

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000000	<p>This was an extended Federal home health recertification survey.</p> <p>Survey Dates: June 2, 3, 4, 5, and 6, 2014.</p> <p>Facility #: 005865</p> <p>Medicaid Vendor #: 200237950</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 84</p> <p>Nurse Care Inc is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 06/06/14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30: Skilled Nursing Services.</p> <p>The Administrator and the Director of Nursing were informed of this preclusion during the exit conference held at this agency on 06/06/14 at 3:00 PM.</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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G000110	<p>Quality Review: Joyce Elder, MSN, BSN, RN June 11, 2014</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency document review and interview, the agency failed to ensure patients were provided the current Indiana Advance Directives, including a description of applicable State law and agency policy of Advance Directives in 10 of 10 records reviewed with the potential to affect all patients of the agency (# 1 - 10).</p> <p>Findings include</p>	G000110	The newest Advanced Directive forms have been acquired and it and the policy on advanced directives will be sent to each client. with an explanation letter. It will be prevented from recurring by copies of the correct information will be included in each new client's packet. The agency will check the web occasionally to be sure that a newer copy hasn't been created. The DON is responsible for correcting and maintaining this deficiency. It will be corrected by	06/30/2014

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	<p>1. The admission package given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana Advanced Directives and agency policy in the admission folder that was distributed to the patients at the start of care (SOC).</p> <p>2. Clinical record number 1, SOC 11/01/17, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>3. Clinical record number 2, SOC 06/12/07, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>4. Clinical record number 3, SOC 01/15/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>5. Clinical record number 4, SOC 03/02/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was</p>		June 30,2014.		

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	<p>received on the SOC date.</p> <p>6. Clinical record number 5, SOC 06/12/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record number 6, SOC 11/25/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>8. Clinical record number 7, SOC 12/20/06, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>9. Clinical record number 8, SOC 01/29/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record number 9, SOC 06/08/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The</p>			

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G000143	<p>patient signed that the document was received on the SOC date.</p> <p>11. Clinical record number 10, SOC 12/13/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>12. The Administrator and the Director of Nursing indicated on 06/06/14 at 11:00 AM they were not aware of the updated version of the advance directors nor were they aware of the need to include the agency policies with advance directives / admission packet.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with the dialysis personnel furnishing services for 1 of 10 records reviewed of patients receiving dialysis services from another provider creating the potential to affect all of the agency's patients that receive more than one</p>	G000143	The Q.A. nurse will contact each client upon admission and at least every thirty days to ascertain if they have any other agencies caring for them. This will be documented on the coordination of care form .There will be a form in the chart stating what agencies are seeing the client, when they began, and when discontinued, along with frequency, treatments,	06/30/2014

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	<p>service. (# 1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1, start of care 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week. The clinical record failed to evidence coordination of care with the dialysis center. 2. The Director of Nursing indicated on 06/06/14 at 11:00 AM that she was not aware of the need to coordinate services with dialysis facilities. 3. An undated policy titled "Coordination of Client Care" stated "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will 		<p>and medications. The information will be documented both in the chart and on the next physician's orders. The Q.A. nurse will be responsible for this RECURRENCE WILL BE PREVENTED BY: the ADON or DON checking the chart at least monthly to see the report, if it is not there, the Q.A. nurse will be notified that it needs done. The DON is ultimately responsible for this being done</p>				

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G000144	<p>maintain liaison to ensure that their efforts are coordinated effectively."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record and policy review, and interview, the agency failed to ensure their efforts were coordinated and documented effectively with the dialysis personnel furnishing services for 1 of 10 records reviewed of patients receiving services from another provider creating the potential to affect all of the agency's patients that receive more than one service. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, start of care 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving</p>	G000144	<p>Each client will be contacted to ascertain if they have any other agencies also seeing them. This will be documented on the Coordination of Care tracking form. Specifics will be obtained as to treatment, medications, etc and it will be documented both in the Coordination of Care form and on the next physician's plan of care. This information will be in the client's record. RECURRENCE WILL BE PREVENTED BY: the ADON or DON checking charts and notes as they are completed. Making calls as necessary to obtain the needed information. The Q.A. nurse will be responsible for the above. The DON will assure that it is done by checking the charts and notes as they are completed.</p>	06/30/2014	

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G000156	<p>dialysis treatments 3 times a week. The clinical record failed to evidence coordination of care with the dialysis center.</p> <p>2. The Director of Nursing indicated on 06/06/14 at 11:00 AM that she was not aware of the need to coordinate services with dialysis facilities.</p> <p>3. An undated policy titled "Coordination of Client Care" stated "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their efforts are coordinated effectively."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on clinical record and policy review, and interview, it was determined the agency failed to ensure staff followed</p>	G000156	A review of the dr. order, client chart will be done by ADON to assure that all DME, meds, new &	06/30/2014			

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	<p>the written plan of care related to skilled nursing visits, home health aide visits, attendant care visits, and treatments for 6 of 10 records reviewed creating the potential to affect all patients currently receiving services from the agency (See G 158); failed to ensure the plan of care was revised to include all DME (durable medical equipment) and supplies for 2 of 10 records reviewed, new and discontinued medications in 4 of 10 records reviewed, specific treatments and instructions in 2 of 10 records reviewed, dialysis medications and permacath maintenance 1 of 10 records reviewed, and specific details in bathing, grooming and activities of daily living for home health aides in 5 of 10 records reviewed creating the potential to affect all current patients receiving services in the agency (See G 159); failed to ensure the physician was notified of a change in condition for 1 of 10 records reviewed creating the potential to affect all of the patients receiving services from the agency (See G 164); failed to ensure treatments were administered by the skilled nurse as ordered by the physician for 1 of 2 records reviewed for patients with wounds creating the potential to affect all patients who had wounds (See G 165); and failed to ensure it's policy was congruent with federal regulations regarding who could take a verbal orders</p>		<p>added, dc'd-are appropriately put on the dr order. Visiting staff will be inserviced on need to inquire about new DME, meds, etc on each client visit, also specific size of items, treatments and supplies. Dr orders will be compared with client chart to see that all info is included on order. responsible persons: ADON and DON The Home Health Aide assignment sheet has been revised, a copy included. The SN will take one to each client, complete it with input form the client, and have the client sign it. A copy will remain in the home, one for the clinical record, and one will go to the assigned aide. Home health aide and Attendant Care assignment sheets will have different duties. The ADON and DON are responsible to see that this is done.</p>	

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G000158	<p>creating the potential to affect all current patients receiving services within the agency (See G 166).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure staff followed the written plan of care related to skilled nursing visits, home health aide visits, attendant care visits, and treatments for 6 of 10 records reviewed creating the potential to affect all patients currently receiving services from the agency. (# 1, 2, 6, 8, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care</p>	G000158	Staffing Coordinators will be inserviced on need to follow physician's orders exactly, keeping visit within the work week, making sure all visits are made as possible- keeping in the physician's frequency. Nurses will also be inserviced on need to follow physician's orders exactly or notify office if unable so a revised plan can be obtained by the physician. THE ADON AND DON WILL MONITOR FREQUENCY BY COMPARIING PHYSICIAN'S ORDER FREQUENCY TO THAT OF THE CLIENT SCHEDULE AND 100% OF THE NOTES AS THEY	06/30/2014

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	<p>established by the physician for certification periods 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The clinical record evidenced a home health aide was in the home for 6 days during the weeks of 04/28/14 to 05/04/14, 05/12/14 to 05/18/14, and 05/19/14 to 05/25/14.</p> <p>b. The clinical record evidence an extra (4th) attendant care visit during the week of 04/07/14 to 04/13/14 and only 2 visits during the week of 05/12/14 to 05/18/14. The clinical record evidence only 1 visit during the week of 03/31/14 to 04/06/14.</p> <p>2. Clinical record 2, SOC 06/12/07, included a plan of care established by the physician for the certification period of 04/29/14 to 06/27/14 with orders for skilled nursing services 9 hours a day 5 days a week for 2 months. The plan of care stated to change the g-tube every 3 months or prn (as needed).</p> <p>a. During a home visit on 06/03/14 at 8:30 AM, employee B, a LPN (licensed practical nurse), had indicated she had</p>		<p>COME IN. Specific orders for all dme, appliances (such as g-tube) shall be obtained, added to the physician's plan of treatment, and followed: size, treatment, frequency to be changed if appropriate. All DME and supplies to be listed. THE RN'S WILL BE INSERVICED ON THE NEED TO ASK CLIENTS ABOUT ANY NEW OR CHANGED EQUIPMENT OR THERAPIES, ANY NEW AGENCIES SERVICING THEM. THE ADON WILL BE RESPONSIBLE FOR ASSURING THAT THE PLAN OF CARE IS COMPLETE AND CORRECT. THE DON WILL MONITOR THE ADON. SPECIFIC ORDERS WILL BE OBTAINED. RECURRENCE WILL BE PREVENTED BY: ADON / DON monitoring notes as they come in , checking physician's orders for completion. The DON will be responsible ultimately.</p>				

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	<p>thought the last time the patient had the g-tube changed was approximately 1 years ago. The clinical record failed to evidence that the g-tube had been changed every 3 months.</p> <p>b. The LPN was in the home for 6 hours on 05/02/14 and 05/16/14, and 4.75 hours on 05/17/14.</p> <p>c. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 11:00 AM.</p> <p>3. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services to assist the patient with ulcer care when ordered. The plan of care stated the treatment to the right heel was vasolex topical twice a day prn.</p> <p>a. A 30 day Comprehensive Assessment dated 04/17/14 stated employee E, a Registered Nurse, provided a treatment of 2 x 2 gauze and paper tape.</p> <p>b. A 30 day Comprehensive Assessment dated 05/14/14 stated</p>				

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	<p>employee E provided a treatment of 2 x 2 gauze and paper tape.</p> <p>4. Clinical record number 8, SOC 01/29/13, included a plan of care established by the physician for the certification period 05/13/14 to 07/11/14 with orders for skilled nursing 1 time a day for 2 months and a home health aide 2 hours a day, 5 days a week for 2 months.</p> <p>a. The skilled nurse was in the home for 4 days (5/12, 5/13, 5/14, and 5/15/14) during the week of 05/12/14 to 05/18/14. The clinical record failed to evidence skilled nursing visits on 5/16, 5/17, and 5/18/14.</p> <p>b. The home health aide was in the home for 3 days (5/13, 5/14, and 5/15/14) during the week of 05/12/14 to 05/18/14. The clinical record failed to evidence home health aide visits on 5/12, 5/16, 5/17, and 5/18/14.</p> <p>5. Clinical record number 9, SOC 06/08/12, included a plan of care established by the physician for the certification period 03/30/14 to 05/28/14 with orders for skilled nursing 1 hour every other week for two months.</p> <p>The clinical record failed to evidence</p>			

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	<p>a skilled nursing visits during the weeks of 03/31/14 to 04/06/14 and 04/14/14 to 04/20/14.</p> <p>6. Clinical record number 10, SOC 12/13/13, included a plan of care established by the physician for the certification period 12/13/13 to 01/16/14 with orders for skilled nursing 7 days a week for 2 months for daily dressing changes.</p> <p>The clinical record evidenced skilled nursing visits daily from 12/13/13 to 12/17/13, 12/21/13 to 12/23/13, 12/26/13, and 01/16/14. The clinical record failed to evidence skilled nursing visits from 12/18/13 to 12/20/13, 12/24/13, 12/25/13, and 12/27/13 to 01/15/14.</p> <p>7. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>8. An undated policy titled "Care Planning" stated "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000159	<p>provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record and policy review and interview, the agency failed to ensure the plan of care was revised to include all DME (durable medical equipment) and supplies (# 1 and 6), new and discontinued medications (# 1, 6, 7, and 9), specific treatments and instructions (# 2 and 6), dialysis medications and permacath maintenance (# 1), and specific details in bathing, grooming and activities of daily living for home health aides (# 1, 3, 5, 8 , and 9) creating the potential to affect all current patients receiving services in the agency.</p>	G000159	Nurses will be inserviced on need to follow physician's orders exactly or notify office if unable so a revised plan can be obtained by the physician. Specific orders for all dme, appliances (such as g-tube) shall be obtained, added to the physician's plan of treatment, and followed: size, treatment, frequency to be changed if appropriate. All DME and supplies to be listed, amount of time splints should be in place. Meds will be noted on the order if new, changed. The meds on the medication sheet will note new, changed, or discontinued.A new	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
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	<p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed. The plan of care failed to be specific in the bathing, grooming, and activities of daily livings.</p> <p>b. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week via a permacath. The patient indicated the permacath was removed approximately a month ago. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week and had his / her permacath removed on</p>		<p>home health aide assignment sheet will be done to show the type of bath to be given, other specifics will be given for the care. Aides will be inserviced on the need for specific documentation. THE PROCESS WILL BE MONITORED BY THE ADON AND DON BY REVIEWING ORDERS BEFORE THEY ARE SENT, LOOKING AT THE CHART FOR ANY CHANGES THAT SHOULD BE NOTED, SPECIFIC TREATMENT ORDERS. THE ADON WILL REVIEW 100% OF NURSES NOTES AS THEY COME IN , THE DON WILL MONITOR THE PHYSICIAN'S ORDERS FOR COMPLETION. THE REVIEW COMMITTEE WILL ALSO BE AWARE AND MONITOR CHARTS FOR COMPLETION. RECURRENCE WILL BE PREVENTED BY: ADON and DON monitoring 100% OF notes as they come in , checking physician's orders for completion, revising as necessary. The DON will be responsible ultimately.</p>				

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	<p>05/12/14. The plan of care failed to evidence that the patient was receiving dialysis 3 times a week, maintenance of the permacath, and dialysis medications received during dialysis treatments.</p> <p>c. The home was observed to have a Hoyer lift in the home and a life line alert. The plan of care failed to evidence the Hoyer lift and the life line alert under DME / supplies section.</p> <p>d. The plan of care stated the patient wore TED hose. The patient indicated she had not worn TED hose for a long time due to the stockings leaving indentations around her ankles.</p> <p>e. The plan of care stated the patient was a diabetic and received insulin. The plan of care failed to evidence diabetic supplies used under the DME / supplies section.</p> <p>f. A physician's order dated 05/15/14 stated the allopurinol was discontinued. The plan of care continued to evidence the patient was taking Allopurinol 100 mg (milligrams) by mouth daily.</p> <p>2. Clinical record 2, SOC 06/12/07, included a plan of care established by the physician for the certification period of 04/29/14 to 06/27/14 with orders for</p>			

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	<p>skilled nursing 9 hours 5 times a week. The plan of care included that "oz [ounce] H2O [water] after feeding ... " and "8 oz H2O flush BID [twice a day], VNS magnet for seizures, change g/tube every 3 months, splints, and foot immobilizers.</p> <p>a. During a home visit on 06/03/14 at 12:00 PM, employee B indicated she provided g-tube care / dressing around stoma site, and applies the hand splints during nap time and foot immobilizers after the naps. Employee B demonstrated how the VNS magnet was utilized.</p> <p>b. The plan of care failed to include the frequency and duration of hand splints and foot immobilizers, g-tube care, amount of water after feedings, the type, amount, and frequency of feedings, size of g-tube for changes, and how to utilize the VNS magnet for seizures.</p> <p>3. Clinical record number 3, SOC 01/15/14, included a plan of care established by the physician for the certification period of 05/15/14 to 07/13/14. The plan of care evidenced the attendant care was to provide bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p>						

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802		
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	<p>4. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification period 04/03/14 to 06/01/14 with orders for home health aide and attendant care services to provide bathing, grooming, and activities of daily living. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>5. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 and 05/24/14 to 07/22/14 with orders for skilled nursing services to assist the patient with any personal care needs; ulcer care when ordered, assess skin, tube feedings, suctioning as needed, med set-up and administer, and monitoring vital signs. The DME (durable medical equipment) / Supplies stated the patient was receiving ileostomy supplies.</p> <p>a. The current plan of care stated the patient was taking Loperamide 1 mg (milligram) / 5 ml (milliliter) per g-tube every 6 hours and Hydrocodone 5 / 325 mg every 8 hours prn (as needed). The plan of care stated the treatment to the right heel was vasolex topical twice a day prn.</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802		
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	<p>b. A physician order dated 05/20/14 stated to increase the Loperamide from 1 mg to 2 mg (milligram) tabs QID (four times a day) with feedings per g-tube, acidophilus OTC (over the counter) 1 tab QID with feedings per g-tube, Tussin DM per label directions per g-tube prn (as needed)", increase Hydrocodone 7.5 mg / 325 mg / 15 ml (milliliters) give 15 ml every 6 hours as needed and to discontinue vasolex topical to right heel twice a day and to apply duoderm. The plan of care failed to include these changes on the medication section as well as the frequency of changes to the duoderm.</p> <p>b. The daily nursing notes evidenced the patient had a g-tube and was receiving care to the area. The plan of care failed to include treatment instructions for the g-tube care.</p> <p>c. The daily nursing notes evidenced the patient had an ileostomy and was receiving care to the area. The plan of care failed to include treatment instructions and size and type of appliance to be applied to the patient's ostomy site.</p> <p>6. Clinical record number 7, SOC 12/20/06, included a plan of care</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>established by a physician for the certification period of 05/02/14 to 06/30/14.</p> <p>The medication profile was revised on 04/14/14 to include Bioxin 250 mg / 5 ml, give 2 teaspoons per g-tube twice a day and Albuterol inhalation, 2 puffs daily. The plan of care failed to evidence the new medications.</p> <p>7. Clinical record number 8, SOC (start of care) 01/29/13, included a plan of care established by the physician for certification period 05/13/14 to 07/11/14. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>8. Clinical record number 9, SOC 06/08/12, included a plan of care established by the physician for the certification period of 05/29/14 to 07/27/14.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily</p>						

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	<p>living.</p> <p>b. A skilled nursing visit note dated 04/24/14 stated the patient had new medications in the home of Ondansetron 4 mg sublingual daily prn for nausea, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg.</p> <p>c. A revised medication profile dated 04/24/14 stated the patient was receiving Ondansetron 4 mg sublingual daily prn for nausea, Celebrex 200 mg by mouth daily, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg. The plan of care failed to evidence the new and discontinued medications.</p> <p>9. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>10. An undated policy titled "Care Planning" stated "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies,</p>				

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G000164	<p>medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record and policy review, the agency failed to ensure the physician was notified of a change in condition for 1 of 10 records reviewed creating the potential to affect all of the patients receiving services from the agency. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC (start of care) 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services.</p> <p>A skilled nursing note dated 04/03/14 stated the patient had a prolapsed colon / anus at 7:15 PM with bleeding. The</p>	G000164	All staff, including on-call will be inserviced on the policies and procedures of emergencies or change in client status. When to notify the MD and DON, caregiver. What constitutes an emergency, When abnormal changes / symptoms should be reported. The DON and ADON will monitor documentation as it comes in. RECURRENCE WILL BE PREVENTED BY: Teaching both clients and staff what should be reported, closely monitoring notes, close communication with nuses and aides. ADON and DON are responsible for this	06/30/2014			

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G000165	<p>nurse on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence that the physician had been notified of the patient's change of condition.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Emergencies in the Home / Reporting Patient Problems" stated "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and policy review, and interview, the agency failed</p>	G000165	Inservice to SN's on need to complete all physician's orders, or	06/30/2014	

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802		
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	<p>to ensure treatments were administered by the skilled nurse as ordered by the physician for 1 of 2 records reviewed for patients with wounds creating the potential to affect all patients who had wounds. (# 8)</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC 01/29/13, included a plan of care established by the physician for the certification period of 03/14/14 to 05/12/14.</p> <p>a. A physician order dated 04/12/14 stated to apply triple antibiotic ointment to the left upper extremity (scratched areas) wound.</p> <p>b. A nursing note dated 04/21/14 stated the nurse applied triple antibiotic ointment and covered with telfa and ace wrap. The skilled nurse failed to follow the plan of care.</p> <p>c. A nursing note dated 04/22/14 stated the nurse applied triple antibiotic ointment, dry gauze, and kling to the wound area. The skilled nurse failed to follow the plan of care.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional</p>		<p>if not able to, to contact physician for revised orders. Need to follow the plan of treatment exactly . ADON will be sure all specific treatments, dme, medications with dosage, route, & frequency are listed on order. InstructSN's to be sure all changes are documented on thirty day assessment or supervisories so that they can be transcribed onto the next physician's order by ADON.RECURRENCE WILL BE PREVENTED: by ADON and DON closely monitoring the notes as they come in as well as good communication with visiting staff.DON is ultimately responsible.</p>		

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G000166	<p>documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Medication / Prescription Orders" stated "Medication orders or prescriptions are clear and accurate. Medication orders must be complete. Elements of a complete medication order are: client name, medication name, dosage, route, frequency, duration '[if applicable]', routine, prn (as needed) ... Blanket medication resume orders after a stoppage or hold due to a change in condition are prohibited."</p> <p>4. An undated policy titled "Physician Orders / Plan of Care" stated "Verbal orders maybe received by the RN (registered nurse) or LPN (licensed practical nurse). Verbal orders are put into writing, signed and dated by the person receiving the order, a copy placed temporarily in the chart."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter)</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000168	<p>responsible for furnishing or supervising the ordered services.</p> <p>Based on policy review, the agency failed to ensure it's policy was congruent with federal regulations regarding who could take a verbal orders creating the potential to affect all current patients receiving services within the agency.</p> <p>Findings include:</p> <p>An undated policy titled "Physician Orders / Plan of Care" stated "Verbal orders maybe received by the RN (registered nurse) or LPN (licensed practical nurse). Verbal orders are put into writing, signed and dated by the person receiving the order, a copy placed temporarily in the chart."</p>	G000166	<p>The policy has been revised to state that only an RN can take a verbal order from a physician. Staff has been made aware of this change</p> <p>RECURRENCE WILL BE PREVENTED BY: the change in policy</p> <p>DON will be responsible to monitor the policy</p>	06/20/2014
G000168	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and policy review and interview, it was determined the agency failed to ensure the Registered Nurse followed the written plan of care related to skilled nursing visits, home health aide visits, attendant care visits, and treatments for 5 of 10 records reviewed creating the potential to affect</p>	G000168	<p>An inservice will be done with SN's on following the plan of care exactly, the need to contact the office with changes as necessary so that a verbal order can be written. Oasis rules and regulations will be reviewed with the R.N's involved, a list of Oasis due will be given to each RN monthly for their clients, with the date due into the office, following</p>	06/30/2014

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	all patients currently receiving services from the agency (See G 170); failed to ensure the registered nurse reevaluated the patient with the completion of a Recertification Comprehensive Assessment during the 5 day window during the certification period for 6 of 10 records reviewed and a Resumption of Care assessment within 48 hours of patient's return home (or knowledge of) from a hospitalization in 2 of 2 records reviewed of patients who had been hospitalized creating the potential to affect all patients who receive services from the agency longer than 60 days or who are hospitalized (See G 172), failed to ensure the plan of care was revised to include all DME (durable medical equipment) and supplies 2 of 2 records reviewed, new and discontinued medications 4 of 10 records reviewed, specific treatments and instructions 2 of 10 records reviewed, dialysis medications and permacath maintenance 1 of 10 records reviewed creating the potential to affect all current patients receiving services in the agency (See G 173); failed to ensure that the Registered Nurse reassessed wounds on a routine basis for 2 of 2 records reviewed who had wounds creating the potential to affect all 2 patients who were receiving wound care within the agency (See G 174); failed to ensure the Registered Nurse notified the		the Oasis guidelines.-the five day window and turning into the office within twenty four hours. Resumptions and time frame will be included. The plan of care will be revised according to the changes made in the care plan. RECURRENCE WILL BE PREVENTED by the ADON giving the list of Oasis due to each RN monthly, informing them of resumes needed, a tracking system will be used to assure compliance. If the deadline is approaching and the RN has not turned it in, the ADON will call her to remind her to get it in into the office before time to transmit. The ADON AND DON are responsible to see that this is done correctly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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G000170	<p>physician of a change in condition for 1 of 10 records reviewed and coordinated care with other providers in 1 of 10 records reviewed creating the potential to affect all of the patients receiving services from the agency (See G 176); and failed to ensure the Licensed Practical Nurse followed agency policy for 1 of 10 records reviewed creating the potential to affect all of the patients with a change in condition (See G 179).</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> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse followed the written plan of care related to skilled nursing visits, home health aide visits, attendant care visits, and treatments for 5 of 10 records reviewed creating the</p>	G000170	<p>The inservice will be given to all staff , including Staffing Coordinators, concerning the need to follow physicians orders with client frequency.SN's will be informed of need to follow orders exactly, or obtain a changed order if necessary, document the reason why. All dme, supplies, specific treatments are</p>	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
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	<p>potential to affect all patients currently receiving services from the agency. (# 2, 6, 8, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record 2, SOC 06/12/07, included a plan of care established by the physician for the certification period of 04/29/14 to 06/27/14 with orders for skilled nursing services 9 hours a day 5 days a week for 2 months. The plan of care stated to change the g-tube every 3 months or prn (as needed).</p> <p>a. During a home visit on 06/03/14 at 8:30 AM, employee B, a LPN (licensed practical nurse), had indicated she had thought the last time the patient had the g-tube changed was approximately 1 years ago. The clinical record failed to evidence that the g-tube had been changed every 3 months.</p> <p>b. The LPN was in the home for 6 hours on 05/02/14 and 05/16/14, and 4.75 hours on 05/17/14.</p> <p>c. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 11:00 AM.</p>		<p>to be written on the plan of care and followed exactly. They will be informed that reprimands will be given if this is not done. RECURRENCE WILL BE PREVENTED by close supervision by ADON and DON, reprimands if necessary, . Visit frequency will be monitored, physicians orders and visit notes reviewed for completion.The DON and ADON are ultimately responsible.</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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	<p>2. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services to assist the patient with ulcer care when ordered. The plan of care stated the treatment to the right heel was vasolex topical twice a day prn.</p> <p>a. A 30 day Comprehensive Assessment dated 04/17/14 stated employee E, a Registered Nurse, provided a treatment of 2 x 2 gauze and paper tape.</p> <p>b. A 30 day Comprehensive Assessment dated 05/14/14 stated employee E provided a treatment of 2 x 2 gauze and paper tape.</p> <p>3. Clinical record number 8, SOC 01/29/13, included a plan of care established by the physician for the certification period 05/13/14 to 07/11/14 with orders for skilled nursing 1 time a day for 2 months and a home health aide 2 hours a day, 5 days a week for 2 months.</p> <p>a. The skilled nurse was in the home for 4 days (5/12, 5/13, 5/14, and 5/15/14) during the week of 05/12/14 to 05/18/14. The clinical record failed to evidence</p>			

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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	<p>skilled nursing visits on 5/16, 5/17, and 5/18/14.</p> <p>b. The home health aide was in the home for 3 days (5/13, 5/14, and 5/15/14) during the week of 05/12/14 to 05/18/14. The clinical record failed to evidence home health aide visits on 5/12, 5/16, 5/17, and 5/18/14.</p> <p>4. Clinical record number 9, SOC 06/08/12, included a plan of care established by the physician for the certification period 03/30/14 to 05/28/14 with orders for skilled nursing 1 hour every other week for two months.</p> <p>The clinical record failed to evidence a skilled nursing visits during the weeks of 03/31/14 to 04/06/14 and 04/14/14 to 04/20/14.</p> <p>5. Clinical record number 10, SOC 12/13/13, included a plan of care established by the physician for the certification period 12/13/13 to 01/16/14 with orders for skilled nursing 7 days a week for 2 months for daily dressing changes.</p> <p>The clinical record evidenced skilled nursing visits daily from 12/13/13 to 12/17/13, 12/21/13 to 12/23/13, 12/26/13, and 01/16/14. The clinical</p>			

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G000172	<p>record failed to evidence skilled nursing visits from 12/18/13 to 12/20/13, 12/24/13, 12/25/13, and 12/27/13 to 01/15/14.</p> <p>6. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>7. An undated policy titled "Care Planning" stated "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse reevaluated</p>	G000172	Oasis and comprehensive assessment rules and regulations will be reviewed with RN's. A list of clients names with	06/30/2014

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	<p>the patient with the completion of a Recertification Comprehensive Assessment during the 5 day window during the certification period for 6 of 10 records reviewed (# 1, 4, 5, 7, 8, and 9) and a Resumption of Care assessment within 48 hours of patient's return home (or knowledge of) from a hospitalization in 2 of 2 records reviewed of patients who had been hospitalized creating the potential to affect all patients who receive services from the agency longer than 60 days or who are hospitalized (# 1 and 5).</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for the certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 for monthly registered nurse supervision, home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. During a home visit on 06/03/14 at 9:00 AM, the patient had indicated he / she was in the hospital in December, 2013. The clinical record failed to evidence a Resumption of Care assessment had been completed within 48 hours of the patient's return to the home from the hospital.</p>		<p>recerts due will be given monthly to each supervisory RN for their assigned clients. Recert comprehensive assessments will be done during the five day window, turned into the office within twenty four hours of completion so that they can be transmitted. When a client who receives skilled nursing services and is over the age of eighteen is discharged from the hospital a resumption of care form will be completed in the client's home. RECURRENCE WILL BE PREVENTED BY THE ADON by giving the list of recerts due to the RN's monthly, informing them of needed information, using a tracking system to assure compliance. If the deadline is approaching and the RN has not turned in the required forms, the RN will be called and reminded. The ADON tracks the timeframe by following the oasis follow-up assessment calendar. The ADON and DON are ultimately responsible.</p>		

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	<p>b. The clinical record evidence the registered made a "30 day Assessment" on 04/17/14 and 05/15/14. The 30 day assessment failed to provide a comprehensive assessment including vital signs and a complete head to toe assessment. The clinical record failed to provide a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p> <p>2. Clinical record number 4, SOC 03/02/12, included a plan of care established by the physician for the certification period 04/26/14 to 06/24/14 for skilled nursing every other day for injections.</p> <p>The clinical record evidenced a "30 day Comprehensive Assessment" on 04/04/14 and 05/08/14. The Recertification Assessment was completed on 04/24/14. The clinical record failed to include a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p> <p>3. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification of 04/03/14 to 06/01//14 for home health aide, attendant care, and</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>homemaker services.</p> <p>a. During a home visit on 06/05/14 at 2:40 PM, the patient had indicated he / she was in the hospital in March, 2013. A skilled nursing visit note dated 03/14/14 stated the patient was discharged from the hospital on 03/12/14. The clinical record failed to evidence a Resumption of Care assessment had been completed within 48 hours of the patient's return to the home from the hospital.</p> <p>c. The clinical record evidenced a "30 day Assessment" on 03/14/14, 04/18/14, and 05/15/14. The 30 day assessment failed to include a comprehensive assessment including vital signs and a complete head to toe assessment. The clinical record failed to include a Recertification Comprehensive Assessment had been completed within the 5 day window during the certification period.</p> <p>4. Clinical record number 7, SOC 12/20/06, included a plan of care established by a physician for the certification period of 05/02/14 to 06/30/14.</p> <p>The clinical record evidenced 30 day Comprehensive Assessments dated</p>						

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>04/15/14 and 05/21/14. The clinical record evidenced a Recertification Assessment dated 05/12/14. The clinical record failed to include a Recertification Comprehensive Assessment completed within the 5 day window during the certification period.</p> <p>5. Clinical record number 8, SOC 01/29/13, included a plan of care established by a physician for the certification period of 03/14/14 to 05/12/14 and 05/13/14 to 07/11/14.</p> <p>The clinical record evidenced 30 day Comprehensive Assessments dated 05/06/14. The clinical record evidenced a Recertification Assessment dated 05/20/14. The clinical record failed to include a Recertification Comprehensive Assessment had been completed within the 5 day window during the certification period.</p> <p>6. Clinical record number 9, SOC 06/08/12, included a plan of care established by a physician for the certification period of 03/30/14 to 05/28/14.</p> <p>The clinical record evidenced a 30 day Assessment on 03/17/14. The 30 day assessment failed to include a comprehensive assessment including</p>						

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000173	<p>vital signs and a complete head to toe assessment. The record failed to evidence a Recertification Comprehensive Assessment had been completed within the 5 day window during the certification period.</p> <p>7. The Director of Nursing indicated on 06/03/14 at 10:20 AM that the 30 day summary notes are done for non-skilled patients and the comprehensive assessments are done for the skilled patients.</p> <p>8. An undated policy titled "OASIS Assessment of Clients" stated "A Resumption of Care assessment will be completed within 48 hours [or knowledge of] on every client following a hospital stay of 24 hours or more for any reason other than diagnostic tests ... Every second calendar month at recertification, a follow up assessment will be performed. The follow-up skilled visit assessment shall be performed no earlier than five days prior to the last day of the certification period [between and including days 56 - 60]."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of</p>			

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	<p>care and necessary revisions.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse revised the plan of care to include all DME (durable medical equipment) and supplies (# 1 and 6), new and discontinued medications (# 1, 6, 7, and 9), specific treatments and instructions (# 2 and 6), dialysis medications, and permacath maintenance (# 1) creating the potential to affect all current patients receiving services in the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed. The plan of care</p>	G000173	<p>The Home Health Aide assignment sheet has been revised, a copy included. The SN will take one to each client, complete it with input from the client, and have the client sign it. A copy will remain in the home, one for the clinical record, and one will go to the assigned aide. Home health aide and Attendant Care assignment sheets will have different duties. The RN's will be inserviced on the need to ask client each visit of any changes and document them. The notes will be read by the ADON or DON and the changes noted for the next physician's order, or a verbal order if needed. All medical equipment and supplies, new and discontinued medications will be noted and added to the next physician's order. All other agencies involved will be contacted and the appropriate medications or equipment added to the physician's order. The specifics will be documented on such as hand splints, dressings, g-tube feedings. The sizes of appliances will be noted and documented. RECURRENCE WILL BE PREVENTED BY: MONITORING the nurses notes as they come in and making appropriate changes on the care plan and next physician's order. The ADON and DON will be responsible to assure compliance. e ADON and DON are responsible to see that this is</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
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	<p>failed to be specific in the bathing, grooming, and activities of daily livings.</p> <p>b. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week via a permacath. The patient indicated the permacath was removed approximately a month ago. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week and had his / her permacath removed on 05/12/14. The plan of care failed to evidence that the patient was receiving dialysis 3 times a week, maintenance of the permacath, and dialysis medications received during dialysis treatments.</p> <p>c. The home was observed to have a Hoyer lift in the home and a life line alert. The plan of care failed to evidence the Hoyer lift and the life line alert under DME / supplies section.</p> <p>d. The plan of care stated the patient wore TED hose. The patient indicated she had not worn TED hose for a long time due to the stockings leaving indentations around her ankles.</p> <p>e. The plan of care stated the patient was a diabetic and received insulin. The plan of care failed to evidence diabetic</p>		done.				

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	<p>supplies used under the DME / supplies section.</p> <p>f. A physician's order dated 05/15/14 stated the allopurinol was discontinued. The plan of care continued to evidence the patient was taking Allopurinol 100 mg (milligrams) by mouth daily.</p> <p>2. Clinical record 2, SOC 06/12/07, included a plan of care established by the physician for the certification period of 04/29/14 to 06/27/14 with orders for skilled nursing 9 hours 5 times a week. The plan of care included that "oz [ounce] H2O [water] after feeding ... " and "8 oz H2O flush BID [twice a day], VNS magnet for seizures, change g/tube every 3 months, splints, and foot immobilizers.</p> <p>a. During a home visit on 06/03/14 at 12:00 PM, employee B indicated she provided g-tube care / dressing around stoma site, and applies the hand splints during nap time and foot immobilizers after the naps. Employee B demonstrated how the VNS magnet was utilized.</p> <p>b. The plan of care failed to include the frequency and duration of hand splints and foot immobilizers, g-tube care, amount of water after feedings, the type, amount, and frequency of feedings,</p>			

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	<p>size of g-tube for changes, and how to utilize the VNS magnet for seizures.</p> <p>3. Clinical record number 3, SOC 01/15/14, included a plan of care established by the physician for the certification period of 05/15/14 to 07/13/14. The plan of care evidenced the attendant care was to provide bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>4. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification period 04/03/14 to 06/01/14 with orders for home health aide and attendant care services to provide bathing, grooming, and activities of daily living. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>5. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 and 05/24/14 to 07/22/14 with orders for skilled nursing services to assist the patient with any personal care needs; ulcer care when ordered, assess skin, tube feedings, suctioning as needed, med</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>set-up and administer, and monitoring vital signs. The DME (durable medical equipment) / Supplies stated the patient was receiving ileostomy supplies.</p> <p>a. The current plan of care stated the patient was taking Loperamide 1 mg (milligram) / 5 ml (milliliter) per g-tube every 6 hours and Hydrocodone 5 / 325 mg every 8 hours prn (as needed). The plan of care stated the treatment to the right heel was vasolex topical twice a day prn.</p> <p>b. A physician order dated 05/20/14 stated to increase the Loperamide from 1 mg to 2 mg (milligram) tabs QID (four times a day) with feedings per g-tube, acidophilus OTC (over the counter) 1 tab QID with feedings per g-tube, Tussin DM per label directions per g-tube prn (as needed)", increase Hydrocodone 7.5 mg / 325 mg / 15 ml (milliliters) give 15 ml every 6 hours as needed and to discontinue vasolex topical to right heel twice a day and to apply duoderm. The plan of care failed to include these changes on the medication section as well as the frequency of changes to the duoderm.</p> <p>b. The daily nursing notes evidenced the patient had a g-tube and was receiving care to the area. The plan of</p>						

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	<p>care failed to include treatment instructions for the g-tube care.</p> <p>c. The daily nursing notes evidenced the patient had an ileostomy and was receiving care to the area. The plan of care failed to include treatment instructions and size and type of appliance to be applied to the patient's ostomy site.</p> <p>6. Clinical record number 7, SOC 12/20/06, included a plan of care established by a physician for the certification period of 05/02/14 to 06/30/14.</p> <p>The medication profile was revised on 04/14/14 to include Bioxin 250 mg / 5 ml, give 2 teaspoons per g-tube twice a day and Albuterol inhalation, 2 puffs daily. The plan of care failed to evidence the new medications.</p> <p>7. Clinical record number 8, SOC (start of care) 01/29/13, included a plan of care established by the physician for certification period 05/13/14 to 07/11/14. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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	<p>8. Clinical record number 9, SOC 06/08/12, included a plan of care established by the physician for the certification period of 05/29/14 to 07/27/14.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>b. A skilled nursing visit note dated 04/24/14 stated the patient had new medications in the home of Ondansetron 4 mg sublingual daily prn for nausea, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg.</p> <p>c. A revised medication profile dated 04/24/14 stated the patient was receiving Ondansetron 4 mg sublingual daily prn for nausea, Celebrex 200 mg by mouth daily, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg. The plan of care failed to evidence the new and discontinued medications.</p> <p>9. The Director of Nursing, employee B, was unable to provide any additional</p>			
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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000174	<p>documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>10. An undated policy titled "Care Planning" stated "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse reassessed wounds on a routine basis for 2 of 2 records reviewed who had wounds creating the potential to affect all 2 patients who were receiving wound care</p>	G000174	<p>SN's have been inserviced on need to measure wounds at least weekly and document the wound measurements onto a wound sheet and in the nursing note. Each has been given a disposable tape and plastic measuring tool to use. More are available as needed. RECURRENCE WILL BE</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>within the agency. (# 6 and 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services. A 30 day Comprehensive assessment dated 05/14/14 provided a wound measurement to the right heel. The clinical record failed to evidence any further measurements after 05/14/14. 2. Clinical record number 10, SOC 12/13/13, included a plan of care established by the physician for the certification period 12/13/13 to 01/16/14 with orders for skilled nursing 7 days a week for 2 months for daily dressing changes. An Admission Assessment dated 12/13/13 provided a wound measurement to an ulcer of the lower extremity. The clinical record failed to evidence any further measurement after 12/13/13. 3. The Director of Nursing indicated on 06/06/14 at 11:00 AM that wound measurements should had been done weekly and she had already identified this was a problem within the agency. 		<p>PREVENTED BY: ADON or DON MONITORING 100% of notes as they come in to determine that this has been done. If not, the SN will be informed and sent to the home for measurements. 100% of The charts with wounds will be reviewed for changes before the next medical plan of care is written to be submitted to the physician. There will also be a review of a sampling of charts every sixty days by the Q.A. committee. The ADON is responsible fo completing this. Person ultimately responsible: ADON and DON</p>				

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G000176	<p>4. An undated policy titled "Wound Care Management" stated "Documentation of wounds must include type of wound, measurements, including length, depth, and width, description of the wound bed, surrounding area, undermining, staging, color, odor and estimated amount of drainage ... wound status or measurements will be documented by the RN and / or LPN ..."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record and policy review, the agency failed to ensure the Registered Nurse notified the physician of a change in condition for 1 of 10 records reviewed and coordinated care with other providers in 1 of 10 records reviewed creating the potential to affect all of the patients receiving services from the agency. (# 1 and 6)</p> <p>Findings include: Related to physician notification</p>	G000176	The deficiency will be corrected by inservicing all staff, including on call, on emergency policies and procedures. What constitutes an emergency. When to call the physician and DON. All notes will be read as they come into the office and any problems will be corrected as soon as appropriate person can be reached. The ADON and DON are responsible for seeing that this is done. Each client will be contacted to ascertain if they have any other agencies also seeing them. This will be documented on the Coordination of Care tracking form. Specifics will be obtained	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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	<p>1. Clinical record number 6, SOC (start of care) 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services.</p> <p>A skilled nursing note dated 04/03/14 stated the patient had a prolapsed colon / anus at 7:15 PM with bleeding. The LPN (licensed practical nurse) on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence the physician had been notified of the patient's change of condition.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Emergencies in the Home / Reporting Patient Problems" stated "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."</p>		<p>as to treatment, medications, etc and it will be documented both in the Coordination of Care form and on the next physician's plan of care. This information will be in the client's record.</p> <p>RECURRENCE WILL BE PREVENTED BY: the ADON or DON checking charts and notes as they are completed. Making calls as necessary to obtain the needed information. The Q.A. nurse will be responsible for the above. The DON will assure that it is done by checking the charts and notes as they are completed.</p>	

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	<p>Related to coordination of care</p> <ol style="list-style-type: none"> 1. Clinical record number 1, start of care 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week. The clinical record failed to evidence coordination of care with the dialysis center. 2. The Director of Nursing indicated on 06/06/14 at 11:00 AM that she was not aware of the need to coordinate services with dialysis facilities. 3. An undated policy titled "Coordination of Client Care" stated "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their efforts are coordinated effectively." 			

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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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.</p> <p>Based on clinical record and policy review, the agency failed to ensure the Licensed Practical Nurse (LPN) followed agency policy for 1 of 10 records reviewed creating the potential to affect all of the patients with a change in condition. (# 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, start of care 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 for skilled nursing services. A skilled nursing note dated 04/03/14 stated the patient had a prolapsed colon / anus at 7:15 PM with bleeding. The LPN on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence the physician had been notified of the patient's change of condition. 2. The Director of Nursing, employee B, was unable to provide any additional 	G000179	<p>The policy has been revised to state that only an RN can take orders from a physician. The entire staff will be inserviced on what is an emergency, who you should call-physician, family, DON, and actions to be taken. This includes aides, homemakers, and on-call personnel. Abnormal occurrences should be reported, to whom. What constitutes an abnormal occurrence. A review of Emergency policies and procedures will be done. RECURRENCES WILL BE PREVENTED BY: having yearly inservices on emergency protocol , constantly reminding staff to be aware of untoward circumstances and to report them The DON will be responsible for seeing that this is done.</p>	06/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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G000224	<p>documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Emergencies in the Home / Reporting Patient Problems" stated, "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the home health aide and attendant care written care instructions did not duplicate services for each shift / visit</p>	G000224	The Home Health Aide assignment sheet has been revised, a copy included. The SN will take one to each client, complete it with input from the client, and have the client sign it. A copy will remain in the home, one for the clinical record, and	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
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	<p>provided in a 24 hour day, 7 days a week care in 2 of 2 records reviewed of patients receiving both home health aide and attendant care services (#1 and 5) creating the potential to affect all of the agency's patients receiving home health aide and attendant care services.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/07, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week. The plan of care included the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed.</p> <p>a. The home health aide care plan included bath, comb hair (prn-as needed), shampoo (prn), nail and foot care (prn), skin care (prn), oral hygiene (prn), shave (prn), change linen (prn), make bed (prn), straighten room, assist with dressing, assist with transfers, up in chair, walker,</p>		<p>one will go to the assigned aide. Home health aide and Attendant Care assignment sheets will have different duties. RECURRENCE WILL BE PREVENTED BY the ADON or DON reviewing all assignment sheets, comparing them with notes that come into the office weekly to be sure there is no crossover The ADON and DON are responsible to see that this is done.</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>encourage activity, encourage socialization, remind to take medications, check bowel movements, check / change depends, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, straighten kitchen, sweep / vacuum (prn), patient laundry (prn), and trash. The home health aide care plan failed to include bathing preference, visit frequency and duration, and failed to follow the plan of care.</p> <p>b. The attendant care services care plan included bath, comb hair (prn-as needed), shampoo (prn), nail and foot care (prn), skin care (prn), oral hygiene (prn), shave (prn), change linen (prn), make bed (prn), straighten room, assist with dressing, assist with transfers, up in chair, walker, encourage activity, encourage socialization, remind to take medications, check bowel movements, check / change depends, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, straighten kitchen, sweep / vacuum (prn), patient laundry (prn), and trash. The attendant care services care plan failed to follow the plan of care.</p> <p>c. The home health aide and attendant care visit notes evidenced matching services provided on the dates of 03/30, 03/31, 04/07, 04/09, 04/11,</p>						

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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	<p>04/12, 04/14, 04/16, 04/18, 04/21, 04/23, 04/25, 04/28/ 04/30, 05/02, 05/05, 05/07, 05/09, 05/14, 05/16, 05/19, and 05/23/14.</p> <p>The visit notes failed to evidence the specific services provided under each service.</p> <p>2. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for certification period 04/03/14 to 06/01/14 for home health aide services 2 hours a day for 3 days a week and attendant care services 2 hours a day for 5 days a week. The plan of care included that the home health aide and the attendant care aide was to assist with bathing, grooming, activities of daily living, and light housekeeping.</p> <p>a. The home health aide care plan included bath, comb hair (prn), shampoo (prn), nail and foot care (prn), skin care (prn), shave (prn), change linen (prn), make bed (prn), straighten room, assist with dressing (prn), assist with transfers (prn), up in chair, walker, encourage activity, ROM (range of motion) exercises (prn), encourage socialization, remind to take medications, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, encourage fluids, straighten kitchen, dishes, sweep / vacuum (prn), and patient laundry (prn).</p>			

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>The home health aide care plan failed to include bathing preference, home health aide frequency and duration, and failed to follow the plan of care.</p> <p>b. The attendant care services care plan included bath, comb hair (prn-as needed), shampoo (prn), nail and foot care (prn), skin care (prn), oral hygiene (prn), shave (prn), change linen (prn), make bed (prn), straighten room, assist with dressing, assist with transfers (prn), up in chair, walker, encourage activity, ROM exercised (prn), encourage socialization, remind to take medications, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, straighten kitchen, encourage fluids, sweep / vacuum (prn), patient laundry (prn), and shopping / errands (prn). The attendant care services care plan failed to include bathing preference, attendant care frequency and duration, and failed to follow the plan of care.</p> <p>c. The home health aide and attendant care visit notes evidenced matching services provided on the dates of 04/07, 04/09, 04/11, 04/14, 04/16, 04/18, 05/21, and 05/23/14. The visit notes failed to evidence the specific services provided under each service.</p> <p>3. The Administrator and Director of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000339	<p>Nursing indicated on 06/06/14 at 11:00 AM that the services should not be duplicated when both services are being provided in the same day back to back.</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record and policy review and interview, the agency failed to ensure OASIS Recertification and Comprehensive Assessments were completed within the 5 day window during the recertification period for 6 of 10 records reviewed creating the potential to affect all patients who were receiving skilled and un-skilled Medicaid and Medicaid Waiver services. (# 1, 4, 5, 7, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care</p>	G000339	An inservice was given to supervising RN's explaining that the Comprehensive Assessment and Recertification for clients with skilled nursing must be done within the five days window of every sixty day period beginning with the start of care date for skilled nursing. Also that the Comprehensive Assessment includes a complete physical with vital signs. This must be turned into the office within twenty four hours of completion of the assessment. This will be monitored by the ADON by keeping a log of certification due dates and notifying the supervising RNs at the first of each month. The ADON reviews	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
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	<p>established by the physician for the certification periods 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 for monthly registered nurse supervision, home health aide services 2 hours a day for 7 days a week, and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>The clinical record evidenced the registered made a "30 day Assessment" on 04/17/14 and 05/15/14. The 30 day assessment failed to include a comprehensive assessment including vital signs and a complete head to toe assessment. The clinical record failed to evidence a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p> <p>2. Clinical record number 4, SOC 03/02/12, included a plan of care established by the physician for the certification period 04/26/14 to 06/24/14 for skilled nursing every other day for injections.</p> <p>The clinical record evidenced a "30 day Comprehensive Assessment" on 04/04/14 and 05/08/14. The Recertification Assessment was completed on 04/24/14. The clinical record failed to evidence a Recertification Comprehensive Assessment within the 5</p>		the calendar weekly and notifies the nurse immediately if the window is closing. The DON is responsible to see that this is carried out.				

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	<p>day window during the certification period.</p> <p>3. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification of 04/03/14 to 06/01/14 for home health aide, attendant care, and homemaker services.</p> <p>The clinical record evidenced a "30 day Assessment" on 03/14/14, 04/18/14, and 05/15/14. The 30 day assessment failed to include a comprehensive assessment including vital signs and a complete head to toe assessment. The clinical record failed to provide a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p> <p>4. Clinical record number 7, SOC 12/20/06, included a plan of care established by a physician for the certification period of 05/02/14 to 06/30/14.</p> <p>The clinical record evidenced 30 day Comprehensive Assessments dated 04/15/14 and 05/21/14. The clinical record evidenced a Recertification Assessment dated 05/12/14. The clinical record failed to include a Recertification Comprehensive Assessment within the 5</p>				

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	<p>day window during the certification period.</p> <p>5. Clinical record number 8, SOC 01/29/13, included a plan of care established by a physician for the certification period of 03/14/14 to 05/12/14 and 05/13/14 to 07/11/14.</p> <p>The clinical record evidenced a 30 day Comprehensive Assessments dated 05/06/14. The clinical record evidenced a Recertification Assessment dated 05/20/14. The clinical record failed to include a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p> <p>6. Clinical record number 9, SOC 06/08/12, included a plan of care established by a physician for the certification period of 03/30/14 to 05/28/14.</p> <p>The clinical record evidenced a 30 day Assessment on 03/17/14. The 30 day assessment failed to include a comprehensive assessment including vital signs and a complete head to toe assessment. The record failed to evidence a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p>						

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000340	<p>7. The Director of Nursing indicated on 06/03/14 at 10:20 AM that the 30 day summary notes are done for non-skilled patients and the comprehensive assessments are done for the skilled patients.</p> <p>8. An undated policy titled "OASIS Assessment of Clients" stated, "Every second calendar month at recertification, a follow up assessment will be performed. The follow-up skilled visit assessment shall be performed no earlier than five days prior to the last day of the certification period [between and including days 56 - 60]."</p> <p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. Based on clinical record and policy review and interview, the agency failed to ensure Resumption of Care assessments had been completed within 48 hours of returning home (or knowledge of) in 2 of</p>	G000340	An inservice was given to supervising RN's explaining that the Comprehensive Assessment and Recertification for clients with skilled nursing must be done withing the five days window of every sixty day period beginning	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>2 records reviewed with patients who had been hospitalized creating the potential to affect all patients who receive services from the agency. (# 1 and 5)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 for home health aide and attendant care services.</p> <p>During a home visit on 06/03/14 at 9:00 AM, the patient had indicated he / she was in the hospital in December, 2013. The clinical record failed to evidence a Resumption of Care assessment had been completed within 48 hours of the patient's return to the home from the hospital.</p> <p>2. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification of 04/03/14 to 06/01//14 for home health aide, attendant care, and homemaker services.</p> <p>a. During a home visit on 06/05/14 at 2:40 PM, the patient had indicated he / she was in the hospital in March, 2013.</p>		<p>with the start of care date for skilled nursing. Also that the Comprehensive Assessment includes a complete physical with vital signs. This must be turned into the office within twenty four hours of completion of the assessment. If there is a hospital admission, upon the return home, a Resumption of Care will be done for skilled nursing clients within the forty eight hour window. The hospital is called daily for accuracy of hospital discharges. and RNs will be notified of discharge date for their client. This will be monitored by the ADON by keeping a log of certification due dates and notifying the supervising RNs at the first of each month. The ADON reviews the calendar weekly and notifies the nurse immediately if the window is closing. She will also notify RN's of The DON is responsible to see that this is carried out.</p>				

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802		
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N000000	<p>b. A skilled nursing visit note dated 03/14/14 stated the patient was discharged from the hospital on 03/12/14. The clinical record failed to evidence a Resumption of Care assessment had been completed within 48 hours of the patient's return to the home from the hospital.</p> <p>3. The Director of Nursing indicated on 06/03/14 at 10:20 AM that the 30 day summary notes are done for non-skilled patients and the comprehensive assessments are done for the skilled patients.</p> <p>4. An undated policy titled "OASIS Assessment of Client's" stated, "A Resumption of Care assessment will be completed within 48 hours [or knowledge of] on every client following a hospital stay of 24 hours or more for any reason other than diagnostic tests."</p> <p>This was a State home health re-licensure survey.</p> <p>Survey Dates: June 2, 3, 4, 5, and 6,</p>	N000000			

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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N000486	<p>2014.</p> <p>Facility #: 5865</p> <p>Medicaid Vendor #: 200237950</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 84</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 11, 2014</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with the dialysis personnel furnishing services for 1 of 10 records reviewed of patients receiving dialysis services from another provider creating the potential to affect all of the agency's patients that receive more than one service. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, start of care</p>	N000486	The Q.A. nurse will review all open cases and determine the ones with other agencies involved in their care. The agencies will be contacted and a will complete the Coordination of Care form and enter the name onto the communication form in the client's chart. A copy of both forms are included RECURRENCE WILL BE PREVENTED BY: the DON reviewing the forms as they come in to assure it is done for each client. A check-off list will be used. The DON will be responsible to assure that it is done It will be completed by	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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N000518	<p>11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week. The clinical record failed to evidence coordination of care with the dialysis center.</p> <p>2. The Director of Nursing indicated on 06/06/14 at 11:00 AM that she was not aware of the need to coordinate services with dialysis facilities.</p> <p>3. An undated policy titled "Coordination of Client Care" stated "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their efforts are coordinated effectively."</p>		6/30/14				
N000518	410 IAC 17-12-3(e)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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	<p>Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency document review and interview, the agency failed to ensure patients were provided the current Indiana Advance Directives, including a description of applicable State law and agency policy of Advance Directives in 10 of 10 records reviewed with the potential to affect all patients of the agency (# 1 - 10).</p> <p>Findings include</p> <ol style="list-style-type: none"> The admission package given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana Advanced Directives and agency policy in the admission folder that was distributed to the patients at the start of care (SOC). Clinical record number 1, SOC 11/01/17, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The 	N000518	The newest Advanced Directive forms have been acquired and it and the policy on advanced directives will be sent to each client. with an explanation letter.It will be prevented from recurring by copies of the correct information will be included in each new client's packet.The agency will check the web occasionally to be sure that a newer copy hasn't been created.The DON is responsible for correcting and maintaining this deficiency.It will be corrected by June 30,2014.	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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	<p>patient signed that the document was received on the SOC date.</p> <p>3. Clinical record number 2, SOC 06/12/07, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>4. Clinical record number 3, SOC 01/15/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>5. Clinical record number 4, SOC 03/02/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>6. Clinical record number 5, SOC 06/12/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record number 6, SOC 11/25/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana</p>			

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	<p>Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>8. Clinical record number 7, SOC 12/20/06, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>9. Clinical record number 8, SOC 01/29/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record number 9, SOC 06/08/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>11. Clinical record number 10, SOC 12/13/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>12. The Administrator and the Director of Nursing indicated on 06/06/14 at</p>						

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N000522	<p>11:00 AM they were not aware of the updated version of the advance directors nor were they aware of the need to include the agency policies with advance directives / admission packet.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review and interview, the agency failed to ensure staff followed the written plan of care related to skilled nursing visits, home health aide visits, attendant care visits, and treatments for 6 of 10 records reviewed creating the potential to affect all patients currently receiving services from the agency. (# 1, 2, 6, 8, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for certification periods 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p>	N000522	The Staffing Coordinators will be inserviced on the need to follow physician's orders in the proper calendar week. As the visiting notes come into the office, the ADON, QA, or DON will check the visits off to verify that frequency is being followed. If a visit has been missed, there will be a note explaining why the visit was missed. (EX: client had doctor's appt). If there is an extra visit, a physician's order will be obtained. 2 & 3 Specific orders for change,, frequency to be changed, and any care will be documented in the physician's orders . The dr. orders will be given to appropriate nursing staff to be followed. The date it is changed will be documented in the clinical notes. All wound orders will be verified with M.D. to assure agency knows type of med, frequency, dosage, coverings, if appropriate. The DON is responsible to see it	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>a. The clinical record evidenced a home health aide was in the home for 6 days during the weeks of 04/28/14 to 05/04/14, 05/12/14 to 05/18/14, and 05/19/14 to 05/25/14.</p> <p>b. The clinical record evidence an extra (4th) attendant care visit during the week of 04/07/14 to 04/13/14 and only 2 visits during the week of 05/12/14 to 05/18/14. The clinical record evidence only 1 visit during the week of 03/31/14 to 04/06/14.</p> <p>2. Clinical record 2, SOC 06/12/07, included a plan of care established by the physician for the certification period of 04/29/14 to 06/27/14 with orders for skilled nursing services 9 hours a day 5 days a week for 2 months. The plan of care stated to change the g-tube every 3 months or prn (as needed).</p> <p>a. During a home visit on 06/03/14 at 8:30 AM, employee B, a LPN (licensed practical nurse), had indicated she had thought the last time the patient had the g-tube changed was approximately 1 years ago. The clinical record failed to evidence that the g-tube had been changed every 3 months.</p> <p>b. The LPN was in the home for 6</p>		<p>carried out. RECURRENCE WILL BE PREVENTED BY: the ADON/ DON monitoring records and orders daily , checking charts, inservicing appropriate staff as necessary THE DON IS RESPONSIBLE FOR SEEING THIS THROUGH</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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	<p>hours on 05/02/14 and 05/16/14, and 4.75 hours on 05/17/14.</p> <p>c. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 11:00 AM.</p> <p>3. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services to assist the patient with ulcer care when ordered. The plan of care stated the treatment to the right heel was vasolex topical twice a day prn.</p> <p>a. A 30 day Comprehensive Assessment dated 04/17/14 stated employee E, a Registered Nurse, provided a treatment of 2 x 2 gauze and paper tape.</p> <p>b. A 30 day Comprehensive Assessment dated 05/14/14 stated employee E provided a treatment of 2 x 2 gauze and paper tape.</p> <p>4. Clinical record number 8, SOC 01/29/13, included a plan of care established by the physician for the certification period 05/13/14 to 07/11/14</p>			

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	<p>with orders for skilled nursing 1 time a day for 2 months and a home health aide 2 hours a day, 5 days a week for 2 months.</p> <p>a. The skilled nurse was in the home for 4 days (5/12, 5/13, 5/14, and 5/15/14) during the week of 05/12/14 to 05/18/14. The clinical record failed to evidence skilled nursing visits on 5/16, 5/17, and 5/18/14.</p> <p>b. The home health aide was in the home for 3 days (5/13, 5/14, and 5/15/14) during the week of 05/12/14 to 05/18/14. The clinical record failed to evidence home health aide visits on 5/12, 5/16, 5/17, and 5/18/14.</p> <p>5. Clinical record number 9, SOC 06/08/12, included a plan of care established by the physician for the certification period 03/30/14 to 05/28/14 with orders for skilled nursing 1 hour every other week for two months.</p> <p>The clinical record failed to evidence a skilled nursing visits during the weeks of 03/31/14 to 04/06/14 and 04/14/14 to 04/20/14.</p> <p>6. Clinical record number 10, SOC 12/13/13, included a plan of care established by the physician for the</p>						

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	<p>certification period 12/13/13 to 01/16/14 with orders for skilled nursing 7 days a week for 2 months for daily dressing changes.</p> <p>The clinical record evidenced skilled nursing visits daily from 12/13/13 to 12/17/13, 12/21/13 to 12/23/13, 12/26/13, and 01/16/14. The clinical record failed to evidence skilled nursing visits from 12/18/13 to 12/20/13, 12/24/13, 12/25/13, and 12/27/13 to 01/15/14.</p> <p>7. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>8. An undated policy titled "Care Planning" stated "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p>						

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the plan of care was revised to include all DME (durable medical equipment) and supplies (# 1 and 6), new and discontinued medications (# 1, 6, 7, and 9), specific treatments and instructions (# 2 and 6), dialysis medications and permacath maintenance (# 1), and specific details in bathing, grooming and activities of daily living for</p>	N000524	The SN's will be inserviced on the items in this deficiency by 6/30/14. Review of the dr. order, client chart will be done by DON after ADON has completed the order. to assure that all DME, meds, new & added, are appropriately put on the dr order. Visiting staff will be inserviced on need to inquire about new DME, meds, etc on each client visit, also specific size of items, treatments and supplies. The	06/30/2014

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	<p>home health aides (# 1, 3, 5, 8 , and 9) creating the potential to affect all current patients receiving services in the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed. The plan of care failed to be specific in the bathing, grooming, and activities of daily livings.</p> <p>b. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week via a permacath. The patient indicated the permacath was removed approximately a month ago. The clinical record</p>		<p>ADON will review 100% of the SN notes to find any new supplies, ADON & DON will review each aide/ attc assignment sheet to determine that correct duties are on them. The aides and attc will also be inserviced on the exact duties and the reasons. Client chart will be compared to physician's plan of care to be sure all medical equipment and supplies are listed, specific instructions given when appropriate. The Q..A. nurse will contact each agency also serving the client to obtain treatments, meds, etc. When the aides are called in for case conferences, they will be asked if the client has any new equipment, or some not being used. They are often the first to know. Frequency for things like hand splints will be gotten from therapist or client, as appropriate. THIS WILL BE MONITORED FOR COMPLIANCE BY: DON RE-CHECKING ADON'S ORDERS, CHART REVIEWS AT LEAST EVERY SIXTY DAYS. CONSTANT 100\$ REVIEW OF NOTES AS THEY COME IN. responsible persons: ADON and DON The Home Health Aide assignment sheet has been revised, a copy included. The SN will take one to each client, complete it with input from the client, and have the client sign it. A copy will remain in the home, one for the clinical record, and one will go to the assigned aide.</p>				

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	<p>evidenced the patient was receiving dialysis treatments 3 times a week and had his / her permacath removed on 05/12/14. The plan of care failed to evidence that the patient was receiving dialysis 3 times a week, maintenance of the permacath, and dialysis medications received during dialysis treatments.</p> <p>c. The home was observed to have a Hoyer lift in the home and a life line alert. The plan of care failed to evidence the Hoyer lift and the life line alert under DME / supplies section.</p> <p>d. The plan of care stated the patient wore TED hose. The patient indicated she had not worn TED hose for a long time due to the stockings leaving indentations around her ankles.</p> <p>e. The plan of care stated the patient was a diabetic and received insulin. The plan of care failed to evidence diabetic supplies used under the DME / supplies section.</p> <p>f. A physician's order dated 05/15/14 stated the allopurinol was discontinued. The plan of care continued to evidence the patient was taking Allopurinol 100 mg (milligrams) by mouth daily.</p> <p>2. Clinical record 2, SOC 06/12/07,</p>		Home health aide and Attendant Care assignment sheets will have different duties. The ADON and DON are responsible to see that this is done.				

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	<p>included a plan of care established by the physician for the certification period of 04/29/14 to 06/27/14 with orders for skilled nursing 9 hours 5 times a week. The plan of care included that "oz [ounce] H2O [water] after feeding ... " and "8 oz H2O flush BID [twice a day], VNS magnet for seizures, change g/tube every 3 months, splints, and foot immobilizers.</p> <p>a. During a home visit on 06/03/14 at 12:00 PM, employee B indicated she provided g-tube care / dressing around stoma site, and applies the hand splints during nap time and foot immobilizers after the naps. Employee B demonstrated how the VNS magnet was utilized.</p> <p>b. The plan of care failed to include the frequency and duration of hand splints and foot immobilizers, g-tube care, amount of water after feedings, the type, amount, and frequency of feedings, size of g-tube for changes, and how to utilize the VNS magnet for seizures.</p> <p>3. Clinical record number 3, SOC 01/15/14, included a plan of care established by the physician for the certification period of 05/15/14 to 07/13/14. The plan of care evidenced the attendant care was to provide bathing, grooming, activities of daily living, and</p>				

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	<p>light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>4. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification period 04/03/14 to 06/01/14 with orders for home health aide and attendant care services to provide bathing, grooming, and activities of daily living. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>5. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 and 05/24/14 to 07/22/14 with orders for skilled nursing services to assist the patient with any personal care needs; ulcer care when ordered, assess skin, tube feedings, suctioning as needed, med set-up and administer, and monitoring vital signs. The DME (durable medical equipment) / Supplies stated the patient was receiving ileostomy supplies.</p> <p>a. The current plan of care stated the patient was taking Loperamide 1 mg (milligram) / 5 ml (milliliter) per g-tube every 6 hours and Hydrocodone 5 / 325 mg every 8 hours prn (as needed). The</p>						

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	<p>plan of care stated the treatment to the right heel was vasolex topical twice a day pm.</p> <p>b. A physician order dated 05/20/14 stated to increase the Loperamide from 1 mg to 2 mg (milligram) tabs QID (four times a day) with feedings per g-tube, acidophilus OTC (over the counter) 1 tab QID with feedings per g-tube, Tussin DM per label directions per g-tube pm (as needed)", increase Hydrocodone 7.5 mg / 325 mg / 15 ml (milliliters) give 15 ml every 6 hours as needed and to discontinue vasolex topical to right heel twice a day and to apply duoderm. The plan of care failed to include these changes on the medication section as well as the frequency of changes to the duoderm.</p> <p>b. The daily nursing notes evidenced the patient had a g-tube and was receiving care to the area. The plan of care failed to include treatment instructions for the g-tube care.</p> <p>c. The daily nursing notes evidenced the patient had an ileostomy and was receiving care to the area. The plan of care failed to include treatment instructions and size and type of appliance to be applied to the patient's ostomy site.</p>			

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	<p>6. Clinical record number 7, SOC 12/20/06, included a plan of care established by a physician for the certification period of 05/02/14 to 06/30/14.</p> <p>The medication profile was revised on 04/14/14 to include Bioxin 250 mg / 5 ml, give 2 teaspoons per g-tube twice a day and Albuterol inhalation, 2 puffs daily. The plan of care failed to evidence the new medications.</p> <p>7. Clinical record number 8, SOC (start of care) 01/29/13, included a plan of care established by the physician for certification period 05/13/14 to 07/11/14. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>8. Clinical record number 9, SOC 06/08/12, included a plan of care established by the physician for the certification period of 05/29/14 to 07/27/14.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily</p>			

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	<p>living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>b. A skilled nursing visit note dated 04/24/14 stated the patient had new medications in the home of Ondansetron 4 mg sublingual daily prn for nausea, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg.</p> <p>c. A revised medication profile dated 04/24/14 stated the patient was receiving Ondansetron 4 mg sublingual daily prn for nausea, Celebrex 200 mg by mouth daily, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg. The plan of care failed to evidence the new and discontinued medications.</p> <p>9. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>10. An undated policy titled "Care Planning" stated "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include,</p>						

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N000527	<p>but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on clinical record and policy review, the agency failed to ensure the physician was notified of a change in condition for 1 of 10 records reviewed creating the potential to affect all of the patients receiving services from the agency. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC (start of care) 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services.</p> <p>A skilled nursing note dated 04/03/14 stated the patient had a prolapsed colon /</p>	N000527	The deficiency will be corrected by inservicing all staff, including on call, on emergency policies and procedures. What constitutes an emergency. When to call the physician and DON. All notes will be read as they come into the office and any problems will be corrected as soon as appropriate person can be reached. The ADON and DON are responsible for seeing that this is done.	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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N000532	<p>anus at 7:15 PM with bleeding. The nurse on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence that the physician had been notified of the patient's change of condition.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Emergencies in the Home / Reporting Patient Problems" stated "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."</p> <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,</p>			

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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	<p>the home health agency must know in advance which emergency system to contact.</p> <p>Based on clinical record and policy review, the agency failed to ensure the physician was notified of a change in condition for 1 of 10 records reviewed creating the potential to affect all of the patients receiving services from the agency. (# 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, SOC (start of care) 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services. A skilled nursing note dated 04/03/14 stated the patient had a prolapsed colon / anus at 7:15 PM with bleeding. The nurse on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence that the physician had been notified of the patient's change of condition. 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM. 3. An undated policy titled "Emergencies 	N000532	<p>Again, all staff will be inserviced on the policies and procedures of Emergencies or a change in client status. When to notify the MD , the caregiver, and the DON. A test will be given. What it is appropriate to do and not do.who to call and when. What constitutes an emergency.RECURRENCE WILL BE PREVENTED BY: the DON closely monitoring notes and charts, re-training as necessary The DON will be responsible to see that this is carried out.</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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N000537	<p>in the Home / Reporting Patient Problems" stated "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and policy review, and interview, the agency failed to ensure treatments were administered by the skilled nurse as ordered by the physician for 1 of 2 records reviewed for patients with wounds creating the potential to affect all patients who had wounds. (# 8)</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC 01/29/13, included a plan of care established by the physician for the certification period of 03/14/14 to</p>	N000537	<p>Inservice SN's on need to exactly follow the plan of care, call MD for clarification or if unable to follow orders. The SN obtaining the order should clarify as taking it , review it with appropriate SN's. Nurses notes are to be read to be certain it is being done correctly. SN's should promptly alert person responsible for medical component of care to any changes needed to alter the plan of care. RECURRENCE WILL BE PREVENTED BY: the DON and ADON closely reviewing notes, communicate with staff and clients as necessary, teach as necessary to prevent it The</p>	06/30/2014

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	<p>05/12/14.</p> <p>a. A physician order dated 04/12/14 stated to apply triple antibiotic ointment to the left upper extremity (scratched areas) wound.</p> <p>b. A nursing note dated 04/21/14 stated the nurse applied triple antibiotic ointment and covered with telfa and ace wrap. The skilled nurse failed to follow the plan of care.</p> <p>c. A nursing note dated 04/22/14 stated the nurse applied triple antibiotic ointment, dry gauze, and kling to the wound area. The skilled nurse failed to follow the plan of care.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Medication / Prescription Orders" stated "Medication orders or prescriptions are clear and accurate. Medication orders must be complete. Elements of a complete medication order are: client name, medication name, dosage, route, frequency, duration '[if applicable]', routine, prn (as needed) ... Blanket medication resume orders after a</p>		ADON and DON are responsible for being sure this is done.				

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N000541	<p>stoppage or hold due to a change in condition are prohibited."</p> <p>4. An undated policy titled "Physician Orders / Plan of Care" stated "Verbal orders maybe received by the RN (registered nurse) or LPN (licensed practical nurse). Verbal orders are put into writing, signed and dated by the person receiving the order, a copy placed temporarily in the chart."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse reevaluated the patient with the completion of a Recertification Comprehensive Assessment during the 5 day window during the certification period for 6 of 10 records reviewed (# 1, 4, 5, 7, 8, and 9) and a Resumption of Care assessment within 48 hours of patient's return home (or knowledge of) from a hospitalization in 2 of 2 records reviewed of patients who had been hospitalized creating the potential to affect all patients who receive</p>	N000541	Oasis and comprehensive assessment rules and regulations will be reviewed with RN's. A list of clients names with recerts due will be given monthly to each supervisory RN for their assigned clients. Recert comprehensive assessments will be done during the five day window, turned into the office within twenty four hours of completion so that they can be transmitted. When a client who receives skilled nursing services and is over the age of eighteen is discharged from the hospital a resumption of care form will be completed in the client's home. RECURRENCE WILL BE	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
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	<p>services from the agency longer than 60 days or who are hospitalized (# 1 and 5).</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for the certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 for monthly registered nurse supervision, home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. During a home visit on 06/03/14 at 9:00 AM, the patient had indicated he / she was in the hospital in December, 2013. The clinical record failed to evidence a Resumption of Care assessment had been completed within 48 hours of the patient's return to the home from the hospital.</p> <p>b. The clinical record evidence the registered made a "30 day Assessment" on 04/17/14 and 05/15/14. The 30 day assessment failed to provide a comprehensive assessment including vital signs and a complete head to toe assessment. The clinical record failed to provide a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p>		<p>PREVENTED BY THE ADON by giving the list of recerts due to the RN's monthly, informing them of needed information, using a tracking system to assure compliance. If the deadline is approaching and the RN has not turned in the required forms, the RN will be called and reminded. The ADON tracks the timeframe by following the oasis follow-up assessment calendar. The ADON and DON are ultimately responsible.</p>				

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	<p>2. Clinical record number 4, SOC 03/02/12, included a plan of care established by the physician for the certification period 04/26/14 to 06/24/14 for skilled nursing every other day for injections.</p> <p>The clinical record evidenced a "30 day Comprehensive Assessment" on 04/04/14 and 05/08/14. The Recertification Assessment was completed on 04/24/14. The clinical record failed to include a Recertification Comprehensive Assessment within the 5 day window during the certification period.</p> <p>3. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification of 04/03/14 to 06/01//14 for home health aide, attendant care, and homemaker services.</p> <p>a. During a home visit on 06/05/14 at 2:40 PM, the patient had indicated he / she was in the hospital in March, 2013. A skilled nursing visit note dated 03/14/14 stated the patient was discharged from the hospital on 03/12/14. The clinical record failed to evidence a Resumption of Care assessment had been completed within 48 hours of the</p>				

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	<p>patient's return to the home from the hospital.</p> <p>c. The clinical record evidenced a "30 day Assessment" on 03/14/14, 04/18/14, and 05/15/14. The 30 day assessment failed to include a comprehensive assessment including vital signs and a complete head to toe assessment. The clinical record failed to include a Recertification Comprehensive Assessment had been completed within the 5 day window during the certification period.</p> <p>4. Clinical record number 7, SOC 12/20/06, included a plan of care established by a physician for the certification period of 05/02/14 to 06/30/14.</p> <p>The clinical record evidenced 30 day Comprehensive Assessments dated 04/15/14 and 05/21/14. The clinical record evidenced a Recertification Assessment dated 05/12/14. The clinical record failed to include a Recertification Comprehensive Assessment completed within the 5 day window during the certification period.</p> <p>5. Clinical record number 8, SOC 01/29/13, included a plan of care established by a physician for the</p>			

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	<p>certification period of 03/14/14 to 05/12/14 and 05/13/14 to 07/11/14.</p> <p>The clinical record evidenced 30 day Comprehensive Assessments dated 05/06/14. The clinical record evidenced a Recertification Assessment dated 05/20/14. The clinical record failed to include a Recertification Comprehensive Assessment had been completed within the 5 day window during the certification period.</p> <p>6. Clinical record number 9, SOC 06/08/12, included a plan of care established by a physician for the certification period of 03/30/14 to 05/28/14.</p> <p>The clinical record evidenced a 30 day Assessment on 03/17/14. The 30 day assessment failed to include a comprehensive assessment including vital signs and a complete head to toe assessment. The record failed to evidence a Recertification Comprehensive Assessment had been completed within the 5 day window during the certification period.</p> <p>7. The Director of Nursing indicated on 06/03/14 at 10:20 AM that the 30 day summary notes are done for non-skilled patients and the comprehensive</p>						

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N000542	<p>assessments are done for the skilled patients.</p> <p>8. An undated policy titled "OASIS Assessment of Clients" stated "A Resumption of Care assessment will be completed within 48 hours [or knowledge of] on every client following a hospital stay of 24 hours or more for any reason other than diagnostic tests ... Every second calendar month at recertification, a follow up assessment will be performed. The follow-up skilled visit assessment shall be performed no earlier than five days prior to the last day of the certification period [between and including days 56 - 60]."</p> <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 clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse revised the plan of care to include all DME (durable medical equipment) and supplies (# 1 and 6), new and discontinued medications (# 1, 6, 7, and 9), specific</p>	N000542	The RN's will be inserviced on the need to ask client each visit of any changes and document them. The Home Health Aide assignment sheet has been revised, a copy included. The SN will take one to each client, complete it with input from the client, and have the client sign it.	06/30/2014

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	<p>treatments and instructions (# 2 and 6), dialysis medications, and permacath maintenance (# 1) creating the potential to affect all current patients receiving services in the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed. The plan of care failed to be specific in the bathing, grooming, and activities of daily livings.</p> <p>b. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week via a permacath. The patient indicated the</p>		<p>A copy will remain in the home, one for the clinical record, and one will go to the assigned aide. Home health aide and Attendant Care assignment sheets will have different duties. The RN's will be inserviced on the need to ask client each visit of any changes and document them. The notes will be read by the ADON or DON and the changes noted for the next physician's order, or a verbal order if needed. All medical equipment and supplies, new and discontinued medications will be noted and added to the next physician's order. All other agencies involved will be contacted and the appropriate medications or equipment added to the physician's order. The specifics will be documented on such as hand splints, dressings, g-tube feedings. The sizes of appliances will be noted and documented. RECURRENCE WILL BE PREVENTED BY THE ADON MONITORING 100% of the nurses notes as they come in and making appropriate changes on the care plan and next physician's order. The DON will review physician's plans of care before they are sent. The ADON and DON will be responsible to assure compliance.. e ADON and DON are responsible to see that this is done. The DON is ultimately responsible.</p>				

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	<p>permacath was removed approximately a month ago. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week and had his / her permacath removed on 05/12/14. The plan of care failed to evidence that the patient was receiving dialysis 3 times a week, maintenance of the permacath, and dialysis medications received during dialysis treatments.</p> <p>c. The home was observed to have a Hoyer lift in the home and a life line alert. The plan of care failed to evidence the Hoyer lift and the life line alert under DME / supplies section.</p> <p>d. The plan of care stated the patient wore TED hose. The patient indicated she had not worn TED hose for a long time due to the stockings leaving indentations around her ankles.</p> <p>e. The plan of care stated the patient was a diabetic and received insulin. The plan of care failed to evidence diabetic supplies used under the DME / supplies section.</p> <p>f. A physician's order dated 05/15/14 stated the allopurinol was discontinued. The plan of care continued to evidence the patient was taking Allopurinol 100 mg (milligrams) by mouth daily.</p>						

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	<p>2. Clinical record 2, SOC 06/12/07, included a plan of care established by the physician for the certification period of 04/29/14 to 06/27/14 with orders for skilled nursing 9 hours 5 times a week. The plan of care included that "oz [ounce] H2O [water] after feeding ... " and "8 oz H2O flush BID [twice a day], VNS magnet for seizures, change g/tube every 3 months, splints, and foot immobilizers.</p> <p>a. During a home visit on 06/03/14 at 12:00 PM, employee B indicated she provided g-tube care / dressing around stoma site, and applies the hand splints during nap time and foot immobilizers after the naps. Employee B demonstrated how the VNS magnet was utilized.</p> <p>b. The plan of care failed to include the frequency and duration of hand splints and foot immobilizers, g-tube care, amount of water after feedings, the type, amount, and frequency of feedings, size of g-tube for changes, and how to utilize the VNS magnet for seizures.</p> <p>3. Clinical record number 3, SOC 01/15/14, included a plan of care established by the physician for the certification period of 05/15/14 to 07/13/14. The plan of care evidenced the</p>			

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	<p>attendant care was to provide bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>4. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for the certification period 04/03/14 to 06/01/14 with orders for home health aide and attendant care services to provide bathing, grooming, and activities of daily living. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>5. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 and 05/24/14 to 07/22/14 with orders for skilled nursing services to assist the patient with any personal care needs; ulcer care when ordered, assess skin, tube feedings, suctioning as needed, med set-up and administer, and monitoring vital signs. The DME (durable medical equipment) / Supplies stated the patient was receiving ileostomy supplies.</p> <p>a. The current plan of care stated the patient was taking Loperamide 1 mg (milligram) / 5 ml (milliliter) per g-tube</p>			

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	<p>every 6 hours and Hydrocodone 5 / 325 mg every 8 hours prn (as needed). The plan of care stated the treatment to the right heel was vasolex topical twice a day prn.</p> <p>b. A physician order dated 05/20/14 stated to increase the Loperamide from 1 mg to 2 mg (milligram) tabs QID (four times a day) with feedings per g-tube, acidophilus OTC (over the counter) 1 tab QID with feedings per g-tube, Tussin DM per label directions per g-tube prn (as needed)", increase Hydrocodone 7.5 mg / 325 mg / 15 ml (milliliters) give 15 ml every 6 hours as needed and to discontinue vasolex topical to right heel twice a day and to apply duoderm. The plan of care failed to include these changes on the medication section as well as the frequency of changes to the duoderm.</p> <p>b. The daily nursing notes evidenced the patient had a g-tube and was receiving care to the area. The plan of care failed to include treatment instructions for the g-tube care.</p> <p>c. The daily nursing notes evidenced the patient had an ileostomy and was receiving care to the area. The plan of care failed to include treatment instructions and size and type of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>appliance to be applied to the patient's ostomy site.</p> <p>6. Clinical record number 7, SOC 12/20/06, included a plan of care established by a physician for the certification period of 05/02/14 to 06/30/14.</p> <p>The medication profile was revised on 04/14/14 to include Bioxin 250 mg / 5 ml, give 2 teaspoons per g-tube twice a day and Albuterol inhalation, 2 puffs daily. The plan of care failed to evidence the new medications.</p> <p>7. Clinical record number 8, SOC (start of care) 01/29/13, included a plan of care established by the physician for certification period 05/13/14 to 07/11/14. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>8. Clinical record number 9, SOC 06/08/12, included a plan of care established by the physician for the certification period of 05/29/14 to 07/27/14.</p> <p>a. The plan of care included that the</p>				

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	<p>home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living.</p> <p>b. A skilled nursing visit note dated 04/24/14 stated the patient had new medications in the home of Ondansetron 4 mg sublingual daily prn for nausea, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg.</p> <p>c. A revised medication profile dated 04/24/14 stated the patient was receiving Ondansetron 4 mg sublingual daily prn for nausea, Celebrex 200 mg by mouth daily, Benicar HCT 40 - 12.5 mg by mouth daily, and to discontinue Benicar 20 mg. The plan of care failed to evidence the new and discontinued medications.</p> <p>9. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>10. An undated policy titled "Care Planning" stated "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care,</p>			

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N000545	<p>developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse coordinated care with the dialysis personnel furnishing services for 1 of 10 records reviewed of patients receiving dialysis services from another provider creating the potential to affect all of the agency's patients that receive more than one service. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, start of care</p>	N000545	<p>Each client will be contacted to ascertain if they have any other agencies also seeing them. This will be documented on the Coordination of Care tracking form. Specifics will be obtained as to treatment, medications, etc and it will be documented both in the Coordination of Care form and on the next physician's plan of care. This information will be in the client's record. RECURRENCE WILL BE PREVENTED BY: the ADON or DON checking charts and notes as they are completed. Making calls as necessary to obtain the needed information. The Q.A.</p>	06/30/2014

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N000546	<p>11/01/17, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week. The clinical record failed to evidence coordination of care with the dialysis center.</p> <p>2. The Director of Nursing indicated on 06/06/14 at 11:00 AM that she was not aware of the need to coordinate services with dialysis facilities.</p> <p>3. An undated policy titled "Coordination of Client Care" stated "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their efforts are coordinated effectively."</p>		nurse will be responsible for the above. The DON will assure that it is done by checking the charts and notes as they are completed.				
	410 IAC 17-14-1(a)(1)(G)						

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	<p>Scope of Services</p> <p>Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and policy review, the agency failed to ensure the physician was notified of a change in condition for 1 of 10 records reviewed creating the potential to affect all of the patients receiving services from the agency. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC (start of care) 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services.</p> <p>A skilled nursing note dated 04/03/14 stated the patient had a prolapsed colon / anus at 7:15 PM with bleeding. The nurse on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence that the physician had been notified of the patient's change of</p>	N000546	The entire staff will be inserviced on what is an emergency, who you should call-physician, family, DON, and actions to be taken. This includes aides, homemakers, and on-call personnel. Abnormal occurrences should be reported, to whom. What constitutes an abnormal occurrence. A review of Emergency policies and procedures will be done. RECURRENCES WILL BE PREVENTED BY: having yearly inservices on emergency protocol , constantly reminding staff to be aware of untoward circumstances and to report them The DON will be responsible for seeing that this is done.	06/30/2014			

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N000550	<p>condition.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Emergencies in the Home / Reporting Patient Problems" stated "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on clinical record and policy review and interview, the agency failed to ensure the home health aide and attendant</p>	N000550	The home health aide and attendant care assignment sheets will be reviewed and rewritten as	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2014
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	<p>care written care instructions did not duplicate services for each shift / visit provided in a 24 hour day, 7 days a week care in 2 of 2 records reviewed of patients receiving both home health aide and attendant care services (#1 and 5) creating the potential to affect all of the agency's patients receiving home health aide and attendant care services.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/07, included a plan of care established by the physician for certification period 03/30/14 to 05/28/14 and 05/29/14 to 07/27/14 for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week. The plan of care included the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed.</p> <p>a. The home health aide care plan included bath, comb hair (prn-as needed), shampoo (prn), nail and foot care (prn), skin care (prn), oral hygiene (prn), shave (prn), change linen (prn), make bed (prn),</p>		<p>necessary. We will make sure that duties are not duplicated as appropriate. Some duties do apply to both. Ex: changing Depends, preparing food. The assignment sheets have been revised to include specifics such as how client is to be bathed: tub, shower, sponge. An example is included. RECURRENCE WILL BE PREVENTED BY: The DON or designee chekcking service plans against notes for consistency. The DON is ultimately responsible.</p>	

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	<p>straighten room, assist with dressing, assist with transfers, up in chair, walker, encourage activity, encourage socialization, remind to take medications, check bowel movements, check / change depends, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, straighten kitchen, sweep / vacuum (prn), patient laundry (prn), and trash. The home health aide care plan failed to include bathing preference, visit frequency and duration, and failed to follow the plan of care.</p> <p>b. The attendant care services care plan included bath, comb hair (prn-as needed), shampoo (prn), nail and foot care (prn), skin care (prn), oral hygiene (prn), shave (prn), change linen (prn), make bed (prn), straighten room, assist with dressing, assist with transfers, up in chair, walker, encourage activity, encourage socialization, remind to take medications, check bowel movements, check / change depends, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, straighten kitchen, sweep / vacuum (prn), patient laundry (prn), and trash. The attendant care services care plan failed to follow the plan of care.</p> <p>c. The home health aide and attendant care visit notes evidenced</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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	<p>matching services provided on the dates of 03/30, 03/31, 04/07, 04/09, 04/11, 04/12, 04/14, 04/16, 04/18, 04/21, 04/23, 04/25, 04/28/ 04/30, 05/02, 05/05, 05/07, 05/09, 05/14, 05/16, 05/19, and 05/23/14. The visit notes failed to evidence the specific services provided under each service.</p> <p>2. Clinical record number 5, SOC 06/12/12, included a plan of care established by the physician for certification period 04/03/14 to 06/01/14 for home health aide services 2 hours a day for 3 days a week and attendant care services 2 hours a day for 5 days a week. The plan of care included that the home health aide and the attendant care aide was to assist with bathing, grooming, activities of daily living, and light housekeeping.</p> <p>a. The home health aide care plan included bath, comb hair (prn), shampoo (prn), nail and foot care (prn), skin care (prn), shave (prn), change linen (prn), make bed (prn), straighten room, assist with dressing (prn), assist with transfers (prn), up in chair, walker, encourage activity, ROM (range of motion) exercises (prn), encourage socialization, remind to take medications, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, encourage</p>						

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802		
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	<p>fluids, straighten kitchen, dishes, sweep / vacuum (prn), and patient laundry (prn). The home health aide care plan failed to include bathing preference, home health aide frequency and duration, and failed to follow the plan of care.</p> <p>b. The attendant care services care plan included bath, comb hair (prn-as needed), shampoo (prn), nail and foot care (prn), skin care (prn), oral hygiene (prn), shave (prn), change linen (prn), make bed (prn), straighten room, assist with dressing, assist with transfers (prn), up in chair, walker, encourage activity, ROM exercised (prn), encourage socialization, remind to take medications, assist to bathroom (prn), clean bathroom, prepare food (prn), serve -cut up, straighten kitchen, encourage fluids, sweep / vacuum (prn), patient laundry (prn), and shopping / errands (prn). The attendant care services care plan failed to include bathing preference, attendant care frequency and duration, and failed to follow the plan of care.</p> <p>c. The home health aide and attendant care visit notes evidenced matching services provided on the dates of 04/07, 04/09, 04/11, 04/14, 04/16, 04/18, 05/21, and 05/23/14. The visit notes failed to evidence the specific services provided under each service.</p>				

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N000553	<p>3. The Administrator and Director of Nursing indicated on 06/06/14 at 11:00 AM that the services should not be duplicated when both services are being provided in the same day back to back.</p> <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.</p> <p>Based on clinical record and policy review, the Licensed Practical Nurse (LPN) failed to ensure agency policies were followed for 1 of 10 records reviewed creating the potential to affect all of the patients with a change in condition. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, start of care 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 for skilled nursing services. A skilled nursing note dated 04/03/14 stated the</p>	N000553	An inservice SN's on timely reporting of changes in client condition. Written communication will be made available within twenty four (24) hours; proper persons will be notified (MD, DON, caregiver, emergency personnel) as soon as necessary. Again, a review of emergency policies and procedures. RECURRENCE WILL BE PREVENTED BY: The DON or ADON working closely with SN's , inquiring about changes, reviewing notes as they come in, inservicing as necessary. The DON and ADON will be responsible for this	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014	
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N000559	<p>patient had a prolapsed colon / anus at 7:15 PM with bleeding. The LPN on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence the physician had been notified of the patient's change of condition.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM.</p> <p>3. An undated policy titled "Emergencies in the Home / Reporting Patient Problems" stated, "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."</p> <p>410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of</p>						

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	<p>changes in the patient's condition and needs after consulting with the supervising registered nurse.</p> <p>Based on clinical record and policy review, the Licensed Practical Nurse (LPN) failed to ensure the registered nurse and physician were notified timely of a change in the patient's condition for 1 of 10 records reviewed creating the potential to affect all of the patients with a change in condition. (# 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, start of care 11/25/13, included a plan of care established by a physician for the certification period 03/25/14 to 05/23/14 for skilled nursing services. A skilled nursing note dated 04/03/14 stated the patient had a prolapsed colon / anus at 7:15 PM with bleeding. The LPN on duty did not notify the agency until 7:40 PM. The clinical record failed to evidence the physician had been notified of the patient's change of condition. 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 06/06/14 at 2:00 PM. 3. An undated policy titled "Emergencies in the Home / Reporting Patient 	N000559	<p>Again, an inservice will be held instructing SN's of importance of informing proper persons of change in client condition. The emergency policies and procedures will be reviewed at that time come into the office and any with a problem will be discussed with that particular employee. RECURRENCE WILL BE PREVENTED BY:</p> <p>Communicating with nurses Constant review will be done. Yearly inservice on when to call office, physician, caregivers. The DON and ADON will be responsible to see that this is followed through.</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2014
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	Problems" stated, "An extreme emergency maybe, but is not limited to ... signs and symptoms of hemorrhage or acute bleeding G.I. (gastro-intestinal), vomiting or diarrhea ... Call for emergency transfer to hospital immediately, call physician, stay with the patient until emergency medical personnel arrive .. complete verbal orders ... Field staff can tell the physician directly when it would cause a delay to call the office first."				