

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2014
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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6505 E 82ND ST STE 200 INDIANAPOLIS, IN 46250
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G000000	<p>This visit was a home health federal complaint investigation survey. This was an extended survey. The investigation was conducted concurrently with a federal recertification survey.</p> <p>Complaint IN00144190 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey date: March, 25, 26, 27, 28, and 31, 2014</p> <p>Facility #: 002773</p> <p>Medicaid Vendor #: 200456380</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 122 patients</p> <p>An Immediate Jeopardy was identified on 03/31/14. The Administrator was notified of the Immediate Jeopardy on 03/31/14 at 3:45 PM. The Immediate Jeopardy remained unremoved at survey exit.</p> <p>Quality Review of Immediate Jeopardy:</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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	<p>Joyce Elder, MSN, BSN, RN April 3, 2014</p> <p>The agency is precluded from providing a home health aide training and competency program for a period of 2 years beginning April 9, 2014, to April 9, 2016, for being found out of compliance with the Conditions of Participation 42 CFR 484.30 Nursing Services.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 9, 2014</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 9, 2014</p>				

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G000164	<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. Based on clinical record and policy review and interview, the agency failed to ensure a qualified professional notified the physician of changes in patients condition for 5 of 12 clinical records reviewed creating the potential to affect all of the agency's 122 patients. (#3, 5, 6, 7, 8)</p> <p>Findings include:</p> <p>1. Clinical record number 3 included a plan of care dated 02/06/14 to 04/05/14 for home health aide to provide services 4 - 7 days a week, 6 - 10 hours a week for 60 days. The patient was eligible for home health aide services via waiver up to 80 hours a month for 60 days.</p> <p>The clinical record included an "Aide weekly note" dated 03/03/14 to 03/08/14 that stated in the comments by Employee A, "Came in a 955 [name of patient # 3] had call told me she had fell in a 10 got her off the floor check her out made sure was okay then call supervisor [name of Employee F] let her know what had happened and call her daughter waited for her call. 11:30 told me to call ambulance they took her to [name of hospital]." The</p>	G000164					

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	<p>clinical record failed to evidence Employee F notified the physician.</p> <p>2. Clinical record number 5, start of care (SOC) 01/29/14, included a plan of care for the certification period of 01/29/14 to 03/29/14 for home health aide services 5 - 7 days a week, 24 - 56 hours a week for 60 days.</p> <p>Clinical record number 5 included a supervisory visit note dated 02/28/14 stating the patient was having constant lower back pain on a scale of 8 out of 10, indicating the patient "hurts whole lot." The assessment indicated the patient's pain medication was ineffective and the "PCG [patient caregiver] to notify MD of increased in pain level once she gets home from work." The clinical record failed to evidence Employee F notified the physician of the findings.</p> <p>3. Clinical record number 6, SOC 06/03/13, included a plan of care for the certification period of 01/29/14 to 03/29/14 with orders for the skilled nurse to provide feedings per gastrostomy tube four times daily via pump at a rate of 999 ml (milliliters) per hour, measure pre feeding residual volume, and to report any nutritional concerns to clinical supervisor, PCG (patient care giver), and PCP (primary care physician).</p>				

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	<p>a. A skilled nurse visit note dated 02/08/14 stated the patient's abdomen was tight on assessment post feeding. The clinical record failed to evidence that the clinical supervisor and PCP were notified.</p> <p>b. A skilled nurse visit note dated 02/24/14 and 02/26/14 stated the nurse documented high pre feeding residual measurements and vomiting. The clinical record failed to evidence that the skilled nurse notified the physician.</p> <p>c. A skilled nurse visit note dated 03/12/14 stated the patient's mother contacted the physician and was instructed to hold the enteral feeding due to vomiting. There was no documentation the nurse had contacted the physician to notify him of the poor tolerance to enteral feeding. The clinical record failed to evidence a physician order to hold the tube feeding.</p> <p>4. Clinical record number 7 included a plan of care established by the physician for the certification periods of 12/16/13 to 02/23/14.</p> <p>a. Review of a "Weekly Aide Note" stated Employee H, a home health aide, saw patient # 7 on 02/03/14 and 02/04/14</p>				

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	<p>between the hours of 7:00 AM and 9:00 AM. The comment section located at the bottom of the note dated 02/03/14 stated Employee H contacted the agency in relation to a "pressure soaked area of what appeared to be beginning of a pressure sore" on patient # 7's heal area. On 02/04/14, a note by Employee H stated upon giving care to patient # 7, "I noticed an additional pressure sore located [blank space] of his foot, swelling present in that foot as well ... Blister present on the heal of his foot." The clinical record failed to evidence that the physician was notified.</p> <p>b. On 02/06/14, the HHA notified office and informed Employee # E, a Registered Nurse, of patient # 7's fall. The clinical record failed to evidence the physician was notified immediately of the fall.</p> <p>5. Clinical record number 8, SOC 03/27/09, included a plan of care established by the physician certification period of 12/31/13 to 02/28/14 for skilled nursing 5 - 7 days a week, 44 - 73 hours a week for 60 days.</p> <p>a. A skilled nurse visit note dated 02/24/14 indicated the patient had a 5 cm (centimeter) scratch from the gastrostomy tube (gastric tube site) to the waste band.</p>			

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	<p>The clinical record failed to evidence the physician was notified.</p> <p>b. A skilled nurse visit note dated 02/25/14 indicated the patient had a reoccurring blister to the right eye. The clinical record failed to evidence the physician was notified.</p> <p>6. The Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 03/13/14 at 3:30 PM.</p> <p>7. An undated job description for a licensed practical nurse (LPN) stated "Changes in patient's condition are identified ... Physician notification to obtain necessary orders for intervention[s] per state regulations ... notification to obtain necessary orders for intervention[s] per state regulations, Performs specific treatments and medication administration in accordance with physician orders ... "</p> <p>8. An undated job description for a registered nurse (RN) stated "Reports changes in the patients medical or mental condition to the attending physician and the Director of Clinical Services ... "</p>			
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G000168	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record review, agency policy review, document review, observation, and interview, it was determined the agency failed to ensure treatments were administered by the skilled nursing staff as ordered by the physician for 1 of 5 home visits creating the potential to affect all current 122 patients receiving services (See G 170); failed to ensure patients were assessed after a fall, after surgery, and with wounds for 4 of 12 patients reviewed creating the potential to affect all current 122 patients who received services from the agency (G 172); failed to ensure the plan of care had been updated to include all types of services and equipment required, frequency of visits, nutritional requirements, medications, and treatments for 5 of 12 records reviewed creating the potential to affect all 122 patients receiving services (See G 173); failed to ensure the Registered Nurse documented coordinated services with agency staff and outside provider services and informed the physician of changes in the patient ' s condition for 6 of 12 records reviewed creating the potential to affect all current 122 patients receiving services with the agency (See G 176); failed to ensure the licensed practical</p>	G000168		
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	<p>nurse (LPN) followed agency policy in regards to checking placement of a gastrostomy tube prior to administering medications and in and out catheter procedure 2 of 2 home visits attended (See G 179); and failed to ensure the LPN provided sterile and/or aseptic technique for 2 of 5 patient's observed during home visits in relation to in and out catheter procedure, administering medications through a gastrostomy tube, and wound care (See G 181 and G 182).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.30: Skilled Nursing Services.</p>			
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G000172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on observation, Indiana State Department of Health (ISDH) document, hospital and clinical record, and policy review and interview, the Registered Nurse / Case Manager failed to ensure patients were assessed after a fall, after surgery, and with wounds for 4 of 12 patients reviewed creating the potential to affect all current 122 patients who received services from the agency. (# 3, 4, 7, and 11)</p> <p>Findings include,</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification periods of 12/16/13 to 02/23/14. The plan of care indicated safety and fall precautions were to be followed. The plan of care also indicated that the group home staff would be responsible for all of the patient's care outside of bathing and morning ADL's (Activities of Daily Living).</p> <p>a. An ISDH narrative report dated 2/6/14 provided by BDDS indicated patient # 7 was transported to a hospital on 2/6/14 due to lethargy, vomiting, and congestion. The group home staff was</p>	G000172	<p>By submitting this POC the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies.</p> <p>The agency intends to request that this POC service as its Credible Allegation of Compliance.</p> <p>Response to G 172 DUTIES OF THE REGISTERED NURSE</p> <p>1. Corrective action(s) accomplished for those patients found to have been affected by the alleged deficient practice:</p> <ul style="list-style-type: none"> Clinical Supervisor (RN) assessed patient from clinical record 3 on 4/3/14. During this visit RN assessed the patient and addressed the fall that was reported by home health aide the week of 3/3/14 and communicated fall to physician. 	04/11/2014			

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	<p>notified at 8:45 A.M. by their own staff person. The group home staff indicated the home health aide from the home health agency assisted patient # 7 with his shower and the shower chair had fallen over onto the left side. The report indicated the the shower chair lost a screw from the leg and did not support the patient's weight. The group home staff indicated the patient did not hit his head nor did he have any noticeable injuries. The group home staff indicated the patient did not complain of pain. The group home nurse had assessed the patient at approximately 3:00 PM after the group home staff reported patient # 7 had vomited and was tired. After the nurse assessed the patient, it was determined that the patient needed further evaluation and 911 was contacted.</p> <p>b. A "Weekly Aide Note" stated Employee H, a home health aide, saw patient # 7 on 02/06/14 between the hours of 7:00 AM and 9:00 PM. The initial [initials]. was signed in place of the patient indicating verification of the home health aide visit.</p> <p>c. A "Clinical Documentation" note dated 02/06/14 stated, "I was providing routine shower care services to [name of patient # 7] [his/her] shower chair gave way causing him to fall over</p>		<ul style="list-style-type: none"> · Clinical Supervisor (RN) assessed patient from clinical record 4 on 4/8/14 During this visit RN to assess the patient's foot and review post op orders from foot surgery. RN to contact physician to clarify new orders. RN to update patient care plan and communicate order changes with home health aide. · Clinical Supervisor (RN) assessed patient from clinical record number 10 on 4/4/14. During this visit RN addressed and assessed patient wound. RN to contact physician to obtain clarification order (physician was scheduled to assess patient on 4/4/2014). RN to update patient plan of care and communicate clarification orders to patient 10's nursing staff. <p>2. Corrective actions to be taken in order to identify and protect other patients who may be affected by the allegedly deficient practice:</p> <ul style="list-style-type: none"> · Office process to be in place by 4/3/14 to direct all clinical calls from direct caregivers regarding change in patient condition or patient status to an RN immediately. The RN will determine if EMS is needed or if an RN assessment is needed. If an RN assessment is needed, the RN will report to the patient's home within 24 hours. Director of Clinical Services, "DOCS"/Clinical Designee to maintain a "change in condition tracking" spreadsheet to capture all 	
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	<p>while [he/she] was strapped in the chair. Call for staff to assist me with getting [him/her] to a safe position and asked if [he/she] wanted me to get [name of patient # 7] vitals which [he/she] responded with a NO. Continued to talk to [name of patient # 7] checking for any visible signs of injury or distress. The patient didn't appear to be confused. Transferred [him/her] to [his/her] wheelchair and into the kitchen for breakfast. [Name of patient # 7] was conscious and sitting up upon my departure. Notified office of [name of patient] fall and spoke with [name of employee E] given an account of my actions in regards to the matter."</p> <p>d. An "Incident Report" dated 2/6/14 stated the incident happened at 7:40 AM on 02/06/14. The report indicated the fall was attended and there was a shower chair malfunction. A brief description of the event stated, "HHA [Home Health Aide] reported that while giving client a shower, the shower chair collapsed and client landed on his left side. The HHA stated that a screw came out of the chair and she believes that is what caused the collapse of the chair. She reports the chair is fairly new and she had not had any safety concerns with the chair prior. [Name of group home] staff was in the home and they were able to get</p>		<p>reports of patient changes in condition in order to track RN assessment and/or RN follow up.</p> <ul style="list-style-type: none"> · DOCS/Clinical Designee will review the spreadsheet daily to ensure appropriate follow up has occurred. Education regarding this office process to be provided by the Administrator "AO" to all internal staff by 4/8/14. · Documentation of education to be maintained in personnel file. Beginning no later than 4/4/14 QI nurse to complete weekly documentation review of 100% of home health aide notes to identify any documentation regarding change in patient condition or status. · Beginning no later than 4/4/14 QI nurse to complete weekly documentation review of 100% of skilled nursing notes to identify any documentation regarding patient wound status or change in patient skin noted on the wound flow sheet section and the narrative section. QI nurse to maintain spreadsheet to track this documentation review and will follow up on any documentation regarding patient change in condition or change in wound status to ensure appropriate RN follow up has occurred and to provide re-education if documentation found not to meet policy. · DOCS/Clinical Designee to 	

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	<p>him up using a draw sheet. Client denied any injury, no bruising or lesions observed by the HHA and client told HHA [he/she] was fine. Communicated to [name of group home] supervisor by Clinical Supervisor." The Incident Report stated follow up notification with the physician was on 02/06/14 at 12:00 PM and the group home representative was contacted by Employee F on 02/06/14 at 11:30 AM. The "Patient Status" section did not indicate an unanticipated ER visit. The "Data Elements utilized in incident/injury analysis" stated an interview with the Director of [name of group home]. "Corrective Action Taken patient/caregiver" action was NA (not applicable) and no employee corrective action was required. The record date was 02/13/14.</p> <p>e. A Hospital Report on 02/06/14 indicated the patient was examined by the physician at 4:33 PM. The reason for the visit was "altered mental status-poor communication ... two episodes of vomiting Tues AM with decreased responsiveness ... Supervisor states staff called her this AM to report pt [patient] had vomited 2 x [twice]. When supervisor went to check on pt later in day he was soaked in urine and unresponsive." General Description</p>		<p>compile list of patients with known wounds by 4/4/2014. DOCS/Clinical Designee to provide re-education to InternalClinical Supervisors on wound policy and staging of wounds by 4/09/2014. Documentation of re-education will be maintained in the personnel file. All identified wound patients will be re-assessed by RN by 4/10/2014 and will be documented in system of record. All field skilled employees currently staffing patients with wounds will receive documented re-education on wound policy requirements and staging of wounds by 4/10/2014. If education not received by 4/10/14 nurse will be placed on Active Restricted status until required education received. Documentation of re-education will be maintained in the Personnel File. All remaining skilled field employees will be sent an in-service mailer with re-education on wound policy and staging of wounds by 4/10/2014. Acknowledgement of re-education completion will be kept in the Personnel File.</p> <p>3. Measures to be put into place/systemic changes to be made to ensure that the alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> · Based on finding that group home RN was not timely notified of patient fall, and to facilitate and ensure coordination of care with staff from the group home: <ul style="list-style-type: none"> o AO developed Memorandum of 				

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	<p>"unresponsive, oral airway in place ... left pupil 304 mm [millimeters] no response, right pupil 2 mm no response ... 2 sm [small] appearing bruises near R [right] temporal area."</p> <p>f. "ED Emergency Record" on 02/06/14 stated "CT head: Large subdural hematoma w/ [with] herniation. Brother here, notified of CT results like fatal nature. Hospice contacted ... "</p> <p>g. CT report on 02/06/14 stated "Large hyperacute right - sided subdural, up to 15 mm thickness. 17 mm subfalcine herniation. Right uncal and parahippocampal herniation. Effaced basal cisterns. Bilateral chronic infarcts of the globus pallid. Impression: Large hyperacute right - sided subdural, subfalcine and transterntorial herniation."</p> <p>h. ER MD Discharge Disposition stated the patient was admitted on 02/06/14 at 4:11 PM with a diagnosis of "Subdural hematoma, acute ... "</p> <p>i. Interview with Director from the group home on 03/26/14 at 12:10 PM indicated the staff in the home were not nurses and she was informed by her staff regarding the fall. Due to the legal situation, she was not able to give details and indicated the Administrator would</p>		<p>Understanding (MOU) presented to group home RN program director by 4/4/14. MOU to require that all changes in condition of any mutual group home patients will be communicated between Maxim and Group Home. MOU will be kept on file at Maxim. MOU will also be used for all other group homes.</p> <ul style="list-style-type: none"> o New office process regarding this group home to be implemented by 4/4/14, and will require that all changes in condition of mutual patients be communicated to RN program director of group home. Likewise, RN program director from group home will communicate all changes condition for such mutual patients to Maxim. o DOCS/Clinical Designee to maintain "change in condition tracking" spreadsheet to track all changes in condition reported specifically from home health aides servicing group home patients. DOCS/Clinical Designee to review spreadsheet daily to ensure appropriate follow up has been provided. o All internal staff educated by AO regarding new process by 4/4/14. Documentation of education to be maintained in personnel file. o AO and DOCS/Clinical Designee to provide education to all home health aides servicing group home patients by 4/10/14. If education not received by 4/10/14, home health aide will be placed on Active Restricted status until required education received. Active 	

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	<p>have to be notified.</p> <p>j. Interview with patient # 7 family member, who was also the power of attorney, indicated he was not notified by the home health agency of the fall until the group home notified him when the patient was enroute to the hospital.</p> <p>k. The Director of Nursing (DoN) indicated on 03/27/14 at 11:30 AM that the nurses do not go out into the homes when there was a change in condition. The agency was instructing the aides to contact 911. The DoN indicated the reason why the nurse did not go out to assess patient # 7 was because the group home nurse was going to assess the patient and when the agency aide left, he/she was "appropriate." The group home did have a nurse available to the residents in the group home but patient # 7 did not go out immediately. The DoN indicated the agency followed up with the group home Director. The DoN indicated there was a protected investigation by the legal department. The DoN indicated if they had parameter where their staff was to go see the patient, someone would have gone.</p> <p>l. The Director of Nursing and the Administrator indicated on 03/27/14 at 6:00 PM the agency needed more staff</p>		<p>restricted status means that the employee will not be working until the requirement is met. Documentation of education to be maintained in personnel file.</p> <ul style="list-style-type: none"> o State specific policy addendum added to Agency Policy titled "Assessment" states as follows: "For Home Health Aide (HHA) cases the HHA will notify the clinical supervisor immediately for all changes in patient condition such as Falls, Injuries, Pain or illness. A Registered Nurse (RN) will make a determination whether the patient's situation requires immediate attention and emergency medical response (911) should be called or whether an assessment is required within 24 hours of agency knowledge." Education to all internal staff regarding update to "Assessment" policy completed by AO and DOCS/Clinical Designee by 4/4/14. Documentation of education to be maintained in the personnel file. · Based on the allegation that power of attorney was not notified of patient fall: <ul style="list-style-type: none"> o DOCS/Clinical Designee to re-educate all clinical supervisors on policy titled "Care Coordination" by 4/09/14. Copy of education to be maintained in personnel file. DOCS/Clinical Designee to review care coordination section of medical record with each recertification to ensure adequate care coordination and notification was provided by 				

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	<p>and indicated Employee F, a Registered Nurse / Case Manager, should have gone to the home and assessed the patient after the fall.</p> <p>m. Employee E, a Registered Nurse, indicated on 03/28/14 at 2:25 PM she had received a call from Employee H at approximately 8:25 AM on 02/26/14. Employee E indicated Employee H had told her patient # 7 had fallen and there was no injury. Employee E indicated she did not immediately notify Employee F (a Registered Nurse / Case Manager) because she had a meeting to attend. Employee E indicated Employee F was informed of the incident when she arrived at the agency at approximately 11:00 AM. Employee E indicated she did not follow up with the incident and she had not heard anything until the Director contacted her between 2:00 PM and 4:00 PM. Employee E indicated the representative wanted to know if something had happened with patient # 7 because the patient was acting "funny" and they were trying to find out why. Employee E indicated she was not sure if the representative was aware of the fall and proceeded to inform her about it.</p> <p>n. Employee F indicated on 03/28/14 at 3:40 PM that she did not go assess patient # 7 after she was made</p>		<p>clinical supervisors.</p> <p>· Based on the allegation that immediate and appropriate action was not taken to assess patient's needs after a fall, after surgery, and with wounds:</p> <ul style="list-style-type: none"> o DOCS/Clinical Designee to provide re-education to all clinical supervisors, including employee C, employee E, and employee F, on "Assessment" Policy, "Care Coordination" Policy, "Wound Policy" and staging of wounds by 4/09/14. Documentation of re-education will be maintained in the personnel file. <p>New office process in place by 4/3/14 to direct all calls from direct caregivers regarding change in patient condition or patient status to an RN immediately. The RN will determine if EMS is needed or if an RN assessment is needed. If an RN assessment is needed, the RN will report to the patient's home within 24 hours. DOCS/Clinical Designee to maintain a "change in condition tracking" spreadsheet to capture all reports of patient changes in condition, including but not limited to patient falls, surgery, and wounds, in order to track RN assessment and/or RN follow up.</p> <p>DOCS/Clinical Designee will review the spreadsheet daily to ensure appropriate follow up has occurred. Education regarding this office process to be provided by the AO to all internal staff by 4/3/14.</p> <p>4. Monitoring of the corrective</p>				

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	<p>aware of the fall. Employee F indicated she was trying to contact the Director and, at the same time, the Director was trying to contact her. Employee F indicated she did contact the physician's office and made them aware of the fall and no orders were given. Employee F indicated she did not notify the family nor did she spoke with Employee H regarding the incident. Employee F indicated Employee E told her patient # 7 had fallen with the shower chair, there was a bruise on his/her side, unsure where, and the group home staff was made aware. Employee F indicated the nurses do not go out into the home on changes of condition on home health aide only cases. Employee F indicated the patient would be given an option if they wanted someone to come out to assess him / her or be sent to the hospital for an evaluation.</p> <p>o. Review of a "Weekly Aide Note" stated Employee H, a home health aide, saw patient # 7 on 02/03/14 and 02/04/14 between the hours of 7:00 AM and 9:00 AM. The comment section located at the bottom of the note dated 02/03/14 stated Employee H contacted the agency in relation to a "pressure soaked area of what appeared to be beginning of a pressure sore" on patient # 7's heal area. On 02/04/14 stated</p>		<p>action(s) to ensure the alleged deficient practice will not recur:</p> <ul style="list-style-type: none"> · DOCS/Clinical Designee to maintain a "change in condition tracking" spreadsheet to capture all reports of patient changes in condition in order to track RN assessment and/or RN follow up. · DOCS/Clinical Designee will review the spreadsheet daily to ensure appropriate follow up has occurred. Beginning no later than 4/4/14 QI nurse to complete weekly documentation review of 100% of home health aide notes to identify any documentation regarding change in patient condition or status. · Beginning no later than 4/4/14 QI nurse to complete weekly documentation review of 100% of skilled nursing notes to identify any documentation regarding patient wound status or change in patient skin noted on the wound flow sheet section and the narrative section. QI nurse to maintain spreadsheet to track this documentation review and will follow up on any documentation regarding patient change in condition or change in wound status to ensure appropriate RN follow up has occurred and to provide re-education if documentation found not to meet policy. · To monitor effectiveness of corrective action and to ensure the alleged deficiency does not recur, 	

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	<p>Employee H upon giving care to patient # 7, "I noticed an additional pressure sore located [blank space] of [his/her] foot, swelling present in that foot as well ... Blister present on the heal of [his/her] foot." The clinical record failed to evidence the patient was seen by the Case Manager or another Registered Nurse.</p> <p>2. Clinical record number 3 included a plan of care dated 02/06/14 to 04/05/14 for home health aide to provide services 4 - 7 days a week, 6 - 10 hours a week for 60 days.</p> <p>a. An "Aide Weekly Visit" note dated 03/03/14 to 03/08/14 stated, in the comments by Employee A, "Came in a 955 [name of patient # 3] had call told me [he/she] had fell in a 10 got [him/her] off the floor check [him/her] out made sure was okay then call supervisor [name of Employee F] let her know what had happened and call [his/her] daughter waited for her call. 11:30 told me to call ambulance they took [him/her] to [name of hospital]." The clinical record failed to evidence Employee F made a visit or had followed up after the patient fell.</p> <p>b. Employee F indicated on 03/28/14 at 3:40 PM that she did not go assess patient # 3 after she was made aware of the fall.</p>		<p>DOCS/Clinical Designee to conduct on-going quarterly Medical Record reviews of a minimum of 10% of patient census. The medical record review to monitor that appropriate and timely RN follow up as occurred following any change in patient condition including but not limited to patient fall, surgery and wound. The medical record review to monitor that appropriate care coordination and communication has occurred between group home RN, patient power of attorney and patient physician.</p> <p>All actions in this plan will be completed by: 4/11/14</p>				

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	<p>3. Clinical record number 4 included a plan of care dated 03/23/14 to 05/22/14 for home health aide service.</p> <p>a. An "Aide Weekly Visit" note dated 03/11/14 to 03/14/14 stated the patient had foot surgery on 03/12/14. The note also stated "Due to recent foot surgery certain aspects of mobility charting has been held per physician."</p> <p>b. Patient # 4 was observed to have a cast on her left foot on 03/28/14 at 9:30 AM. The patient indicated he/she had a bunionectomy.</p> <p>c. Employee F indicated on 03/28/14 at 3:40 PM that she did not go assess patient # 3 after her surgery nor did she speak with the physician for verification of post op orders. Employee F indicated she had spoken with the surgery center prior to the patient's surgery.</p> <p>4. Clinical record number 10 included a plan of care established by the physician for certification 02/14/14 to 04/14/14 for skilled nursing services 3 to 5 days a week, 24 to 40 hours a week for 60 days.</p> <p>a. The plan of care indicated the right anterior tibia wound care was to be</p>						

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	<p>performed every Monday and Thursday, and as needed for soiling or loss of dressing. The treatment orders stated to wash the wound with sterile water and note size, depth, drainage, and granulation tissue while uncovered. Aqua Cell or collagen dressing was to be covered with a foam dressing.</p> <p>b. Employee C indicated on 03/31/14 at 12:00 PM that she was not aware the patient continued to have a wound to the right shin. The clinical record failed to evidence the wound had been assessed weekly.</p> <p>5. A policy titled "Care Coordination / Case Conference" dated 01/06/14 stated "Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the Director of Clinical Services or clinical designee ... Direct Care Staff will communicate changes in a timely manner via telephone, one - on - one meetings, case conferences and / or home visits. Documentation of communications will be included in the medical record on a communication note, case conference note, clinical visit note, supervisory visit note or in the system of record. A facsimile communication may also be received. Documentation will include: the date and time of the communication, individuals involved</p>				

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	<p>with the communication, information discussed, and the outcome of the communication ... "</p> <p>6. A policy dated 01/06/14 titled "Ongoing Evaluation" stated, "During each home visit, the Direct Care Staff will re-evaluate the patient according to the problems identified during the initial and subsequent visits. As qualified by skill level, the Direct Care Staff will re-evaluate the patient [as appropriate] for ... Pain status ... Skin integrity ... Neuro / Mental status. Re-evaluation should focus on ... Changes in patient condition ... changes in patient's care environment or support systems. Based on each re-evaluation, the plan of care, including problems, needs, goals, and outcomes will be reviewed and revised. Based on the findings of the re-evaluation, additional orders will be obtained and forwarded to the physician ... The Direct Care Staff shall notify the Director of Clinical Services or clinical designee and / or physician when there is a change in the patient condition which might warrant a change in medication and / or a change to the plan of care."</p> <p>7. An undated Job Description / Essential Functions for a Clinical Supervisor was provided by the Director of Nursing on 03/31/14 at 5:00 PM. The</p>						

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	<p>job description states, "The Clinical Supervisor is directly responsible for clinical activities of the field staff. Plans, implements and evaluates patient's plans of care for appropriateness to individual patients needs ... Reports changes in the patients medical or mental condition to the attending physician and the Director of Clinical Services."</p> <p>8. A policy titled "Integumentary - Pressure Ulcer and Wound Assessment" dated 09/10 stated, "Reassess the wound weekly ... reevaluate the treatment plan as soon as any evidence of deterioration is noted ... If progress is not demonstrated within two to four weeks, reevaluate the overall treatment plan, adherence to the treatment plan and make appropriate changes and referrals ... "</p> <p>The agency failed to ensure immediate and appropriate action was taken to assess patient's needs after a fall, after surgery, and with wounds to safely provide services to patients of the facility. The findings at G 172 resulted in the determination that an immediate jeopardy existed. The agency was notified on 3/31/14 at 3:45 PM that it was determined the health and safety of the patients was in immediate jeopardy. This deficient practice had the potential for</p>			
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	harm to any of the 122 agency patients. The immediate jeopardy was unremoved at survey exit.			

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G000173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on observation, clinical record and policy review, and interview, the agency failed to ensure the plan of care had been updated to include all types of services and equipment required, frequency of visits, nutritional requirements, medications, and treatments for 5 of 12 records reviewed creating the potential to affect all 122 patients receiving services. (#4, 5, 8, 10, and 11)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC 08/21/08, included a plan of care established by the physician dated 01/22/14 to 03/22/14 and 03/23/14 to 05/22/14 for home health aide to provide services 4 - 7 days a week, 17 - 28 hours a week for 60 days. The plan of care failed to evidence the registered nurse had updated the plan of care with the changes related to the patient ' s surgery.</p> <p>a. An "Aide Weekly Visit" note dated 03/11/14 to 03/14/14 indicated the patient had foot surgery on 03/12/14. The note also stated "Due to recent foot surgery certain aspects of mobility charting has been held per physician."</p>	G000173					

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	<p>b. Patient # 4 was observed to have a cast on her right foot on 03/28/14 at 9:30 AM. The patient indicated she had a bunionectomy.</p> <p>c. Employee F indicated on 03/28/14 at 3:40 PM that she did not assess patient # 3 after her surgery nor did she speak with the physician for verification of post op (operation) orders. Employee F indicated she had spoken with the surgery center prior to the patient's surgery. The clinical record failed to evidence changes to the plan of care after the patient's surgery.</p> <p>2. Clinical record number 5, SOC 01/30/14, included a plan of care established by the physician dated 01/30/14 to 03/30/14 for home health aide services 5 - 7 days a week, 34 - 56 hours a week for 60 days. The plan of care failed to evidence the registered nurse had revised the plan of care with orders for management of pain.</p> <p>3. Clinical record number 8, SOC 03/27/09, included a plan of care established by the physician certification period of 12/31/13 to 02/28/14 for skilled nursing 5 - 7 days a week, 44 - 73 hours a week for 60 days. The plan of care failed to evidence the registered nurse had revised the plan of care to include</p>			
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	<p>ventilator settings and management and amount, frequency, and duration of tube feedings.</p> <p>4. Clinical record number 10's plan of care stated the patient was to receive Jevity 1.2 cal, 2 cans with 300 milliliters (ml) water to run from 6:00 PM to 6:00 AM at 65 ml / hour by gastrostomy tube. During a home visit on 03/28/14 at 8:15 AM, containers of Repleat were observed on the shelf. Employee D indicated the patient had been on this supplement since 2010. The plan of care failed to evidence the registered nurse had revised the plan of care to include the current nutritional supplement to be infused through the patient's gastrostomy tube.</p> <p>5. Clinical record number 11, SOC 02/25/10, included a plan of care established by the physician certification period of 02/04/14 to 04/04/14 for home health aide services 5 - 7 days a week, 17 - 28 hours a week for 60 days. The plan of care stated DME (durable medical equipment) and supplies included Hoyer lift, belt, suprapubic catheter, leg brace, hospital bed, and stand assist device. Physical and occupational therapy was listed as provided by a Medicare home health agency. Nutritional requirement indicated the patient was to receive nectar thick water with instructions to mix 2</p>						

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	<p>teaspoons with 4 ounces fluid as needed with intake water, and safety measures included aspiration and choking precautions.</p> <p>a. During a home visit on 03/31/14 at 10:00 AM, the patient was observed to have a trapeze bar over his bed, electronic air flow mattress and a bedside table. Employee C, a Registered Nurse / Case Manager, indicated the patient does not use the Hoyer lift and the patient had not received therapy services for a while. The trapeze, table, and mattress were not included on the plan of care.</p> <p>b. The patient was observed to have breakfast with hot tea, juice, and water. The fluids did not appear to have thickener in them and the patient was continuously clearing his throat. The home health aide indicated the patient did not like the thickener in his fluids, so his wife did not put it in his fluids. The home health aide indicated she doesn't leave the patient alone during meals and encourages the patient to clear his throat frequently.</p> <p>c. The plan of care failed to evidence the registered nurse had revised the plan of care to include the changes.</p>				

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	6. A policy titled "Assessment" dated 01/06/14 stated, "The plan of service is reviewed at least once every 60 days or when there is a change in the client / patient's response to therapy, when physician orders change, or at the request of the patient / client. If the service is ordered by a physician, there is evidence of communication to the physician regarding the patient / client's condition and orders are received prior to the change in the Plan of Services implemented. If new or revised treatment goals are indicated, these changes are documented in the record and reflected in any subsequent Plan of Service documents ... "			
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G000176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record, policy, and document review and interview, the agency failed to ensure the Registered Nurse documented coordinated services with agency staff and outside provider services and informed the physician of changes in the patient ' s condition for 6 of 12 records reviewed creating the potential to affect all current 122 patients receiving services with the agency. (# 2, 3, 4, 6, 7, 8)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 1/11/2014 to 03/11/2014 with orders for a LPN (Licensed Practical Nurse) 5 - 7 days per week, 30 - 50 hours per week for 60 days. The plan of care indicated the patient was eligible for 60 hours a month of skilled nursing via waiver.</p> <p>a. The plan of care included a Medicare home health agency was providing foley catheter changes monthly.</p>	G000176					

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	<p>b. The plan of care included an outside agency was providing Waiver services.</p> <p>c. The record failed to evidence any communication and/or coordination with the Medicare home health agency or the outside agency providing skilled nursing via Waiver.</p> <p>2. Clinical record number 3 included a plan of care dated 02/06/14 to 04/05/14 for home health aide to provide services 4 - 7 days a week, 6 - 10 hours a week for 60 days. The patient was eligible for home health aide services via waiver up to 80 hours a month for 60 days.</p> <p>The clinical record included an "Aide weekly note" dated 03/03/14 to 03/08/14 that stated in the comments by Employee A, "Came in a 955 [name of patient # 3] had call told me [he/she] had fell in a 10 got her off the floor check [him/her] out made sure was okay then call supervisor [name of Employee F] let her know what had happened and call [patient 's family member] waited for ... call. 11:30 told me to call ambulance they took [him/her] to [name of hospital]." The record failed to evidence Employee F notified the physician of the fall.</p>						

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	<p>3. Clinical record number 4, SOC 08/21/08, included plans of care dated 01/22/14 to 03/22/14 and 03/23/14 to 05/22/14 for home health aide to provide services 4 - 7 days a week, 17-28 hours a week for 60 days.</p> <p>a. An "Aide Weekly Visit" note dated 03/11/14 to 03/14/14 indicated the patient had foot surgery on 03/12/14. The note also stated, "Due to recent foot surgery certain aspects of mobility charting has been held per physician."</p> <p>b. Patient # 4 was observed to have a cast on her left foot on 03/28/14 at 9:30 AM. The patient indicated she had a bunionectomy.</p> <p>c. Employee F indicated on 03/28/14 at 3:40 PM that she did not speak with the physician for post op orders. Employee F indicated she had spoken with the surgery center prior to the patient's surgery.</p> <p>4. Clinical record number 5, SOC 01/29/14, included a plan of care for the certification period of 01/29/14 to 03/29/14 for home health aide services 5 - 7 days a week, 24 - 56 hours a week for 60 days. Clinical record number 5 included a supervisory visit note dated 02/28/14 stating the patient was having</p>			

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	<p>constant lower back pain at 8 on a scale of 1-10, indicating the patient "hurts whole lot." The assessment indicated the patient's pain medication was ineffective and the "PCG [patient caregiver] to notify MD of increased in pain level once she gets home from work." The clinical record failed to evidence Employee F notified the physician of the patient ' s pain and the ineffectiveness of the pain medication.</p> <p>5. Clinical record number 6, SOC 06/03/13, included a plan of care for the certification period of 01/29/14 to 03/29/14 with orders for the skilled nurse to provide feedings per gastrostomy tube four times daily via pump at a rate of "999 ml (milliliters) per hour, measure pre feeding residual volume, and to report any nutritional concerns to clinical supervisor, PCG (patient care giver), and PCP (primary care physician).</p> <p>a. Skilled nurse visit note dated 02/08/14 stated the patient's abdomen was tight on assessment after feeding. The clinical record failed to evidence the clinical supervisor, physician, and PCP were notified.</p> <p>b. Skilled nurse visit notes dated 02/24/14 and 02/26/14 stated the nurse documented high pre feeding residual</p>			
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	<p>measurements and vomiting. The clinical record failed to evidence the skilled nurse notified the physician.</p> <p>c. A skilled nurse visit note dated 03/12/14 stated the patient's mother contacted the physician and was instructed to hold the enteral feeding due to vomiting. There was no documentation that the nurse had contacted the physician to notify him of the poor tolerance to enteral feeding.</p> <p>6. Clinical record number 7 included a plan of care established by the physician for the certification periods of 12/16/13 to 02/23/14. The plan of care indicated safety and fall precautions were to be followed. The plan of care also indicated the group home staff would be responsible for all of the patient's care outside of bathing and morning ADL's (Activities of Daily Living).</p> <p>a. A "Clinical Documentation" note dated 02/06/14 stated, "I was providing routine shower care services to [name of patient # 7] [his/her] shower chair gave way causing him to fall over while [he/she] was strapped in the chair. Call for staff to assist me with getting [him/her] to a safe position and asked if [he/she] wanted me to get [name of patient # 7] vitals which [he/she]</p>						

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	<p>responded with a NO. Continued to talk to [name of patient # 7] checking for any visible signs of injury or distress. The patient didn't appear to be confused. Transferred [him/her] to [his/her] wheelchair and into the kitchen for breakfast. [Name of patient # 7] was conscious and sitting up upon my departure. Notified office of [name of patient] fall and spoke with [name of employee E] given an account of my actions in regards to the matter."</p> <p>b. An "Incident Report" dated 2/6/14 stated the incident happened at 7:40 AM on 02/06/14. The report indicated the fall was attended and there was a shower chair malfunction. A brief description of the event stated, "HHA [Home Health Aide] reported that while giving client a shower, the shower chair collapsed and client landed on his left side. The HHA stated that a screw came out of the chair and she believes that is what caused the collapse of the chair. She reports the chair is fairly new and she had not had any safety concerns with the chair prior. [Name of group home] staff was in the home and they were able to get him up using a draw sheet. Client denied any injury, no bruising or lesions observed by the HHA and client told HHA [he/she] was fine. Communicated to [name of group home] supervisor by</p>				

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	<p>Clinical Supervisor." The Incident Report stated follow up notification with the physician was on 02/06/14 at 12:00 PM and the group home representative was contacted by Employee F on 02/06/14 at 11:30 AM. The "Patient Status" section did not indicate an unanticipated ER visit. The "Data Elements utilized in incident/injury analysis" stated an interview with the Director of [name of group home]. "Corrective Action Taken patient/caregiver" action was NA (not applicable) and no employee corrective action was required. The record date was 02/13/14.</p> <p>c. Interview with Director from the group home on 03/26/14 at 12:10 PM indicated the staff in the home were not nurses and she was informed by her staff regarding the fall. Due to the legal situation, she was not able to give details and indicated the Administrator would have to be notified.</p> <p>d. Interview with patient # 7 family member, who was also the power of attorney, indicated he/she was not notified by the home health agency of the fall until the group home notified him/her when the patient was enroute to the hospital.</p>			
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	<p>e. Employee E, a Registered Nurse, indicated on 03/28/14 at 2:25 PM she had received a call from Employee H at approximately 8:25 AM on 02/26/14. Employee E indicated Employee H had told her patient # 7 had fallen and there was no injury. Employee E indicated she did not immediately notify Employee F (a Registered Nurse / Case Manager) because she had a meeting to attend. Employee E indicated Employee F was informed of the incident when she arrived at the agency at approximately 11:00 AM. Employee E indicated she did not follow up with the incident and she had not heard anything until the Director contacted her between 2:00 PM and 4:00 PM. Employee E indicated the representative wanted to know if something had happened with patient # 7 because the patient was acting "funny" and they were trying to find out why. Employee E indicated she was not sure if the representative was aware of the fall and proceeded to inform her about it. The clinical record failed to evidence any communication between Employees E, F, and H and the Director of the group home.</p> <p>f. Employee F indicated on 03/28/14 at 3:40 PM that she did not go assess patient # 7 after she was made aware of the fall. Employee F indicated</p>			

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	<p>she was trying to contact the Director and, at the same time, the Director was trying to contact her. Employee F indicated she did contact the physician's office and made them aware of the fall and no orders were given. Employee F indicated she did not notify the family nor did she spoke with Employee H regarding the incident. Employee F indicated Employee E told her patient # 7 had fallen with the shower chair, there was a bruise on his/her side, unsure where, and the group home staff was made aware. Employee F indicated the nurses do not go out into the home on changes of condition on home health aide only cases. Employee F indicated the patient would be given an option if they wanted someone to come out to assess him / her or be sent to the hospital for an evaluation. The clinical record failed to evidence any communication between Employees E, F, and H and the Director of the group home.</p> <p>7. Clinical record number 8, SOC 03/27/09, included a plan of care established by the physician certification period of 12/31/13 to 02/28/14 for skilled nursing 5 - 7 days a week, 44 - 73 hours a week for 60 days.</p> <p>a. A skilled nurse visit note dated 02/24/14 indicated the patient had a 5 cm</p>						

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	<p>(centimeter) scratch from the gastrostomy tube (gastric tube site) to the waist band. The clinical record failed to evidence the physician was notified.</p> <p>b. A skilled nurse visit note dated 02/25/14 indicated the patient had a reoccurring blister to the right eye. The clinical record failed to evidence the physician was notified.</p> <p>8. A policy titled "Care Coordination / Case Conference" dated 01/06/14 stated "Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the Director of Clinical Services or clinical designee ... Direct Care Staff will communicate changes in a timely manner via telephone, one - on - one meetings, case conferences and / or home visits. Documentation of communications will be included in the medical record on a communication note, case conference note, clinical visit note, supervisory visit note or in the system of record. A facsimile communication may also be received. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication ... "</p> <p>9. A policy titled "Assessment" dated</p>				

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	01/06/14 stated "The qualified clinician shall notify the Director of Clinical Services or clinical designee and / or physician of assessment findings or when there is a change in the patient condition which might warrant a change in medication and / or a change to the plan of care / service.			
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G000179	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy. Based on observation, clinical record review, and interview, the agency failed to ensure the licensed practical nurse (LPN) followed agency policy in regards to checking placement of a gastrostomy tube (g / tube) prior to administering medications and in and out catheter procedure 2 of 2 home visits attended (Employee G and D)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a home visit with patient # 2 on 03/27/14 at 8:25 AM, Employee G was observed to administer crushed pills dissolved in water through the g / tube without checking for placement by residual check or by auscultation. <p>The Director of Nursing indicated on 03/27/14 at 11:45 AM there was a policy for administration of medications through the g / tube and the observed practice was not consistent with their policy.</p> <ol style="list-style-type: none"> 2. During a home visit with patient # 10 on 3/28/14 at 8:20 AM, Employee D was observed to don gloves, remove a catheter from a package, wrap the catheter in her 	G000179			

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	<p>right hand, and walk to the next room (kitchen) to throw away the package. Upon Employee D ' s return, she lowered the head of the patient ' s bed with her left hand, removed the sheet over the patient, and proceeded to insert the foley catheter without lubricant or cleaning the urinary meatus before insertion.</p> <p>a. The plan of care dated 02/14/14 to 04/14/14 indicated the right anterior tibia wound care was to be performed every Monday and Thursday, and as needed for soiling or loss of dressing. The treatment orders stated to wash the wound with sterile water and to note the size, depth, drainage, and granulation tissue while uncovered. Aqua Cell or collagen dressing was to be used covered with a foam dressing.</p> <p>b. During a home visit on 03/31/14 at 8:00 AM, the patient was observed to have a dressing on the right shin. Employee D, a LPN, removed the dressing during the bed bath. The wound was open and draining. The LPN was observed to wash the area with soap and water that was used during the bath. The LPN was moistened a dressing with saline and applied it to the open wound and covered it with a dry dressing and secured it with tape. The LPN indicated the patient's leg brace tends to rub a sore</p>						

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	<p>to the area and she has to remind caregivers to use a long sock to prevent friction.</p> <p>c. Employee C, Registered Nurse / Case Manager, indicated on 03/31/14 at 12:00 PM she was not aware the patient continued to have a wound to the right shin.</p> <p>3. A policy titled "Gastrostomy or Jejunostomy Tube Feeding" dated 09/10 stated, "Medications may be administered through the feeding tube. Liquid preparations are preferred ... Flush tubing with water before and after to ensure full instillation of complete dose of medication. Each medication should be given separately and flushed with 20 to 30 ml (milliliters) water between each medication ... Aspirate stomach contents with syringe. Note amount of residual withdrawn and inject gastric fluid back into tube ... "</p> <p>4. A policy titled "Urinary - Intermittent Catheterization: Male" dated 09/10 stated, "Position the patient on back and wash the perineal area and penis thoroughly with soap and water ... open the catheterization tray and place the waterproof absorbent underpad under the buttocks extending forward between the legs. Open sterile packets. Put on sterile</p>						

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	<p>gloves using sterile technique. Place the fenestrated drape from the sterile catheter tray over the patient's penis. Adequate lubrication of catheter is necessary to prevent urethral trauma and pain and to aide in passage of catheter ..."</p> <p>5. A policy titled "Integumentary - Application of Wound Dressing" dated 09/10 stated, "Adhere to Standard Precautions ... Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves ... Clean wound with normal saline or wound cleanser per wound care orders ... Dress wound with appropriate dressings following manufacturer's guidelines and physician orders. "</p>			
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G000181	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the physician and registered nurse in performing specialized procedures. Based on observation, clinical record review, and interview, the licensed practical nurse (LPN) failed to provide sterile and/or aseptic technique for 2 of 5 patient's observed during home visits in relation to in and out catheter procedure, administering medications through a gastrostomy tube (g / tube), and wound care. (# 2 and 10)</p> <p>Findings include:</p> <p>1. During a home visit with patient # 2 on 03/27/14 at 8:25 AM, Employee G, LPN, was observed to administer crushed pills dissolved in water through the g / tube without donning gloves.</p> <p>The Director of Nursing indicated on 03/27/14 at 11:45 AM there was a policy for administration of medications through a g / tube and that the observed practice was not consistent with their policy.</p> <p>2. During a home visit with patient # 10 on 3/31/14 at 8:00 AM, Employee D, LPN, was observed to don gloves, removed a catheter from a package, wrap</p>	G000181					

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	<p>the catheter in her right hand, and walk to the next room (kitchen) to throw away the package. Upon Employee D 's return, she lowered the head of the patient 's bed with her left hand, removed the sheet over the patient, and proceeded to insert the foley catheter without cleaning the urinary meatus before insertion. Employee D indicated they don't do sterile technique in the home.</p> <p>While Employee D was nearing the end of the bed bath, the patient was observed to have a dressing on the right shin. Employee D removed the dressing during the bed bath wearing the same gloves used during the bath. The wound was open and draining. The LPN was observed to wash the area with soap and water that was used during the bath. Using the same gloves, the LPN was observed to moisten a dressing with saline, apply it to the open wound, cover it with a dry dressing, and secure it with tape.</p> <p>a. Employee C, Registered Nurse / Case Manager, indicated on 03/31/14 at 12:00 PM that she was not aware the patient continued to have a wound to the right shin. Employee C indicated Employee D did not follow proper nursing procedure and she will need to educate and have surprise</p>				

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	<p>supervisory visits.</p> <p>b. The Director of Nursing and the Administrator indicated on 03/31/14 at 4:00 PM that Employee D did not follow proper policy and procedure.</p> <p>4 A policy titled "Hand Hygiene" dated 01/06/14 stated "Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings ... "</p> <p>5. A policy titled "Urinary - Intermittent Catheterization: Male" dated 09/10 stated "Position the patient on back and wash the perineal area and penis thoroughly with soap and water ... open the catheterization tray and place the waterproof absorbent underpad under the buttocks extending forward between the legs. Open sterile packets. Put on sterile gloves using sterile technique. Place the fenestrated drape from the sterile catheter tray over the patient's penis ..."</p> <p>6. A policy titled "Integumentary - Application of Wound Dressing" dated 09/10 stated "Adhere to Standard Precautions ... Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in</p>			
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	appropriate containers. Decontaminate hands and don clean gloves ... "			

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G000182	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares equipment and materials for treatments, observing aseptic technique as required. Based on observation, clinical record review, and interview, the licensed practical nurse (LPN) failed to provide sterile and/or aseptic technique for 2 of 5 patient's observed during home visits in relation to in and out catheter procedure, administering medications through a gastrostomy tube (g / tube), and wound care. (# 2 and 10)</p> <p>Findings include:</p> <p>1. During a home visit with patient # 2 on 03/27/14 at 8:25 AM, Employee G, LPN, was observed to administer crushed pills dissolved in water through the g / tube without donning gloves.</p> <p>The Director of Nursing indicated on 03/27/14 at 11:45 AM there was a policy for administration of medications through a g / tube and that the observed practice was not consistent with their policy.</p> <p>2. During a home visit with patient # 10 on 3/31/14 at 8:00 AM, Employee D, LPN, was observed to don gloves,</p>	G000182					

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	<p>removed a catheter from a package, wrap the catheter in her right hand, and walk to the next room (kitchen) to throw away the package. Upon Employee D ' s return, she lowered the head of the patient ' s bed with her left hand, removed the sheet over the patient, and proceeded to insert the foley catheter without cleaning the urinary meatus before insertion. Employee D indicated they don't do sterile technique in the home.</p> <p>While Employee D was nearing the end of the bed bath, the patient was observed to have a dressing on the right shin. Employee D removed the dressing during the bed bath wearing the same gloves used during the bath. The wound was open and draining. The LPN was observed to wash the area with soap and water that was used during the bath. Using the same gloves, the LPN was observed to moisten a dressing with saline, apply it to the open wound, cover it with a dry dressing, and secure it with tape.</p> <p>The Director of Nursing and the Administrator indicated on 03/31/14 at 4:00 AM that the employee did not practice clean or sterile technique.</p> <p>4 A policy titled "Hand Hygiene" dated 01/06/14 stated "Personnel providing care</p>			
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	<p>in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings ... "</p> <p>5. A policy titled "Urinary - Intermittent Catheterization: Male" dated 09/10 stated "Position the patient on back and wash the perineal area and penis thoroughly with soap and water ... open the catheterization tray and place the waterproof absorbent underpad under the buttocks extending forward between the legs. Open sterile packets. Put on sterile gloves using sterile technique. Place the fenestrated drape from the sterile catheter tray over the patient's penis ... "</p> <p>6. A policy titled "Integumentary - Application of Wound Dressing" dated 09/10 stated "Adhere to Standard Precautions ... Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves ... "</p>			
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N000000	<p>This visit was a home health state complaint investigation survey.</p> <p>Complaint IN00144190 - Substantiated: State deficiencies related to the allegation are cited.</p> <p>Survey date: March, 25, 26, 27, 28, and 31, 2014</p> <p>Facility #: 002773</p> <p>Medicaid Vendor #: 200456380</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 122 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 9, 2014</p>	N000000			

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure a qualified professional notified the physician of changes in patients condition for 5 of 12 clinical records reviewed creating the potential to affect all of the agency's 122 patients. (#3, 5, 6, 7, 8)</p> <p>Findings include:</p> <p>1. Clinical record number 3 included a plan of care dated 02/06/14 to 04/05/14 for home health aide to provide services 4 - 7 days a week, 6 - 10 hours a week for 60 days. The patient was eligible for home health aide services via waiver up to 80 hours a month for 60 days.</p> <p>The clinical record included an "Aide weekly note" dated 03/03/14 to 03/08/14 that stated in the comments by Employee A, "Came in a 955 [name of patient # 3] had call told me she had fell in a 10 got her off the floor check her out made sure was okay then call supervisor [name of</p>	N000527		
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	<p>Employee F] let her know what had happened and call her daughter waited for her call. 11:30 told me to call ambulance they took her to [name of hospital]." The clinical record failed to evidence Employee F notified the physician.</p> <p>2. Clinical record number 5, start of care (SOC) 01/29/14, included a plan of care for the certification period of 01/29/14 to 03/29/14 for home health aide services 5 - 7 days a week, 24 - 56 hours a week for 60 days.</p> <p>Clinical record number 5 included a supervisory visit note dated 02/28/14 stating the patient was having constant lower back pain on a scale of 8 out of 10, indicating the patient "hurts whole lot." The assessment indicated the patient's pain medication was ineffective and the "PCG [patient caregiver] to notify MD of increased in pain level once she gets home from work." The clinical record failed to evidence Employee F notified the physician of the findings.</p> <p>3. Clinical record number 6, SOC 06/03/13, included a plan of care for the certification period of 01/29/14 to 03/29/14 with orders for the skilled nurse to provide feedings per gastrostomy tube four times daily via pump at a rate of 999 ml (milliliters) per hour, measure pre</p>				

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	<p>feeding residual volume, and to report any nutritional concerns to clinical supervisor, PCG (patient care giver), and PCP (primary care physician).</p> <p>a. A skilled nurse visit note dated 02/08/14 stated the patient's abdomen was tight on assessment post feeding. The clinical record failed to evidence that the clinical supervisor and PCP were notified.</p> <p>b. A skilled nurse visit note dated 02/24/14 and 02/26/14 stated the nurse documented high pre feeding residual measurements and vomiting. The clinical record failed to evidence that the skilled nurse notified the physician.</p> <p>c. A skilled nurse visit note dated 03/12/14 stated the patient's mother contacted the physician and was instructed to hold the enteral feeding due to vomiting. There was no documentation the nurse had contacted the physician to notify him of the poor tolerance to enteral feeding. The clinical record failed to evidence a physician order to hold the tube feeding.</p> <p>4. Clinical record number 7 included a plan of care established by the physician for the certification periods of 12/16/13 to 02/23/14.</p>						

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	<p>a. Review of a "Weekly Aide Note" stated Employee H, a home health aide, saw patient # 7 on 02/03/14 and 02/04/14 between the hours of 7:00 AM and 9:00 AM. The comment section located at the bottom of the note dated 02/03/14 stated Employee H contacted the agency in relation to a "pressure soaked area of what appeared to be beginning of a pressure sore" on patient # 7's heal area. On 02/04/14, a note by Employee H stated upon giving care to patient # 7, "I noticed an additional pressure sore located [blank space] of his foot, swelling present in that foot as well ... Blister present on the heal of his foot." The clinical record failed to evidence that the physician was notified.</p> <p>b. On 02/06/14, the HHA notified office and informed Employee # E, a Registered Nurse, of patient # 7's fall. The clinical record failed to evidence the physician was notified immediately of the fall.</p> <p>5. Clinical record number 8, SOC 03/27/09, included a plan of care established by the physician certification period of 12/31/13 to 02/28/14 for skilled nursing 5 - 7 days a week, 44 - 73 hours a week for 60 days.</p>			
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	<p>a. A skilled nurse visit note dated 02/24/14 indicated the patient had a 5 cm (centimeter) scratch from the gastrostomy tube (gastric tube site) to the waste band. The clinical record failed to evidence the physician was notified.</p> <p>b. A skilled nurse visit note dated 02/25/14 indicated the patient had a reoccurring blister to the right eye. The clinical record failed to evidence the physician was notified.</p> <p>6. The Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 03/13/14 at 3:30 PM.</p> <p>7. An undated job description for a licensed practical nurse (LPN) stated "Changes in patient's condition are identified ... Physician notification to obtain necessary orders for intervention[s] per state regulations ... notification to obtain necessary orders for intervention[s] per state regulations, Performs specific treatments and medication administration in accordance with physician orders ... "</p> <p>8. An undated job description for a registered nurse (RN) stated "Reports changes in the patients medical or mental</p>				

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	condition to the attending physician and the Director of Clinical Services ... "			

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N000532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure a qualified professional notified the physician of changes in patients condition for 5 of 12 clinical records reviewed creating the potential to affect all of the agency's 122 patients. (#3, 5, 6, 7, 8)</p> <p>Findings include:</p> <p>1. Clinical record number 3 included a plan of care dated 02/06/14 to 04/05/14 for home health aide to provide services 4 - 7 days a week, 6 - 10 hours a week for 60 days. The patient was eligible for home health aide services via waiver up to 80 hours a month for 60 days.</p> <p>The clinical record included an "Aide weekly note" dated 03/03/14 to 03/08/14 that stated in the comments by Employee A, "Came in a 955 [name of patient # 3] had call told me she had fell in a 10 got</p>	N000532					

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	<p>her off the floor check her out made sure was okay then call supervisor [name of Employee F] let her know what had happened and call her daughter waited for her call. 11:30 told me to call ambulance they took her to [name of hospital]." The clinical record failed to evidence Employee F notified the physician.</p> <p>2. Clinical record number 5, start of care (SOC) 01/29/14, included a plan of care for the certification period of 01/29/14 to 03/29/14 for home health aide services 5 - 7 days a week, 24 - 56 hours a week for 60 days.</p> <p>Clinical record number 5 included a supervisory visit note dated 02/28/14 stating the patient was having constant lower back pain on a scale of 8 out of 10, indicating the patient "hurts whole lot." The assessment indicated the patient's pain medication was ineffective and the "PCG [patient caregiver] to notify MD of increased in pain level once she gets home from work." The clinical record failed to evidence Employee F notified the physician of the findings.</p> <p>3. Clinical record number 6, SOC 06/03/13, included a plan of care for the certification period of 01/29/14 to 03/29/14 with orders for the skilled nurse to provide feedings per gastrostomy tube</p>				

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	<p>four times daily via pump at a rate of 999 ml (milliliters) per hour, measure pre feeding residual volume, and to report any nutritional concerns to clinical supervisor, PCG (patient care giver), and PCP (primary care physician).</p> <p>a. A skilled nurse visit note dated 02/08/14 stated the patient's abdomen was tight on assessment post feeding. The clinical record failed to evidence that the clinical supervisor and PCP were notified.</p> <p>b. A skilled nurse visit note dated 02/24/14 and 02/26/14 stated the nurse documented high pre feeding residual measurements and vomiting. The clinical record failed to evidence that the skilled nurse notified the physician.</p> <p>c. A skilled nurse visit note dated 03/12/14 stated the patient's mother contacted the physician and was instructed to hold the enteral feeding due to vomiting. There was no documentation the nurse had contacted the physician to notify him of the poor tolerance to enteral feeding. The clinical record failed to evidence a physician order to hold the tube feeding.</p> <p>4. Clinical record number 7 included a plan of care established by the physician</p>			
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	<p>for the certification periods of 12/16/13 to 02/23/14.</p> <p>a. Review of a "Weekly Aide Note" stated Employee H, a home health aide, saw patient # 7 on 02/03/14 and 02/04/14 between the hours of 7:00 AM and 9:00 AM. The comment section located at the bottom of the note dated 02/03/14 stated Employee H contacted the agency in relation to a "pressure soaked area of what appeared to be beginning of a pressure sore" on patient # 7's heal area. On 02/04/14, a note by Employee H stated upon giving care to patient # 7, "I noticed an additional pressure sore located [blank space] of his foot, swelling present in that foot as well ... Blister present on the heal of his foot." The clinical record failed to evidence that the physician was notified.</p> <p>b. On 02/06/14, the HHA notified office and informed Employee # E, a Registered Nurse, of patient # 7's fall. The clinical record failed to evidence the physician was notified immediately of the fall.</p> <p>5. Clinical record number 8, SOC 03/27/09, included a plan of care established by the physician certification period of 12/31/13 to 02/28/14 for skilled nursing 5 - 7 days a week, 44 - 73 hours a</p>			
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	<p>week for 60 days.</p> <p>a. A skilled nurse visit note dated 02/24/14 indicated the patient had a 5 cm (centimeter) scratch from the gastrostomy tube (gastric tube site) to the waste band. The clinical record failed to evidence the physician was notified.</p> <p>b. A skilled nurse visit note dated 02/25/14 indicated the patient had a reoccurring blister to the right eye. The clinical record failed to evidence the physician was notified.</p> <p>6. The Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 03/13/14 at 3:30 PM.</p> <p>7. An undated job description for a licensed practical nurse (LPN) stated "Changes in patient's condition are identified ... Physician notification to obtain necessary orders for intervention[s] per state regulations ... notification to obtain necessary orders for intervention[s] per state regulations, Performs specific treatments and medication administration in accordance with physician orders ... "</p> <p>8. An undated job description for a</p>				

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	registered nurse (RN) stated "Reports changes in the patients medical or mental condition to the attending physician and the Director of Clinical Services ... "			

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N000541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, Indiana State Department of Health (ISDH) document, hospital and clinical record, and policy review and interview, the Registered Nurse / Case Manager failed to ensure patients were assessed after a fall, after surgery, and with wounds for 4 of 12 patients reviewed creating the potential to affect all current 122 patients who received services from the agency. (# 3, 4, 7, and 11)</p> <p>Findings include,</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification periods of 12/16/13 to 02/23/14. The plan of care indicated safety and fall precautions were to be followed. The plan of care also indicated the group home staff would be responsible for all of the patient's care outside of bathing and morning ADL's (Activities of Daily Living).</p> <p>a. An ISDH narrative report dated 2/6/14 provided by BDDS indicated</p>	N000541			

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	<p>patient # 7 was transported to a hospital on 2/6/14 due to lethargy, vomiting, and congestion. The group home staff was notified at 8:45 A.M. by their own staff person. The group home staff indicated the home health aide from the home health agency assisted patient # 7 with his shower and the shower chair had fallen over onto the left side. The report indicated the the shower chair lost a screw from the leg and did not support the patient's weight. The group home staff indicated the patient did not hit his head nor did he have any noticeable injuries. The group home staff indicated the patient did not complain of pain. The group home nurse had assessed the patient at approximately 3:00 PM after the group home staff reported patient # 7 had vomited and was tired. After the nurse assessed the patient, it was determined that the patient needed further evaluation and 911 was contacted.</p> <p>b. A "Weekly Aide Note" stated Employee H, a home health aide, saw patient # 7 on 02/06/14 between the hours of 7:00 AM and 9:00 PM. The initial [initials]. was signed in place of the patient indicating verification of the home health aide visit.</p> <p>c. A "Clinical Documentation" note dated 02/06/14 stated, "I was providing</p>				

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	<p>routine shower care services to [name of patient # 7] [his/her] shower chair gave way causing him to fall over while [he/she] was strapped in the chair. Call for staff to assist me with getting [him/her] to a safe position and asked if [he/she] wanted me to get [name of patient # 7] vitals which [he/she] responded with a NO. Continued to talk to [name of patient # 7] checking for any visible signs of injury or distress. The patient didn't appear to be confused. Transferred [him/her] to [his/her] wheelchair and into the kitchen for breakfast. [Name of patient # 7] was conscious and sitting up upon my departure. Notified office of [name of patient] fall and spoke with [name of employee E] given an account of my actions in regards to the matter."</p> <p>d. An "Incident Report" dated 2/6/14 stated the incident happened at 7:40 AM on 02/06/14. The report indicated the fall was attended and there was a shower chair malfunction. A brief description of the event stated, "HHA [Home Health Aide] reported that while giving client a shower, the shower chair collapsed and client landed on his left side. The HHA stated that a screw came out of the chair and she believes that is what caused the collapse of the chair. She reports the chair is fairly new and she had not had</p>			
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	<p>any safety concerns with the chair prior. [Name of group home] staff was in the home and they were able to get him up using a draw sheet. Client denied any injury, no bruising or lesions observed by the HHA and client told HHA [he/she] was fine. Communicated to [name of group home] supervisor by Clinical Supervisor." The Incident Report stated follow up notification with the physician was on 02/06/14 at 12:00 PM and the group home representative was contacted by Employee F on 02/06/14 at 11:30 AM. The "Patient Status" section did not indicate an unanticipated ER visit. The "Data Elements utilized in incident/injury analysis" stated an interview with the Director of [name of group home].</p> <p>"Corrective Action Taken patient/caregiver" action was NA (not applicable) and no employee corrective action was required. The record date was 02/13/14.</p> <p>e. A Hospital Report on 02/06/14 indicated the patient was examined by the physician at 4:33 PM. The reason for the visit was "altered mental status-poor communication ... two episodes of vomiting Tues AM with decreased responsiveness ... Supervisor states staff called her this AM to report pt [patient] had vomited 2 x [twice]. When supervisor went to check on pt later in</p>			
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	<p>day he was soaked in urine and unresponsive." General Description "unresponsive, oral airway in place ... left pupil 304 mm [millimeters] no response, right pupil 2 mm no response ... 2 sm [small] appearing bruises near R [right] temporal area."</p> <p>f. "ED Emergency Record" on 02/06/14 stated "CT head: Large subdural hematoma w/ [with] herniation. [Family Member] here, notified of CT results like fatal nature. Hospice contacted ... "</p> <p>g. CT report on 02/06/14 stated "Large hyperacute right - sided subdural, up to 15 mm thickness. 17 mm subfalcine herniation. Right uncus and parahippocampal herniation. Effaced basal cisterns. Bilateral chronic infarcts of the globus pallid. Impression: Large hyperacute right - sided subdural, subfalcine and transterntorial herniation."</p> <p>h. ER MD Discharge Disposition stated the patient was admitted on 02/06/14 at 4:11 PM with a diagnosis of "Subdural hematoma, acute ... "</p> <p>i. Interview with Director from the group home on 03/26/14 at 12:10 PM indicated the staff in the home were not nurses and she was informed by her staff</p>				

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	<p>regarding the fall. Due to the legal situation, she was not able to give details and indicated the Administrator would have to be notified.</p> <p>j. Interview with patient # 7 family member, who was also the power of attorney, indicated he was not notified by the home health agency of the fall until the group home notified him when the patient was enroute to the hospital.</p> <p>k. The Director of Nursing (DoN) indicated on 03/27/14 at 11:30 AM that the nurses do not go out into the homes when there was a change in condition. The agency was instructing the aides to contact 911. The DoN indicated the reason why the nurse did not go out to assess patient # 7 was because the group home nurse was going to assess the patient and when the agency aide left, he/she was "appropriate." The group home did have a nurse available to the residents in the group home but patient # 7 did not go out immediately. The DoN indicated the agency followed up with the group home Director. The DoN indicated there was a protected investigation by the legal department. The DoN indicated if they had parameter where their staff was to go see the patient, someone would have gone.</p>			
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	<p>l. The Director of Nursing and the Administrator indicated on 03/27/14 at 6:00 PM the agency needed more staff and indicated Employee F, a Registered Nurse / Case Manager, should have gone to the home and assessed the patient after the fall.</p> <p>m. Employee E, a Registered Nurse, indicated on 03/28/14 at 2:25 PM she had received a call from Employee H at approximately 8:25 AM on 02/26/14. Employee E indicated Employee H had told her patient # 7 had fallen and there was no injury. Employee E indicated she did not immediately notify Employee F (a Registered Nurse / Case Manager) because she had a meeting to attend. Employee E indicated Employee F was informed of the incident when she arrived at the agency at approximately 11:00 AM. Employee E indicated she did not follow up with the incident and she had not heard anything until the Director contacted her between 2:00 PM and 4:00 PM. Employee E indicated the representative wanted to know if something had happened with patient # 7 because the patient was acting "funny" and they were trying to find out why. Employee E indicated she was not sure if the representative was aware of the fall and proceeded to inform her about it.</p>				

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	<p>n. Employee F indicated on 03/28/14 at 3:40 PM that she did not go assess patient # 7 after she was made aware of the fall. Employee F indicated she was trying to contact the Director and, at the same time, the Director was trying to contact her. Employee F indicated she did contact the physician's office and made them aware of the fall and no orders were given. Employee F indicated she did not notify the family nor did she spoke with Employee H regarding the incident. Employee F indicated Employee E told her patient # 7 had fallen with the shower chair, there was a bruise on his/her side, unsure where, and the group home staff was made aware. Employee F indicated the nurses do not go out into the home on changes of condition on home health aide only cases. Employee F indicated the patient would be given an option if they wanted someone to come out to assess him / her or be sent to the hospital for an evaluation.</p> <p>o. Review of a "Weekly Aide Note" stated Employee H, a home health aide, saw patient # 7 on 02/03/14 and 02/04/14 between the hours of 7:00 AM and 9:00 AM. The comment section located at the bottom of the note dated 02/03/14 stated Employee H contacted the agency in relation to a "pressure soaked area of</p>						

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	<p>what appeared to be beginning of a pressure sore" on patient # 7's heal area. On 02/04/14 stated Employee H upon giving care to patient # 7, "I noticed an additional pressure sore located [blank space] of [his/her] foot, swelling present in that foot as well ... Blister present on the heal of [his/her] foot." The clinical record failed to evidence the patient was seen by the Case Manager or another Registered Nurse.</p> <p>2. Clinical record number 3 included a plan of care dated 02/06/14 to 04/05/14 for home health aide to provide services 4 - 7 days a week, 6 - 10 hours a week for 60 days.</p> <p>a. An "Aide Weekly Visit" note dated 03/03/14 to 03/08/14 stated, in the comments by Employee A, "Came in a 955 [name of patient # 3] had call told me [he/she] had fell in a 10 got [him/her] off the floor check [him/her] out made sure was okay then call supervisor [name of Employee F] let her know what had happened and call [his/her] daughter waited for her call. 11:30 told me to call ambulance they took [him/her] to [name of hospital]." The clinical record failed to evidence Employee F made a visit or had followed up after the patient fell.</p> <p>b. Employee F indicated on 03/28/14</p>			
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	<p>at 3:40 PM that she did not go assess patient # 3 after she was made aware of the fall.</p> <p>3. Clinical record number 4 included a plan of care dated 03/23/14 to 05/22/14 for home health aide service.</p> <p>a. An "Aide Weekly Visit" note dated 03/11/14 to 03/14/14 stated the patient had foot surgery on 03/12/14. The note also stated "Due to recent foot surgery certain aspects of mobility charting has been held per physician."</p> <p>b. Patient # 4 was observed to have a cast on her left foot on 03/28/14 at 9:30 AM. The patient indicated he/she had a bunionectomy.</p> <p>c. Employee F indicated on 03/28/14 at 3:40 PM that she did not go assess patient # 3 after her surgery nor did she speak with the physician for verification of post op orders. Employee F indicated she had spoken with the surgery center prior to the patient's surgery.</p> <p>4. Clinical record number 10 included a plan of care established by the physician for certification 02/14/14 to 04/14/14 for skilled nursing services 3 to 5 days a week, 24 to 40 hours a week for 60 days.</p>			

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	<p>a. The plan of care indicated the right anterior tibia wound care was to be performed every Monday and Thursday, and as needed for soiling or loss of dressing. The treatment orders stated to wash the wound with sterile water and note size, depth, drainage, and granulation tissue while uncovered. Aqua Cell or collagen dressing was to be covered with a foam dressing.</p> <p>b. Employee C indicated on 03/31/14 at 12:00 PM that she was not aware the patient continued to have a wound to the right shin. The clinical record failed to evidence the wound had been assessed weekly.</p> <p>5. A policy titled "Care Coordination / Case Conference" dated 01/06/14 stated "Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the Director of Clinical Services or clinical designee ... Direct Care Staff will communicate changes in a timely manner via telephone, one - on - one meetings, case conferences and / or home visits. Documentation of communications will be included in the medical record on a communication note, case conference note, clinical visit note, supervisory visit note or in the system of record. A facsimile communication may also be received. Documentation will</p>				

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	<p>include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication ... "</p> <p>6. A policy dated 01/06/14 titled "Ongoing Evaluation" stated, "During each home visit, the Direct Care Staff will re-evaluate the patient according to the problems identified during the initial and subsequent visits. As qualified by skill level, the Direct Care Staff will re-evaluate the patient [as appropriate] for ... Pain status ... Skin integrity ... Neuro / Mental status. Re-evaluation should focus on ... Changes in patient condition ... changes in patient's care environment or support systems. Based on each re-evaluation, the plan of care, including problems, needs, goals, and outcomes will be reviewed and revised. Based on the findings of the re-evaluation, additional orders will be obtained and forwarded to the physician ... The Direct Care Staff shall notify the Director of Clinical Services or clinical designee and / or physician when there is a change in the patient condition which might warrant a change in medication and / or a change to the plan of care."</p> <p>7. An undated Job Description / Essential Functions for a Clinical</p>				

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	<p>Supervisor was provided by the Director of Nursing on 03/31/14 at 5:00 PM. The job description states, "The Clinical Supervisor is directly responsible for clinical activities of the field staff. Plans, implements and evaluates patient's plans of care for appropriateness to individual patients needs ... Reports changes in the patients medical or mental condition to the attending physician and the Director of Clinical Services."</p> <p>8. A policy titled "Integumentary - Pressure Ulcer and Wound Assessment" dated 09/10 stated, "Reassess the wound weekly ... reevaluate the treatment plan as soon as any evidence of deterioration is noted ... If progress is not demonstrated within two to four weeks, reevaluate the overall treatment plan, adherence to the treatment plan and make appropriate changes and referrals ... "</p>			
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N000542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on observation, clinical record and policy review, and interview, the agency failed to ensure the plan of care had been updated to include all types of services and equipment required, frequency of visits, nutritional requirements, medications, and treatments for 5 of 12 records reviewed creating the potential to affect all 122 patients receiving services. (#4, 5, 8, 10, and 11)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC 08/21/08, included a plan of care established by the physician dated 01/22/14 to 03/22/14 and 03/23/14 to 05/22/14 for home health aide to provide services 4 - 7 days a week, 17 - 28 hours a week for 60 days. The plan of care failed to evidence the registered nurse had updated the plan of care with the changes related to the patient ' s surgery.</p> <p>a. An "Aide Weekly Visit" note dated 03/11/14 to 03/14/14 indicated the patient had foot surgery on 03/12/14.</p>	N000542			

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	<p>The note also stated "Due to recent foot surgery certain aspects of mobility charting has been held per physician."</p> <p>b. Patient # 4 was observed to have a cast on her right foot on 03/28/14 at 9:30 AM. The patient indicated she had a bunionectomy.</p> <p>c. Employee F indicated on 03/28/14 at 3:40 PM that she did not assess patient # 3 after her surgery nor did she speak with the physician for verification of post op (operation) orders. Employee F indicated she had spoken with the surgery center prior to the patient's surgery. The clinical record failed to evidence changes to the plan of care after the patient's surgery.</p> <p>2. Clinical record number 5, SOC 01/30/14, included a plan of care established by the physician dated 01/30/14 to 03/30/14 for home health aide services 5 - 7 days a week, 34 - 56 hours a week for 60 days. The plan of care failed to evidence the registered nurse had revised the plan of care with orders for management of pain.</p> <p>3. Clinical record number 8, SOC 03/27/09, included a plan of care established by the physician certification period of 12/31/13 to 02/28/14 for skilled</p>			
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	<p>nursing 5 - 7 days a week, 44 - 73 hours a week for 60 days. The plan of care failed to evidence the registered nurse had revised the plan of care to include ventilator settings and management and amount, frequency, and duration of tube feedings.</p> <p>4. Clinical record number 10's plan of care stated the patient was to receive Jevity 1.2 cal, 2 cans with 300 milliliters (ml) water to run from 6:00 PM to 6:00 AM at 65 ml / hour by gastrostomy tube. During a home visit on 03/28/14 at 8:15 AM, containers of Repleat were observed on the shelf. Employee D indicated the patient had been on this supplement since 2010. The plan of care failed to evidence the registered nurse had revised the plan of care to include the current nutritional supplement to be infused through the patient's gastrostomy tube.</p> <p>5. Clinical record number 11, SOC 02/25/10, included a plan of care established by the physician certification period of 02/04/14 to 04/04/14 for home health aide services 5 - 7 days a week, 17 - 28 hours a week for 60 days. The plan of care stated DME (durable medical equipment) and supplies included Hoyer lift, belt, suprapubic catheter, leg brace, hospital bed, and stand assist device. Physical and occupational therapy was</p>			

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	<p>listed as provided by a Medicare home health agency. Nutritional requirement indicated the patient was to receive nectar thick water with instructions to mix 2 teaspoons with 4 ounces fluid as needed with intake water, and safety measures included aspiration and choking precautions.</p> <p>a. During a home visit on 03/31/14 at 10:00 AM, the patient was observed to have a trapeze bar over his bed, electronic air flow mattress and a bedside table. Employee C, a Registered Nurse / Case Manager, indicated the patient does not use the Hoyer lift and the patient had not received therapy services for a while. The trapeze, table, and mattress were not included on the plan of care.</p> <p>b. The patient was observed to have breakfast with hot tea, juice, and water. The fluids did not appear to have thickener in them and the patient was continuously clearing his throat. The home health aide indicated the patient did not like the thickener in his fluids, so his wife did not put it in his fluids. The home health aide indicated she doesn't leave the patient alone during meals and encourages the patient to clear his throat frequently.</p>			
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	<p>c. The plan of care failed to evidence the registered nurse had revised the plan of care to include the changes.</p> <p>6. A policy titled "Assessment" dated 01/06/14 stated, "The plan of service is reviewed at least once every 60 days or when there is a change in the client / patient's response to therapy, when physician orders change, or at the request of the patient / client. If the service is ordered by a physician, there is evidence of communication to the physician regarding the patient / client's condition and orders are received prior to the change in the Plan of Services implemented. If new or revised treatment goals are indicated, these changes are documented in the record and reflected in any subsequent Plan of Service documents ... "</p>						

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N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record, policy, and document review and interview, the agency failed to ensure the Registered Nurse documented coordinated services with agency staff and outside provider services for 2 of 12 records reviewed creating the potential to affect all current 122 patients receiving services with the agency. (# 2, 7)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 1/11/2014 to 03/11/2014 with orders for a LPN (Licensed Practical Nurse) 5 - 7 days per week, 30 - 50 hours per week for 60 days. The plan of care indicated the patient was eligible for 60 hours a month of skilled nursing via waiver.</p> <p>a. The plan of care included a Medicare home health agency was providing foley catheter changes monthly.</p> <p>b. The plan of care included an</p>	N000545		
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	<p>outside agency was providing Waiver services.</p> <p>c. The record failed to evidence any communication and/or coordination with the Medicare home health agency or the outside agency providing skilled nursing via Waiver.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification periods of 12/16/13 to 02/23/14. The plan of care indicated safety and fall precautions were to be followed. The plan of care also indicated the group home staff would be responsible for all of the patient's care outside of bathing and morning ADL's (Activities of Daily Living).</p> <p>a. A "Clinical Documentation" note dated 02/06/14 stated, "I was providing routine shower care services to [name of patient # 7] [his/her] shower chair gave way causing him to fall over while [he/she] was strapped in the chair. Call for staff to assist me with getting [him/her] to a safe position and asked if [he/she] wanted me to get [name of patient # 7] vitals which [he/she] responded with a NO. Continued to talk to [name of patient # 7] checking for any visible signs of injury or distress. The patient didn't appear to be confused.</p>			
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	<p>Transferred [him/her] to [his/her] wheelchair and into the kitchen for breakfast. [Name of patient # 7] was conscious and sitting up upon my departure. Notified office of [name of patient] fall and spoke with [name of employee E] given an account of my actions in regards to the matter."</p> <p>b. An "Incident Report" dated 2/6/14 stated the incident happened at 7:40 AM on 02/06/14. The report indicated the fall was attended and there was a shower chair malfunction. A brief description of the event stated, "HHA [Home Health Aide] reported that while giving client a shower, the shower chair collapsed and client landed on his left side. The HHA stated that a screw came out of the chair and she believes that is what caused the collapse of the chair. She reports the chair is fairly new and she had not had any safety concerns with the chair prior. [Name of group home] staff was in the home and they were able to get him up using a draw sheet. Client denied any injury, no bruising or lesions observed by the HHA and client told HHA [he/she] was fine. Communicated to [name of group home] supervisor by Clinical Supervisor." The Incident Report stated follow up notification with the physician was on 02/06/14 at 12:00 PM and the group home representative</p>			
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	<p>was contacted by Employee F on 02/06/14 at 11:30 AM. The "Patient Status" section did not indicate an unanticipated ER visit. The "Data Elements utilized in incident/injury analysis" stated an interview with the Director of [name of group home]. "Corrective Action Taken patient/caregiver" action was NA (not applicable) and no employee corrective action was required. The record date was 02/13/14.</p> <p>c. Interview with Director from the group home on 03/26/14 at 12:10 PM indicated the staff in the home were not nurses and she was informed by her staff regarding the fall. Due to the legal situation, she was not able to give details and indicated the Administrator would have to be notified.</p> <p>d. Interview with patient # 7 family member, who was also the power of attorney, indicated he/she was not notified by the home health agency of the fall until the group home notified him/her when the patient was enroute to the hospital.</p> <p>e. Employee E, a Registered Nurse, indicated on 03/28/14 at 2:25 PM she had received a call from Employee H at approximately 8:25 AM on 02/26/14.</p>			
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	<p>Employee E indicated Employee H had told her patient # 7 had fallen and there was no injury. Employee E indicated she did not immediately notify Employee F (a Registered Nurse / Case Manager) because she had a meeting to attend. Employee E indicated Employee F was informed of the incident when she arrived at the agency at approximately 11:00 AM. Employee E indicated she did not follow up with the incident and she had not heard anything until the Director contacted her between 2:00 PM and 4:00 PM. Employee E indicated the representative wanted to know if something had happened with patient # 7 because the patient was acting "funny" and they were trying to find out why. Employee E indicated she was not sure if the representative was aware of the fall and proceeded to inform her about it. The clinical record failed to evidence any communication between Employees E, F, and H and the Director of the group home.</p> <p>f. Employee F indicated on 03/28/14 at 3:40 PM that she did not go assess patient # 7 after she was made aware of the fall. Employee F indicated she was trying to contact the Director and, at the same time, the Director was trying to contact her. Employee F indicated she did contact the physician's</p>						

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	<p>office and made them aware of the fall and no orders were given. Employee F indicated she did not notify the family nor did she spoke with Employee H regarding the incident. Employee F indicated Employee E told her patient # 7 had fallen with the shower chair, there was a bruise on his/her side, unsure where, and the group home staff was made aware. Employee F indicated the nurses do not go out into the home on changes of condition on home health aide only cases. Employee F indicated the patient would be given an option if they wanted someone to come out to assess him / her or be sent to the hospital for an evaluation. The clinical record failed to evidence any communication between Employees E, F, and H and the Director of the group home.</p> <p>3. A policy titled "Care Coordination / Case Conference" dated 01/06/14 stated "Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the Director of Clinical Services or clinical designee ... Direct Care Staff will communicate changes in a timely manner via telephone, one - on - one meetings, case conferences and / or home visits. Documentation of communications will be included in the medical record on a communication note, case conference note, clinical visit note,</p>						

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N000553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies. Based on observation, clinical record review, and interview, the agency failed to ensure the licensed practical nurse (LPN) followed agency policy in regards to checking placement of a gastrostomy tube (g / tube) prior to administering medications and in and out catheter procedure 2 of 2 home visits attended (Employee G and D)</p> <p>Findings include:</p> <p>1. During a home visit with patient # 2 on 03/27/14 at 8:25 AM, Employee G was observed to administer crushed pills dissolved in water through the g / tube without checking for placement by residual check or by auscultation.</p> <p>The Director of Nursing indicated on 03/27/14 at 11:45 AM there was a policy for administration of medications through the g / tube and the observed practice was not consistent with their policy.</p> <p>2. During a home visit with patient # 10</p>	N000553		
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	<p>on 3/28/14 at 8:20 AM, Employee D was observed to don gloves, remove a catheter from a package, wrap the catheter in her right hand, and walk to the next room (kitchen) to throw away the package. Upon Employee D ' s return, she lowered the head of the patient ' s bed with her left hand, removed the sheet over the patient, and proceeded to insert the foley catheter without lubricant or cleaning the urinary meatus before insertion.</p> <p>a. The plan of care dated 02/14/14 to 04/14/14 indicated the right anterior tibia wound care was to be performed every Monday and Thursday, and as needed for soiling or loss of dressing. The treatment orders stated to wash the wound with sterile water and to note the size, depth, drainage, and granulation tissue while uncovered. Aqua Cell or collagen dressing was to be used covered with a foam dressing.</p> <p>b. During a home visit on 03/31/14 at 8:00 AM, the patient was observed to have a dressing on the right shin. Employee D, a LPN, removed the dressing during the bed bath. The wound was open and draining. The LPN was observed to wash the area with soap and water that was used during the bath. The LPN was moistened a dressing with saline and applied it to the open wound</p>						

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	<p>and covered it with a dry dressing and secured it with tape. The LPN indicated the patient's leg brace tends to rub a sore to the area and she has to remind caregivers to use a long sock to prevent friction.</p> <p>c. Employee C, Registered Nurse / Case Manager, indicated on 03/31/14 at 12:00 PM she was not aware the patient continued to have a wound to the right shin.</p> <p>3. A policy titled "Gastrostomy or Jejunostomy Tube Feeding" dated 09/10 stated, "Medications may be administered through the feeding tube. Liquid preparations are preferred ... Flush tubing with water before and after to ensure full instillation of complete dose of medication. Each medication should be given separately and flushed with 20 to 30 ml (milliliters) water between each medication ... Aspirate stomach contents with syringe. Note amount of residual withdrawn and inject gastric fluid back into tube ... "</p> <p>4. A policy titled "Urinary - Intermittent Catheterization: Male" dated 09/10 stated, "Position the patient on back and wash the perineal area and penis thoroughly with soap and water ... open the catheterization tray and place the</p>			
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	<p>waterproof absorbent underpad under the buttocks extending forward between the legs. Open sterile packets. Put on sterile gloves using sterile technique. Place the fenestrated drape from the sterile catheter tray over the patient's penis. Adequate lubrication of catheter is necessary to prevent urethral trauma and pain and to aide in passage of catheter ..."</p> <p>5. A policy titled "Integumentary - Application of Wound Dressing" dated 09/10 stated, "Adhere to Standard Precautions ... Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves ... Clean wound with normal saline or wound cleanser per wound care orders ... Dress wound with appropriate dressings following manufacturer's guidelines and physician orders. "</p>				

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N000555	<p>410 IAC 17-14-1(a)(2)(C) Scope of Services Rule 14 Sec. 1(a) (2)(C) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (C) Assist the physician and/or registered nurse in performing specialized procedures. Based on observation, clinical record review, and interview, the licensed practical nurse (LPN) failed to provide sterile and/or aseptic technique for 2 of 5 patient's observed during home visits in relation to in and out catheter procedure, administering medications through a gastrostomy tube (g / tube), and wound care. (# 2 and 10)</p> <p>Findings include:</p> <p>1. During a home visit with patient # 2 on 03/27/14 at 8:25 AM, Employee G, LPN, was observed to administer crushed pills dissolved in water through the g / tube without donning gloves.</p> <p>The Director of Nursing indicated on 03/27/14 at 11:45 AM there was a policy for administration of medications through a g / tube and that the observed practice was not consistent with their policy.</p> <p>2. During a home visit with patient # 10 on 3/31/14 at 8:00 AM, Employee D,</p>	N000555					

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	<p>LPN, was observed to don gloves, removed a catheter from a package, wrap the catheter in her right hand, and walk to the next room (kitchen) to throw away the package. Upon Employee D ' s return, she lowered the head of the patient ' s bed with her left hand, removed the sheet over the patient, and proceeded to insert the foley catheter without cleaning the urinary meatus before insertion. Employee D indicated they don't do sterile technique in the home.</p> <p>While Employee D was nearing the end of the bed bath, the patient was observed to have a dressing on the right shin. Employee D removed the dressing during the bed bath wearing the same gloves used during the bath. The wound was open and draining. The LPN was observed to wash the area with soap and water that was used during the bath. Using the same gloves, the LPN was observed to moisten a dressing with saline, apply it to the open wound, cover it with a dry dressing, and secure it with tape.</p> <p>a. Employee C, Registered Nurse / Case Manager, indicated on 03/31/14 at 12:00 PM that she was not aware the patient continued to have a wound to the right shin. Employee C indicated Employee D did not follow</p>						

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	<p>proper nursing procedure and she will need to educate and have surprise supervisory visits.</p> <p>b. The Director of Nursing and the Administrator indicated on 03/31/14 at 4:00 PM that Employee D did not follow proper policy and procedure.</p> <p>4 A policy titled "Hand Hygiene" dated 01/06/14 stated "Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings ... "</p> <p>5. A policy titled "Urinary - Intermittent Catheterization: Male" dated 09/10 stated "Position the patient on back and wash the perineal area and penis thoroughly with soap and water ... open the catheterization tray and place the waterproof absorbent underpad under the buttocks extending forward between the legs. Open sterile packets. Put on sterile gloves using sterile technique. Place the fenestrated drape from the sterile catheter tray over the patient's penis ..."</p> <p>6. A policy titled "Integumentary - Application of Wound Dressing" dated 09/10 stated "Adhere to Standard Precautions ... Remove tape by pushing</p>			

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	skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves ... "			
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N000556	<p>410 IAC 17-14-1(a)(2)(D) Scope of Services Rule 14 Sec. 1(a) (2)(D) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (D) Prepare equipment and materials for treatments observing aseptic technique as required. Based on observation, clinical record review, and interview, the licensed practical nurse (LPN) failed to provide sterile and/or aseptic technique for 2 of 5 patient's observed during home visits in relation to in and out catheter procedure, administering medications through a gastrostomy tube (g / tube), and wound care. (# 2 and 10)</p> <p>Findings include:</p> <p>1. During a home visit with patient # 2 on 03/27/14 at 8:25 AM, Employee G, LPN, was observed to administer crushed pills dissolved in water through the g / tube without donning gloves.</p> <p>The Director of Nursing indicated on 03/27/14 at 11:45 AM there was a policy for administration of medications through a g / tube and that the observed practice was not consistent with their policy.</p> <p>2. During a home visit with patient # 10 on 3/31/14 at 8:00 AM, Employee D,</p>	N000556					

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	<p>LPN, was observed to don gloves, removed a catheter from a package, wrap the catheter in her right hand, and walk to the next room (kitchen) to throw away the package. Upon Employee D ' s return, she lowered the head of the patient ' s bed with her left hand, removed the sheet over the patient, and proceeded to insert the foley catheter without cleaning the urinary meatus before insertion. Employee D indicated they don't do sterile technique in the home.</p> <p>While Employee D was nearing the end of the bed bath, the patient was observed to have a dressing on the right shin. Employee D removed the dressing during the bed bath wearing the same gloves used during the bath. The wound was open and draining. The LPN was observed to wash the area with soap and water that was used during the bath. Using the same gloves, the LPN was observed to moisten a dressing with saline, apply it to the open wound, cover it with a dry dressing, and secure it with tape.</p> <p>The Director of Nursing and the Administrator indicated on 03/31/14 at 4:00 AM that the employee did not practice clean or sterile technique.</p> <p>4 A policy titled "Hand Hygiene" dated</p>						

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	<p>01/06/14 stated "Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings ... "</p> <p>5. A policy titled "Urinary - Intermittent Catheterization: Male" dated 09/10 stated "Position the patient on back and wash the perineal area and penis thoroughly with soap and water ... open the catheterization tray and place the waterproof absorbent underpad under the buttocks extending forward between the legs. Open sterile packets. Put on sterile gloves using sterile technique. Place the fenestrated drape from the sterile catheter tray over the patient's penis ..."</p> <p>6. A policy titled "Integumentary - Application of Wound Dressing" dated 09/10 stated "Adhere to Standard Precautions ... Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves ... "</p>				