-21-14 to 5-19-14 that identified a secondary diagnosis of diabetes mellitus type II uncontrolled. The plan of care states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury or new/increased sensations of numbness/tingling." The plan of care evidenced orders for dressing changes to the left foot great toe amputation site.</p>			

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	<p>A. SN visit notes, dated 3-21-14 ( start of care comprehensive assessment), 3-24-14, 3-26-14, 3-28-14, 3-31-14, 4-2-14, and 4-4-14, included an assessment of the amputation wound of the left great toe with the dressing change, but failed to evidence an assessment of the patient's lower legs and right foot.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>6. Clinical record number 10 included a plan of care established by the physician for the certification period 2-26-14 to 4-26-14 that evidenced a secondary diagnosis of diabetes mellitus uncontrolled. The plan of care included orders for the SN to "focus on . . . blood glucose control, skin integrity, blood glucose testing and evaluation" with a goal to "demonstrate blood glucose levels within normal limits for patient by 3-28-14."</p> <p>A. A SN visit note dated 2-26-14 (start of care comprehensive assessment) states, "Glucometer reading: did not do today." The note failed to evidence the SN had assessed the patient's past performance of blood glucose testing and how often, the results, the type of glucometer used, if the patient knew how to use it properly, and if the patient kept a log of the blood glucose readings.</p> <p>B. A SN visit note dated 3-4-14 states, "FBS [fasting blood sugar] = 155." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar</p>			

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	<p>readings.</p> <p>C. The record included a SN discharge visit note dated 3-25-14 that states, "Pt feels is managing DM well with diet and does not need to test all the time."</p> <p>D. A SN visit note dated 3-7-14 states, "FBS [fasting blood sugar] = 160." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>E. A SN visit note dated 3-11-14 states, "FBS [fasting blood sugar] = 182 after eating." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>F. A SN visit note dated 3-19-14 failed to evidence the SN had assessed the patient's blood glucose control, how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings. The blood sugar reading portion of the note was blank.</p> <p>G. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 1:10 PM.</p> <p>7. Clinical record number 11 failed to evidence blood samples were obtained and medication changes had been implemented per the physician's orders. The record included a plan of care for the certification period 3-7-14 to 5-5-14 that states, "SN to</p>						

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	<p>instruct on . . . medications including purpose, S/E [side effects], and interactions . . . SN to perform INR/Protime as ordered and report results via fax to MD for further orders."</p> <p>A. The record included a verbal order dated 3-14-14 that states, "SN to obtain INR/Protime 3-17-14." A SN visit note dated 3-17-14 failed to evidence the SN had obtained the ordered laboratory blood test.</p> <p>The supervising nurse stated, on 4-8-14 at 3:10 PM, "The blood draw was done but it is not documented."</p> <p>B. The record included a start of care comprehensive assessment dated 3-7-14 that identified the patient had "blindness of both eyes", vision "severely impaired", and that the patient was "able to take medications at the correct times if individual dosages are prepared in advance by another person."</p> <p>1). The record included a verbal order dated 3-17-14 that states, "effective 3-17-14 . . . change Coumadin to 7 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>2.) The record included a verbal order effective 3-21-14 that states, "change Coumadin to 6.5 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>C. The supervising nurse stated, on 4-8-14 at 3-10-14, "The SN calls the MD from the patient's home and reports the PT/INR results. She gets orders for medication</p>			

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	<p>changes at that time and makes the changes then. She did not document this."</p> <p>8. Clinical record number 12 included a plan of care established by the physician for the certification period 2-14-14 to 4-14-14. The plan of care states, "OT [occupational therapy] 1 week 1 OT to eval [evaluate] and treat. PT [physical therapy] 1 week 1 PT to eval and treat."</p> <p>A. The record failed to evidence the OT and PT evaluations had been completed.</p> <p>B. The supervising nurse stated, on 4-8-14 at 10:30 AM, "There is no PT or OT evaluation done."</p> <p>C. The record included a verbal order dated 2-14-14 that states, "Skilled nurse to collect UA/C&amp;S [urine sample for analysis and culture and sensitivity]." SN visit notes, dated 2-14-14, 2-18-14, 2-21-14, 2-26-14, 2-28-14, and 3-3-14, failed to evidence the SN had obtained the urine sample.</p> <p>The record included a verbal order dated 3-3-14 that states, "SN to obtain UA C &amp; S in one week." SN visit notes, dated 3-6-14, 3-18-14, 3-19-14, 3-25-14, and 4-1-14 (SN discharge visit) failed to evidence the SN had obtained the urine sample for testing.</p> <p>D. The supervising nurse stated, on 4-8-14 at 10:30 AM, "The urine samples were not obtained."</p> <p>9. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for</p>			

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G000166	<p>every client in conjunction with their attending/treating physician and to provide our clients with services and care consistent with their plan of care . . . All care and services provided is according to current physician orders."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS 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 and interview, the agency failed to ensure verbal orders included signatures and dates in 1 (# 11) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 11 included a verbal order for physical therapy services signed by the physician on 3-21-14. The verbal order failed to evidence a clinician signature or the date the order was taken.</li> <li>2. The supervising nurse indicated, on 4-8-14 at 3:10 PM, the verbal order for the physical therapy services did not evidence the therapist's signature or a date.</li> </ol>	G000166	<p>G166 Mandatory inservices held 4/21/14 and 4/23/14 for the Therapist regarding Policy #33.24 Plan of Care and Physicians Orders, Policy #33.09 Physical Therapist Services and Policy #33.11 Occupational Therapist Services. Education will include requirement of clinician signatures and date on verbal physician orders. Patient #11- Physical Therapy was discharged on 4/11/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor verbal orders for clinicians signatures and dates for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and</p>				

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G000168	484.30 SKILLED NURSING SERVICES  Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure skilled nursing services and treatments had been provided in accordance with physician orders in 8 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 170); by failing to ensure the registered nurse accurately and completely evaluated the patient for start of care comprehensive assessments in 5 of 10 records reviewed with start of care comprehensive assessments completed by the registered nurse creating the potential to affect all of the agency's future patients (See G 171); by failing to ensure reevaluation of the patient's needs was accurate and complete and reflected the patients' status in 1 of 3 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's patients that receive services longer than 60 days (See G 172); and by failing to ensure the registered nurse had alerted the physician to changes in the patients' conditions in 3 of 12 records reviewed and failed to ensure the RN had coordinated care in 1 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 176).	G000168	Regional Vice President.  G168See G170, 171,172, and G176				
G000170	484.30 SKILLED NURSING SERVICES						

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	<p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services and treatments had been provided in accordance with physician orders in 8 (#s 1, 2, 5, 6, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 1 included a resumption of care after an inpatient stay comprehensive assessment dated 11-26-14 completed by employee CC, a physical therapist. The assessment states, "Pt [patient] has 3 skin tears on [left] forearm and 1 on right. Pt has bandages on all of them. Pt did not want bandages removed so unable to assess. RN order obtained. RN to assess."</li> <li>A. The record included a verbal order dated 11-26-13 that states, "SN [skilled nurse] 1 day 1. SN to eval [evaluate] and treat patient assess for wound care and medication management."</li> <li>B. The record failed to evidence any SN visits had been completed until 12-11-13.</li> <li>C. The supervising nurse indicated, on 4-7-11 at 2:35 PM, a SN visit had not been completed on 11-26-13.</li> </ol> <ol style="list-style-type: none"> <li>Clinical record number 2 included plans of care established by the physician for the certification periods 1-14-14 to 3-14-14 and</li> </ol>	G000170	<p>G170 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.09 Physical Therapy Services, #33.11 Occupational Therapy Services and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient # 1- Discharged on 2/4/14. Patient #2- Depression, stoma and skin integrity assessment completed on 4/22/14. No significant findings noted. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. Patient #6-Lesion assessment completed on 4/14/14 order received from physician for wound care of lesion. Patient #9-Lower legs and right and left foot assessment completed on 4/21/14 no significant findings noted. Patient #10-Nursing was discharged on 3/25/14. Patient #11- Late entry on 4/22/14 to SN</p>	05/07/2014			

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	<p>3-15-14 to 5-13-14. The plans of care identify SN visits were to be provided 1 time per week for 9 weeks. The plans state, "Monitor for S/S [signs and symptoms] of depression . . . SN to assess/observe stoma/skin integrity."</p> <p>A. SN visit notes, dated 2-5-14, 3-4-14, 3-10-14, and 3-18-14, failed to evidence the SN had assessed the stoma or had monitored the patient for signs and symptoms of depression.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:10 PM, the SN visit notes did not evidence assessments of the stoma or that the patient had been monitored for signs and symptoms of depression." The nurse stated, "It's not there."</p> <p>3. Clinical record number 5 included a verbal order dated 2-27-14 that states, "SN to deaccess port per protocol." The record included a faxed order dated 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>A. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, 3-12-14, 3-18-14, and 3-26-14. The SN visit notes failed to evidence the port had been deaccessed per the physician's order.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p>		<p>note for 3/17/14 stating PT/INR was obtained on 3/17/14 and Physician was notified. SN documented ordered medication changes and assistance given to patient to implement dose changes. Patient #12- Discharged on 4/1/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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	<p>4. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that identifies SN services are to be provided 2 times per week for 2 weeks, 1 time per week for 2 weeks, and 1 every other week for 5 weeks. The plan of care states, "Monitor for S/S depression, monitor effectiveness of depression medication, refer to physician of client experiencing signs of depression . . . Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 2-17-14 (the start of care comprehensive assessment) identified "lesions on RLE". The visit note failed to evidence an assessment of the lesions. The note states, "Flat affect noted; wife verbalizes understanding of S/S of depression and who to contact."</p> <p>B. A SN visit note dated 2-21-14 failed to evidence the SN (employee A) had addressed the lesions on the right lower extremity or signs and symptoms of depression.</p> <p>C. A SN visit note dated 2-28-14 identified the patient had been hospitalized and "now has a dermatologist and was diagnosed with a disease that is causing blisters and itching, still has blisters on legs that the patient picks and itches and pops the blisters."</p> <p>D. A SN visit note dated 3-7-14 failed to evidence any mention of the lesions/blisters on the patient's lower extremities.</p> <p>E. A SN visit note dated 3-18-14 identified</p>			

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	<p>the patient's "right leg from knee down is red, wrm [sic] . . . is warm to touch" and that the physician had been notified. A SN visit note dated 3-21-14 identified the patient had been admitted to the hospital.</p> <p>F. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the visit notes did not evidence the SN had focused care on the lesions on the right lower extremity during the SN visits."</p> <p>5. Clinical record number 9 included a plan of care established by the physician for the certification period 3-21-14 to 5-19-14 that identified a secondary diagnosis of diabetes mellitus type II uncontrolled. The plan of care states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury or new/increased sensations of numbness/tingling." The plan of care evidenced orders for dressing changes to the left foot great toe amputation site.</p> <p>A. SN visit notes, dated 3-21-14 ( start of care comprehensive assessment), 3-24-14, 3-26-14, 3-28-14, 3-31-14, 4-2-14, and 4-4-14, included an assessment of the amputation wound of the left great toe with the dressing change, but failed to evidence an assessment of the patient's lower legs and right foot.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>6. Clinical record number 10 included a plan of care established by the physician for the certification period 2-26-14 to 4-26-14 that evidenced a secondary diagnosis of diabetes</p>			

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	<p>mellitus uncontrolled. The plan of care included orders for the SN to "focus on . . . blood glucose control, skin integrity, blood glucose testing and evaluation" with a goal to "demonstrate blood glucose levels within normal limits for patient by 3-28-14."</p> <p>A. A SN visit note dated 2-26-14 (start of care comprehensive assessment) states, "Glucometer reading: did not do today." The note failed to evidence the SN had assessed the patient's past performance of blood glucose testing and how often, the results, the type of glucometer used, if the patient knew how to use it properly, and if the patient kept a log of the blood glucose readings.</p> <p>B. A SN visit note dated 3-4-14 states, "FBS [fasting blood sugar] = 155." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>C. The record included a SN discharge visit note dated 3-25-14 that states, "Pt feels is managing DM well with diet and does not need to test all the time."</p> <p>D. A SN visit note dated 3-7-14 states, "FBS [fasting blood sugar] = 160." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>E. A SN visit note dated 3-11-14 states, "FBS [fasting blood sugar] = 182 after eating." The visit note failed to evidence the SN had assessed how often the patient took</p>			

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	<p>the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>F. A SN visit note dated 3-19-14 failed to evidence the SN had assessed the patient's blood glucose control, how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings. The blood sugar reading portion of the note was blank.</p> <p>G. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 1:10 PM.</p> <p>7. Clinical record number 11 failed to evidence blood samples were obtained and medication changes had been implemented per the physician's orders. The record included a plan of care for the certification period 3-7-14 to 5-5-14 that states, "SN to instruct on . . . medications including purpose, S/E [side effects], and interactions . . . SN to perform INR/Protime as ordered and report results via fax to MD for further orders."</p> <p>A. The record included a verbal order dated 3-14-14 that states, "SN to obtain INR/Protime 3-17-14." A SN visit note dated 3-17-14 failed to evidence the SN had obtained the ordered laboratory blood test.</p> <p>The supervising nurse stated, on 4-8-14 at 3:10 PM, "The blood draw was done but it is not documented."</p> <p>B. The record included a start of care comprehensive assessment dated 3-7-14 that identified the patient had "blindness of</p>			

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	<p>both eyes", vision "severely impaired", and that the patient was "able to take medications at the correct times if individual dosages are prepared in advance by another person."</p> <p>1). The record included a verbal order dated 3-17-14 that states, "effective 3-17-14 . . . change Coumadin to 7 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>2.) The record included a verbal order effective 3-21-14 that states, "change Coumadin to 6.5 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>C. The supervising nurse stated, on 4-8-14 at 3-10-14, "The SN calls the MD from the patient's home and reports the PT/INR results. She gets orders for medication changes at that time and makes the changes then. She did not document this."</p> <p>8. Clinical record number 12 included a plan of care established by the physician for the certification period 2-14-14 to 4-14-14. The plan of care states, "OT [occupational therapy] 1 week 1 OT to eval [evaluate] and treat. PT [physical therapy] 1 week 1 PT to eval and treat."</p> <p>A. The record failed to evidence the OT and PT evaluations had been completed.</p> <p>B. The supervising nurse stated, on 4-8-14 at 10:30 AM, "There is no PT or OT evaluation done."</p> <p>C. The record included a verbal order</p>			

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G000171	<p>dated 2-14-14 that states, "Skilled nurse to collect UA/C&amp;S [urine sample for analysis and culture and sensitivity]." SN visit notes, dated 2-14-14, 2-18-14, 2-21-14, 2-26-14, 2-28-14, and 3-3-14, failed to evidence the SN had obtained the urine sample.</p> <p>The record included a verbal order dated 3-3-14 that states, "SN to obtain UA C &amp; S in one week." SN visit notes, dated 3-6-14, 3-18-14, 3-19-14, 3-25-14, and 4-1-14 (SN discharge visit) failed to evidence the SN had obtained the urine sample for testing.</p> <p>D. The supervising nurse stated, on 4-8-14 at 10:30 AM, "The urine samples were not obtained."</p> <p>9. The agency's undated "Nursing Service" policy number 33.08 states, "Duties and responsibilities of the registered nurse: A. The Registered Nurse: 1. Follows a written plan of care established and periodically reviewed by the physician. 2. Provides care only in conformance with the physician's orders." 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse accurately and completely evaluated the patient for start of care comprehensive assessments in 5 (#s 2, 6, 9, 10, and 11) of 10 records reviewed with start of care comprehensive assessments completed by the registered nurse creating the potential to affect all of the agency's</p>	G000171	G171 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.106 Comprehensive Assessment and Oasis Management, and #33.43 Assessment of Patient. The	

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	<p>future patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a start of care comprehensive assessment completed by the registered nurse (RN), employee F, on 1-14-14. The assessment states, "Patient has ostomy for bowel elimination."</p> <p>A. The assessment failed to include an evaluation of the condition, location, or any other details about the ostomy and the stoma.</p> <p>B. The plan of care for the certification period 1-14-14 to 3-14-14 identified the skilled nurse is to "assess/observe stoma/skin integrity . . . instruct on ostomy care, skin care, nutrition, hydration, where to obtain supplies, and problem solving techniques."</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment completed by the RN, employee A, on 2-17-14. The assessment states, "Lesions on RLE [right lower extremity]."</p> <p>A. The assessment failed to include an evaluation of the lesions, size, color, condition, etc.</p> <p>B. The plan of care for the certification period 2-17-14 to 4-17-14 states, "Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE."</p> <p>3. Clinical record number 9 included a start of care comprehensive assessment completed by the RN, employee F, on</p>		<p>inservices include information that all visits and treatments, care and services are provided according to physician orders and the comprehensive assessment is complete and accurate. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #2- Depression, stoma and skin integrity assessment completed on 4/22/14. No significant findings noted. Patient #6-Lesion assessment completed on 4/14/14 order received from physician for wound care of lesion. Patient #9-Lower legs and right and left foot assessment completed on 4/21/14 no significant findings noted. Patient #10-Nursing was discharged on 3/25/14. Patient #11- Physician clarification order obtained regarding blood glucose monitoring on 4/23/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, comprehensive assessments and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>3-21-14. The assessment identified a diagnosis of diabetes mellitus with peripheral circulatory disorders and "traumatic amputation of toes."</p> <p>A. The assessment failed to include an evaluation of the patient's lower extremities to include both legs and feet.</p> <p>B. The plan of care for the certification period 3-21-14 to 5-19-14 states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury, or new/increased sensations of numbness/tingling."</p> <p>4. Clinical record number 10 included a start of care comprehensive assessment completed by the RN, employee E, on 2-26-14. The assessment identified a diagnosis of diabetes mellitus.</p> <p>A. The assessment failed to include an evaluation of the patient's blood glucose monitoring practices, ability to perform, and recent readings.</p> <p>B. The plan of care for the certification period 2-26-14 to 4-26-14 states, "SN [skilled nurse] for assessment / observation with focus on . . . blood glucose control . . . blood glucose testing and evaluation."</p> <p>5. Clinical record number 11 included a start of care comprehensive assessment completed by the RN, employee E, on 3-7-14. The assessment identified a diagnosis of diabetes mellitus and that the patient has "blindness of both eyes . . . vision . . . severely impaired . . ." with "mild to moderate hearing impairment." The assessment includes a glucometer reading of 133.</p>			

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G000172	<p>A. The assessment failed to include an evaluation of how the patient takes a blood glucose reading given the patient's impairments, how often, and a range of recent readings.</p> <p>B. The plan of care for the certification period 3-7-14 to 5-5-14 states, "SN to assess/observe blood glucose control. . . teach blood glucose testing and evaluation."</p> <p>6. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM, 1:10 PM, and 2:25 PM.</p> <p>7. The agency's undated "Comprehensive Assessment and OASIS Management" policy number 33.106 states, "A standard core data set, the 'Outcome and Assessment Information Set' (OASIS) is used when evaluating adult (18 years and older) non maternity patients who are receiving skilled services. The OASIS is combined with the history and physical and past medical history to provide a comprehensive assessment of the patient." 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure reevaluation of the patient's needs was accurate and complete and reflected the patients' status in 1 (#2) of 3 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's patients</p>	G000172	G172 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.106 Comprehensive Assessment and Oasis Management, and #33.43	

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G000176	<p>that receive services longer than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a recertification comprehensive assessment completed by the registered nurse (RN), employee F, on 3-10-14. The assessment states, "Patient has ostomy for bowel elimination."</p> <p>A. The assessment failed to include an evaluation of the condition, location, or any other details about the ostomy and the stoma.</p> <p>B. The plan of care for the certification period 3-15-14 to 5-13-14 identified the skilled nurse is to "assess/observe stoma/skin integrity . . . instruct on ostomy care, skin care, nutrition, hydration, where to obtain supplies, and problem solving techniques."</p> <p>2. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had alerted</p>	G000176	<p>Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders and comprehensive assessment is complete and accurate. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #2- Stoma and skin integrity assessment completed on 4/22/14. No significant findings noted. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, comprehensive assessments and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p> <p>G176 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator</p>	

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	<p>the physician to changes in the patients' conditions in 3 (#s 5, 6, and 10 ) of 12 records reviewed and coordinated care in 1 of 12 records reviewed (#5) creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>Regarding alerting the physician to changes in the patient's condition:</p> <p>1. Clinical record number 5 included skilled nurse (SN) visit notes, dated 3-12-14 and 3-26-14, that identify the patient had experienced angina (chest pain) and had taken medication for relief. SN visit notes, dated 3-6-14 and 3-18-14 note the patient "denies angina."</p> <p>A. The record failed to evidence the SN had informed the physician of the episodes of chest pain.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the record did not evidence the SN had informed the physician of the chest pain episodes.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that states, "Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 3-13-14 states, "Patient blisters on legs and feet are called bollous. They are putting a cream on it and they look better but has new ones popping up on left and right foot. Goes to dermatologist</p>		<p>regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.20 Case Conference-Interdisciplinary Group Meeting/Coordination of Services, and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders and coordination of care. Educational packets to be mailed all Professional staff unable to attend the inservices on 4/28/14. Patient #5-Physician was notified of angina on 4/7/14, new orders received from physician on 4/8/14. Patient #6-Physician was notified of blisters on right and left foot on 3/28/14 order received from physician for wound care of lesion. Patient # 10- Physician notified on 4/22/14 of patient experiencing pain, no new orders received. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This</p>				

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	<p>in April."</p> <p>The record failed to evidence the SN had informed the physician of the "new" blisters "popping up on left and right foot."</p> <p>B. The record evidenced the patient had been admitted to the hospital on 3-21-14. During a home visit to the patient with employee B, a registered nurse (RN), on 4-3-14 at 10:00 AM, to observe dressing changes to the patient's bilateral feet, the RN stated, "[The patient] did not have the blisters on the feet before [the patient] went into the hospital. [The patient] came home with these blisters on the feet."</p> <p>3. During a home visit to patient number 10, on 4-3-14 at 1:55 PM, with employee FF, a physical therapy assistant, the patient indicated severe pain in the lower back, buttocks, and upper legs. The patient stated, "This is the worst it's ever been. I've never hurt like this before."</p> <p>The record failed to evidence agency professional staff had notified the physician of the patient's increased, severe pain.</p> <p>4. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM and 1:10 PM.</p> <p>5. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "Clinicians are responsible for alerting the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p>		<p>compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>Regarding coordination of care</p> <p>Findings include:</p> <p>1. Clinical record number 5 failed to evidence the director of clinical services had communicated with the physician and coordinated with the skilled nurse (SN) to obtain supplies needed to flush and deaccess a patient's intravenous access.</p> <p>A. The record included a verbal order dated 2-27-14 that states, "SN [skilled nurse] to deaccess port per protocol."</p> <p>B. The record included a SN visit note dated 2-28-14 that states, "SN [employee E] called DCS [director of clinical services] as pt [patient] does not have needed supplies to flush and remove port access. SN informed by [director of clinical services] that she will order the supplies and have them sent to pts home so SN can do the flush the next visit."</p> <p>C. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, and 3-12-14 by employee E. The SN visit notes failed to evidence the port had been flushed and deaccessed.</p> <p>D. The record included a faxed order signed and dated by employee E on 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>E. The record evidenced SN visits had been completed on 3-18-14, and 3-26-14 by employee E. The SN visit notes failed to evidence the port had been deaccessed per the physician's order.</p>			

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G000330	<p>2. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p> <p>3. The agency's undated "Nursing Service" policy number 33.08 states, "Duties and responsibilities of the registered nurse: 1. The Registered Nurse . . . 8. Coordinates services." 484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p>	G000330	G330See	

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	Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure start of care comprehensive assessments were complete and accurately reflected the patients' status in 5 of 10 records reviewed with start of care comprehensive assessments completed by the registered nurse creating the potential to affect all of the agency's future patients (See G 335); by failing to ensure start of care comprehensive assessments completed by the physical therapist were complete and accurately reflected the patient's status in 2 of 2 records reviewed where the therapist completed the start of care comprehensive assessment creating the potential to affect all of the agency's future patients that receive therapy only services (See G 336); by failing to ensure all medications the patient was known to be using had been checked in 1 of 12 records reviewed creating the potential to affect all of the agency's 129 current patients (See G 337); by failing to ensure updated comprehensive assessments were complete and accurately reflected the patients' status in 1 of 3 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's patients that receive services longer than 60 days (See G 339); and by failing to ensure comprehensive assessments completed upon the patient's return home from the hospital were complete and accurately reflected the patients' status in 1 of 2 records reviewed of patients that had been hospitalized creating the potential to affect all of the agency's patients who have been hospitalized (See G 340).		G335,G336,G337,G339,G340	

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G000335	<p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT</p> <p>Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure start of care comprehensive assessments were complete and accurately reflected the patients' status in 5 (#s 2, 6, 9, 10, and 11) of 10 records reviewed with start of care comprehensive assessments completed by the registered nurse creating the potential to affect all of the agency's future patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 2 included a start of care comprehensive assessment completed by the registered nurse (RN), employee F, on 1-14-14. The assessment states, "Patient has ostomy for bowel elimination." <ul style="list-style-type: none"> <li>A. The assessment failed to include an evaluation of the condition, location, or any other details about the ostomy and the stoma.</li> <li>B. The plan of care for the certification</li> </ul> </li> </ol>	G000335	<p>G335 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.106 Comprehensive Assessment and Oasis Management, and #33.43 Assessment of Patient. The inservices include information ensuring the start of care comprehensive assessment is complete and accurately reflects the patient's status. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #2- Stoma and skin integrity assessment completed on 4/22/14. No significant findings reported. Patient #6-Lesion assessment completed on 4/14/14 order received from physician for wound care of lesion. Patient #9-Lower legs and right and left foot assessment completed on 4/21/14 no significant findings</p>	
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	<p>period 1-14-14 to 3-14-14 identified the skilled nurse is to "assess/observe stoma/skin integrity . . . instruct on ostomy care, skin care, nutrition, hydration, where to obtain supplies, and problem solving techniques."</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment completed by the RN, employee A, on 2-17-14. The assessment states, "Lesions on RLE [right lower extremity]."</p> <p>A. The assessment failed to include an evaluation of the lesions, size, color, condition, etc.</p> <p>B. The plan of care for the certification period 2-17-14 to 4-17-14 states, "Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE."</p> <p>3. Clinical record number 9 included a start of care comprehensive assessment completed by the RN, employee F, on 3-21-14. The assessment identified a diagnosis of diabetes mellitus with peripheral circulatory disorders and "traumatic amputation of toes."</p> <p>A. The assessment failed to include an evaluation of the patient's lower extremities to include both legs and feet.</p> <p>B. The plan of care for the certification period 3-21-14 to 5-19-14 states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury, or new/increased sensations of numbness/tingling."</p> <p>4. Clinical record number 10 included a start of care comprehensive assessment</p>		<p>noted. Patient #10-Nursing was discharged on 3/25/14. Patient #11- Physician clarification order obtained regarding blood glucose monitoring on 4/23/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, comprehensive assessments and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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	<p>completed by the RN, employee E, on 2-26-14. The assessment identified a diagnosis of diabetes mellitus.</p> <p>A. The assessment failed to include an evaluation of the patient's blood glucose monitoring practices, ability to perform, and recent readings.</p> <p>B. The plan of care for the certification period 2-26-14 to 4-26-14 states, "SN [skilled nurse] for assessment / observation with focus on . . . blood glucose control . . . blood glucose testing and evaluation."</p> <p>5. Clinical record number 11 included a start of care comprehensive assessment completed by the RN, employee E, on 3-7-14. The assessment identified a diagnosis of diabetes mellitus and that the patient has "blindness of both eyes . . . vision . . . severely impaired . . ." with "mild to moderate hearing impairment." The assessment includes a glucometer reading of 133.</p> <p>A. The assessment failed to include an evaluation of how the patient takes a blood glucose reading given the patient's impairments, how often, and a range of recent readings.</p> <p>B. The plan of care for the certification period 3-7-14 to 5-5-14 states, "SN to assess/observe blood glucose control. . . teach blood glucose testing and evaluation."</p> <p>6. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM, 1:10 PM, and 2:25 PM.</p>			

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G000336	<p>7. The agency's undated "Comprehensive Assessment and OASIS Management" policy number 33.106 states, "A standard core data set, the 'Outcome and Assessment Information Set' (OASIS) is used when evaluating adult (18 years and older) non maternity patients who are receiving skilled services. The OASIS is combined with the history and physical and past medical history to provide a comprehensive assessment of the patient." 484.55(b)(3) COMPLETION OF THE COMPREHENSIVE ASSESSMENT When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure start of care comprehensive assessments completed by the physical therapist were complete and accurately reflected the patient's status in 2 (#s 1 and 3 ) of 2 records reviewed where the therapist completed the start of care comprehensive assessment creating the potential to affect all of the agency's future patients that receive therapy only services.</p> <p>The findings include:</p>	G000336	G336 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.106 Comprehensive Assessment and Oasis Management, #33.09 Physical Therapist Services, #33.11 Occupational Therapist Services and #33.43 Assessment of Patient. The inservices include information regarding comprehensive assessments and their completion to reflect the	

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	<p>1. Clinical record number 1 included a start of care comprehensive assessment completed by the physical therapist, employee CC, on 10-25-13. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The assessment identified the patient had been discharged from the hospital. The assessment failed to evidence the discharge date from the hospital.</p> <p>B. The assessment of the peripheral pulses had been left blank.</p> <p>C. The assessment of the presence of absence of a vascular access had been left blank.</p> <p>D. The assessment of the breath sounds had been left blank.</p> <p>E. The assessment of the urine color and clarity had been left blank.</p> <p>F. The assessment identified the patient experienced diarrhea. The assessment failed to identify the date of the last bowel movement.</p> <p>G. The presence or absence of bowel sounds and their location had been left blank.</p> <p>H. The diet consistency or whether any modifications were required had been left blank. Compliance with diet had been left blank.</p> <p>2. Clinical record number 3 included a start of care comprehensive assessment completed by the physical therapist,</p>		<p>patients status. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient # 1 -Discharged on 2/4/14. Patient #3- Discharged on 4/10/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, completion of comprehensive assessments and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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	<p>employee GG, on 3-21-14. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The assessment identified the patient had been discharged from a skilled nursing facility. The date of discharge had been left blank.</p> <p>B. The primary diagnoses portion of the assessment had been left blank.</p> <p>C. The patient's height and weight had been left blank.</p> <p>D. The presence or absence of a vascular access had been left blank.</p> <p>E. The breath sounds had been left blank.</p> <p>F. The urine odor, color, and clarity had been left blank.</p> <p>G. The gastrointestinal status and bowel status had been left blank.</p> <p>H. The abdominal status and bowel sounds had been left blank.</p> <p>I. The diet consistency and whether any modifications were required had been left blank. Diet compliance had been left blank.</p> <p>3. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>4. The agency's undated "Comprehensive Assessment and OASIS Management" policy number 33.106 states, "A standard core data</p>			

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G000337	<p>set, the 'Outcome and Assessment Information Set' (OASIS) is used when evaluating adult (18 years and older) non maternity patients who are receiving skilled services. The OASIS is combined with the history and physical and past medical history to provide a comprehensive assessment of the patient . . . If the referral is made for physical therapy only, then the assessment may be completed by the PT."</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record and drug book review, observation, and interview, the agency failed to ensure all medications the patient was known to be using had been checked in 1 (# 6) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 failed to evidence the registered nurse had checked the medicated ointment used to treat open blisters on the patient's feet.</p> <p>The record included resumption of care verbal orders dated 3-18-14. The orders state, "SN to perform wound care as follows to bilateral feet blisters . . . apply ointment and cover." The orders failed to specify the</p>	G000337	G337 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.04 Medication Management and Policy# 33.48 Comprehensive Drug Regimen Review, Adverse Drug Reactions, and Medication Errors Response. The inservices include information regarding reviews of all medications with the comprehensive assessment and ongoing. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #6-Physician clarification order obtained for specific ointment on 4/14/14. To ensure compliance with the above policies and				

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G000339	<p>name of the ointment to be used.</p> <p>2. During a home visit to patient number 6, on 4-3-14 at 10:00 AM, observation noted the registered nurse, employee B, applied a medicated ointment to the open blisters on the patient's bilateral feet. When asked what the ointment was the RN replied, "Clobetasol cream. It is used to keep the wounds moist. It is an antibacterial, kind of like Neosporin."</p> <p>3. The NURSING 2014 DRUG HANDBOOK identifies Clobetasol as corticosteroid used to treat moderate to severe plaque-type psoriasis. The reference states, on page 347, the medication is "considered a very-high-potency to high-potency drug, according to vasoconstrictive properties." 484.55(d)(1)</p> <p>UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review and interview, the agency failed to ensure updated comprehensive assessments were complete and accurately reflected the patients' status in 1 (#2) of 3 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's patients that receive services longer than 60 days.</p> <p>The findings include:</p>	G000339	<p>procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, physicians orders and drug regime review for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p> <p>G339 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.106 Comprehensive Assessment and Oasis Management, and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according</p>	

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G000340	<p>1. Clinical record number 2 included a recertification comprehensive assessment completed by the registered nurse (RN), employee F, on 3-10-14. The assessment states, "Patient has ostomy for bowel elimination."</p> <p>A. The assessment failed to include an evaluation of the condition, location, or any other details about the ostomy and the stoma.</p> <p>B. The plan of care for the certification period 3-15-14 to 5-13-14 identified the skilled nurse is to "assess/observe stoma/skin integrity . . . instruct on ostomy care, skin care, nutrition, hydration, where to obtain supplies, and problem solving techniques."</p> <p>2. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>Based on clinical record review and interview, the agency failed to ensure comprehensive assessments completed upon the patient's return home from the hospital were complete and accurately reflected the patients' status</p>	G000340	<p>to physician orders and the Comprehensive assessment to be completed and updated as required. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #2- Stoma and skin integrity assessment completed on 4/22/14. No significant findings noted. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, comprehensive assessments and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p> <p>G340 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.106 Comprehensive Assessment and</p>				

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	<p>in 1 (# 1) of 2 records reviewed of patients that had been hospitalized creating the potential to affect all of the agency's patients who have been hospitalized.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a resumption of care comprehensive assessment completed by the physical therapist, employee CC, on 11-26-13. The assessment failed to be complete and accurately reflect the patient's status at the time the patient returned home from the hospital.</p> <p>A. The assessment identified the patient had been discharged from the hospital. The date of the discharge had been left blank.</p> <p>B. The primary diagnosis portion of the assessment had been left blank.</p> <p>C. The assessment of the peripheral pulses had been left blank.</p> <p>D. The assessment of whether the patient had a vascular access had been left blank.</p> <p>E. The assessment of the breath sounds had been left blank.</p> <p>F. The assessment of the urine color and clarity had been left blank.</p> <p>G. The assessment identified the patient had experienced diarrhea. The date of the last bowel movement had been left blank.</p> <p>H. The assessment of the bowel sounds had been left blank.</p>		<p>Oasis Management, and #33.43 Assessment of Patient. The inservices include information that the comprehensive assessment must be complete and reflect the patient status on returning from a hospital admission. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient # 1 -Discharged on 2/4/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, comprehensive assessment and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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N000000	<p>I. The assessment of the diet consistency and whether any modifications were required had been left blank. Compliance with diet had been left blank.</p> <p>2. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 4-2-14, 4-3-14, 4-4-14, 4-7-14, and 4-8-14</p> <p>Facility #: 004372</p> <p>Medicaid Vendor #: 200272600A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p>	N000000		
N000458	<p>Quality Review: Joyce Elder, MSN, BSN, RN April 14, 2014 410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description.</p>			

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N000462	<p>(2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.</p> <p>Based on personnel file review and interview, the agency failed to ensure personnel files included copies of limited criminal histories from the Indiana Central Repository in 2 (files EE and FF) of 10 personnel files reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Personnel file EE evidenced the individual had been hired on 10-9-12 to provide occupational therapy assistant services to patients of the agency. The file failed to evidence a copy of a limited criminal history pursuant to IC 16-27-2.</li> <li>Personnel file FF evidenced the individual had been hired on 2-2-09 to provide physical therapy assistant services to patients of the agency. The file failed to evidence a copy of a limited criminal history pursuant to IC 16-27-2.</li> <li>The agency's Employment Coordinator, employee HH, indicated, on 4-8-14 at 9:25 AM, the files did not include a copy of the individuals' limited criminal history pursuant to IC 16-27-2.</li> </ol> <p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a</p>	N000458	N458 The Employment Coordinator was inserviced on 04/08/14 on Policy #32.61 Criminal /Sanction Screening and Policy #32.88 Hiring Process/Direct Caregivers. Personnel File EE-Limited Criminal Background history was completed on 4/8/14. Personnel File FF-Limited Criminal Background history was completed on 4/8/14. To ensure compliance with the above policies the Director of Operations or designee will conduct 3 random employee record reviews per month to monitor limited criminal history for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.	05/07/2014

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N000464	<p>physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review, observation, and interview, the agency failed to ensure each employee had a physical examination at least 180 days prior to patient contact in 1 (file EE) of 5 files reviewed of employees hired since the previous survey on 4-8-11 creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file EE evidenced the individual had been hired on 10-9-12 to provide occupational therapy assistant services to patients of the agency. The file failed to evidence a physical examination completed at any time.</li> <li>2. Employee EE was observed to provide services to patient number 7 on 4-3-14 at 1:00 PM.</li> <li>3. The agency's Employment Coordinator, employee HH, indicated, on 4-8-14 at 9:25 AM, the file did not include a physical examination.</li> </ol> <p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf</p>	N000462	<p>N462 The Employment Coordinator was inserviced on 04/16/14 on Policy# 32.120 Employment Physicals. Personnel File EE- Documentation of physical exam was obtained on 4/8/14. To ensure compliance with the above policies the Director of Operations or designee will conduct 3 random employee record reviews per month to monitor for physical examination 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	05/07/2014

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

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N000470	<p>showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file review, observation, and interview, the agency failed to ensure each employee had been evaluated for tuberculosis prior to patient contact in 1 (file EE) of 5 files reviewed of employees hired since the previous survey on 4-8-11 creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file EE evidenced the individual had been hired on 10-9-12 to provide occupational therapy assistant services to patients of the agency. The file failed to evidence the employee had been evaluated for tuberculosis.</li> <li>2. Employee EE was observed to provide services to patient number 7 on 4-3-14 at 1:00 PM.</li> <li>3. The agency's Employment Coordinator, employee HH, indicated, on 4-8-14 at 9:25 AM, the file did not evidence the employee had been evaluated for tuberculosis.</li> </ol> <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>	N000464	<p>N464 The Employment Coordinator was inserviced on 04/16/14 on Policy# 32.62 TB Screening/Education. Personnel File EE- Documentation received on 4/8/14 that employee has been evaluated for Tuberculosis. To ensure compliance with the above policies the Director of Operations or designee will conduct 3 random employee record reviews per month to monitor for tuberculous evaluation for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	05/07/2014

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	<p>Based on observation, interview, and review of agency policy, the agency failed to ensure its staff had provided services in accordance with its own infection control policies and procedures in 4 (Employees B, E, I, and O) of 6 home visit observations completed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The agency's undated "Infection Control Plan" policy number 33.28 states, "The Infection Control Plan will comply with applicable local, state and/or federal regulations, OSHA regulations, and CDC guidelines and currently accepted standards of practice . . . Activities to be performed by the company to prevent and control the spread of infection include but are not limited to: . . . Observe universal precautions."</li> <li>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</li> </ol>	N000470	<p>N470 Mandatory inservices for all Professional/Paraprofessional staff held on 4/16/14, 4/21/14, 4/22/14, 4/23/14, and 4/25/14 by the Director of Clinical Services (DCS) and/or Clinical Educator regarding Policy # 33.39 Standard (Universal) Precautions, Policy #33.28 Infection Control Plan and Policy #33.900 Hand Hygiene. Return demonstration of appropriate hand hygiene technique demonstration was included. Education packets will be mailed to all Professional and Paraprofessional staff that were unable to attend the inservice on 4/28/14. Return demonstration of hand hygiene is being individually scheduled with staff unable to attend. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 home visits per month for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly quality monitoring. This compliance process will be under the direct supervision of the Director of Operations with oversight by Regional Clinical Manager and Regional Vice President.</p>	05/07/2014

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	<p>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 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>3. A home visit was made to patient number 4 with employee I, a home health aide, on 4-3-14 at 8:00 AM. The aide was observed to provide the patient with assistance with a shower bath. The aide was observed to wash her hands and don a clean pair of gloves. The aide assisted the patient to wash the patient's face. The aide then assisted the patient to undress and enter the shower and be seated on a shower bench. The aide washed and rinsed the patient's back and handed the washcloth to the patient and the patient completed the bath. The patient washed the front and rear perineal area. The patient handed the soiled washcloth to the aide and the aide placed it on the faucet.</p> <p>Without changing her gloves or cleansing her hands, the aide then applied lotion to the patient's body, assisted the patient to dress the lower part of the body, retrieved a</p>			

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	<p>garment from the patient's drawer, and then applied the patient's socks.</p> <p>4. A home visit was made to patient number 6 with employee B, a registered nurse (RN), on 4-3-14 at 10:00 AM. The RN was observed to change the dressings to the patient's feet. The RN prepared the supplies for the dressing change and reached into her pocket, retrieved a pen, charted, and then placed the pen back into her pocket. The RN soaked a gauze pad with normal saline and donned clean gloves without cleansing her hands.</p> <p>A. After the RN had completed the dressing change to the right foot, she removed her gloves, and, without cleansing her hands, reached into her pocket to retrieve her pen. The RN marked the dressing with the date.</p> <p>B. After completing the dressing change to the right foot, the RN removed the old dressing from the left foot. Without changing her gloves or cleansing her hands, the RN then soaked a gauze with normal saline and cleaned wounds on the toes of the right foot. The RN applied a medicated ointment, removed her gloves, cleansed her hands, retrieved the Mepilex dressing from the patient's supplies, and completed the dressing change to the patient's right toes.</p> <p>5. A home visit was made to patient number 8 with employee O, a RN, on 4-4-14 at 9:15 AM. The RN was observed to assess the patient and provide medication teaching. Without cleansing her hands or donning gloves, the RN was observed to open a bottle of pills, pour one out into her hand and show the patient the pill. The RN then replaced the</p>			

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N000484	<p>pill back into the bottle. The RN repeated these actions with a second medication.</p> <p>The nurse's failure to cleanse her hands and don clean gloves prior to touching the patient's medication was discussed with employee BB, the RN branch manager, on 4-4-14 at 10:15 AM. The RN branch manager indicated the RN had not complied with agency procedure.</p> <p>6. A home visit was made to patient number 9 with employee E, a RN, on 4-4-14 at 1:10 PM. The RN was observed to change the dressing to the patient's left foot. The RN was observed to obtain saline and gauze from supplies in the patient's home. The RN soaked a gauze with saline and donned clean gloves without cleansing her hands. The RN was observed to repeat the actions a second time.</p> <p>7. The above-stated home visit observations were discussed with the administrator and the supervising nurse on 4-7-14 at 8:45 AM. The administrator and the supervising nurse indicated agency staff had not provided services in accordance with the agency's infection control policies and procedures. 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 and agency policy</p>	N000484	N484 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by	

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	<p>review and interview, the agency failed to ensure all personnel communicated and coordinated services to support the plan of care in 2 (#s 5 and 10) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to evidence the director of clinical services had communicated with the physician and coordinated with the skilled nurse (SN) to obtain supplies needed to flush and deaccess a patient's intravenous access.</p> <p>A. The record included a verbal order dated 2-27-14 that states, "SN [skilled nurse] to deaccess port per protocol."</p> <p>B. The record included a SN visit note dated 2-28-14 that states, "SN [employee E] called DCS [director of clinical services] as pt [patient] does not have needed supplies to flush and remove port access. SN informed by [director of clinical services] that she will order the supplies and have them sent to pts home so SN can do the flush the next visit."</p> <p>C. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, and 3-12-14 by employee E. The SN visit notes failed to evidence the port had been flushed and deaccessed.</p> <p>D. The record included a faxed order signed and dated by employee E on 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>E. The record evidenced SN visits had</p>		<p>the Director of Clinical Services (DCS) and the Clinical Educator regarding Policy #33.20 Case Conference-Interdisciplinary Group Meeting/Coordination of Service. Information regarding coordination of services among agency staff and other healthcare providers was included. Education was provided regarding Policy #33.24 Plan of Care and Physician orders. The inservice included appropriate documentation and physician notification if services are provided elsewhere or refused. Education packets will be mailed to all Professional staff that were unable to attend the inservice on 4/28/14. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. Patient #10 -Physician was notified on 4/22/14 of patient experiencing pain no new orders received To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, coordination of care and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the</p>	



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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure it had coordinated with other service providers in 3 (#s 1, 11, and 12) of 3 records reviewed of patients that received services from other providers creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a start of care comprehensive assessment dated 102-25-13 and a resumption of care comprehensive assessment dated 11-26-13 that identified the patient was a resident of an assisted living facility.</p> <p>The record failed to evidence agency staff had communicated and coordinated with the assisted living staff.</p> <p>2. Clinical record number 11 included a start of care comprehensive assessment dated 3-7-14 that identified the patient received "homemaker/attendant care" services from "another agency."</p> <p>The record failed to evidence agency staff had communicated and coordinated with the other agency.</p> <p>3. Clinical record number 12 included a start of care comprehensive assessment dated 2-14-14 that states, "Pt [patient] lives in congregate situation (e.g., assisted living) around the clock."</p> <p>The record failed to evidence agency staff had communicated and coordinated with the assisted living staff.</p>		<p>4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and the Clinical Educator regarding Policy #33.20 Case Conference-Interdisciplinary Group Meeting/Coordination of Service. Information regarding coordination of services among agency staff and other healthcare providers was included. Education packets to be mailed to all Professional staff that were unable to attend the inservice on 4/28/14. Patient #1 -Discharged on 2/4/14. Patient #11 -The agency providing Homemaker/ Attendant Care services was notified 4/22/14 that we we are also providing care to coordinate services. Physician notified on 4/22/14 regarding other agency providing homemaker/attendant care. Patient #12- Discharged on 4/1/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, care coordination and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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N000522	<p>4. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 1:10 PM and 3:10 PM.</p> <p>5. The agency's undated "Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" policy number 33.20 states, "Care will be coordinated with other involved external organizations (i.e. home medical equipment providers, infusion therapy/pharmacy companies and community agencies.)" 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:</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician orders in 8 (#s 1, 2, 5, 6, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a resumption of care after an inpatient stay comprehensive assessment dated 11-26-14 completed by employee CC, a physical therapist. The assessment states, "Pt [patient] has 3 skin tears on [left] forearm and 1 on right. Pt has bandages on all of them. Pt did not want bandages removed so unable to assess. RN order obtained. RN to assess."</p>	N000522	N522 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.09 Physical Therapy Services, #33.11 Occupational Therapy Services, #33.106 Comprehensive Assessment & Oasis Management and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders as well as need for accurate assessment reflecting the patient's current status. Educational packets to be mailed to all Professional staff	

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	<p>A. The record included a verbal order dated 11-26-13 that states, "SN [skilled nurse] 1 day 1. SN to eval [evaluate] and treat patient assess for wound care and medication management."</p> <p>B. The record failed to evidence any SN visits had been completed until 12-11-13.</p> <p>C. The supervising nurse indicated, on 4-7-11 at 2:35 PM, a SN visit had not been completed on 11-26-13.</p> <p>2. Clinical record number 2 included plans of care established by the physician for the certification periods 1-14-14 to 3-14-14 and 3-15-14 to 5-13-14. The plans of care identify SN visits were to be provided 1 time per week for 9 weeks. The plans state, "Monitor for S/S [signs and symptoms] of depression . . . SN to assess/observe stoma/skin integrity."</p> <p>A. SN visit notes, dated 2-5-14, 3-4-14, 3-10-14, and 3-18-14, failed to evidence the SN had assessed the stoma or had monitored the patient for signs and symptoms of depression.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:10 PM, the SN visit notes did not evidence assessments of the stoma or that the patient had been monitored for signs and symptoms of depression." The nurse stated, "It's not there."</p> <p>3. Clinical record number 5 included a verbal order dated 2-27-14 that states, "SN to deaccess port per protocol." The record included a faxed order dated 3-13-14 that states, "Also, could you order heparin flush</p>		<p>unable to attend the inservices on 4/28/14. Patient#1 -Discharged on 2/4/14. Patient #2- Depression, stoma and skin integrity assessment completed on 4/22/14. No significant findings noted. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. Patient #6- Lesion assessment completed on 4/14/14, order received from physician for wound care of lesion. Patient #9- Lower legs and right and left foot assessment completed on 4/21/14 no significant findings noted. Patient #10-nursing was discharged on 3/25/14. Patient #11-Late entry on 4/22/14 to SN note for 3/17/14 stating PT/INR was obtained on 3/17/14 and Physician was notified. SN documented ordered medication changes and assistance given to patient to implement dose changes. Patient #12- Discharged on 4/1/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, comprehensive assessment and services per physicians orders for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This</p>	

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	<p>so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>A. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, 3-12-14, 3-18-14, and 3-26-14. The SN visit notes failed to evidence the port had been deaccessed per the physician's order.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p> <p>4. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that identifies SN services are to be provided 2 times per week for 2 weeks, 1 time per week for 2 weeks, and 1 every other week for 5 weeks. The plan of care states, "Monitor for S/S depression, monitor effectiveness of depression medication, refer to physician of client experiencing signs of depression . . . Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 2-17-14 (the start of care comprehensive assessment) identified "lesions on RLE". The visit note failed to evidence an assessment of the lesions. The note states, "Flat affect noted; wife verbalizes understanding of S/S of depression and who to contact."</p> <p>B. A SN visit note dated 2-21-14 failed to evidence the SN (employee A) had</p>		<p>compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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	<p>addressed the lesions on the right lower extremity or signs and symptoms of depression.</p> <p>C. A SN visit note dated 2-28-14 identified the patient had been hospitalized and "now has a dermatologist and was diagnosed with a disease that is causing blisters and itching, still has blisters on legs that the patient picks and itches and pops the blisters."</p> <p>D. A SN visit note dated 3-7-14 failed to evidence any mention of the lesions/blisters on the patient's lower extremities.</p> <p>E. A SN visit note dated 3-18-14 identified the patient's "right leg from knee down is red, wrm [sic] . . . is warm to touch" and that the physician had been notified. A SN visit note dated 3-21-14 identified the patient had been admitted to the hospital.</p> <p>F. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the visit notes did not evidence the SN had focused care on the lesions on the right lower extremity during the SN visits."</p> <p>5. Clinical record number 9 included a plan of care established by the physician for the certification period 3-21-14 to 5-19-14 that identified a secondary diagnosis of diabetes mellitus type II uncontrolled. The plan of care states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury or new/increased sensations of numbness/tingling." The plan of care evidenced orders for dressing changes to the left foot great toe amputation site.</p> <p>A. SN visit notes, dated 3-21-14 ( start of</p>			

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	<p>care comprehensive assessment), 3-24-14, 3-26-14, 3-28-14, 3-31-14, 4-2-14, and 4-4-14, included an assessment of the amputation wound of the left great toe with the dressing change, but failed to evidence an assessment of the patient's lower legs and right foot.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>6. Clinical record number 10 included a plan of care established by the physician for the certification period 2-26-14 to 4-26-14 that evidenced a secondary diagnosis of diabetes mellitus uncontrolled. The plan of care included orders for the SN to "focus on . . . blood glucose control, skin integrity, blood glucose testing and evaluation" with a goal to "demonstrate blood glucose levels within normal limits for patient by 3-28-14."</p> <p>A. A SN visit note dated 2-26-14 (start of care comprehensive assessment) states, "Glucometer reading: did not do today." The note failed to evidence the SN had assessed the patient's past performance of blood glucose testing and how often, the results, the type of glucometer used, if the patient knew how to use it properly, and if the patient kept a log of the blood glucose readings.</p> <p>B. A SN visit note dated 3-4-14 states, "FBS [fasting blood sugar] = 155." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p>			

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	<p>C. The record included a SN discharge visit note dated 3-25-14 that states, "Pt feels is managing DM well with diet and does not need to test all the time."</p> <p>D. A SN visit note dated 3-7-14 states, "FBS [fasting blood sugar] = 160." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>E. A SN visit note dated 3-11-14 states, "FBS [fasting blood sugar] = 182 after eating." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>F. A SN visit note dated 3-19-14 failed to evidence the SN had assessed the patient's blood glucose control, how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings. The blood sugar reading portion of the note was blank.</p> <p>G. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 1:10 PM.</p> <p>7. Clinical record number 11 failed to evidence blood samples were obtained and medication changes had been implemented per the physician's orders. The record included a plan of care for the certification period 3-7-14 to 5-5-14 that states, "SN to instruct on . . . medications including purpose, S/E [side effects], and interactions .</p>			

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	<p>. . SN to perform INR/Protime as ordered and report results via fax to MD for further orders."</p> <p>A. The record included a verbal order dated 3-14-14 that states, "SN to obtain INR/Protime 3-17-14." A SN visit note dated 3-17-14 failed to evidence the SN had obtained the ordered laboratory blood test.</p> <p>The supervising nurse stated, on 4-8-14 at 3:10 PM, "The blood draw was done but it is not documented."</p> <p>B. The record included a start of care comprehensive assessment dated 3-7-14 that identified the patient had "blindness of both eyes", vision "severely impaired", and that the patient was "able to take medications at the correct times if individual dosages are prepared in advance by another person."</p> <p>1). The record included a verbal order dated 3-17-14 that states, "effective 3-17-14 . . . change Coumadin to 7 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>2.) The record included a verbal order effective 3-21-14 that states, "change Coumadin to 6.5 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>C. The supervising nurse stated, on 4-8-14 at 3-10-14, "The SN calls the MD from the patient's home and reports the PT/INR results. She gets orders for medication changes at that time and makes the changes then. She did not document this."</p>			

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	<p>8. Clinical record number 12 included a plan of care established by the physician for the certification period 2-14-14 to 4-14-14. The plan of care states, "OT [occupational therapy] 1 week 1 OT to eval [evaluate] and treat. PT [physical therapy] 1 week 1 PT to eval and treat."</p> <p>A. The record failed to evidence the OT and PT evaluations had been completed.</p> <p>B. The supervising nurse stated, on 4-8-14 at 10:30 AM, "There is no PT or OT evaluation done."</p> <p>C. The record included a verbal order dated 2-14-14 that states, "Skilled nurse to collect UA/C&amp;S [urine sample for analysis and culture and sensitivity]." SN visit notes, dated 2-14-14, 2-18-14, 2-21-14, 2-26-14, 2-28-14, and 3-3-14, failed to evidence the SN had obtained the urine sample.</p> <p>The record included a verbal order dated 3-3-14 that states, "SN to obtain UA C &amp; S in one week." SN visit notes, dated 3-6-14, 3-18-14, 3-19-14, 3-25-14, and 4-1-14 (SN discharge visit) failed to evidence the SN had obtained the urine sample for testing.</p> <p>D. The supervising nurse stated, on 4-8-14 at 10:30 AM, "The urine samples were not obtained."</p> <p>9. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for every client in conjunction with their attending/treating physician and to provide</p>			

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N000524	<p>our clients with services and care consistent with their plan of care . . . All care and services provided is according to current physician orders." 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 plans of care included all required items in 4 (#s 5, 6, 11, &amp; 12) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p>	N000524	N524 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and the Clinical Educator regarding Policy #33.20 Case Conference-Interdisciplinary Group Meeting/Coordination of Service. Information regarding coordination of services among agency staff and other healthcare	

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	<p>1. Clinical record number 5 included a plan of care for the certification period 2-23-14 to 4-23-14. The plan of care states, "SN [skilled nurse] 3 week 1; 2 week 1; 1 week 2; 1 every other week 6; 2 as needed." The plan of care failed to include specific orders and interventions for the SN services.</p> <p>2. Clinical record number 6 included resumption of care verbal orders dated 3-18-14. The orders state, "SN to perform wound care as follows to bilateral feet blisters . . . apply ointment and cover." The orders failed to specify the name of the ointment to be used.</p> <p>3. Clinical record number 11 included a start of care comprehensive assessment dated 3-7-14 that identifies homemaker/attendant care is provided to the patient through another agency.</p> <p>The plan of care for the certification period 3-7-14 to 5-5-14 failed to include the homemaker/attendant care provided by the other agency.</p> <p>4. Clinical record number 12 included a plan of care for the certification period 2-14-14 to 4-14-14 that evidenced orders for wound care to be performed by the skilled nurse to a pressure ulcer on the coccyx. The orders included 2 different frequencies for the wound care to be completed, "2 time(s) a week" and "Change every 5-7 days and prn [when necessary] for non-secure dressing."</p> <p>The supervising nurse indicated, on 4-8-14 at 10:30 AM, the wound care orders did include 2 conflicting frequencies for the dressing change to be completed.</p>		<p>providers was included. Education was provided regarding Policy #33.24 Plan of Care and Physician orders and Policy #33.43 Assessment of Patient. The inservice included appropriate documentation. Education packets to be mailed to all Professional staff that were unable to attend the inservice on 4/28/14. Patient #5 - Physician clarification order was obtained 4/21/14 for specific orders and interventions for SN services. Patient #6 -Physician clarification order obtained for specific ointment on 4/14/14.Patient #11 -The agency providing Homemaker/ Attendant Care services was notified 4/22/14 that we we are also providing care to coordinate services. Physician notified on 4/22/14 regarding other agency providing homemaker/attendant care. Patient #12- Discharged on 4/1/14.To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice</p>		

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N000527	<p>5. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM and at 2:25 PM.</p> <p>6. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "The plan of care should be based upon a current assessment of the client's needs for care. The plan of care must include: . . . types of services . . . all treatments." 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 clinical record and agency policy review and interview, the agency failed to ensure professional staff alerted the physician to changes in the patients' conditions in 3 (#s 5, 6, and 10 ) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included skilled nurse (SN) visit notes, dated 3-12-14 and 3-26-14, that identify the patient had experienced angina (chest pain) and had taken medication for relief. SN visit notes, dated 3-6-14 and 3-18-14 note the patient "denies angina."</p> <p>A. The record failed to evidence the SN had informed the physician of the episodes of</p>	N000527	<p>President.</p> <p>N527 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and the Clinical Educator regarding Policy #33.20 Case Conference-Interdisciplinary Group Meeting/Coordination of Service. Information regarding coordination of services among agency staff and other healthcare providers was included. Education was provided regarding Policy #33.24 Plan of Care and Physician orders and Policy #33.17 Medical Supervision. The inservices included appropriate documentation and physician notification. Education packets to be mailed to all Professional staff that were unable to attend the</p>	

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	<p>chest pain.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the record did not evidence the SN had informed the physician of the chest pain episodes.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that states, "Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 3-13-14 states, "Patient blisters on legs and feet are called bollous. They are putting a cream on it and they look better but has new ones popping up on left and right foot. Goes to dermatologist in April."</p> <p>The record failed to evidence the SN had informed the physician of the "new" blisters "popping up on left and right foot."</p> <p>B. The record evidenced the patient had been admitted to the hospital on 3-21-14. During a home visit to the patient with employee B, a registered nurse (RN), on 4-3-14 at 10:00 AM, to observe dressing changes to the patient's bilateral feet, the RN stated, "[The patient] did not have the blisters on the feet before [the patient] went into the hospital. [The patient] came home with these blisters on the feet."</p> <p>3. During a home visit to patient number 10, on 4-3-14 at 1:55 PM, with employee FF, a physical therapy assistant, the patient indicated severe pain in the lower back, buttocks, and upper legs. The patient stated,</p>		<p>inservice on 4/28/14. Patient #5-Physician was notified of angina on 4/7/14. New orders received from physician on 4/8/14. Patient #6-Physician notified of blisters on right and left foot on 3/28/14 treatment orders for the blisters were received by the physician. Patient #10 -Physician was notified on 4/22/14 of patient experiencing pain no new orders received. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice President.</p>				

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N000537	<p>"This is the worst it's ever been. I've never hurt like this before."</p> <p>The record failed to evidence agency professional staff had notified the physician of the patient's increased, severe pain.</p> <p>4. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM and 1:10 PM.</p> <p>5. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "Clinicians are responsible for alerting the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services and treatments had been provided in accordance with physician orders in 8 (#s 1, 2, 5, 6, 9, 10, 11, and 12) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a resumption of care after an inpatient stay comprehensive assessment dated 11-26-14 completed by employee CC, a physical</p>	N000537	N537 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.09 Physical Therapy Services, #33.11 Occupational Therapy Services and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff	

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	<p>therapist. The assessment states, "Pt [patient] has 3 skin tears on [left] forearm and 1 on right. Pt has bandages on all of them. Pt did not want bandages removed so unable to assess. RN order obtained. RN to assess."</p> <p>A. The record included a verbal order dated 11-26-13 that states, "SN [skilled nurse] 1 day 1. SN to eval [evaluate] and treat patient assess for wound care and medication management."</p> <p>B. The record failed to evidence any SN visits had been completed until 12-11-13.</p> <p>C. The supervising nurse indicated, on 4-7-11 at 2:35 PM, a SN visit had not been completed on 11-26-13.</p> <p>2. Clinical record number 2 included plans of care established by the physician for the certification periods 1-14-14 to 3-14-14 and 3-15-14 to 5-13-14. The plans of care identify SN visits were to be provided 1 time per week for 9 weeks. The plans state, "Monitor for S/S [signs and symptoms] of depression . . . SN to assess/observe stoma/skin integrity."</p> <p>A. SN visit notes, dated 2-5-14, 3-4-14, 3-10-14, and 3-18-14, failed to evidence the SN had assessed the stoma or had monitored the patient for signs and symptoms of depression.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:10 PM, the SN visit notes did not evidence assessments of the stoma or that the patient had been monitored for signs and symptoms of depression." The nurse stated, "It's not there."</p>		<p>unable to attend the inservices on 4/28/14. Patient #1- Discharged on 2/4/14. Patient #2- Depression, stoma and skin integrity assessment completed on 4/22/14 no significant findings noted. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. Patient #6- Lesion assessment completed on 4/14/14 and treatment orders for the blisters were received by the physician. Patient #9-Lower legs and right and left foot assessment completed on 4/21/14 no significant findings noted. Patient #10- Nursing was discharged on 3/25/14. Patient #11-Late entry on 4/22/14 to SN note for 3/17/14 stating PT/INR was obtained on 3/17/14 and Physician was notified. SN documented ordered medication changes and assistance given to patient to implement dose changes. Patient #12- Discharged on 4/1/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency</p>	

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	<p>3. Clinical record number 5 included a verbal order dated 2-27-14 that states, "SN to deaccess port per protocol." The record included a faxed order dated 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>A. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, 3-12-14, 3-18-14, and 3-26-14. The SN visit notes failed to evidence the port had been deaccessed per the physician's order.</p> <p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p> <p>4. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that identifies SN services are to be provided 2 times per week for 2 weeks, 1 time per week for 2 weeks, and 1 every other week for 5 weeks. The plan of care states, "Monitor for S/S depression, monitor effectiveness of depression medication, refer to physician of client experiencing signs of depression . . . Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 2-17-14 (the start of care comprehensive assessment) identified "lesions on RLE". The visit note failed to evidence an assessment of the</p>		<p>quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice President.</p>	

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	<p>lesions. The note states, "Flat affect noted; wife verbalizes understanding of S/S of depression and who to contact."</p> <p>B. A SN visit note dated 2-21-14 failed to evidence the SN (employee A) had addressed the lesions on the right lower extremity or signs and symptoms of depression.</p> <p>C. A SN visit note dated 2-28-14 identified the patient had been hospitalized and "now has a dermatologist and was diagnosed with a disease that is causing blisters and itching, still has blisters on legs that the patient picks and itches and pops the blisters."</p> <p>D. A SN visit note dated 3-7-14 failed to evidence any mention of the lesions/blisters on the patient's lower extremities.</p> <p>E. A SN visit note dated 3-18-14 identified the patient's "right leg from knee down is red, wrm [sic] . . . is warm to touch" and that the physician had been notified. A SN visit note dated 3-21-14 identified the patient had been admitted to the hospital.</p> <p>F. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the visit notes did not evidence the SN had focused care on the lesions on the right lower extremity during the SN visits."</p> <p>5. Clinical record number 9 included a plan of care established by the physician for the certification period 3-21-14 to 5-19-14 that identified a secondary diagnosis of diabetes mellitus type II uncontrolled. The plan of care states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury or</p>			

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	<p>new/increased sensations of numbness/tingling." The plan of care evidenced orders for dressing changes to the left foot great toe amputation site.</p> <p>A. SN visit notes, dated 3-21-14 ( start of care comprehensive assessment), 3-24-14, 3-26-14, 3-28-14, 3-31-14, 4-2-14, and 4-4-14, included an assessment of the amputation wound of the left great toe with the dressing change, but failed to evidence an assessment of the patient's lower legs and right foot.</p> <p>B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>6. Clinical record number 10 included a plan of care established by the physician for the certification period 2-26-14 to 4-26-14 that evidenced a secondary diagnosis of diabetes mellitus uncontrolled. The plan of care included orders for the SN to "focus on . . . blood glucose control, skin integrity, blood glucose testing and evaluation" with a goal to "demonstrate blood glucose levels within normal limits for patient by 3-28-14."</p> <p>A. A SN visit note dated 2-26-14 (start of care comprehensive assessment) states, "Glucometer reading: did not do today." The note failed to evidence the SN had assessed the patient's past performance of blood glucose testing and how often, the results, the type of glucometer used, if the patient knew how to use it properly, and if the patient kept a log of the blood glucose readings.</p> <p>B. A SN visit note dated 3-4-14 states, "FBS [fasting blood sugar] = 155." The visit</p>			

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	<p>note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>C. The record included a SN discharge visit note dated 3-25-14 that states, "Pt feels is managing DM well with diet and does not need to test all the time."</p> <p>D. A SN visit note dated 3-7-14 states, "FBS [fasting blood sugar] = 160." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>E. A SN visit note dated 3-11-14 states, "FBS [fasting blood sugar] = 182 after eating." The visit note failed to evidence the SN had assessed how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings.</p> <p>F. A SN visit note dated 3-19-14 failed to evidence the SN had assessed the patient's blood glucose control, how often the patient took the blood sugar readings, the range of blood sugar reading, or if the patient kept a log of blood sugar readings. The blood sugar reading portion of the note was blank.</p> <p>G. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 1:10 PM.</p> <p>7. Clinical record number 11 failed to evidence blood samples were obtained and</p>			

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	<p>medication changes had been implemented per the physician's orders. The record included a plan of care for the certification period 3-7-14 to 5-5-14 that states, "SN to instruct on . . . medications including purpose, S/E [side effects], and interactions . . . SN to perform INR/Protime as ordered and report results via fax to MD for further orders."</p> <p>A. The record included a verbal order dated 3-14-14 that states, "SN to obtain INR/Protime 3-17-14." A SN visit note dated 3-17-14 failed to evidence the SN had obtained the ordered laboratory blood test.</p> <p>The supervising nurse stated, on 4-8-14 at 3:10 PM, "The blood draw was done but it is not documented."</p> <p>B. The record included a start of care comprehensive assessment dated 3-7-14 that identified the patient had "blindness of both eyes", vision "severely impaired", and that the patient was "able to take medications at the correct times if individual dosages are prepared in advance by another person."</p> <p>1). The record included a verbal order dated 3-17-14 that states, "effective 3-17-14 . . . change Coumadin to 7 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p> <p>2.) The record included a verbal order effective 3-21-14 that states, "change Coumadin to 6.5 mg daily." The record failed to evidence the SN had assisted the patient to implement the change in the Coumadin dose.</p>			

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	<p>C. The supervising nurse stated, on 4-8-14 at 3-10-14, "The SN calls the MD from the patient's home and reports the PT/INR results. She gets orders for medication changes at that time and makes the changes then. She did not document this."</p> <p>8. Clinical record number 12 included a plan of care established by the physician for the certification period 2-14-14 to 4-14-14. The plan of care states, "OT [occupational therapy] 1 week 1 OT to eval [evaluate] and treat. PT [physical therapy] 1 week 1 PT to eval and treat."</p> <p>A. The record failed to evidence the OT and PT evaluations had been completed.</p> <p>B. The supervising nurse stated, on 4-8-14 at 10:30 AM, "There is no PT or OT evaluation done."</p> <p>C. The record included a verbal order dated 2-14-14 that states, "Skilled nurse to collect UA/C&amp;S [urine sample for analysis and culture and sensitivity]." SN visit notes, dated 2-14-14, 2-18-14, 2-21-14, 2-26-14, 2-28-14, and 3-3-14, failed to evidence the SN had obtained the urine sample.</p> <p>The record included a verbal order dated 3-3-14 that states, "SN to obtain UA C &amp; S in one week." SN visit notes, dated 3-6-14, 3-18-14, 3-19-14, 3-25-14, and 4-1-14 (SN discharge visit) failed to evidence the SN had obtained the urine sample for testing.</p> <p>D. The supervising nurse stated, on 4-8-14 at 10:30 AM, "The urine samples were not obtained."</p>				

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N000540	<p>9. The agency's undated "Nursing Service" policy number 33.08 states, "Duties and responsibilities of the registered nurse: A. The Registered Nurse: 1. Follows a written plan of care established and periodically reviewed by the physician. 2. Provides care only in conformance with the physician's orders." 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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse accurately and completely evaluated the patient for start of care comprehensive assessments in 5 (#s 2, 6, 9, 10, and 11) of 10 records reviewed with start of care comprehensive assessments completed by the registered nurse creating the potential to affect all of the agency's future patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a start of care comprehensive assessment completed by the registered nurse (RN), employee F, on 1-14-14. The assessment states, "Patient has ostomy for bowel elimination."  A. The assessment failed to include an evaluation of the condition, location, or any other details about the ostomy and the stoma.</p>	N000540	N540 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.106 Comprehensive Assessment & Oasis Management and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #2- Depression, stoma and skin integrity assessment completed on 4/22/14. No significant findings noted. Patient #6- Lesion assessment completed on 4/14/14. Order received from physician for wound care of lesion. Patient #9-Lower legs and	

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	<p>B. The plan of care for the certification period 1-14-14 to 3-14-14 identified the skilled nurse is to "assess/observe stoma/skin integrity . . . instruct on ostomy care, skin care, nutrition, hydration, where to obtain supplies, and problem solving techniques."</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment completed by the RN, employee A, on 2-17-14. The assessment states, "Lesions on RLE [right lower extremity]."</p> <p>A. The assessment failed to include an evaluation of the lesions, size, color, condition, etc.</p> <p>B. The plan of care for the certification period 2-17-14 to 4-17-14 states, "Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE."</p> <p>3. Clinical record number 9 included a start of care comprehensive assessment completed by the RN, employee F, on 3-21-14. The assessment identified a diagnosis of diabetes mellitus with peripheral circulatory disorders and "traumatic amputation of toes."</p> <p>A. The assessment failed to include an evaluation of the patient's lower extremities to include both legs and feet.</p> <p>B. The plan of care for the certification period 3-21-14 to 5-19-14 states, "Diabetic foot care: Assess feet and lower extremities for open areas, injury, or new/increased sensations of numbness/tingling."</p> <p>4. Clinical record number 10 included a start</p>		<p>right and left foot assessment completed on 4/21/14 no significant findings noted. Patient #10-Nursing was discharged on 3/25/14. Patient#11- Physician clarification order obtained regarding blood glucose monitoring on 4/23/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice President.</p>	

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	<p>of care comprehensive assessment completed by the RN, employee E, on 2-26-14. The assessment identified a diagnosis of diabetes mellitus.</p> <p>A. The assessment failed to include an evaluation of the patient's blood glucose monitoring practices, ability to perform, and recent readings.</p> <p>B. The plan of care for the certification period 2-26-14 to 4-26-14 states, "SN [skilled nurse] for assessment / observation with focus on . . . blood glucose control . . . blood glucose testing and evaluation."</p> <p>5. Clinical record number 11 included a start of care comprehensive assessment completed by the RN, employee E, on 3-7-14. The assessment identified a diagnosis of diabetes mellitus and that the patient has "blindness of both eyes . . . vision . . .severely impaired . . ." with "mild to moderate hearing impairment." The assessment includes a glucometer reading of 133.</p> <p>A. The assessment failed to include an evaluation of how the patient takes a blood glucose reading given the patient's impairments, how often, and a range of recent readings.</p> <p>B. The plan of care for the certification period 3-7-14 to 5-5-14 states, "SN to assess/observe blood glucose control. . . teach blood glucose testing and evaluation."</p> <p>6. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM, 1:10 PM, and 2:25 PM.</p>			

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N000541	<p>7. The agency's undated "Comprehensive Assessment and OASIS Management" policy number 33.106 states, "A standard core data set, the 'Outcome and Assessment Information Set' (OASIS) is used when evaluating adult (18 years and older) non maternity patients who are receiving skilled services. The OASIS is combined with the history and physical and past medical history to provide a comprehensive assessment of the patient."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure reevaluation of the patient's needs was accurate and complete and reflected the patients' status in 1 (#2) of 3 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's patients that receive services longer than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a recertification comprehensive assessment completed by the registered nurse (RN), employee F, on 3-10-14. The assessment states, "Patient has ostomy for bowel elimination."</p> <p>A. The assessment failed to include an</p>	N000541	N541 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.24 Plan of Care and Physician Orders, #33.08 Nursing Service, #33.106 Comprehensive Assessment & Oasis Management and #33.43 Assessment of Patient. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #2- Depression, stoma and skin integrity assessment completed on	

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N000545	<p>evaluation of the condition, location, or any other details about the ostomy and the stoma.</p> <p>B. The plan of care for the certification period 3-15-14 to 5-13-14 identified the skilled nurse is to "assess/observe stoma/skin integrity . . . instruct on ostomy care, skin care, nutrition, hydration, where to obtain supplies, and problem solving techniques."</p> <p>2. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <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 and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had coordinated care in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to evidence the director of clinical services had communicated with the physician and coordinated with the skilled nurse (SN) to obtain supplies needed to flush and</p>	N000545	<p>4/22/14 no significant findings noted.To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice President.</p> <p>N545 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and the Clinical Educator regarding Policy #33.20 Case Conference-Interdisciplinary Group Meeting/Coordination of service and Policy #33.08 Nursing Service. Information regarding coordination of services among agency staff and other healthcare providers was included.The inservices included appropriate documentation and physician notification. Education packets to</p>	

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	<p>deaccess a patient's intravenous access.</p> <p>A. The record included a verbal order dated 2-27-14 that states, "SN [skilled nurse] to deaccess port per protocol."</p> <p>B. The record included a SN visit note dated 2-28-14 that states, "SN [employee E] called DCS [director of clinical services] as pt [patient] does not have needed supplies to flush and remove port access. SN informed by [director of clinical services] that she will order the supplies and have them sent to pts home so SN can do the flush the next visit."</p> <p>C. The record evidenced SN visits had been completed on 2-28-14, 3-6-14, and 3-12-14 by employee E. The SN visit notes failed to evidence the port had been flushed and deaccessed.</p> <p>D. The record included a faxed order signed and dated by employee E on 3-13-14 that states, "Also, could you order heparin flush so port can be deaccessed from pharmacy?" The physician had written "OK."</p> <p>E. The record evidenced SN visits had been completed on 3-18-14, and 3-26-14 by employee E. The SN visit notes failed to evidence the port had been deaccessed per the physician's order.</p> <p>2. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the SN visit notes did not evidence the port had been deaccessed per the physician's order. The supervising nurse stated, "The patient went back to the pain clinic and the port was deaccessed and flushed there. The clinician did not document the flush was done at the pain clinic."</p>		<p>be mailed to all Professional staff that were unable to attend the inservice on 4/28/14. Patient # 5-The Physician was notified 4/21/14 that the port was deaccessed at the pain clinic. Physician order was received for skilled nurse to discontinue services for deaccessing the port on 4/22/14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice President.</p>		

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N000546	<p>3. The agency's undated "Nursing Service" policy number 33.08 states, "Duties and responsibilities of the registered nurse: 1. The Registered Nurse . . . 8. Coordinates services." 410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had alerted the physician to changes in the patients' conditions in 3 (#s 5, 6, and 10 ) of 12 records reviewed creating the potential to affect all of the agency's 129 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included skilled nurse (SN) visit notes, dated 3-12-14 and 3-26-14, that identify the patient had experienced angina (chest pain) and had taken medication for relief. SN visit notes, dated 3-6-14 and 3-18-14 note the patient "denies angina."</p> <p>A. The record failed to evidence the SN had informed the physician of the episodes of chest pain.</p>	N000546	N546 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy #33.24 Plan of Care and Physician Orders and #33.17 Medical Supervision. The inservices include information that all visits and treatments, care and services are provided according to physician orders. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #5- Physician was notified of angina on 4/7/14. New orders received from physician on 4/8/14. Patient #6-Physician notified of blisters on right and left foot on 3/28/14. Treatment orders for the blisters were received by the physician. Patient #10				

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	<p>B. The supervising nurse indicated, on 4-7-14 at 1:25 PM, the record did not evidence the SN had informed the physician of the chest pain episodes.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 2-17-14 to 4-17-14 that states, "Patient to be seen for skilled care with focus on care for UTI [urinary tract infection], lesions on RLE [right lower extremity]."</p> <p>A. A SN visit note dated 3-13-14 states, "Patient blisters on legs and feet are called bollous. They are putting a cream on it and they look better but has new ones popping up on left and right foot. Goes to dermatologist in April."</p> <p>The record failed to evidence the SN had informed the physician of the "new" blisters "popping up on left and right foot."</p> <p>B. The record evidenced the patient had been admitted to the hospital on 3-21-14. During a home visit to the patient with employee B, a registered nurse (RN), on 4-3-14 at 10:00 AM, to observe dressing changes to the patient's bilateral feet, the RN stated, "[The patient] did not have the blisters on the feet before [the patient] went into the hospital. [The patient] came home with these blisters on the feet."</p> <p>3. During a home visit to patient number 10, on 4-3-14 at 1:55 PM, with employee FF, a physical therapy assistant, the patient indicated severe pain in the lower back, buttocks, and upper legs. The patient stated, "This is the worst it's ever been. I've never</p>		<p>-Physician was notified on 4/22/14 of patient experiencing pain no new orders received To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice President.</p>	

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N000562	<p>hurt like this before."</p> <p>The record failed to evidence agency professional staff had notified the physician of the patient's increased, severe pain.</p> <p>4. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM and 1:10 PM.</p> <p>5. The agency's undated "Plan of Care and Physician Orders" policy number 33.24 states, "Clinicians are responsible for alerting the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>410 IAC 17-14-1(c) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (1) make an initial evaluation visit to the patient for whom only therapy services are required;</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the physical therapist completed and accurately evaluated the patient for the start of care comprehensive assessments in 2 (#s 1 and 3 ) of 2 records reviewed where the therapist completed the start of care comprehensive assessment creating the potential to affect all of the agency's future patients that receive therapy only services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a start of care comprehensive assessment completed by the physical therapist, employee CC, on 10-25-13. The</p>	N000562	N562 Mandatory inservices held 4/21/14, 4/22/14, 4/23/14 and 4/25/14 for Professional staff by the Director of Clinical Services (DCS) and Clinical Educator regarding Policy # 33.106 Comprehensive Assessment & Oasis Management. The inservices include information the comprehensive assessment be completed and updated to reflect the patients status. Educational packets to be mailed to all Professional staff unable to attend the inservices on 4/28/14. Patient #1- Discharged on 2/4/14. Patient #3- Discharged on 4/10/14. To ensure compliance	

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	<p>assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The assessment identified the patient had been discharged from the hospital. The assessment failed to evidence the discharge date from the hospital.</p> <p>B. The assessment of the peripheral pulses had been left blank.</p> <p>C. The assessment of the presence of absence of a vascular access had been left blank.</p> <p>D. The assessment of the breath sounds had been left blank.</p> <p>E. The assessment of the urine color and clarity had been left blank.</p> <p>F. The assessment identified the patient experienced diarrhea. The assessment failed to identify the date of the last bowel movement.</p> <p>G. The presence or absence of bowel sounds and their location had been left blank.</p> <p>H. The diet consistency or whether any modifications were required had been left blank. Compliance with diet had been left blank.</p> <p>2. Clinical record number 3 included a start of care comprehensive assessment completed by the physical therapist, employee GG, on 3-21-14. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The assessment identified the patient</p>		<p>with the above policies and procedures the DCS or designee will conduct 4 random clinical record reviews per month to monitor provisions of care, comprehensive assessment and services per physicians orders and coordination of care for 3 months starting week of 4/28/14 and then ongoing as part of the agency quarterly review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and the Regional Vice President.</p>	

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	<p>had been discharged from a skilled nursing facility. The date of discharge had been left blank.</p> <p>B. The primary diagnoses portion of the assessment had been left blank.</p> <p>C. The patient's height and weight had been left blank.</p> <p>D. The presence or absence of a vascular access had been left blank.</p> <p>E. The breath sounds had been left blank.</p> <p>F. The urine odor, color, and clarity had been left blank.</p> <p>G. The gastrointestinal status and bowel status had been left blank.</p> <p>H. The abdominal status and bowel sounds had been left blank.</p> <p>I. The diet consistency and whether any modifications were required had been left blank. Diet compliance had been left blank.</p> <p>3. The supervising nurse was unable to provide any additional documentation and/or information when asked on 4-7-14 at 8:45 AM.</p> <p>4. The agency's undated "Comprehensive Assessment and OASIS Management" policy number 33.106 states, "A standard core data set, the 'Outcome and Assessment Information Set' (OASIS) is used when evaluating adult (18 years and older) non maternity patients who are receiving skilled services. The OASIS is combined with the</p>			

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	history and physical and past medical history to provide a comprehensive assessment of the patient . . . If the referral is made for physical therapy only, then the assessment may be completed by the PT."			