STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157276	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEDIATRIC NURSING SPECIALISTS OF INDIANA	4900 SHAMROCK DR STE 201 EVANSVILLE, IN 47715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This was a federal home health recertification survey. This was a partial extended survey. Facility #: 005942 Survey Dates: 10-23-12, 10-24-12, 10-25-12, and 10-26-12. Medicaid Vendor #: 200852870C Surveyor: Vicki Harmon, RN, PHNS Agency Census: 22 skilled patients 0 home health aide only 0 personal services Quality Review: Joyce Elder, MSN, BSN, RN November 1, 2012	G0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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G0108	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed in advance of the disciplines that would furnish care and the proposed frequency of visits in 9 (#s 1, 2, 3, 4, 5, 6, 7, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency. The findings include: 1. Clinical record number 1 evidenced a start of care (SOC) date of 10-3-12 and that the physician had ordered skilled nurse (SN) services 1 time per week for 4 weeks during the certification period 10-3-12 to 12-1-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits.	G0108	The Administrator/Director of Nursing (Admin/DON) will educate the nursing staff responsible for admitting patients for Private Duty Nursing (PDN) and Skilled Nursing Visits (SNV) that written documentation of disciplines furnishing care and frequency of visits must be documented in the nurses notes and client handbook on admission and as changes occur. 10% of all active clinical records will be audited quarterly for evidence that admission nurses notes are in compliance and clients handbooks will be viewed with supervisory visits to assure compliance. Admin/DON and Case Managers will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/26/2012

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	2. Clinical record number 2 evidenced a SOC date of 10-11-12 and that the physician had ordered SN services 1 time per week during the certification period 10-11-12 to 12-9-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 3. Clinical record number 3 evidenced a SOC date of 4-16-12 and that the physician had ordered SN services 1 to 5 days a week during the certification period 4-16-12 to 6-14-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 4. Clinical record number 4 evidenced a SOC date of 7-10-12 and that the physician had ordered SN services 1 to 5 times per week for 9 weeks during the certification period 7-10-12 to 9-7-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 5. Clinical record number 5 evidenced a SOC date of 9-29-11 and that the physician had ordered SN services 1 to 7 times per week for 9 weeks during the certification period 9-29-11 to 11-28-11. The record failed to evidence the patient			

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	had been informed of the services to be provided and the proposed frequency of visits. 6. Clinical record number 6 evidenced a SOC date of 4-10-12 and that the physician had ordered SN services 1 to 5 days per week for 60 days during the certification period 4-10-12 to -9-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 7. Clinical record number 7 evidenced a SOC date of 10-24-11 and that the physician had ordered SN services 1 to 5 days per week for 60 days during the certification period 10-24-11 to 12-22-11. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 8. Clinical record number 8 evidenced a SOC date of 10-13-11 and that the physician had ordered SN services 1 to 7 days per week for 60 days during the certification period 10-13-11 to 12-12-11. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits.			

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	9. Clinical record number 9 evidenced a SOC date of 9-6-12 and that the physician had ordered SN services 1 to 3 days per week for 57 days during the certification period 9-6-12 to 11-4-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 10. The administrator, employee A, stated, on 10-24-12 at 10:10 AM, "I usually put that I told the patient the disciplines and frequency in my notes." The administrator was unable to provide any additional documentation and/or information when asked on 10-24-12 at 10:10 AM and on 10-26-12 at 11:10 AM. 11. The agency's 10-30-09 "Home Care Bill of Rights / Grievance Procedure-Indiana" policy number CI-380 states, "A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Rill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated." The agency's "Patient / Client Bill of Rights-Indiana" states, "To be notified in writing what discipline(s) will furnish care and the frequency of visits proposed to be furnished, prior to the start of care."			

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G0121	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 furnishing services in an HHA. Based on agency policy review, observation, and interview, the agency failed to ensure services had been provided in accordance with the agency's own infection control policies and procedures and the Centers for Disease Control (CDC) Standard Precautions in 2 (#s 1 and 3) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among patients and staff. The findings include: 1. The agency's February 2012 "OSHA Infection Control/Exposure Control Plan" policy number B-405 states, "Client infection control procedures shall include, but not be limited to: Wearing and changing gloves as necessary during the delivery of client care . . . Frequent hand washing by home health employees: Before and after the provision of direct client care . . . After removing gloves . . . All materials related to OSHA regulations and all agency infection control activities shall be incorporated into an infection control plan which includes: . . . Standard	G0121	Admin/DON will reinservice all nursing staff on Home Health Agency Infection Control Policy and Center for Disease Control Standard Precautions. Admin/DON and Case Managers will observe direct patient care when performing supervisory visits and recertifications every 60 days for adherence to the policies and standards while performing patient care. The Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. 3. Nurse E will be educated individually by the Admin/DON on proper bag technique and infection control policies including but not limited to handwashing and cleaning of equipment. 4 Nurse D will be individually educated on infection control policies and "use of barriers" including but not limited to bag technique and proper use of barriers.	11/26/2012

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	precautions procedures." 2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies 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			

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	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. 3. On 10-23-12 at 11:05 AM, a home visit was made to patient number 1 with employee E, a registered nurse (RN). The RN placed her stethoscope and blood pressure machine on a table and prepared for the visit. The RN picked up the stethoscope and placed it around her neck potentially carrying organisms from the table to her clothing. The RN measured the patient's temperature, pulse, and respirations, then removed the stethoscope from around her neck and listed to the patient's apical pulse and lung sounds. The RN placed the equipment back onto the table. The RN then checked the patient's tibial pulse and then the radial pulse. The RN then cleansed her hands and charted the results on a visit note. Upon completion of the visit the RN was observed to gather the equipment used during the visit and hold it against her body potentially contaminating her clothing with organisms from the table.			

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	The RN walked to her car, opened the back and placed the used equipment in the car potentially contaminating her car with organisms from the patient's home. The RN cleaned the equipment while standing at the back of her car. 4. On 10-24-12 at 3:25 PM, a home visit was made to patient number 3 with employee D, a licensed practical nurse (LPN). The LPN was observed to perform an in and out catheterization on the patient. The LPN washed her hands and gathered the supplies needed to perform the procedure from a cabinet in the patient's bathroom The LPN placed the packaged sterile catheter on the bathroom floor, without a barrier, and partially opened the package. The LPN placed the sterile catheterization kit on the bathroom floor without a barrier. The LPN then donned sterile gloves without cleansing her hands. A. The agency's undated "Catheterization-Straight Cath Procedure" number SN-303 states, "Place protective barrier on clean surface. Assemble equipment and place on protective barrier." B. The LPN completed the in and out catheterization and then removed her gloves. The LPN gathered the trash and			

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	was not observed to cleanse her hands. C. The agency's undated "Catheterization-Straight Cath Procedure" number SN-303 states, "Discard equipment. Remove gloves. Wash hands with antibacterial soap." 5. The above-stated observations were discussed with the administrator, employee A, on 10-25-12 at 11:40 AM. The administrator, employee A, verbalized understanding of the concerns.			

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G0129	484.14(b) GOVERNING BODY The governing body appoints a qualified administrator. Based on administrative record and Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure the current administrator had been appointed by the governing body creating the potential to affect all of the agency's 22 current patients. The findings include: 1. On 10-26-12, the administrator, employee A, indicated, on the Centers for Medicare and Medicaid Services (CMS) form 1572 and the "Division of Acute Care Indiana State Department of Health Home Health Agencies Report" form, she was the agency's administrator. 2. Employee A identified herself as the agency's administrator during the entrance conference held on 10-23-12 at 9:10 AM. 3. ISDH documents dated 10-22-12 identified employee A as the agency's administrator. 4. The agency's Board of Director meeting minutes dated 2-13-12, identified the board had appointed employee H the agency's administrator.	G0129	The Admin/DON was provided with Board of Director's Meeting Minutes on 10/25/12 reflecting that Employee A is the Admin of the Evansville office.	10/26/2012

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	5. The administrator, employee A, indicated, on 10-26-12 at 11:05 AM, the February 2012 Board of Director meeting minutes were not the most recent ones and that there were meeting minutes that identified the Board had appointed her administrator of the agency. The administrator was unable to provide any additional documentation and/or information when asked about updated Board of Directors meeting minutes when asked on 10-26-12 at 11:35 AM.			

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G0158	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. Based on clinical record review and interview, the agency failed to ensure medications and treatments had been provided in accordance with the written plan of care in 7 (#s 2, 3, 4, 5, 6, 7, and 8) of 10 records reviewed creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 10-11-12 to 12-9-12. The plan of care states, "Assess blood sugar, blood sugar log and diabetic status." The start of care comprehensive assessment dated 10-11-12 and a skilled nurse visit note dated 10-18-12 failed to evidence the registered nurse had assessed the patient's blood sugar, blood sugar log, or diabetic status. 2. Clinical record number 3 included plans of care established by the physician for the certification periods 8-14-12 to	G0158	Admin/DON will educate field staff on sending a copy of the client's Medication Administration Records(MARS) and Treatment Administration Records (TARS) to the office to be placed in the client's chart every week. Admin/DON will further educate field staff to indicate with an "F" = family in the legend box on the MARS/TARS and mark appropriate box with an "F" when the family has given the medication. Admin/DON and Case Managers will incorporate into the POC who is responsible for the medications and treatments when the nurse is not in the home. If treatments/medications are only done by family, this will be included in POC. !0% of all active clinical records will be audited quarterly for evidence that the written Plan of Care (POC) signed by the physician is being documented accordingly. The Admin/DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 1. -3. Admin/Don will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to	11/26/2012

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	10-12-12 and 10-13-12 to 12-11-12. The plans of care state, "Bowel program: Administer soap suds enema every other day per orders." A. The "Medication / Treatment Record" (received on 10-26-12 at 9:10 AM) failed to evidence the soap suds enema had been administered every other day per the physician's order. B. Employee D, a licensed practical nurse, stated, on 10-24-12 at 3:25 PM, "The family does the enema every other evening." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 9-8-12 to 11-6-12 that states, "Gastric feedings: . . . Change extension tubing weekly . . . Change trach 2x month." A. The "Medication / Treatment Record" for September 2012 failed to evidence the trach had been changed at any time during the month. B. The September 2012 record failed to evidence the gastric feeding extension tubing had been changed at any time during the month. 4. Clinical record number 5 included a		document when/if family/caregiver administers treatments/medications. 4.-5. Admin/DON will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to document when/if family /caregiver administers treatments. 6. Admin/DON has educated the staff via the HHA policy on Missed Visits and importance of timely notification of physician and completion of missed visit f7. Admin/DON will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to document when/if family /caregiver administers treatments. 7. Admin/DON will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to document when/if family /caregiver administers treatments.	

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	plan of care established by the physician for the certification period 9-23-12 to 11-21-12 that states, "Change feeding extension tube twice per week. Change feeding bag daily." A. The "Medication / Treatment Record" for September 2012 evidenced the tubing had been changed only once per week during the month on 9-6-12, 9-10-12, 9-17-12, and 9-24-12. B. The "Medication / Treatment Record" for October 2012 (received on 10-26-12 at 9:10 AM) evidenced the tubing had been changed only once per week during the month, on 10-8-12, 10-14-12, 10-22-12, and 10-26-12. 5. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12. The plan of care states, "Transderm-Scop 1.5 MG (1 Packet) Transdermal Every 72 Hours." The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:00 AM) failed to evidence the medication had ever been administered. 6. Clinical record number 7 included a plan of care established by the physician for the certification period 8-19-12 to			

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NAME OF PROVIDER OR SUPPLIER PEDIATRIC NURSING SPECIALISTS OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 SHAMROCK DR STE 201 EVANSVILLE, IN 47715	

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	10-17-12 that identified skilled nurse services were to be provided 1 to 5 days per week. The record failed to evidence any skilled nurse visits had been provided the week of 9-30-12. 7. Clinical record number 8 included plans of care established by the physician for the certification periods 8-8-12 to 10-6-12 and 10-7-12 to 12-5-12. The plans of care state, "Change J-tube extension weekly and as needed for leaking." A. The "Medication / Treatment Record" for September 2012 failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 9-3-12 and 9-23-12. B. The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:10 AM) failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 10-8-12 and 10-21-12. 8. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-25-12 at 10:10 AM and on 10-26-12 at 11:10 AM regarding the			

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	above-stated findings.			

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G0159	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. Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included specific treatment orders in 3 (#s 6, 9, and 10) of 10 records reviewed. The findings include: 1. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12. The plan of care states, "Maintain bowel protocol per Dr's order and assess." The plan failed to include the specifics of the bowel protocol to be followed; i.e., what medications and/or enemas to be used, how often to use them, etc. 2. Clinical record number 9 included a plan of care established by the physician for the certification period 9-6-12 to 11-4-12. The plan of care states,	G0159	Admin/DON will educate and will continue to reinforce education to nursing staff that POC will cover all pertinent information related to the patient and care being performed. Also instructed staff in importance of following POC. 10% of all active clinical records will be audited quarterly for evidence that the POC is accurate and pertinent to patient and is reflected in the documentation. The Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. 1. Admin/DON will obtain an order for clarification of the bowel protocol 2. Admin/DON will obtain an order for wound care stating all the parameters necessary for appropriate wound care delivery to the primary care physician. Nursing staff performing skilled nursing visits will be educated and provided with updates to the plan of care. 3. A request for clarification will be sent to the	11/26/2012

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	"Instruct/perform dressing change, wound care as ordered. Wound Location coccyx: Wound care order: Turn off wound vac. Remove old dressing, clean wound with wound wash and reapply wound vac; Wound care to be done 3X/ [three times per] week." The order failed to address the type of foam to be used, the suction pressure to be maintained in millimeters of mercury, the therapy settings (continuous or intermittent suction), or if any adjunct dressings were to be used. 3. Clinical record number 10 included an interim physician's order dated 9-5-12. The order states, "Silvadene Cream: Apply small amount to burn area bid [twice a day] until healed." The order failed to specify the anatomical location of the burn area. 4. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-26-12 at 11:10 AM. 5. The agency's July 2012 "Plan of Care" policy number C-580 states, "The Plan of Care shall be completed in full to include: . . . Medications, treatments, or procedures."		physician by the Admin/DON. Nursing staff providing skilled visits were educated to assure clear concise orders are received when obtaining orders for wound care.	

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G0170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and interview, the agency failed to ensure the skilled nurse had provided medications and treatments in accordance with the written plan of care in 7 (#s 2, 3, 4, 5, 6, 7, and 8) of 10 records reviewed creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 10-11-12 to 12-9-12. The plan of care states, "Assess blood sugar, blood sugar log and diabetic status." The start of care comprehensive assessment dated 10-11-12 and a skilled nurse visit note dated 10-18-12 failed to evidence the registered nurse had assessed the patient's blood sugar, blood sugar log, or diabetic status. 2. Clinical record number 3 included plans of care established by the physician for the certification periods 8-14-12 to 10-12-12 and 10-13-12 to 12-11-12. The plans of care state, "Bowel program: Administer soap suds enema every other	G0170	Admin/DON will educate field staff on sending a copy of the client's Medication Administration Records(MARS) and Treatment Administration Records (TARS) to the office to be placed in the client's chart every week. Admin/DON will further educate field staff to indicate with an "F" = family in the legend box on the MARS/TARS and mark appropriate box with an "F" when the family has given the medication. Admin/DON and Case Managers will incorporate into the POC who is responsible for the medications and treatments when the nurse is not in the home.	11/26/2012

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	day per orders." A. The "Medication / Treatment Record" (received on 10-26-12 at 9:10 AM) failed to evidence the soap suds enema had been administered every other day per the physician's order. B. Employee D, a licensed practical nurse, stated, on 10-24-12 at 3:25 PM, "The family does the enema every other evening." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 9-8-12 to 11-6-12 that states, "Gastric feedings: . . . Change extension tubing weekly . . . Change trach 2x month." A. The "Medication / Treatment Record" for September 2012 failed to evidence the trach had been changed at any time during the month. B. The September 2012 record failed to evidence the gastric feeding extension tubing had been changed at any time during the month. 4. Clinical record number 5 included a plan of care established by the physician for the certification period 9-23-12 to 11-21-12 that states, "Change feeding			

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	extension tube twice per week. Change feeding bag daily." A. The "Medication / Treatment Record" for September 2012 evidenced the tubing had been changed only once per week during the month on 9-6-12, 9-10-12, 9-17-12, and 9-24-12. B. The "Medication / Treatment Record" for October 2012 (received on 10-26-12 at 9:10 AM) evidenced the tubing had been changed only once per week during the month, on 10-8-12, 10-14-12, 10-22-12, and 10-26-12. 5. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12. The plan of care states, "Transderm-Scop 1.5 MG (1 Packet) Transdermal Every 72 Hours." The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:00 AM) failed to evidence the medication had ever been administered. 6. Clinical record number 7 included a plan of care established by the physician for the certification period 8-19-12 to 10-17-12 that identified skilled nurse services were to be provided 1 to 5 days per week.			

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	The record failed to evidence any skilled nurse visits had been provided the week of 9-30-12. 7. Clinical record number 8 included plans of care established by the physician for the certification periods 8-8-12 to 10-6-12 and 10-7-12 to 12-5-12. The plans of care state, "Change J-tube extension weekly and as needed for leaking." A. The "Medication / Treatment Record" for September 2012 failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 9-3-12 and 9-23-12. B. The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:10 AM) failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 10-8-12 and 10-21-12. 8. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-25-12 at 10:10 AM and on 10-26-12 at 11:10 AM regarding the above-stated findings.			

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G0175	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review and interview, the registered nurse (RN) had initiated nursing measures to monitor a patient's health status in 1 (# 1) of 10 records reviewed creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Clinical record number 1 included a plan of care established by the physician for the certification period 10-3-12 to 12-1-12 with a start of care date of 10-3-12 and diagnoses of coronary artery disease, hypertension, and atrial fibrillation. A. The plan included orders for skilled nurse (SN) services 1 time per week for 4 weeks. The plan identified the skilled nurse was to "assess fluid retention." B. The record included a start of care comprehensive assessment completed by the RN, employee A, on 10-3-12 that included a measurement of the patient's weight, identified the patient had increased shortness of breath since	G0175	The Admin/DON will educate the nursing staff that the skilled nursing services provided to the patient must be in accordance with the POC and thoroughly documented. (See also G158 & 159) 10% of all active clinical records will be audited quarterly for evidence that the POC is being followed. The Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/26/2012

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	returning home from the hospital, had hypertension (high blood pressure), and had "Edema Pitting." The assessment failed to identify the location and character of the pitting edema. C. The record evidenced the RN had provided care to the patient on 10-9-12, 10-18-12, and 10-23-12. The SN visit notes failed to evidence the RN had weighed the patient to assess for fluid retention. 2. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-25-12 at 10:10 AM and on 10-26-12 at 11:10 AM regarding the above-stated findings.			

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G0176	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. Based on clinical record review and interview, the registered nurse (RN) failed to coordinate services with other providers in 2 (#s 5 & 6) of 10 records reviewed creating the potential to affect all of the agency's patients receiving services from other providers. The findings include: 1. Clinical record number 5 included a skilled nurse visit note dated 10-11-12 that states, "Therapy started at 1130 . . . was placed in stander for therapy." The record failed to evidence the registered nurse had coordinated with the therapy provider regarding what therapy treatment was to be administered by the nurse, for how long, and how many days per week the therapy treatment was to occur. 2. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12 that identified diagnoses of quadriplegia and neurogenic bladder. The plan of care states, "Maintain bowel protocol per Dr's order and assess."	G0176	The Admin/DON will inservice the nursing staff on thorough documentation of coordination of services between all entities involved with the client. 10% of all active clinical records will be audited quarterly for evidence that coordination of care has been thoroughly documented in the nursing progress notes. Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. 1.-2. Admin/DON will further instruct nursing staff on importance of coordination of patient care with therapy services the patient is receiving as well as thorough documentation of follow-up including notifying the DON of any problems or concerns.	11/26/2012

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	A. The record included a skilled nurse (SN) visit note completed by employee F, a RN, on 10-3-12. The note states, "[Parent] arrives home & states was unable to fill enema prescription due to MCD [Medicaid] refusing to cover med now. (MCD had previously covered it). Enemas [without] MCD cost approx seventy dollars & [parent] states is unable to pay for it. Will inform MD in am." B. A SN visit note completed by employee F on 10-4-12 evidenced the nurse had called and informed the physician the patient's parent was unable to afford the currently prescribed enema. The note states, "No new orders received." C. A SN visit note completed by employee F on 10-5-12 failed to evidence any mention of the problem with obtaining the prescribed enema. D. A SN visit note completed by employee F on 10-10-12 evidenced the RN called the physician's office again with the same information and that "no orders received at this time." E. A SN visit note completed by employee F on 10-11-12 failed to evidence any mention of the problem with			

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	obtaining the prescribed enema. F. A SN visit note completed by employee F on 10-12-12 states, "No BM [bowel movement] this AM [after] glycerin supp [suppository] last night. Sm [small] BM on 10-10-12 & sm BM on 10-11-12 . . . [Parent] states no return call from MD yet regarding unfilled Docusate Na enemas." G. The record failed to evidence any further communication and/or follow-up by the RN regarding the patient's status. 3. The administrator, employee A, was unable to provide any additional documentation and/or information regarding clinical record number 6 when asked on 10-26-12 at 11:10 AM.			

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G0339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT 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. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments had been revised and updated the last five (5) days of every 60 days in 4 (#s 3, 4, 7, and 8) of 6 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Clinical record number 3 evidenced a start of care (SOC) date of 4-16-12. The record evidenced the comprehensive assessment had been updated on 8-8-12, 1 day prior to the last 5 days of the 6-15-12 to 8-13-12 recertification period. The record failed to evidence a new plan of care that corresponded to the comprehensive assessment that was not completed in the 5-day window.	G0339	When pediatric patient reassessments are done before day 55 of the current certification period for the purpose of recertification, the tracking mechanisms in place will be strengthened to assure that no more than 60 days elapses between comprehensive assessments for recertification. The tracking process will be monitored by the Director of Nursing (DON). Office staff and RN Case Managers will be inserviced by the DON regarding the need to assure that the pediatric comprehensive assessments, that are done earlier than day 55-60 of the current certification for recertification, are done no less frequently than every 60 days from the prior assessment date. The DON will audit 10% of the active pediatric charts quarterly to assure compliance. All clients receiving adult skilled services will continue to have OASIS comprehensive assessments done in the 5 day window (day	11/26/2012

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	2. Clinical record number 4 evidenced a SOC date of 7-10-12. The record evidenced the comprehensive assessment had been updated on 8-29-12, 5 days prior to the last 5 days of the 7-10-12 to 9-7-12 certification period. The record failed to evidence a new plan of care that corresponded to the comprehensive assessment that was not completed in the 5-day window. 3. Clinical record number 7 evidenced a SOC date of 10-24-11. The record evidenced the comprehensive assessment had been updated on 8-13-12, 3 days prior to the last 5 days of the 6-22-12 to 8-20-12 recertification period. The record failed to evidence a new plan of care that corresponded to the comprehensive assessment that was not completed in the 5-day window. 4. Clinical record number 8 evidenced a SOC date of 10-13-11. The record evidenced the comprehensive assessment had been updated on 10-1-12, 1 day prior to the last 5 days of the 8-8-12 to 10-6-12 recertification period. The record failed to evidence a new plan of care that corresponded to the comprehensive assessment that was not completed in the 5-day window. 5. The administrator was unable to		55-60 of the current cert period) for recertification as directed by CMS in the State Operations Manual. (See Attachment #2) There is no way to correct the history on client #3. The client is receiving skilled pediatric services. The next pediatric comprehensive assessment will be completed no more that 60 days from the previous assessment (which was done 10/9/12) as permitted by CMS. (see attachment #1 & #2.)2. There is no way to correct the history on record #4. The client is receiving skilled pediatric services. The next pediatric comprehensive assessment will be completed no more that 60 days from the previous assessment (which was done 11/5/12) as permitted by CMS. (see attachment #1 & #2.)3. There is no way to correct the history on record #7. The client is receiving skilled pediatric services. The next pediatric comprehensive assessment will be completed no more that 60 days from the previous assessment (which was done 10/16/12) as permitted by CMS. (see attachment #1 & #2.)4. There is no way to correct the history on record #8. The client is receiving skilled pediatric services. The next pediatric comprehensive assessment will be completed no more that 60 days from the previous assessment (which was done	

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	provide any additional documentation and/or information when asked on 10-25-12 at 10:10 AM and on 10-26-12 at 11:10 AM regarding the above-stated findings. 6. The agency's June 2012 "Comprehensive Client Assessment" policy number C-145 policy states, "Reassessments are conducted based on client needs, physician orders, professional judgement and/or OASIS or other regulatory requirements, and for any changes indicated in the plan of care."		10/1/12) as permitted by CMS. (see attachment #1 & #2.) When pediatric patient reassessments are done before day 55 of the current certification period for the purpose of recertification, the tracking mechanisms in place will be strengthened to assure that no more than 60 days elapses between comprehensive assessments for recertification. The tracking process will be monitored by the Director of Nursing (DON). Office staff and RN Case Managers will be inserviced by the DON regarding the need to assure that the pediatric comprehensive assessments, that are done earlier than day 55-60 of the current certification for recertification, are done no less frequently than every 60 days from the prior assessment date.The DON will audit 100% of the active pediatric charts quarterly to assure compliance. All clients receiving adult skilled services will continue to have OASIS comprehensive assessments done in the 5 day window (day 55-60 of the current cert period) for recertification as directed by CMS in the State Operations Manual. (See Attachment #2)	

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N0000	This was a state home health re-licensure survey. Facility #: 005942 Survey Dates: 10-23-12, 10-24-12, 10-25-12, and 10-26-12. Medicaid Vendor #: 200852870C Surveyor: Vicki Harmon, RN, PHNS Agency Census: 22 skilled patients 0 home health aide only 0 personal services Quality Review: Joyce Elder, MSN, BSN, RN November 1, 2012	N0000		

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N0442	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on administrative record and Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure the current administrator had been appointed by the governing body creating the potential to affect all of the agency's 22 current patients. The findings include: 1. On 10-26-12, the administrator, employee A, indicated, on the Centers for Medicare and Medicaid Services (CMS) form 1572 and the "Division of Acute Care Indiana State Department of Health Home Health Agencies Report" form, she was the agency's administrator. 2. Employee A identified herself as the agency's administrator during the entrance conference held on 10-23-12 at 9:10 AM.	N0442	Admin/DON Board of Director meeting minutes have been placed in the policy book in the office.	10/26/2012

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	3. ISDH documents dated 10-22-12 identified employee A as the agency's administrator. 4. The agency's Board of Director meeting minutes dated 2-13-12, identified the board had appointed employee H the agency's administrator. 5. The administrator, employee A, indicated, on 10-26-12 at 11:05 AM, the February 2012 Board of Director meeting minutes were not the most recent ones and that there were meeting minutes that identified the Board had appointed her administrator of the agency. The administrator was unable to provide any additional documentation and/or information when asked about updated Board of Directors meeting minutes when asked on 10-26-12 at 11:35 AM.			

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N0460	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.			
	Based on personnel file review and interview, the agency failed to ensure personnel files included a copy of limited criminal history that had been obtained timely in 2 (files E and G) of 6 files reviewed and failed to include a copy of annual performance evaluations in 2 (files C and F) of 6 files reviewed of individuals employed for longer than 1 year. The findings include: 1. Personnel file E evidenced the individual had been hired on 1-3-11 to provide registered nursing services. The file evidenced the agency had not obtained a copy of the individual's limited criminal history until 5-5-11.	N0460	The Admin/DON and nursing staff involved in entering data into the computer for tracking have reviewed the policies on limited criminal history check and performance evaluations and importance of thorough and timely data entry into the computer. 25% of active employee files will be audited quarterly to ensure that performance evaluations are done according to policy. Auditing results will be compared to entry in computer and updated as necessary. The Admin/DON in this office will check computer report for upcoming evaluations that will be due monthly and incorporate this into her workflow. The Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. 1-3. There is no	11/26/2012

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	2. Personnel file G evidenced the individual had been hired on 9-16-11 to provide licensed practical nursing services. The file evidenced the agency had not obtained a copy of the individual's limited criminal history until 3-13-12. 3. The administrator, employee A, was unable to provide the first patient contact dates for employees E and G when asked on 10-26-12 at 12:25 PM. The administrator indicated employees E and G had both provided services to patients prior to obtaining their limited criminal histories. 4. Personnel file C evidenced the individual had been hired on 6-22-11 to provide registered nursing services. The file failed to evidence an annual performance evaluation had been completed. 5. Personnel file F evidenced the individual had been hired on 6-4-10 to provide registered nursing services. The file failed to evidence any annual performance evaluations had been completed. 6. The administrator, employee A, was unable to provide any additional documentation and/or information regarding the annual performance		way to correct the history of late Limited Criminal History. We can only move forward and ensure that this does not happen again by educating and reinforcing the importance of obtaining a criminal history before care is provided to the client as a safety and security measure. 4. An annual performance evaluation was completed on employee C and placed in personnel file.5. An annual performance evaluation was completed on employee C and placed in personnel file. 6. An annual performance evaluation was completed on employee C and placed in personnel file.	

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	evaluations when asked on 10-26-12 at 12:45 PM.			

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N0470	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. Based on agency policy review, observation, and interview, the agency failed to ensure services had been provided in accordance with the agency's own infection control policies and procedures and the Centers for Disease Control (CDC) Standard Precautions in 2 (#s 1 and 3) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among patients and staff. The findings include: 1. The agency's February 2012 "OSHA Infection Control/Exposure Control Plan" policy number B-405 states, "Client infection control procedures shall include, but not be limited to: Wearing and changing gloves as necessary during the delivery of client care . . . Frequent hand washing by home health employees: Before and after the provision of direct client care . . . After removing gloves . . . All materials related to OSHA regulations and all agency infection control activities shall be incorporated into an infection	N0470	Admin/DON will reinservice all nursing staff on Home Health Agency Infection Control Policy and Center for Disease Control Standard Precautions. Admin/DON and Case Managers will observe direct patient care when performing supervisory visits and recertifications every 60 days for adherence to the policies and standards while performing patient care. The Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. 3. Employee E was educated individually by the Admin/DON on proper bag technique and infection control policies including but not limited to handwashing and cleaning of equipment.4. Nurse D will be individually educated on infection control policies, and use of barrier, including but not limited to bag technique and proper use of barriers.	11/26/2012

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	control plan which includes: . . . Standard precautions procedures." 2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies 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			

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	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. 3. On 10-23-12 at 11:05 AM, a home visit was made to patient number 1 with employee E, a registered nurse (RN). The RN placed her stethoscope and blood pressure machine on a table and prepared for the visit. The RN picked up the stethoscope and placed it around her neck potentially carrying organisms from the table to her clothing. The RN measured the patient's temperature, pulse, and respirations, then removed the stethoscope from around her neck and listed to the patient's apical pulse and lung sounds. The RN placed the equipment back onto the table. The RN then checked the patient's tibial pulse and then the radial pulse. The RN then cleansed her hands and charted the results on a visit note. Upon completion of the visit the RN was observed to gather the equipment used during the visit and hold it against her body potentially contaminating her			

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	clothing with organisms from the table. The RN walked to her car, opened the back and placed the used equipment in the car potentially contaminating her car with organisms from the patient's home. The RN cleaned the equipment while standing at the back of her car. 4. On 10-24-12 at 3:25 PM, a home visit was made to patient number 3 with employee D, a licensed practical nurse (LPN). The LPN was observed to perform an in and out catheterization on the patient. The LPN washed her hands and gathered the supplies needed to perform the procedure from a cabinet in the patient's bathroom The LPN placed the packaged sterile catheter on the bathroom floor, without a barrier, and partially opened the package. The LPN placed the sterile catheterization kit on the bathroom floor without a barrier. The LPN then donned sterile gloves without cleansing her hands. A. The agency's undated "Catheterization-Straight Cath Procedure" number SN-303 states, "Place protective barrier on clean surface. Assemble equipment and place on protective barrier." B. The LPN completed the in and out catheterization and then removed her			

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	gloves. The LPN gathered the trash and was not observed to cleanse her hands. C. The agency's undated "Catheterization-Straight Cath Procedure" number SN-303 states, "Discard equipment. Remove gloves. Wash hands with antibacterial soap." 5. The above-stated observations were discussed with the administrator, employee A, on 10-25-12 at 11:40 AM. The administrator, employee A, verbalized understanding of the concerns.			

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N0504	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed in advance of the disciplines that would furnish care and the proposed frequency of visits in 9 (#s 1, 2, 3, 4, 5, 6, 7, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency. The findings include: 1. Clinical record number 1 evidenced a start of care (SOC) date of 10-3-12 and that the physician had ordered skilled nurse (SN) services 1 time per week for 4 weeks during the certification period 10-3-12 to 12-1-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits.	N0504	The Administrator/Director of Nursing (Admin/DON) will educate the nursing staff responsible for admitting patients for Private Duty Nursing (PDN) and Skilled Nursing Visits (SNV) that written documentation of disciplines furnishing care and frequency of visits must be documented in the nurses notes and client handbook on first contact with client. 10% of all active clinical records will be audited quarterly for evidence that admission nurses notes are in compliance and clients handbooks will be viewed with supervisory visits to assure compliance. Admin/DON and Case Managers will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/26/2012

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	2. Clinical record number 2 evidenced a SOC date of 10-11-12 and that the physician had ordered SN services 1 time per week during the certification period 10-11-12 to 12-9-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 3. Clinical record number 3 evidenced a SOC date of 4-16-12 and that the physician had ordered SN services 1 to 5 days a week during the certification period 4-16-12 to 6-14-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 4. Clinical record number 4 evidenced a SOC date of 7-10-12 and that the physician had ordered SN services 1 to 5 times per week for 9 weeks during the certification period 7-10-12 to 9-7-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 5. Clinical record number 5 evidenced a SOC date of 9-29-11 and that the physician had ordered SN services 1 to 7 times per week for 9 weeks during the certification period 9-29-11 to 11-28-11. The record failed to evidence the patient			

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NAME OF PROVIDER OR SUPPLIER PEDIATRIC NURSING SPECIALISTS OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 SHAMROCK DR STE 201 EVANSVILLE, IN 47715	

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	had been informed of the services to be provided and the proposed frequency of visits. 6. Clinical record number 6 evidenced a SOC date of 4-10-12 and that the physician had ordered SN services 1 to 5 days per week for 60 days during the certification period 4-10-12 to -9-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 7. Clinical record number 7 evidenced a SOC date of 10-24-11 and that the physician had ordered SN services 1 to 5 days per week for 60 days during the certification period 10-24-11 to 12-22-11. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 8. Clinical record number 8 evidenced a SOC date of 10-13-11 and that the physician had ordered SN services 1 to 7 days per week for 60 days during the certification period 10-13-11 to 12-12-11. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits.			

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	9. Clinical record number 9 evidenced a SOC date of 9-6-12 and that the physician had ordered SN services 1 to 3 days per week for 57 days during the certification period 9-6-12 to 11-4-12. The record failed to evidence the patient had been informed of the services to be provided and the proposed frequency of visits. 10. The administrator, employee A, stated, on 10-24-12 at 10:10 AM, "I usually put that I told the patient the disciplines and frequency in my notes." The administrator was unable to provide any additional documentation and/or information when asked on 10-24-12 at 10:10 AM and on 10-26-12 at 11:10 AM. 11. The agency's 10-30-09 "Home Care Bill of Rights/Grievance Procedure-Indiana" policy number CI-380 states, "A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Rill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated." The agency's "Patient/Client Bill of Rights-Indiana" states, "To be notified in writing what discipline(s) will furnish care and the frequency of visits proposed to be furnished, prior to the start of care."			

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PEDIATRIC NURSING SPECIALISTS OF INDIANA	4900 SHAMROCK DR STE 201 EVANSVILLE, IN 47715

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N0522	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 and interview, the agency failed to ensure medications and treatments had been provided in accordance with the written plan of care in 7 (#s 2, 3, 4, 5, 6, 7, and 8) of 10 records reviewed creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 10-11-12 to 12-9-12. The plan of care states, "Assess blood sugar, blood sugar log and diabetic status." The start of care comprehensive assessment dated 10-11-12 and a skilled nurse visit note dated 10-18-12 failed to evidence the registered nurse had assessed the patient's blood sugar, blood sugar log, or diabetic status. 2. Clinical record number 3 included plans of care established by the physician for the certification periods 8-14-12 to	N0522	Admin/DON will educate field staff on sending a copy of the client's Medication Administration Records(MARS) and Treatment Administration Records (TARS) to the office to be placed in the client's chart every week. Admin/DON will further educate field staff to indicate with an"F" = family in the legend box on the MARS/TARS and mark appropriate box with an "F" when the family has given the medication. Admin/DON adn Case Managers will incorporate into the written Plan of Care, who is responsible for the medications and treatments when the nurse is not in the home. If treatments/medications are only done by family, this will be included in POC. 10% of all active clinical records will be audited quarterly for evidence that the written Plan of Care (POC) signed by the physician is being documented accordingly. The Admin/DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 1. -3. Admin/Don will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to	11/26/2012

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	10-12-12 and 10-13-12 to 12-11-12. The plans of care state, "Bowel program: Administer soap suds enema every other day per orders." A. The "Medication / Treatment Record" (received on 10-26-12 at 9:10 AM) failed to evidence the soap suds enema had been administered every other day per the physician's order. B. Employee D, a licensed practical nurse, stated, on 10-24-12 at 3:25 PM, "The family does the enema every other evening." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 9-8-12 to 11-6-12 that states, "Gastric feedings: . . . Change extension tubing weekly . . . Change trach 2x month." A. The "Medication / Treatment Record" for September 2012 failed to evidence the trach had been changed at any time during the month. B. The September 2012 record failed to evidence the gastric feeding extension tubing had been changed at any time during the month. 4. Clinical record number 5 included a		document when/if family/caregiver administers treatments/medications. 4. Admin/DON will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to document when/if family/caregiver administers treatments. 5. Admin/DON will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to document when/if family/caregiver administers treatments. 6. Admin/DON will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to document when/if family/caregiver administers treatments. 7. Admin/DON will educate field staff on adhering to Physician's orders noted on 485. Nursing staff will be instructed to document when/if family/caregiver administers treatments.	

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	plan of care established by the physician for the certification period 9-23-12 to 11-21-12 that states, "Change feeding extension tube twice per week. Change feeding bag daily." A. The "Medication / Treatment Record" for September 2012 evidenced the tubing had been changed only once per week during the month on 9-6-12, 9-10-12, 9-17-12, and 9-24-12. B. The "Medication / Treatment Record" for October 2012 (received on 10-26-12 at 9:10 AM) evidenced the tubing had been changed only once per week during the month, on 10-8-12, 10-14-12, 10-22-12, and 10-26-12. 5. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12. The plan of care states, "Transderm-Scop 1.5 MG (1 Packet) Transdermal Every 72 Hours." The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:00 AM) failed to evidence the medication had ever been administered. 6. Clinical record number 7 included a plan of care established by the physician for the certification period 8-19-12 to			

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	10-17-12 that identified skilled nurse services were to be provided 1 to 5 days per week. The record failed to evidence any skilled nurse visits had been provided the week of 9-30-12. 7. Clinical record number 8 included plans of care established by the physician for the certification periods 8-8-12 to 10-6-12 and 10-7-12 to 12-5-12. The plans of care state, "Change J-tube extension weekly and as needed for leaking." A. The "Medication / Treatment Record" for September 2012 failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 9-3-12 and 9-23-12. B. The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:10 AM) failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 10-8-12 and 10-21-12. 8. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-25-12 at 10:10 AM and on 10-26-12 at 11:10 AM regarding the			

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	above-stated findings.			

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N0524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included specific treatment orders in 3 (#s 6, 9, and 10) of 10 records reviewed. The findings include: 1. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12. The plan of care states,	N0524	The Admin/DON will educate and will continue to reinforce education to nursing staff that POC will cover all pertinent information related to the patient and care being performed and documentation must be complete. 10% of all active clinical records will be audited quarterly for evidence that the POC is accurate and pertinent to patient and is reflected in the documentation. The Admin/DON will be responsible for monitoring these	11/26/2012

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	"Maintain bowel protocol per Dr's order and assess." The plan failed to include the specifics of the bowel protocol to be followed; i.e., what medications and/or enemas to be used, how often to use them, etc. 2. Clinical record number 9 included a plan of care established by the physician for the certification period 9-6-12 to 11-4-12. The plan of care states, "Instruct/perform dressing change, wound care as ordered. Wound Location coccyx: Wound care order: Turn off wound vac. Remove old dressing, clean wound with wound wash and reapply wound vac; Wound care to be done 3X/ [three times per] week." The order failed to address the type of foam to be used, the suction pressure to be maintained in millimeters of mercury, the therapy settings (continuous or intermittent suction), or if any adjunct dressings were to be used. 3. Clinical record number 10 included an interim physician's order dated 9-5-12. The order states, "Silvadene Cream: Apply small amount to burn area bid [twice a day] until healed." The order failed to specify the anatomical location of the burn area.		corrective actions to ensure that this deficiency is corrected and will not recur.	

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	4. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-26-12 at 11:10 AM. 5. The agency's July 2012 "Plan of Care" policy number C-580 states, "The Plan of Care shall be completed in full to include: . . . Medications, treatments, or procedures."			

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N0537	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 and interview, the agency failed to ensure the skilled nurse had provided medications and treatments in accordance with the written plan of care in 7 (#s 2, 3, 4, 5, 6, 7, and 8) of 10 records reviewed creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 10-11-12 to 12-9-12. The plan of care states, "Assess blood sugar, blood sugar log and diabetic status." The start of care comprehensive assessment dated 10-11-12 and a skilled nurse visit note dated 10-18-12 failed to evidence the registered nurse had assessed the patient's blood sugar, blood sugar log, or diabetic status. 2. Clinical record number 3 included plans of care established by the physician for the certification periods 8-14-12 to	N0537	Admin/DON will educate field staff on sending a copy of the client's Medication Administration Records(MARS) and Treatment Administration Records (TARS) to the office to be placed in the client's chart every week. Admin/DON will further educate field staff to indicate with an"F" = family in the legend box on the MARS/TARS and mark appropriate box with an "F" when the family has given the medication. Admin/DON and Case Managers will incorporate into the POC who is responsible for the medications and treatments when the nurse is not in the home. If treatments/medications are only done by family, this will be included in the POC.10% of all active clinical records will be audited quarterly for evidence that the written POC signed by the physician is being documented accordingly.The Admin/DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	11/26/2012

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	10-12-12 and 10-13-12 to 12-11-12. The plans of care state, "Bowel program: Administer soap suds enema every other day per orders." A. The "Medication / Treatment Record" (received on 10-26-12 at 9:10 AM) failed to evidence the soap suds enema had been administered every other day per the physician's order. B. Employee D, a licensed practical nurse, stated, on 10-24-12 at 3:25 PM, "The family does the enema every other evening." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 9-8-12 to 11-6-12 that states, "Gastric feedings: . . . Change extension tubing weekly . . . Change trach 2x month." A. The "Medication / Treatment Record" for September 2012 failed to evidence the trach had been changed at any time during the month. B. The September 2012 record failed to evidence the gastric feeding extension tubing had been changed at any time during the month. 4. Clinical record number 5 included a			

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	plan of care established by the physician for the certification period 9-23-12 to 11-21-12 that states, "Change feeding extension tube twice per week. Change feeding bag daily." A. The "Medication / Treatment Record" for September 2012 evidenced the tubing had been changed only once per week during the month on 9-6-12, 9-10-12, 9-17-12, and 9-24-12. B. The "Medication / Treatment Record" for October 2012 (received on 10-26-12 at 9:10 AM) evidenced the tubing had been changed only once per week during the month, on 10-8-12, 10-14-12, 10-22-12, and 10-26-12. 5. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12. The plan of care states, "Transderm-Scop 1.5 MG (1 Packet) Transdermal Every 72 Hours." The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:00 AM) failed to evidence the medication had ever been administered. 6. Clinical record number 7 included a plan of care established by the physician for the certification period 8-19-12 to			

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	10-17-12 that identified skilled nurse services were to be provided 1 to 5 days per week. The record failed to evidence any skilled nurse visits had been provided the week of 9-30-12. 7. Clinical record number 8 included plans of care established by the physician for the certification periods 8-8-12 to 10-6-12 and 10-7-12 to 12-5-12. The plans of care state, "Change J-tube extension weekly and as needed for leaking." A. The "Medication / Treatment Record" for September 2012 failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 9-3-12 and 9-23-12. B. The "Medication / Treatment Record" for October 2012 (received 10-26-12 at 9:10 AM) failed to evidence the J-tube had been changed weekly. The record evidenced the tube had been changed on 10-8-12 and 10-21-12. 8. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-25-12 at 10:10 AM and on 10-26-12 at 11:10 AM regarding the			

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NAME OF PROVIDER OR SUPPLIER PEDIATRIC NURSING SPECIALISTS OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 SHAMROCK DR STE 201 EVANSVILLE, IN 47715	

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	above-stated findings.			

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N0543	410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record review and interview, the registered nurse (RN) had initiated nursing measures to monitor a patient's health status in 1 (# 1) of 10 records reviewed creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Clinical record number 1 included a plan of care established by the physician for the certification period 10-3-12 to 12-1-12 with a start of care date of 10-3-12 and diagnoses of coronary artery disease, hypertension, and atrial fibrillation. A. The plan included orders for skilled nurse (SN) services 1 time per week for 4 weeks. The plan identified the skilled nurse was to "assess fluid retention." B. The record included a start of care comprehensive assessment completed by the RN, employee A, on 10-3-12 that	N0543	The Admin/DON will educate the nursing staff on thorough documentation of coordination of services between all entities involved with the client. 10% of all active clinical records will be audited quarterly for evidence that coordination of care has been thoroughly documented in the nursing progress notes. Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/26/2012

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	included a measurement of the patient's weight, identified the patient had increased shortness of breath since returning home from the hospital, had hypertension (high blood pressure), and had "Edema Pitting." The assessment failed to identify the location and character of the pitting edema. C. The record evidenced the RN had provided care to the patient on 10-9-12, 10-18-12, and 10-23-12. The SN visit notes failed to evidence the RN had weighed the patient to assess for fluid retention. 2. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 10-25-12 at 10:10 AM and on 10-26-12 at 11:10 AM regarding the above-stated findings.			

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N0545	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. Based on clinical record review and interview, the registered nurse (RN) failed to coordinate services with other providers in 2 (#s 5 & 6) of 10 records reviewed creating the potential to affect all of the agency's patients receiving services from other providers. The findings include: 1. Clinical record number 5 included a skilled nurse visit note dated 10-11-12 that states, "Therapy started at 1130 . . . was placed in stander for therapy." The record failed to evidence the registered nurse had coordinated with the therapy provider regarding what therapy treatment was to be administered by the nurse, for how long, and how many days per week the therapy treatment was to occur. 2. Clinical record number 6 included a plan of care established by the physician for the certification period 10-7-12 to 12-5-12 that identified diagnoses of quadriplegia and neurogenic bladder. The plan of care states, "Maintain bowel	N0545	The Admin/DON will inservice the nursing staff that the skilled nursing services provided and coordination of other services patient is receiving such as therapy must be thoroughly documented and in accordance with the POC. See also G158 & 159) 10% of all active clinical records will be audited quarterly for evidence that the POC is being followed and all coordination of services is being documented. The Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/26/2012

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	protocol per Dr's order and assess." A. The record included a skilled nurse (SN) visit note completed by employee F, a RN, on 10-3-12. The note states, "[Parent] arrives home & states was unable to fill enema prescription due to MCD [Medicaid] refusing to cover med now. (MCD had previously covered it). Enemas [without] MCD cost approx seventy dollars & [parent] states is unable to pay for it. Will inform MD in am." B. A SN visit note completed by employee F on 10-4-12 evidenced the nurse had called and informed the physician the patient's parent was unable to afford the currently prescribed enema. The note states, "No new orders received." C. A SN visit note completed by employee F on 10-5-12 failed to evidence any mention of the problem with obtaining the prescribed enema. D. A SN visit note completed by employee F on 10-10-12 evidenced the RN called the physician's office again with the same information and that "no orders received at this time." E. A SN visit note completed by employee F on 10-11-12 failed to			

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	evidence any mention of the problem with obtaining the prescribed enema. F. A SN visit note completed by employee F on 10-12-12 states, "No BM [bowel movement] this AM [after] glycerin supp [suppository] last night. Sm [small] BM on 10-10-12 & sm BM on 10-11-12 . . . [Parent] states no return call from MD yet regarding unfilled Docusate Na enemas." G. The record failed to evidence any further communication and/or follow-up by the RN regarding the patient's status. 3. The administrator, employee A, was unable to provide any additional documentation and/or information regarding clinical record number 6 when asked on 10-26-12 at 11:10 AM.			

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N0608	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on clinical record review and interview, the agency failed to ensure clinical notes had been incorporated into the records within 14 days in 6 (#s 3, 4, 5, 6, 7, and 8) of 8 active records reviewed creating the potential to affect all of the agency's 22 current patients. The findings include: 1. Employee C, a registered nurse, stated, on 10-24-12 at 9:45 AM, "The medication administration records are kept in the home for the current month. At the end of the month the nurse brings them in."	N0608	The Admin/DON will inservice the nursing staff on the policy which has been revised to state that all clinical documentation will be incorporated into the clinical record within fourteen days of the date the care is provided for Indiana clients. 10% of all active clinical records will be audited monthly for compliance with this policy. The Admin/DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/26/2012

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	2. The administrator, employee A, stated, on 10-24-12 at 1:25 PM, "All of our MARS [medication administration records] and TARS [treatment administration records] are kept out in the home for 30 days. They are a part of the clinical note to document services provided that day." 3. Clinical record number 3 failed to evidence medication administration records and treatment administration records for the month of October 2012 had been incorporated into the record as of the survey date 10-26-12. 4. Clinical record number 4 failed to evidence medication administration records and treatment administration records for the month of October 2012 had been incorporated into the record as of the survey date 10-26-12. 5. Clinical record number 5 failed to evidence medication administration records and treatment administration records for the month of October 2012 had been incorporated into the record as of the survey date 10-26-12. 6. Clinical record number 6 failed to evidence medication administration records and treatment administration records for the month of October 2012			

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	had been incorporated into the record as of the survey date 10-26-12. 7. Clinical record number 7 failed to evidence medication administration records and treatment administration records for the month of October 2012 had been incorporated into the record as of the survey date 10-26-12. 8. Clinical record number 8 failed to evidence medication administration records and treatment administration records for the month of October 2012 had been incorporated into the record as of the survey date 10-26-12.			