

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K039	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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G000000	<p>This was a revisit survey for the extended Federal recertification survey completed on 7-30-2014. This was an extended survey.</p> <p>Survey date: 9-10-2014</p> <p>Facility: 011480</p> <p>Medicaid Vendor: 200893000</p> <p>Surveyors: Shannon Pietraszewski, RN, PHNS Deborah Franco, RN, PHNS</p> <p>During this survey, one condition and 8 standard level deficiencies were corrected, one condition and 4 standard level deficiencies were recited, and two new standard level deficiencies were cited.</p> <p>The agency is precluded from providing a home health aide training and competency program for a period of 2 years beginning 08/07/14 for being found out of compliance with the Condition of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision.</p>	G000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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G000156	<p>Quality Review: Joyce Elder, MSN, BSN, RN October 1, 2014</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure treatments were provided only as ordered by the physician for 1 of 5 records reviewed of patients receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing services from the agency (See G 158); failed to ensure the physician was notified of the patient's non healing wounds for 1 of 3 records reviewed of patients who were receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing wound care (See G 164); and failed to ensure staff administered drugs and treatments only as ordered by the physician for 1 of 5 records reviewed of patients receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing services from the agency</p>	G000156	The Director of Nurses and Alternate Director of Nurses have educated the staff on the requirement to follow physician ordered plan of care and to notify the physician of record from any deviation from the ordered plan of care. Physician notification is required for any changes in the ordered plan of care and for lack of progress in meeting a stated goal. Regularly schedule meetings with the case managers to ensure their understanding of the necessity of communicating any deviations in the plan of care to the physician, lack of progress toward stated goals also must be communicated to the physician and notification of any changes in the plan of care to obtain a physicians order. Documentation must be concise and detailed, reflect plan of care and if physician notification is necessary this is included in the documentation. Clinical records	10/10/2014

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G000158	<p>(See G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, & Medical Supervision.</p>		<p>have been audited for adherence to the plan of care, physician notification for any deviations or changes in the plan and physician notification regarding lack of progress toward stated goals. Individualized counseling provided to skilled nurse regarding following physician order plan of care, specifically noting wound care and TED hose. 10% of clinical records will be audited quarterly for adherence with the physician ordered plan of care, documentation to support that plan of care is followed and documentation of physician notification for any deviations from ordered plan of care and lack of progress toward stated goals. New hire orientation will include education on following the physician ordered plan of care, physician notification for any deviations from the plan of care and lack of progress toward stated goals. If deficiencies are discovered on clinical record audits, additional education will be provided or immediate corrective action will be taken based on deficiency found. The Director of Nurses will be responsible for monitoring the corrective actions to ensure that this deficiency will not recur.</p>	
	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care</p>			

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	<p>established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure treatments were provided only as ordered by the physician for 1 of 5 records reviewed of patients (# 11) receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing services from the agency.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Clinical record 11, start of care 4-28-12, contained a plan of care for the certification period 8-14 to 10-12-14 with orders for the skilled nurse (SN) to perform wound care to the ulcer on lower left leg, dressing change 3 times weekly; cleanse wounds vigorously with wound cleanser, dry, cover with Mepilex, tape in place and wrap with Kerlix. Measure wounds weekly. 2. SN notes dated 9-8, 9-5, 9-3, 8-29, and 8-27-14 failed to evidence that Mepilex was used for the dressing change, documented telfa was used with the dressing change, documented the use of Mupericin ointment 2% with the dressing change; and documented the 	G000158	<p>Director of Nurses and Alternate Director of Nurses have instructed all staff on the requirement to follow the physician ordered plan of care. Professional staff has been educated on the requirement of following the physician ordered plan of care and documentation must reflect that the plan of care is being followed. Clinical records have been audited for documentation that the physician ordered plan of care is being followed. Individualized counseling provided to skilled nurse regarding following physician order plan of care, specifically noting wound care and TED hose. 10% of clinical records will be audited quarterly for compliance with the ordered plan of care. New hire orientation will include education on the requirement of following the physician ordered plan of care. Deficiencies discovered on clinical record audits will have immediate corrective action taken. The Director of Nurses will be responsible for monitoring corrective action and to ensure that this deficiency does not recur.</p>	10/10/2014

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G000164	<p>application of TED hose to both legs on 8-27-14. Mupericin 2% ointment and TED hose were not included on the plan of care.</p> <p>3. Agency policy "Physician Orders" stated on page 1 "All medication, treatments, and services provided to clients must be ordered by the physician."</p> <p>4. On 9-10-14 at 3:00 PM, the Director of Nursing indicated Mepilex had not been used as ordered on each dressing change and Telfa, Mupericin 2% ointment, and TED hose had been applied without physician order. Mepilex had been ordered for patient's wound care and was available in the home.</p> <p>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 policy review and interview, the agency failed to ensure the physician was notified of the patient's non healing wounds for 1 of 3 records reviewed (# 11) of patients who were receiving skilled nursing wound care with the potential to affect all</p>	G000164	Director of Nurse has educated case managers on the requirement to notify the physician of any changes that may indicate that a change in the plan of care is needed. Regularly scheduled meetings with case managers are being held to educate on the requirement to notify the physician promptly of	10/10/2014

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	<p>patients receiving skilled nursing wound care.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Clinical record 11, start of care date of 4-28-12, included plans of care for the certification periods 8-14 to 10-12-14, 6-15 to 8-13-14, 4-16 to 6-14-14, and 2-15 to 4-15-14 with orders for Skilled Nursing (SN) services for wound care to left lower leg and foot for stasis ulcers. The goals of care included "leg / foot ulcers will heal without complications within cert period." The patient's stasis ulcers had been treated since they developed during the certification period of 2-15 to 4-15-14. 2. SN notes dated 8-14 to 10-12-14, 9-8, 9-5, 9-3, 8-29, and 8-27-14 evidenced the 3 stasis ulcers on the patient's lower left leg and foot remained at the same length, width, and depth. The lower leg was noted to be edematous and the ulcers had serous drainage. The record failed to evidence the physician was notified of the non-healing wounds. 3. At 3:00 PM on 9-10-14, the Director of Nursing indicated agency policy was not followed in this instance because the SN failed to notify the attending physician when the patient failed to show 		<p>any changes in the client that may indicate a change in the plan of care is needed. Charts have been audited to review clients current plan of care to ensure that their condition does not warrant a change in the plan of care as evidence by lack of progress toward goals. 10% of the clinical records will be audited quarterly to ensure that the plan of care is effective for the client's needs and that there is progress toward stated goals. New hire orientation will include education regarding reviewing plan of care to ensure that client's needs are being met and that there is progress toward stated goals. Deficiencies discovered on clinical record audits will have immediate corrective action. The Director of Nurses will be responsible for monitoring corrective actions to ensure this deficiency does not recur.</p>	

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G000165	<p>improvement toward a defined goal in the plan of care. The SN assessments demonstrated the plan of care was not effective in relation to wound care and the attending physician should have been contacted to review/revise the plan of care.</p> <p>4. Agency policy "Plan of Care" stated "#8 Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record review, policy review, and interview, the agency failed to ensure staff administered drugs and treatments only as ordered by the physician for 1 of 5 records reviewed of patients (# 11) receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing services from the agency.</p> <p>Findings included:</p> <p>1. Clinical record 11, start of care 4-28-12, contained a plan of care for the</p>	G000165	<p>Director of Nurses has inserviced skilled nursing staff on the requirement of following the physician ordered plan of care and if the plan of care changes a physician order must be obtained. Documentation must reflect that the physician ordered plan of care is being followed. Clinical records have been audited to ensure that the physician ordered plan of care is being followed. Individualized counseling provided to skilled nurse regarding following physician order plan of care, specifically noting wound care and TED hose. 10% of the</p>	10/10/2014

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	<p>certification period 8-14 to 10-12-14 with orders for the skilled nurse (SN) to perform wound care to the ulcer on lower left leg, dressing change 3 times weekly; cleanse wounds vigorously with wound cleanser, dry, cover with Mepilex, tape in place and wrap with Kerlix. Measure wounds weekly.</p> <p>2. SN notes dated 9-8, 9-5, 9-3, 8-29, and 8-27-14 failed to evidence that Mepilex was used for the dressing change, documented telfa was used with the dressing change, documented the use of Mupericin ointment 2% with the dressing change; and documented the application of TED hose to both legs on 8-27-14. Mupericin 2% ointment and TED hose were not included on the plan of care.</p> <p>3. Undated agency policy "Physician Orders" stated on page 1 "All medication, treatments, and services provided to clients must be ordered by the physician."</p> <p>4. On 9-10-14 at 3:00 PM, the Director of Nursing indicated Mepilex had not been used as ordered on each dressing change and Telfa, Mupericin 2% ointment, and TED hose had been applied without physician order. Mepilex had been ordered for patient's wound care and was available in the home.</p>		<p>clinical records will be audited quarterly for compliance with following the physician ordered plan of care and documentation reflects the ordered plan of care. New hire orientation will include education of the requirement on following the physician ordered plan of care and the documentation requirements to reflect the plan of care is being followed. Education will also include the need to obtain a physician order if the plan of care changes. Deficiencies discovered on clinical record audits will have immediate corrective action. The Director of Nurses will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure skilled nursing services were provided only as ordered by the physician on the plan of care for 1 of 5 records reviewed of patients (# 11) receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing services from the agency.</p> <p>Findings included:</p> <p>1. Clinical record 11, start of care 4-28-12, contained a plan of care for the certification period 8-14 to 10-12-14 with orders for the skilled nurse (SN) to perform wound care to the ulcer on lower left leg, dressing change 3 times weekly; cleanse wounds vigorously with wound cleanser, dry, cover with Mepilex, tape in place and wrap with Kerlix. Measure wounds weekly.</p>	G000170	<p>Director of Nurses has inserviced skilled nursing staff on the requirement of following the physician ordered plan of care and if the plan of care changes a physician order must be obtained. Documentation must reflect that the physician ordered plan of care is being followed. Clinical records have been audited to ensure that the physician ordered plan of care is being followed. Individualized counseling provided to skilled nurse regarding following physician order plan of care, specifically noting wound care and TED hose. 10% of the clinical records will be audited quarterly for compliance with following the physician ordered plan of care and documentation reflects the ordered plan of care. New hire orientation will include education of the requirement on following the physician ordered plan of care and the documentation requirements to reflect the plan of care is being followed. Education will also</p>	10/10/2014

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G000225	<p>2. SN notes dated 9-8, 9-5, 9-3, 8-29, and 8-27-14 failed to evidence that Mepilex was used for the dressing change, documented telfa was used with the dressing change, documented the use of Mupericin ointment 2% with the dressing change; and documented the application of TED hose to both legs on 8-27-14. Mupericin 2% ointment and TED hose were not included on the plan of care.</p> <p>3. Undated agency policy "Physician Orders" stated on page 1 "All medication, treatments, and services provided to clients must be ordered by the physician."</p> <p>4. On 9-10-14 at 3:00 PM, the Director of Nursing indicated Mepilex had not been used as ordered on each dressing change and Telfa, Mupericin 2% ointment, and TED hose had been applied without physician order. Mepilex had been ordered for patient's wound care and was available in the home.</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of</p>		include the need to obtain a physician order if the plan of care changes. Deficiencies discovered on clinical record audits will have immediate corrective action. The Director of Nurses will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.	

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	<p>care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Home Health Aide provided services ordered by the physician in the plan of care for 1 of 3 records reviewed of patients (#11) receiving Home Health Aide services with the potential to affect all patients receiving Home Health Aide services from the agency.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Clinical record 11, start of care date 4-28-12, contained a plan of care for the certification period 8-14 to 10-12-14 with orders for the Home Health Aide (HHA) to "Remind client to check BS [blood sugars]. To provide assistance with bathing (shower), dressing, grooming, hair care prn [as needed], shampoo prn, nail/foot care prn, assist with oral hygiene, peri care, PROM [passive range of motion] to lower extremities, reposition in bed every 2 hours, keep side rails up as needed. Assist with transfers to help prevent falls. Empty drainage bag and bedside commode as need. Light housekeeping duties, laundry [client will instruct]. Change linen weekly and prn. Assist with meal prep/serve prn." The HHA visit notes dated 9-5, 9-3, 	G000225	<p>The Director of Nurses has educated all home health aide staff regarding the requirement to follow the care as outlined on the plan of care. All home health aide visit records have been audited to ensure that the plan of care is being followed. Case managers have been instructed to review plan of care at least every 60 days and as needed to ensure the plan of care is appropriate for the client and updates to the plan of care are done based on any necessary changes. Clinical records audited for compliance with plan of care to ensure documentation reflects the plan of care. 10% of clinical records will be audited quarterly for compliance with physician ordered plan of care and to ensure documentation reflects the plan of care is being followed as written. Orientation includes education on the requirement of following the physician ordered plan of care, assignment sheet and the documentation requirements to reflect that the plan of care is being followed. Deficiencies discovered on clinical record audits will have immediate corrective action. The Director of Nurses will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	10/10/2014

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N000000	<p>9-1, 8-29, 8027, and 8-25-14 failed to evidence the HHA had reminded the client to check blood sugar as per plan of care.</p> <p>3. On 9-10-14 at 3:00 PM, the Director of Musing indicated the HHA had not followed agency policy and should have documented reminders to patient to check blood sugar on the HHA visit form with each visit.</p> <p>4. An undated policy titled "Medical Supervision" stated, "A physician Plan of Care is developed for each client at the time of admission and signed by the physician within an appropriate time frame. The physician orders shall outline the disciplines providing care and the type, frequency, and duration of services to be provided ... "</p> <p>This was a revisit for the State re-licensure survey completed on 7-30-2014.</p> <p>Survey Date: 9-10-2014</p>	N000000		

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N000522	<p>Facility #: 011480</p> <p>Medicaid Vendor #: 200893000</p> <p>Surveyors: Shannon Pietraszewski, RN, PHNS Deborah Franco, RN, PHNS</p> <p>During this survey, 6 deficiencies were corrected, one new deficiency was cited, and 2 deficiencies were recited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 1, 2014</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure treatments were provided only as ordered by the physician for 1 of 5 records reviewed of patients (# 11)</p>	N000522	Director of Nurses and Alternate Director of Nurses have instructed all staff on the requirement to follow the physician ordered plan of care. Professional staff has been	10/10/2014

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NAME OF PROVIDER OR SUPPLIER LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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	<p>receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing services from the agency.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Clinical record 11, start of care 4-28-12, contained a plan of care for the certification period 8-14 to 10-12-14 with orders for the skilled nurse (SN) to perform wound care to the ulcer on lower left leg, dressing change 3 times weekly; cleanse wounds vigorously with wound cleanser, dry, cover with Mepilex, tape in place and wrap with Kerlix. Measure wounds weekly. SN notes dated 9-8, 9-5, 9-3, 8-29, and 8-27-14 failed to evidence that Mepilex was used for the dressing change, documented telfa was used with the dressing change, documented the use of Mupericin ointment 2% with the dressing change; and documented the application of TED hose to both legs on 8-27-14. Mupericin 2% ointment and TED hose were not included on the plan of care. Undated agency policy "Physician Orders" stated on page 1 "All medication, treatments, and services provided to clients must be ordered by the physician." 		<p>educated on the requirement of following the physician ordered plan of care and documentation must reflect that the plan of care is being followed. Clinical records have been audited for adherence to the physician ordered plan of care. Individualized counseling provided to skilled nurse regarding following physician order plan of care, specifically noting wound care and TED hose. 10% of clinical records will be audited quarterly for adherence to the physician ordered plan of care. New hire orientation will include education on the requirement of following the physician ordered plan of care. Deficiencies discovered on clinical record audits will have immediate corrective action taken. The Director of Nurses will be responsible for monitoring corrective action and to ensure that this deficiency does not recur.</p>	

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N000527	<p>4. On 9-10-14 at 3:00 PM, the Director of Nursing indicated Mepilex had not been used as ordered on each dressing change and Telfa, Mupericin 2% ointment, and TED hose had been applied without physician order. Mepilex had been ordered for patient's wound care and was available in the home.</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the physician was notified of the patient's non healing wounds for 1 of 3 records reviewed (# 11) of patients who were receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing wound care.</p> <p>Findings included:</p> <p>1. Clinical record 11, start of care date of 4-28-12, included plans of care for the</p>	N000527	Director of Nurse has educated case managers on the requirement to notify the physician of any changes that may indicate that a change in the plan of care is needed. Regularly scheduled meetings with case managers are being held to educate on the requirement to notify the physician promptly of any changes in the client that may indicate a change in the plan of care is needed. Charts have been audited to review clients current plan of care to ensure that their condition does not warrant a change in the plan of care as evidence by lack of progress toward goals. 10% of the clinical	10/10/2014

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	<p>certification periods 8-14 to 10-12-14, 6-15 to 8-13-14, 4-16 to 6-14-14, and 2-15 to 4-15-14 with orders for Skilled Nursing (SN) services for wound care to left lower leg and foot for stasis ulcers. The goals of care included "leg / foot ulcers will heal without complications within cert period." The patient's stasis ulcers had been treated since they developed during the certification period of 2-15 to 4-15-14.</p> <p>2. SN notes dated 8-14 to 10-12-14, 9-8, 9-5, 9-3, 8-29, and 8-27-14 evidenced the 3 stasis ulcers on the patient's lower left leg and foot remained at the same length, width, and depth. The lower leg was noted to be edematous and the ulcers had serous drainage. The record failed to evidence the physician was notified of the non-healing wounds.</p> <p>3. At 3:00 PM on 9-10-14, the Director of Nursing indicated agency policy was not followed in this instance because the SN failed to notify the attending physician when the patient failed to show improvement toward a defined goal in the plan of care. The SN assessments demonstrated the plan of care was not effective in relation to wound care and the attending physician should have been contacted to review/revise the plan of care.</p>		<p>records will be audited quarterly to ensure that the plan of care is effective for the client's needs and that there is progress toward stated goals. New hire orientation will include education regarding reviewing plan of care to ensure that client's needs are being met and that there is progress toward stated goals. Deficiencies discovered on clinical record audits will have immediate corrective action. The Director of Nurses will be responsible for monitoring corrective actions to ensure this deficiency does not recur.</p>	

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N000537	<p>4. Agency policy "Plan of Care" stated "#8 Professional staff shall promptly alert the physician to any changes 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: Based on clinical record review, policy review, and interview, the agency failed to ensure nursing services were provided only as ordered by the physician on the plan of care for 1 of 5 records reviewed of patients (# 11) receiving skilled nursing wound care with the potential to affect all patients receiving skilled nursing services from the agency.</p> <p>Findings included:</p> <p>1. Clinical record 11, start of care 4-28-12, contained a plan of care for the certification period 8-14 to 10-12-14 with orders for the skilled nurse (SN) to perform wound care to the ulcer on lower left leg, dressing change 3 times weekly; cleanse wounds vigorously with wound cleanser, dry, cover with Mepilex, tape in place and wrap with Kerlix. Measure wounds weekly.</p>	N000537	Director of Nurses has inserviced skilled nursing staff on the requirement of following the physician ordered plan of care and if the plan of care changes a physician order must be obtained. Documentation must reflect that the physician ordered plan of care is being followed. Clinical records have been audited to ensure that the physician ordered plan of care is being followed. Individualized counseling provided to skilled nurse regarding following physician order plan of care, specifically noting wound care and TED hose. 10% of the clinical records will be audited quarterly for compliance with following the physician ordered plan of care and documentation reflects the ordered plan of care. New hire orientation will include education of the requirement on following the physician ordered plan of care and the documentation requirements to reflect the plan of care is being followed. Education	10/10/2014

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	<p>2. SN notes dated 9-8, 9-5, 9-3, 8-29, and 8-27-14 failed to evidence that Mepilex was used for the dressing change, documented telfa was used with the dressing change, documented the use of Mupericin ointment 2% with the dressing change; and documented the application of TED hose to both legs on 8-27-14. Mupericin 2% ointment and TED hose were not included on the plan of care.</p> <p>3. Undated agency policy "Physician Orders" stated on page 1 "All medication, treatments, and services provided to clients must be ordered by the physician."</p> <p>4. On 9-10-14 at 3:00 PM, the Director of Nursing indicated Mepilex had not been used as ordered on each dressing change and Telfa, Mupericin 2% ointment, and TED hose had been applied without physician order. Mepilex had been ordered for patient's wound care and was available in the home.</p>		will also include the need to obtain a physician order if the plan of care changes. Deficiencies discovered on clinical record audits will have immediate corrective action. The Director of Nurses will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.				