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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br>157179 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>12/06/2011 |
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| G0000              | <p>This was a federal recertification survey.<br/>This was an extended survey.</p> <p>Survey Dates: 11-29-11 to 12-6-11<br/>Extended Dates: 12-2-11 to 12-6-11</p> <p>Facility #: 005346</p> <p>Medicaid Vendor #: 100264890A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>St. Francis Home Health is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 12-6-11 due to being found out of compliance with the Condition of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN<br/>December 12, 2011</p> | G0000         |   |                      |

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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| G0110              | <p>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 policy review and interview, the agency failed to ensure it had provided patients with written information regarding policies on advance directives in 20 (#s 1 through 20) of 20 records reviewed affecting all of the agency's 141 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical records numbered 1 through 20 failed to evidence the agency had provided the patients with written information regarding its policies on advance directives.</li> <li>2. The Director, employee A, indicated, on 12-1-11 at 9:20 AM, that patients had not received written information regarding this agency's policy on advance directives. When asked if the agency provided written information to the patients</li> </ol> | G0110         | The patient handbook has been updated to provide written information to the patient concerning agency policies on advance directives. The handbook will be reviewed annually for required changes/updates. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 12/06/2011           |

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| G0121  | <p>regarding this agency's policy on advance directives the Director replied, "We don't."</p> <p>3. The agency's undated "Advance Directives" policy number 1-003.1 states, "Upon admission, the admitting clinician will provide information regarding . . . the right to execute advance directives, and applicable agency policies. Written information . . . designed for this purpose will be provided to the patient/client." The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, interview, and agency policy review, the agency failed to ensure employees provided services in accordance with the agency's infection control policies and procedures and the Centers for Disease Control "Standard Precautions" in 6 (employees K, I, L, D, M, and N ) of 10 employees observed during home visits creating the potential for the transfer of disease causing organisms among patients and staff.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Precautions" policy number 9-002.1 states, "Hands and other skin surfaces should be washed with soap and water</p> | G0121   | The Clinical Manager will inservice the nursing and home health aide direct pateint care staff on the agency infection control policies and procedures and the Center for Disease Control "Standard Precautions" All nursing and home health aide clinical staff will be observed in the home by the clinical manager by the end of the first quarter 2012, then annually thereafter to ensure that the deficiencies are corrected and will not recur. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 01/04/2012           |   |

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|  | <p>immediately and thoroughly before and after patient/client contact, if contaminated with body substances, before and after gloves are worn, and before preparing food."</p> <p>2. The Centers for Disease Control "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" states, " IV. Standard Precautions . . . IV.A. Hand Hygiene. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . IV.A.3. Perform hand hygiene: . . . IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings . . . IV.A.3.d. If hands will be moving from a contaminated body site to a clean body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves."</p> <p>3. Employee K, a registered nurse, was observed to complete a dressing change on patient number 1 on 11-29-11 at 9:45 AM. The employee was observed to</p> |   |   |                      |   |

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|  | <p>remove the old dressings from the patient's left lower leg, measure the wound, and cleanse the wound with normal saline. The employee cleaned the bandage scissors with alcohol, cut the medicated dressing to be applied to the wound to size and applied the medicated dressing to the wound.</p> <p>A. The employee failed to remove her soiled old gloves after removing the old dressing and before touching the medicated dressing and applying it to the patient's wound.</p> <p>B. The employee completed the dressing change to the left lower leg and then removed the dressing to the patient's right upper thigh. The employee failed to change her gloves prior to moving to the thigh wound.</p> <p>C. After measuring the thigh wound, the employee removed her gloves and cleansed her hands. The employee obtained a pen from her pocket, touched the computer, placed the pen in her pocket and donned clean gloves without cleansing her hands. The employee then measured a third wound on the right thigh located above the first wound, removed her gloves, touched her pen and the computer, and donned clean gloves without cleansing her hands. The</p> |   |   |  |  |   |  |

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|                    | <p>employee cut a medicated dressing to size and applied it to the first right thigh wound. The employee then opened a dressing package that had been brought into the home and applied the dressing to the wound. After completing the dressing change the employee removed her gloves and cleansed her hands.</p> <p>4. Employee I, a home health aide, was observed to complete a shower bath on patient number 2 on 11-29-11 at 11:00 AM. The employee was observed to change her gloves and cleanse her hands 4 times, each time reaching into her pocket to obtain the hand cleanser and clean gloves.</p> <p>5. Employee L, a registered nurse, was observed to change a dressing to the right hip of patient number 7 on 11-30-11 at 10:50 AM. The employee was observed to set up the needed supplies for the dressing change. During the set-up, the employee obtained a syringe from the patient's dresser drawer and donned gloves without cleansing her hands.</p> <p>6. Employee D, a registered nurse, was observed to change a dressing to the right foot of patient number 8 on 11-30-11 at 12:10 PM. The employee failed to cleanse her hands after gathering and opening supplies and before donning</p> |               |   |                      |

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|  | <p>clean gloves. The employee failed to change her gloves after opening supplies and prior to cutting a medicated dressing to size and applying the dressing to the wound.</p> <p>7. Employee M, a registered nurse, was observed to perform a dressing change to the midsternal chest of patient number 9 on 11-29-11 at 2:15 PM. The employee was observed to remove the old dressing, remove her gloves, and reach into her nursing bag to obtain the hand cleanser. The employee cleansed her hands and reached into her bag to obtain clean gloves and tape. The employee then donned clean gloves without cleansing her hands.</p> <p>A. The employee was observed to remove dirty gloves and reach into her bag to obtain her hand cleanser 4 additional times.</p> <p>B. Observation noted the employee's long hair hanging over the clean field while performing the dressing change.</p> <p>8. Employee N, a registered nurse, was observed to perform a dressing change to ulcers on the left lower leg of patient number 10 on 11-29-11 at 3:25 PM. The employee was observed to remove the old dressing and change her gloves without</p> |   |   |                      |   |

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| G0143  | <p>cleansing her hands. The employee reached into the patient's supply box to obtain the supplies and opened the supplies. The employee then changed her gloves without cleansing her hands. The employee then cleansed the wound and applied an antibiotic ointment to the wound using her gloved fingertip. The employee completed the dressing change, removed her gloves and failed to cleanse her hands.</p> <p>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 review and interview, the agency failed to ensure the skilled nurse had communicated with the physician and the therapist to ensure optimal care for the patients in 2 (#s 2 and 6) of 20 records reviewed creating the potential to affect all of the agency's current 141 patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a skilled nurse admission visit note dated 11-11-11. The note identified discrepancies with medications. The note states, "SN [skilled nurse] completed</p> | G0143   | <p>The Clinical and Rehab Managers will inservice the clinical field staff on appropriate communication with physicians and other disciplines to ensure optimal care for the patients. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have appropriately communicated with the physician and other disciplines involved in the patients care. The Director of Home Health Care Services will be responsible or monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p> | 01/04/2012           |   |

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|  | <p>medication review guide. Flexeril, Colace, Pepcid, Robinul, Atrovent, Flagyl, Provigil - listed on med sheet but caregiver sts [states] pt [patient] not taking these meds. SN will call Dr. [name of physician] Monday."</p> <p>A. A skilled nurse visit note dated 11-14-11 states, "SN called Dr [name of physician]-spoke with [name] regarding complaints, It [left?] heel and med discrepancies on admission. [name] states he will talk w/Dr. [name of physician] and return call.</p> <p>B. The record failed to evidence any follow-up by the registered nurse, employee L, to ensure the medication discrepancies were resolved.</p> <p>C. The Director, employee A, stated, on 12-6-11 at 11:30 AM, "There is no documentation of follow-up by the nurse."</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1 hr [hour] X [times/for] 4 days . . . Pt stated [the patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms occurred, we would need to page MD on call. SN instr on all possible side effects</p> |   |   |                      |   |

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|  | <p>of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10 milligram (mg) dose pack over 30 days starting 11-27-11.</p> <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>E. A PT (physical therapy) visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking predinsone and seeing some bizarre things . . . hair on everything, bugs, etc. [The patient] states [the patient] had this same</p> |   |   |                      |   |

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| G0156              | <p>problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the patient's reports of seeing things. In retrospect, I should have called the doctor."</p> <p>G. The Director, employee A, indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> |               |   |                      |

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|  | <p>Based on clinical record and agency policy review, interview, and observation, it was determined the agency failed to ensure compliance with plans of care and informing the physician creating the potential to affect all of the agency's current 141 patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency failed to ensure treatments and visits had been provided as ordered by the physician on the plan of care in 8 of 20 records reviewed. (See G 158).</li> <li>2. The agency failed to ensure the physician had been provided significant information related to patient needs in 4 of 20 records reviewed. (See G 164).</li> <li>3. The agency failed to ensure treatments had been provided as ordered by the physician on the plan of care in 7 of 20 records reviewed. (See G 165).</li> </ol> <p>The cumulative effect of the agency not providing care in accordance with physician orders and not informing physicians of significant patient needs resulted in the agency being found out of compliance with this condition, 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p> | G0156   | <p>The Clinical and Rehab Managers will in-service the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. They will also be educated on communication with the physician to ensure he / she has significant information related to the needs of the patient. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have followed the plan of care or interim orders and provided visits, procedures, treatments, and patient teaching accordingly. The records will also be reviewed to ensure communication to the physician of significant information related to the patient needs. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p> | 01/04/2012           |   |

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| G0158              | <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered by the physician on the plan of care in 8 (#s 1, 7, 9, 10, 12, 14, 16, and 19) of 20 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a skilled nurse visit note dated 11-25-11 that identified wound care had been completed on a wound on the patient's "right thigh proximal." The note states, "Wound Dressing applied (specify type): POLYMEM SECURED WITH COVEROLL." The record failed to include an order for wound care to the right proximal thigh.</p> <p>A. The record included a physician order dated 10-25-11 that states, "Rt [right] LE [lower extremity] thigh trauma wound: cleanse with NS [normal saline] apply Bacitracin, apply ABD pads, secure with tape/coveroll daily."</p> | G0158         | <p>The Clinical and Rehab Managers will in-service the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. The nursing staff will also be educated on wound care treatments and documentation. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. The audit will include a review a wound care treatments and documentation. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p> | 01/04/2012           |

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|  | <p>B. A skilled nurse visit note dated 11-3-11 failed to evidence Bacitracin had been applied to the right thigh trauma wound.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period 10-23-11 to 12-21-11 that states, "Apply Smith Nephew's negative pressure wound vac using black foam. Set @ 120 mmHg [millimeters of mercury] continuous suction."</p> <p>A. A skilled nurse visit note dated 10-24-11 evidenced documentation the skilled nurse had completed the dressing change and had set the pressure at 75 mmHg.</p> <p>B. The Director, employee A, indicated, on 12-5-11 at 1:30 PM, that the order was for 120 mmHg. The Director stated, "I don't know why the skilled nurse (SN) put 75 [on the 10-24-11 skilled nurse visit note]."</p> <p>3. Clinical record number 9 included a physician order dated 10-8-11 that states, "SN 1 week 1; 7 week 6, [one time week 1 and 7 times a week for 6 weeks] 4 [visits] as needed." The record failed to evidence any skilled nurse visits had been</p> |   |   |                      |   |

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|                    | <p>provided on 10-26-11.</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 11-12-11 to 01-10-12. The plan of care states, "Wound Care: Cleanse with 1/4 str [strength] Dakins pack wd [wound] with dakins moist gauze. Cover with soft gauze and tape to secure.</p> <p>A. A skilled nurse visit note dated 11-12-11 states, "Wound packed (specify packing material): moist soft gauze." The note failed to evidence the wound had been packed with Dakins moist gauze."</p> <p>B. The record included a skilled nurse visit note dated 11-13-11 that states, "Wound dressing applied (specify type): MOISTENED 1/4 STR [strength] DAIKINS [sic]SOLUTION 4 X 4/ABD [type of dressing] /KERLEX [type of dressing] /COBAN . . . PT [patient] DID NOT WANT COBAN ON LLE [left lower extremity], SN ED [educated] PT THAT THE DRSG [dressing] NEEDS TO BE SECURE AND THE EDEMA NEEDS TO BE RELIEVED WITH COBAN."</p> <p>1.) The record failed to evidence an order for the application of the coban to the wound.</p> |               |   |                      |

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|  | <p>2.) The Clinical Manager stated, on 12-5-11 at 1:10 PM, "There is no order for the Coban."</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 10-22-11 to 12-20-11. The plan of care states, "Wound Vac @ 125 mmHg cont [continuous]."</p> <p>A. Skilled nurse visit notes, dated 10-24-11, 10-26-11, 10-28-11, 11-2-11, 11-4-11, 11-7-11, 11-9-11, 11-11-11, 11-21-11, 11-23-11, and 11-25-11, evidenced the wound vac pressure was 75 mmHg.</p> <p>B. Skilled nurse visit notes, dated 11-16-11 and 11-18-11, failed to evidence at what pressure the wound vac had been set.</p> <p>C. The Clinical Manager, employee B, stated, on 12-5-11 at 1:15 PM, "There must have been a typing error on the plan of care."</p> <p>6. Clinical record number 14 included a plan of care established by the physician for the certification period 11-06-11 to 01-04-12. The plan of care states, "SN for wound care 3X/week and prn. SN to</p> |   |   |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br>ST FRANCIS HOME HEALTH AND HOSPICE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>438 S EMERSON AVE<br>GREENWOOD, IN46143 |
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|--------------------|---|---------------|---|----------------------|
|                    | <p>cleanse/irrigate left 4th toe amputation site and left plantar medial wound with 1/4 str Dakins solution, rinse periwound with normal saline, apply santyl ointment to yellow sloughing tissue, cover/pack wounds with black granufoam, apply wound vac at 125 mmHg cont."</p> <p>A. Skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, failed to evidence the skilled nurse had used the Dakins solution as ordered.</p> <p>B. A skilled nurse visit note dated 11-25-11 evidenced the wound vac pressure was set at 120 mmHg.</p> <p>C. The Clinical Manager indicated, on 12-5-11 at 3:30 PM, skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, did not evidence the Dakins solution had been used and that the pressure setting on 11-25-11 was not as ordered.</p> <p>7. Clinical record number 16 included a skilled nurse visit note dated 11-15-11 that states, "SN OUT TO SEE PT. CATHFLO ACTIVASE 2 mg X 1 USED WITH SUCCESS AFTER 30 MIN."</p> <p>A. The record failed to include a physician order for the use of the Cathflo Activase.</p> |               |   |                      |

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|                    | <p>B. The Clinical Manager indicated, on 12-6-11 at 9:20 AM, the order for the use of the Cathflo Activase was from the pharmacy.</p> <p>C. The agency's 03-02-10 "Adult &amp; Pediatric: Dec clotting Central Venous Catheters" policy number 421.33 states, "Use of Cathflo . . . An order is to be written per this policy for the use of Cathflo. The order will be written as: Cathflo 2 mg / 2 mL IV, instill 2 mg per _____ occluded lumen(s). May repeat one (1) time if needed."</p> <p>8. Clinical record number 19 included skilled nurse visit notes, dated 5-20-11, 5-21-11, and 5-22-11, that evidenced the skilled nurse had applied Mepilex to the patient's left lower extremity wound. The record failed to evidence an order for the application of the Mepilex.</p> <p>A. The record included a physician order dated 5-23-11 that states, "Wound # 3 Bilat [bilateral] legs Cleanse wound and periwound with Normal Saline. Apply to wound bed (Primary dressing) Mepilex. Cover with ABD."</p> <p>B. Skilled nurse visit notes, dated 5-24-11, 5-25-11, 5-26-11, and 5-27-11, failed to evidence the Mepilex had been</p> |               |   |                      |

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| G0164  | <p>applied.</p> <p>9. The Director, employee A, and the Clinical Manager, employee B, were unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record review, observation, and interview, the agency failed to ensure the physician had been provided significant information related to patient needs in 4 (#s 3, 6, 11, and 13) of 20 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a skilled nurse (SN) admit visit note dated 11-8-11 that identified the patient had pain in the "hands" that was "acute" and "aches/burns" and was "on-off."</p> <p>A. The record included a physical therapy (PT) evaluation visit note dated 11-9-11 that identified the patient had pain in the right hand that was an "ache in the the surface of [the patient's] palm and into fingers. Dx [diagnosed] with gouty</p> | G0164   | The Clinical and Rehab Manager will educate the nursing and therapy clinical field staff on the importance of communicating significant information related to the patient needs to the physician in order to review and update the plan of care. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has communicated significant information related to the patient needs to the physicians and that the plan of care has been reviewed and updated accordingly. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 01/04/2012           |   |

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|                    | <p>arthritis." The note identifies the patient's highest level of pain was an 8 on a scale of 1 to 10, was constant, and the lowest level of pain relief was a 4 and that the relief level of the pain was not acceptable.</p> <p>B. The record included an occupational therapy (OT) initial evaluation visit note dated 11-14-11 that identified the patient had pain the right hand that was "intermittent", was a 4 on a scale of 1 to 10, and that the patient "wears glove on R hand to keep it warm."</p> <p>C. The record included a SN visit note dated 11-17-11 that states, "Pt [patient] c/o [complains of] increased pain in wrist. P.T./O.T. aware. Pt instructed to set apt [appointment] with PCP [primary care giver] for follow up."</p> <p>D. The record included an OT visit note dated 11-17-11 that identified the patient had pain in the "R [right] hand over median N [nerve] distribution unable to rate . . . sharp, jabbing pain w [with] /movement."</p> <p>E. The record included a SN visit note dated 11-21-11 that identified the patient had pain in the "rt wrist" that was "chronic", a 6 on a scale of 1 to 10, with the best response to control measures being a 5, that the pain was an "ache", and</p> |               |   |                      |

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|  | <p>prevented the patient from "lifting objects."</p> <p>F. The record included an OT visit note dated 11-22-11 that states the patient had pain the the "R hand over median N distribution unable to rate . . . sharp, jabbing pain w/movement."</p> <p>G. The record included a PT visit note dated 11-25-11 that states, "Pt is c/o pain in R hand and states OT feels [the patient] has carpal tunnel syndrome. [The patient] has a splint for this that was given to [the patient] in ECF [extended care facility], but we were unable to find it today."</p> <p>H. The record included a SN visit note dated 11-28-11 that identified the patient has pain in the "Rt hand" that is "chronic", a 6 on a scale of 1 to 10, "ache/tender", "constant", and worsened "with activity."</p> <p>I. The record included an OT note dated 11-29-11 that states, "Location of pain: R hand over median N distribution . . . says it is numb more than painful." The note states further, "Pt. has obtained a wrist splint which [the patient] says offers some relief of symptoms in [the patient's] R hand. Tried using soft sock aid for donning TED hose, but pt does not have the hand strength to get the stocking on the device or to pull it up."</p> |   |   |                      |   |

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|  | <p>J. A home visit was made to patient number 3 with the occupational therapist on 11-29-11 at 1:15 PM. The patient indicated to the therapist the patient had found the splint from another time and had decided to start wearing it. The therapist checked the splint for proper fit. Observation noted the occupational therapist work with the patient to use a soft sock aid. The patient indicated the pain in the right hand prevented getting the stocking on the device and pulling it up.</p> <p>K. The record failed to evidence the skilled nurse nor the occupational or physical therapists had informed the physician of the patient's complaints regarding pain and numbness in the right wrist, the inability to use assistive devices, and the use of the splint by the patient.</p> <p>L. The Director, employee A, indicated, on 12-5-11 at 1:25 PM, the record did not evidence any documentation the nurse or therapists had informed the physician of the patient's complaints of pain or use of the splint.</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1</p> |   |   |                      |   |

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|  | <p>hr X [times/for] 4 days . . . Pt stated [the patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms occurred, we would need to page MD on call. SN instr on all possible side effects of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10 milligram (mg) dose pack over 30 days starting 11-27-11.</p> <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> |   |   |                      |   |

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|  | <p>E. A PT visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking predinsone and seeing some bizarre things . . . hair on everything, bugs, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the patient's reports of seeing things. In retrospect, I should have called the doctor."</p> <p>G. The Director, employee A, indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> |   |   |                      |   |

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|  | <p>3. Clinical record number 11 included a PT "agency admit" visit note dated 11-23-11 that identified the patient needed assistance with understanding and setting up medications. The note states, "States [the patient] does not understand [the patient's] medications or how to set them up. PT has obtained orders for nursing for med set up and education. [The patient] has not taken [the patient's] insulin and [the patient's] BS [blood sugar] was 271."</p> <p>A. The record included a SN visit note dated 11-26-11 that states, "I sat down with [the patient] and made [the patient] tell me what insulins [the patient] was on and when to take them. At first [the patient] really couldn't tell me much of anything about [the patient's] meds except [the patient] didn't have them all and didn't have the money to get them . . . I had [the patient] fill [the patient's] pillboxes with what medcs [medicines] [the patient] has and told [the patient] when the social worker comes and figures out a way for [the patient] to get the remaining meds, a nurse can help [the patient] fill the pillboxes with the rest of the meds . . . I feel that it is best to have [the patient] do as much for [the patient's] self b/c [because] [the patient] is overwhelmed and has I just want to give up attitude." The note states, "Plan for</p> |   |   |                      |   |

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|  | <p>Next Visit: F/U [follow-up] med ed [education] and diabetic ed."</p> <p>B. The record failed to evidence the physician had been notified of the continued need for skilled nursing for medication and diabetic education.</p> <p>4. Clinical record number 13 included a plan of care, established by the physician for the certification period 10-8-11 to 12-6-11 that identified the principal diagnosis as diabetes mellitus type II without complications.</p> <p>A. The record included a SN visit note dated 10-19-11 that states, "Glucometer Reading: 267." A SN visit note dated 10-21-11 evidenced the patient's glucometer reading was 358.</p> <p>B. A SN visit note dated 10-25-11 states, "Pt has had some HI blood sugars and states [the patient] is sure [the patient] has a UTI [urinary tract infection]. States [the patient] is to see Dr. [name] today as well."</p> <p>C. A SN visit note dated 10-31-11 evidenced the glucometer reading was 315. A SN visit note dated 11-7-11 states, "Pt states [the patient] has felt bad all weekend. States [the patient] has not been eating or drinking like [the patient]</p> |   |   |                      |   |

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|                    | <p>should because [the patient] has had vomiting and diarrhea. States [the patient] had some blood in the stool the other day. Pts blood pressure is up. Instructed on the need to go to ER [emergency room] if [the patient] is unable to keep anything down and is not taking meds. Pt verbalized understanding and states [the patient] thinks [the patient] will go in a bit if not better."</p> <p>D. A SN visit note dated 11-11-11 states, "Glucometer Reading: 307 . . . Pt states [the patient] has been having N/V [nausea, vomiting] and diarrhea today and [the patient] is going to call Dr. today and see if [the patient] needs to go back to hospital. Pt states [the patient] has been having some issues with [the patient's] children and I think [the patient] has been putting off calling MD b/c [the patient] feels [the patients] needs to tend to the kids. Appetite poor. Pt eating few crackers and still [the patient's] BS was 307. I asked if I could just call Dr. to expedite things and [the patient] said no, I'll do it."</p> <p>E. A SN visit note dated 11-15-11 states, "Pt states [the patient] has continued to be sick but is improving. States [the patient] is not eating much due to nausea . . . States [the patient's] bladder is bothering [the patient] again . . . Pt</p> |               |   |                      |

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|                    | <p>states [the patient] has informed Dr. [name]."</p> <p>F. A SN visit note dated 11-23-11 states, "Pt states [the patient] went to the ER at IU med center over the weekend . . . Pt states [the patient's] blood sugar was high. Pt states [the patient] was given an IV and released within a few hours. Pt states [the patient] also received antibiotics IV due to UTI. Blood sugar is hi today. Instructed pt to call MD if next reading is also hi."</p> <p>G. The record failed to evidence the SN had informed and communicated with the physician regarding the patient's high blood sugar readings and complaints of urinary tract infection symptoms.</p> <p>H. The Director, employee A, stated, on 12-5-11 at 3:00 PM, "Everybody knows this patient and know that the patient is noncompliant. The nurse did not document conversations with the doctor and case manager."</p> <p>5. The Director, employee A, and the Clinical Manager, employee B, were unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> |               |   |                      |

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| G0165              | <p>Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and agency policy review and interview, the agency failed to ensure treatments had been provided as ordered by the physician on the plan of care in 7 (#s 1, 7, 10, 12, 14, 16, and 19) of 20 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a skilled nurse visit note dated 11-25-11 that identified wound care had been completed on a wound on the patient's "right thigh proximal." The note states, "Wound Dressing applied (specify type): POLYMEM SECURED WITH COVEROLL." The record failed to include an order for wound care to the right proximal thigh.</p> <p>A. The record included a physician order dated 10-25-11 that states, "Rt [right] LE [lower extremity] thigh trauma wound: cleanse with NS [normal saline] apply Bacitracin, apply ABD pads, secure with tape/coveroll daily."</p> <p>B. A skilled nurse visit note dated</p> | G0165         | <p>The Clinical and Rehab Managers will in-service the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. The nursing staff will also be educated on wound care treatments and documentation. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. The audit will include a review a wound care treatments and documentation. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p> | 01/04/2012           |

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|  | <p>11-3-11 failed to evidence Bacitracin had been applied to the right thigh trauma wound.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period 10-23-11 to 12-21-11 that states, "Apply Smith Nephew's negative pressure wound vac using black foam. Set @ 120 mmHg [millimeters of mercury] continuous suction."</p> <p>A. A skilled nurse visit note dated 10-24-11 evidenced documentation the skilled nurse had completed the dressing change and had set the pressure at 75 mmHg.</p> <p>B. The Director, employee A, indicated, on 12-5-11 at 1:30 PM, that the order was for 120 mmHg. The Director stated, "I don't know why the skilled nurse (SN) put 75 [on the 10-24-11 skilled nurse visit note]."</p> <p>3. Clinical record number 10 included a plan of care established by the physician for the certification period 11-12-11 to 01-10-12. The plan of care states, "Wound Care: Cleanse with 1/4 str [strength] Dakins pack wd [wound] with dakins moist gauze. Cover with soft gauze and tape to secure.</p> |   |   |                      |   |

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|  | <p>A. A skilled nurse visit note dated 11-12-11 states, "Wound packed (specify packing material): moist soft gauze." The note failed to evidence the wound had been packed with Dakins moist gauze."</p> <p>B. The record included a skilled nurse visit note dated 11-13-11 that states, "Wound dressing applied (specify type): MOISTENED 1/4 STR [strength] DAIKINS [sic]SOLUTION 4 X 4/ABD [type of dressing] /KERLEX [type of dressing] /COBAN . . . PT [patient] DID NOT WANT COBAN ON LLE [left lower extremity], SN ED [educated] PT THAT THE DRSG [dressing] NEEDS TO BE SECURE AND THE EDEMA NEEDS TO BE RELIEVED WITH COBAN."</p> <p>1.) The record failed to evidence an order for the application of the coban to the wound.</p> <p>2.) The Clinical Manager stated, on 12-5-11 at 1:10 PM, "There is no order for the Coban."</p> <p>4. Clinical record number 12 included a plan of care established by the physician for the certification period 10-22-11 to 12-20-11. The plan of care states, "Wound Vac @ 125 mmHg cont</p> |   |   |                      |   |

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|  | <p>[continuous]."</p> <p>A. Skilled nurse visit notes, dated 10-24-11, 10-26-11, 10-28-11, 11-2-11, 11-4-11, 11-7-11, 11-9-11, 11-11-11, 11-21-11, 11-23-11, and 11-25-11, evidenced the wound vac pressure was 75 mmHg.</p> <p>B. Skilled nurse visit notes, dated 11-16-11 and 11-18-11, failed to evidence at what pressure the wound vac had been set.</p> <p>C. The Clinical Manager, employee B, stated, on 12-5-11 at 1:15 PM, "There must have been a typing error on the plan of care."</p> <p>5. Clinical record number 14 included a plan of care established by the physician for the certification period 11-06-11 to 01-04-12. The plan of care states, "SN for wound care 3X/week and prn. SN to cleanse/irrigate left 4th toe amputation site and left plantar medial wound with 1/4 str Dakins solution, rinse periwound with normal saline, apply santyl ointment to yellow sloughing tissue, cover/pack wounds with black granufoam, apply wound vac at 125 mmHg cont."</p> <p>A. Skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, failed to</p> |   |   |                      |   |

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|  | <p>evidence the skilled nurse had used the Dakins solution as ordered.</p> <p>B. A skilled nurse visit note dated 11-25-11 evidenced the wound vac pressure was set at 120 mmHg.</p> <p>C. The Clinical Manager indicated, on 12-5-11 at 3:30 PM, skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, did not evidence the Dakins solution had been used and that the pressure setting on 11-25-11 was not as ordered.</p> <p>6. Clinical record number 16 included a skilled nurse visit note dated 11-15-11 that states, "SN OUT TO SEE PT. CATHFLO ACTIVASE 2 mg X 1 USED WITH SUCCESS AFTER 30 MIN."</p> <p>A. The record failed to include a physician order for the use of the Cathflo Activase.</p> <p>B. The Clinical Manager indicated, on 12-6-11 at 9:20 AM, the order for the use of the Cathflo Activase was from the pharmacy.</p> <p>C. The agency's 03-02-10 "Adult &amp; Pediatric: Dec clotting Central Venous Catheters" policy number 421.33 states, "Use of Cathflo . . . An order is to be</p> |   |   |                      |   |

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|  | <p>written per this policy for the use of Cathflo. The order will be written as: Cathflo 2 mg / 2 mL IV, instill 2 mg per _____ occluded lumen(s). May repeat one (1) time if needed."</p> <p>7. Clinical record number 19 included skilled nurse visit notes, dated 5-20-11, 5-21-11, and 5-22-11, that evidenced the skilled nurse had applied Mepilex to the patient's left lower extremity wound. The record failed to evidence an order for the application of the Mepilex.</p> <p>A. The record included a physician order dated 5-23-11 that states, "Wound # 3 Bilat [bilateral] legs Cleanse wound and periwound with Normal Saline. Apply to wound bed (Primary dressing) Mepilex. Cover with ABD."</p> <p>B. Skilled nurse visit notes, dated 5-24-11, 5-25-11, 5-26-11, and 5-27-11, failed to evidence the Mepilex had been applied.</p> <p>8. The Director, employee A, and the Clinical Manager, employee B, were unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> |   |   |                      |   |

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| G0170  | <p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had provided treatments and visits as ordered by the physician on the plan of care in 8 (#s 1, 7, 9, 10, 12, 14, 16, and 19) of 20 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 included a skilled nurse visit note dated 11-25-11 that identified wound care had been completed on a wound on the patient's "right thigh proximal." The note states, "Wound Dressing applied (specify type): POLYMEM SECURED WITH COVEROLL." The record failed to include an order for wound care to the right proximal thigh.</li> </ol> <p>A. The record included a physician order dated 10-25-11 that states, "Rt [right] LE [lower extremity] thigh trauma wound: cleanse with NS [normal saline] apply Bacitracin, apply ABD pads, secure with tape/coveroll daily."</p> <p>B. A skilled nurse visit note dated 11-3-11 failed to evidence Bacitracin had been applied to the right thigh trauma</p> | G0170   | <p>The Clinical and Rehab Managers will in-service the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. The nursing staff will also be educated on wound care treatments and documentation. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. The audit will include a review a wound care treatments and documentation. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p> | 01/04/2012   |  |   |  |

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|  | <p>wound.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period 10-23-11 to 12-21-11 that states, "Apply Smith Nephew's negative pressure wound vac using black foam. Set @ 120 mmHg [millimeters of mercury] continuous suction."</p> <p>A. A skilled nurse visit note dated 10-24-11 evidenced documentation the skilled nurse had completed the dressing change and had set the pressure at 75 mmHg.</p> <p>B. The Director, employee A, indicated, on 12-5-11 at 1:30 PM, that the order was for 120 mmHg. The Director stated, "I don't know why the skilled nurse (SN) put 75 [on the 10-24-11 skilled nurse visit note]."</p> <p>3. Clinical record number 9 included a physician order dated 10-8-11 that states, "SN 1 week 1; 7 week 6, [one time week 1 and 7 times a week for 6 weeks] 4 [visits] as needed." The record failed to evidence any skilled nurse visits had been provided on 10-26-11.</p> <p>4. Clinical record number 10 included a plan of care established by the physician</p> |   |   |                      |   |

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|  | <p>for the certification period 11-12-11 to 01-10-12. The plan of care states, "Wound Care: Cleanse with 1/4 str [strength] Dakins pack wd [wound] with dakins moist gauze. Cover with soft gauze and tape to secure.</p> <p>A. A skilled nurse visit note dated 11-12-11 states, "Wound packed (specify packing material): moist soft gauze." The note failed to evidence the wound had been packed with Dakins moist gauze."</p> <p>B. The record included a skilled nurse visit note dated 11-13-11 that states, "Wound dressing applied (specify type): MOISTENED 1/4 STR [strength] DAIKINS [sic]SOLUTION 4 X 4/ABD [type of dressing] /KERLEX [type of dressing] /COBAN . . . PT [patient] DID NOT WANT COBAN ON LLE [left lower extremity], SN ED [educated] PT THAT THE DRSG [dressing] NEEDS TO BE SECURE AND THE EDEMA NEEDS TO BE RELIEVED WITH COBAN."</p> <p>1.) The record failed to evidence an order for the application of the coban to the wound.</p> <p>2.) The Clinical Manager stated, on 12-5-11 at 1:10 PM, "There is no order for the Coban."</p> |   |   |                      |   |

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|                    | <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 10-22-11 to 12-20-11. The plan of care states, "Wound Vac @ 125 mmHg cont [continuous]."</p> <p>A. Skilled nurse visit notes, dated 10-24-11, 10-26-11, 10-28-11, 11-2-11, 11-4-11, 11-7-11, 11-9-11, 11-11-11, 11-21-11, 11-23-11, and 11-25-11, evidenced the wound vac pressure was 75 mmHg.</p> <p>B. Skilled nurse visit notes, dated 11-16-11 and 11-18-11, failed to evidence at what pressure the wound vac had been set.</p> <p>C. The Clinical Manager, employee B, stated, on 12-5-11 at 1:15 PM, "There must have been a typing error on the plan of care."</p> <p>6. Clinical record number 14 included a plan of care established by the physician for the certification period 11-06-11 to 01-04-12. The plan of care states, "SN for wound care 3X/week and prn. SN to cleanse/irrigate left 4th toe amputation site and left plantar medial wound with 1/4 str Dakins solution, rinse periwound with normal saline, apply santyl ointment</p> |               |   |                      |

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|                    | <p>to yellow sloughing tissue, cover/pack wounds with black granufoam, apply wound vac at 125 mmHg cont."</p> <p>A. Skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, failed to evidence the skilled nurse had used the Dakins solution as ordered.</p> <p>B. A skilled nurse visit note dated 11-25-11 evidenced the wound vac pressure was set at 120 mmHg.</p> <p>C. The Clinical Manager indicated, on 12-5-11 at 3:30 PM, skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, did not evidence the Dakins solution had been used and that the pressure setting on 11-25-11 was not as ordered.</p> <p>7. Clinical record number 16 included a skilled nurse visit note dated 11-15-11 that states, "SN OUT TO SEE PT. CATHFLO ACTIVASE 2 mg X 1 USED WITH SUCCESS AFTER 30 MIN."</p> <p>A. The record failed to include a physician order for the use of the Cathflo Activase.</p> <p>B. The Clinical Manager indicated, on 12-6-11 at 9:20 AM, the order for the use of the Cathflo Activase was from the</p> |               |   |                      |

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|  | <p>pharmacy.</p> <p>C. The agency's 03-02-10 "Adult &amp; Pediatric: Declotting Central Venous Catheters" policy number 421.33 states, "Use of Cathflo . . . An order is to be written per this policy for the use of Cathflo. The order will be written as: Cathflo 2 mg / 2 mL IV, instill 2 mg per _____ occluded lumen(s). May repeat one (1) time if needed."</p> <p>8. Clinical record number 19 included skilled nurse visit notes, dated 5-20-11, 5-21-11, and 5-22-11, that evidenced the skilled nurse had applied Mepilex to the patient's left lower extremity wound. The record failed to evidence an order for the application of the Mepilex.</p> <p>A. The record included a physician order dated 5-23-11 that states, "Wound # 3 Bilat [bilateral] legs Cleanse wound and periwound with Normal Saline. Apply to wound bed (Primary dressing) Mepilex. Cover with ABD."</p> <p>B. Skilled nurse visit notes, dated 5-24-11, 5-25-11, 5-26-11, and 5-27-11, failed to evidence the Mepilex had been applied.</p> <p>9. The Director, employee A, and the Clinical Manager, employee B, were</p> |   |   |                      |   |

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| G0176  | <p>unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record review, observation, and interview, the agency failed to ensure the registered nurse had provided the physician with significant information related to patient needs in 4 (#s 3, 6, 11, and 13) of 20 records reviewed and communicated with the physician and therapist to ensure optimal care for the patients in 2 (#s 2 and 6) of 20 records reviewed creating the potential to affect all of the agency's 141 patients.</p> <p>The findings include:</p> <p>Related to providing the physician with information:</p> <p>1. Clinical record number 3 included a skilled nurse (SN) admit visit note dated 11-8-11 that identified the patient had pain in the "hands" that was "acute" and "aches/burns" and was "on-off."</p> <p>A. The record included a physical</p> | G0176   | <p>The Clinical Manager will educate the nursing field staff on coordination of care including the importance of communicating significant information related to patient needs to the physician and therapist in order to review and update the plan of care. 10% of all clinical records will be audited quarterly for evidence that the nursing staff has coordinated the patients care including communication of significant information related to patient needs to the physicians and therapist, and that the plan of care has been reviewed and updated accordingly. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p> | 01/04/2012           |   |

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|  | <p>therapy (PT) evaluation visit note dated 11-9-11 that identified the patient had pain in the right hand that was an "ache in the the surface of [the patient's] palm and into fingers. Dx [diagnosed] with gouty arthritis." The note identifies the patient's highest level of pain was an 8 on a scale of 1 to 10, was constant, and the lowest level of pain relief was a 4 and that the relief level of the pain was not acceptable.</p> <p>B. The record included an occupational therapy (OT) initial evaluation visit note dated 11-14-11 that identified the patient had pain the right hand that was "intermittent", was a 4 on a scale of 1 to 10, and that the patient "wears glove on R hand to keep it warm."</p> <p>C. The record included a SN visit note dated 11-17-11 that states, "Pt [patient] c/o [complains of] increased pain in wrist. P.T./O.T. aware. Pt instructed to set apt [appointment] with PCP [primary care giver] for follow up."</p> <p>D. The record included an OT visit note dated 11-17-11 that identified the patient had pain in the "R [right] hand over median N [nerve] distribution unable to rate . . . sharp, jabbing pain w [with] /movement."</p> <p>E. The record included a SN visit note</p> |   |   |                      |   |

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|  | <p>dated 11-21-11 that identified the patient had pain in the "rt wrist" that was "chronic", a 6 on a scale of 1 to 10, with the best response to control measures being a 5, that the pain was an "ache", and prevented the patient from "lifting objects."</p> <p>F. The record included an OT visit note dated 11-22-11 that states the patient had pain the the "R hand over median N distribution unable to rate . . . sharp, jabbing pain w/movement."</p> <p>G. The record included a PT visit note dated 11-25-11 that states, "Pt is c/o pain in R hand and states OT feels [the patient] has carpal tunnel syndrome. [The patient] has a splint for this that was given to [the patient] in ECF [extended care facility], but we were unable to find it today."</p> <p>H. The record included a SN visit note dated 11-28-11 that identified the patient has pain in the "Rt hand" that is "chronic", a 6 on a scale of 1 to 10, "ache/tender", "constant", and worsened "with activity."</p> <p>I. The record included an OT note dated 11-29-11 that states, "Location of pain: R hand over median N distribution . . . says it is numb more than painful." The note states further, "Pt. has obtained a wrist splint which [the patient] says offers</p> |   |   |                      |   |

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|  | <p>some relief of symptoms in [the patient's] R hand. Tried using soft sock aid for donning TED hose, but pt does not have the hand strength to get the stocking on the device or to pull it up."</p> <p>J. A home visit was made to patient number 3 with the occupational therapist on 11-29-11 at 1:15 PM. The patient indicated to the therapist the patient had found the splint from another time and had decided to start wearing it. The therapist checked the splint for proper fit. Observation noted the occupational therapist work with the patient to use a soft sock aid. The patient indicated the pain in the right hand prevented getting the stocking on the device and pulling it up.</p> <p>K. The record failed to evidence the skilled nurse nor the occupational or physical therapists had informed the physician of the patient's complaints regarding pain and numbness in the right wrist, the inability to use assistive devices, and the use of the splint by the patient.</p> <p>L. The Director, employee A, indicated, on 12-5-11 at 1:25 PM, the record did not evidence any documentation the nurse or therapists had informed the physician of the patient's</p> |   |   |                      |   |

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|                    | <p>complaints of pain or use of the splint.</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1 hr X [times/for] 4 days . . . Pt stated [the patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms occurred, we would need to page MD on call. SN instr on all possible side effects of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10 milligram (mg) dose pack over 30 days starting 11-27-11.</p> <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient]</p> |               |   |                      |

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|  | <p>reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>E. A PT visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking predinsone and seeing some bizarre things . . . hair on everything, bugs, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the patient's reports of seeing things. In retrospect, I should have called the doctor."</p> <p>G. The Director, employee A,</p> |   |   |                      |   |

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|  | <p>indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> <p>3. Clinical record number 11 included a PT "agency admit" visit note dated 11-23-11 that identified the patient needed assistance with understanding and setting up medications. The note states, "States [the patient] does not understand [the patient's] medications or how to set them up. PT has obtained orders for nursing for med set up and education. [The patient] has not taken [the patient's] insulin and [the patient's] BS [blood sugar] was 271."</p> <p>A. The record included a SN visit note dated 11-26-11 that states, "I sat down with [the patient] and made [the patient] tell me what insulins [the patient] was on and when to take them. At first [the patient] really couldn't tell me much of anything about [the patient's] meds except [the patient] didn't have them all and didn't have the money to get them . . . I had [the patient] fill [the patient's] pillboxes with what medcs [medicines] [the patient] has and told [the patient] when the social worker comes and figures out a way for [the patient] to get the remaining meds, a nurse can help [the patient] fill the pillboxes with the rest of</p> |   |   |                      |   |

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|  | <p>the meds . . . I feel that it is best to have [the patient] do as much for [the patient's] self b/c [because] [the patient] is overwhelmed and has I just want to give up attitude." The note states, "Plan for Next Visit: F/U [follow-up] med ed [education] and diabetic ed."</p> <p>B. The record failed to evidence the physician had been notified of the continued need for skilled nursing for medication and diabetic education.</p> <p>4. Clinical record number 13 included a plan of care, established by the physician for the certification period 10-8-11 to 12-6-11 that identified the principal diagnosis as diabetes mellitus type II without complications.</p> <p>A. The record included a SN visit note dated 10-19-11 that states, "Glucometer Reading: 267." A SN visit note dated 10-21-11 evidenced the patient's glucometer reading was 358.</p> <p>B. A SN visit note dated 10-25-11 states, "Pt has had some HI blood sugars and states [the patient] is sure [the patient] has a UTI [urinary tract infection]. States [the patient] is to see Dr. [name] today as well."</p> <p>C. A SN visit note dated 10-31-11</p> |   |   |                      |   |

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|  | <p>evidenced the glucometer reading was 315. A SN visit note dated 11-7-11 states, "Pt states [the patient] has felt bad all weekend. States [the patient] has not been eating or drinking like [the patient] should because [the patient] has had vomiting and diarrhea. States [the patient] had some blood in the stool the other day. Pts blood pressure is up. Instructed on the need to go to ER [emergency room] if [the patient] is unable to keep anything down and is not taking meds. Pt verbalized understanding and states [the patient] thinks [the patient] will go in a bit if not better."</p> <p>D. A SN visit note dated 11-11-11 states, "Glucometer Reading: 307 . . . Pt states [the patient] has been having N/V [nausea, vomiting] and diarrhea today and [the patient] is going to call Dr. today and see if [the patient] needs to go back to hospital. Pt states [the patient] has been having some issues with [the patient's] children and I think [the patient] has been putting off calling MD b/c [the patient] feels [the patients] needs to tend to the kids. Appetite poor. Pt eating few crackers and still [the patient's] BS was 307. I asked if I could just call Dr. to expedite things and [the patient] said no, I'll do it."</p> <p>E. A SN visit note dated 11-15-11</p> |   |   |                      |   |

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|  | <p>states, "Pt states [the patient] has continued to be sick but is improving. States [the patient] is not eating much due to nausea . . . States [the patient's] bladder is bothering [the patient] again . . . Pt states [the patient] has informed Dr. [name]."</p> <p>F. A SN visit note dated 11-23-11 states, "Pt states [the patient] went to the ER at IU med center over the weekend . . . Pt states [the patient's] blood sugar was high. Pt states [the patient] was given an IV and released within a few hours. Pt states [the patient] also received antibiotics IV due to UTI. Blood sugar is hi today. Instructed pt to call MD if next reading is also hi."</p> <p>G. The record failed to evidence the SN had informed and communicated with the physician regarding the patient's high blood sugar readings and complaints of urinary tract infection symptoms.</p> <p>H. The Director, employee A, stated, on 12-5-11 at 3:00 PM, "Everybody knows this patient and know that the patient is noncompliant. The nurse did not document conversations with the doctor and case manager."</p> <p>5. The Director, employee A, and the Clinical Manager, employee B, were</p> |   |   |  |  |   |  |

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|--------------------|---|---------------|---|----------------------|
|                    | <p>unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> <p>Related to communication with the physician and therapist:</p> <p>1. Clinical record number 2 included a skilled nurse admission visit note dated 11-11-11. The note identified discrepancies with medications. The note states, "SN [skilled nurse] completed medication review guide. Flexeril, Colace, Pepcid, Robinul, Atrovent, Flagyl, Provigil - listed on med sheet but caregiver sts [states] pt [patient] not taking these meds. SN will call Dr. [name of physician] Monday."</p> <p>A. A skilled nurse visit note dated 11-14-11 states, "SN called Dr [name of physician]-spoke with [name] regarding complaints, lt [left?] heel and med discrepancies on admission. [name] states he will talk w/Dr. [name of physician] and return call.</p> <p>B. The record failed to evidence any follow-up by the registered nurse, employee L, to ensure the medication discrepancies were resolved.</p> |               |   |                      |

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|                    | <p>C. The Director, employee A, stated, on 12-6-11 at 11:30 AM, "There is no documentation of follow-up by the nurse."</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1 hr [hour] X [times/for] 4 days . . . Pt stated [the patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms occurred, we would need to page MD on call. SN instr on all possible side effects of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10 milligram (mg) dose pack over 30 days starting 11-27-11.</p> |               |   |                      |

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|--------------------|---|---------------|---|----------------------|
|                    | <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>E. A PT (physical therapy) visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bugs, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the patient's reports of seeing things. In retrospect, I should have called the</p> |               |   |                      |

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| N0462  | <p>doctor."</p> <p>G. The Director, employee A, indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> <p>Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review and interview, the agency failed to ensure employees that had direct patient contact had a physical examination at least 180 days before the first patient contact in 1 (file C) of 4 personnel files reviewed of employees hired since the last survey on 12-09-08.</p> <p>The findings include:</p> <p>1. Personnel file C identified the employee had been hired to provide registered nursing services to patients on</p> | N0462   | Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than 180 days before the date the employee has direct patient contact. 100% audit of all employee health files will be completed prior to an employee having direct patient contact to ensure the physical exam has been completed within the last 180 days. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 12/06/2011           |   |

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| N0470  | <p>4-12-10. The file failed to evidence a physical examination completed at least 180 days before the date that the employee had direct patient contact.</p> <p>2. The clinical manager, employee B, stated, on 12-6-11 at 1:15 PM, "We do not have a physical before the first date of patient contact, 4-13-10."</p> <p>Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and agency policy review, the agency failed to ensure employees provided services in accordance with the agency's infection control policies and procedures and the Centers for Disease Control "Standard Precautions" in 6 (employees K, I, L, D, M, and N ) of 10 employees observed during home visits creating the potential for the transfer of disease causing organisms among patients and staff.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Precautions" policy number 9-002.1 states, "Hands and other skin surfaces should be washed with soap and water immediately and thoroughly before and after patient/client contact, if</p> | N0470   | The Clinical and Rehab Managers will inservice the nursing and home health aide direct patient care staff on the agency infection control policies and procedures and the Center for Disease Control "Standard Precautions" All nursing and home health aide clinical staff will be observed in the home by the clinical manager by the end of the first quarter 2012, then annually thereafter to ensure that the deficiencies are corrected and will not recur. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 01/04/2012           |   |

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|                    | <p>contaminated with body substances, before and after gloves are worn, and before preparing food."</p> <p>2. The Centers for Disease Control "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" states, " IV. Standard Precautions . . . IV.A. Hand Hygiene. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . IV.A. 3. Perform hand hygiene: . . . IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings . . . IV.A.3.d. If hands will be moving from a contaminated body site to a clean body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves."</p> <p>3. Employee K, a registered nurse, was observed to complete a dressing change on patient number 1 on 11-29-11 at 9:45 AM. The employee was observed to remove the old dressings from the patient's left lower leg, measure the</p> |               |   |                      |

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|  | <p>wound, and cleanse the wound with normal saline. The employee cleaned the bandage scissors with alcohol, cut the medicated dressing to be applied to the wound to size and applied the medicated dressing to the wound.</p> <p>A. The employee failed to remove her soiled old gloves after removing the old dressing and before touching the medicated dressing and applying it to the patient's wound.</p> <p>B. The employee completed the dressing change to the left lower leg and then removed the dressing to the patient's right upper thigh. The employee failed to change her gloves prior to moving to the thigh wound.</p> <p>C. After measuring the thigh wound, the employee removed her gloves and cleansed her hands. The employee obtained a pen from her pocket, touched the computer, placed the pen in her pocket and donned clean gloves without cleansing her hands. The employee then measured a third wound on the right thigh located above the first wound, removed her gloves, touched her pen and the computer, and donned clean gloves without cleansing her hands. The employee cut a medicated dressing to size and applied it to the first right thigh</p> |   |   |                      |   |

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|  | <p>wound. The employee then opened a dressing package that had been brought into the home and applied the dressing to the wound. After completing the dressing change the employee removed her gloves and cleansed her hands.</p> <p>4. Employee I, a home health aide, was observed to complete a shower bath on patient number 2 on 11-29-11 at 11:00 AM. The employee was observed to change her gloves and cleanse her hands 4 times, each time reaching into her pocket to obtain the hand cleanser and clean gloves.</p> <p>5. Employee L, a registered nurse, was observed to change a dressing to the right hip of patient number 7 on 11-30-11 at 10:50 AM. The employee was observed to set up the needed supplies for the dressing change. During the set-up, the employee obtained a syringe from the patient's dresser drawer and donned gloves without cleansing her hands.</p> <p>6. Employee D, a registered nurse, was observed to change a dressing to the right foot of patient number 8 on 11-30-11 at 12:10 PM. The employee failed to cleanse her hands after gathering and opening supplies and before donning clean gloves. The employee failed to change her gloves after opening supplies</p> |   |   |  |  |   |  |

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|  | <p>and prior to cutting a medicated dressing to size and applying the dressing to the wound.</p> <p>7. Employee M, a registered nurse, was observed to perform a dressing change to the midsternal chest of patient number 9 on 11-29-11 at 2:15 PM. The employee was observed to remove the old dressing, remove her gloves, and reach into her nursing bag to obtain the hand cleanser. The employee cleansed her hands and reached into her bag to obtain clean gloves and tape. The employee then donned clean gloves without cleansing her hands.</p> <p>A. The employee was observed to remove dirty gloves and reach into her bag to obtain her hand cleanser 4 additional times.</p> <p>B. Observation noted the employee's long hair hanging over the clean field while performing the dressing change.</p> <p>8. Employee N, a registered nurse, was observed to perform a dressing change to ulcers on the left lower leg of patient number 10 on 11-29-11 at 3:25 PM. The employee was observed to remove the old dressing and change her gloves without cleansing her hands. The employee reached into the patient's supply box to</p> |   |   |                      |   |

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| N0484  | <p>obtain the supplies and opened the supplies. The employee then changed her gloves without cleansing her hands. The employee then cleansed the wound and applied an antibiotic ointment to the wound using her gloved fingertip. The employee completed the dressing change, removed her gloves and failed to cleanse her hands.</p> <p>Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record review and interview, the agency failed to ensure the skilled nurse had communicated with the physician and the therapist to ensure optimal care for the patients in 2 (#s 2 and 6) of 20 records reviewed creating the potential to affect all of the agency's current 141 patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a skilled nurse admission visit note dated 11-11-11. The note identified</p> | N0484   | The Clinical and Rehab Managers will inservice the clinical field staff on appropriate communication with physicians and other disciplines to ensure optimal care for the patients. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have appropriately communicated with the physician and other disciplines involved in the patients care. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 01/04/2012           |   |

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|  | <p>discrepancies with medications. The note states, "SN [skilled nurse] completed medication review guide. Flexeril, Colace, Pepcid, Robinul, Atrovent, Flagyl, Provigil - listed on med sheet but caregiver sts [states] pt [patient] not taking these meds. SN will call Dr. [name of physician] Monday."</p> <p>A. A skilled nurse visit note dated 11-14-11 states, "SN called Dr [name of physician]-spoke with [name] regarding complaints, It [left?] heel and med discrepancies on admission. [name] states he will talk w/Dr. [name of physician] and return call.</p> <p>B. The record failed to evidence any follow-up by the registered nurse, employee L, to ensure the medication discrepancies were resolved.</p> <p>C. The Director, employee A, stated, on 12-6-11 at 11:30 AM, "There is no documentation of follow-up by the nurse."</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1 hr [hour] X [times/for] 4 days . . . Pt stated [the patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms</p> |   |   |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157179 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>12/06/2011 |
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|                    | <p>occurred, we would need to page MD on call. SN instr on all possible side effects of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10 milligram (mg) dose pack over 30 days starting 11-27-11.</p> <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>E. A PT (physical therapy) visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking predinsone and seeing some bizarre things</p> |               |   |                      |

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|  | <p>... hair on everything, bugs, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the patient's reports of seeing things. In retrospect, I should have called the doctor."</p> <p>G. The Director, employee A, indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> |   |   |                      |   |

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| N0518  | <p>Rule 12 Sec. 3(e)<br/>(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 policy review and interview, the agency failed to ensure it had provided patients with written information regarding policies on advance directives in 20 (#s 1 through 20) of 20 records reviewed affecting all of the agency's 141 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical records numbered 1 through 20 failed to evidence the agency had provided the patients with written information regarding its policies on advance directives.</li> <li>2. The Director, employee A, indicated, on 12-1-11 at 9:20 AM, that patients had not received written information regarding this agency's policy on advance directives. When asked if the agency provided written information to the patients regarding this agency's policy on advance directives the Director replied, "We</li> </ol> | N0518   | The patient handbook has been updated to provide written information to the patient concerning agency policies on advance directives. The handbook will be reviewed annually for required changes/updates. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 12/06/2011           |   |

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| N0522  | <p>don't."</p> <p>3. The agency's undated "Advance Directives" policy number 1-003.1 states, "Upon admission, the admitting clinician will provide information regarding . . . the right to execute advance directives, and applicable agency policies. Written information . . . designed for this purpose will be provided to the patient/client."</p> <p>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:<br/>Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered by the physician on the plan of care in 8 (#s 1, 7, 9, 10, 12, 14, 16, and 19) of 20 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a skilled nurse visit note dated 11-25-11 that identified wound care had been completed on a wound on the patient's "right thigh proximal." The note states, "Wound Dressing applied (specify type): POLYMEM SECURED WITH COVEROLL." The record failed to include an order for wound care to the right proximal thigh.</p> | N0522   | The Clinical Manager will in-service the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. The nursing staff will also be educated on wound care treatments and documentation. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. The audit will include a review a wound care treatments and documentation. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected | 01/04/2012           |   |

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|  | <p>A. The record included a physician order dated 10-25-11 that states, "Rt [right] LE [lower extremity] thigh trauma wound: cleanse with NS [normal saline] apply Bacitracin, apply ABD pads, secure with tape/coveroll daily."</p> <p>B. A skilled nurse visit note dated 11-3-11 failed to evidence Bacitracin had been applied to the right thigh trauma wound.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period 10-23-11 to 12-21-11 that states, "Apply Smith Nephew's negative pressure wound vac using black foam. Set @ 120 mmHg [millimeters of mercury] continuous suction."</p> <p>A. A skilled nurse visit note dated 10-24-11 evidenced documentation the skilled nurse had completed the dressing change and had set the pressure at 75 mmHg.</p> <p>B. The Director, employee A, indicated, on 12-5-11 at 1:30 PM, that the order was for 120 mmHg. The Director stated, "I don't know why the skilled nurse (SN) put 75 [on the 10-24-11 skilled nurse visit note]."</p> |   | and will not recur.   |                      |   |

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|                    | <p>3. Clinical record number 9 included a physician order dated 10-8-11 that states, "SN 1 week 1; 7 week 6, [one time week 1 and 7 times a week for 6 weeks] 4 [visits] as needed." The record failed to evidence any skilled nurse visits had been provided on 10-26-11.</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 11-12-11 to 01-10-12. The plan of care states, "Wound Care: Cleanse with 1/4 str [strength] Dakins pack wd [wound] with dakins moist gauze. Cover with soft gauze and tape to secure.</p> <p>A. A skilled nurse visit note dated 11-12-11 states, "Wound packed (specify packing material): moist soft gauze." The note failed to evidence the wound had been packed with Dakins moist gauze."</p> <p>B. The record included a skilled nurse visit note dated 11-13-11 that states, "Wound dressing applied (specify type): MOISTENED 1/4 STR [strength] DAIKINS [sic] SOLUTION 4 X 4/ABD [type of dressing] /KERLEX [type of dressing] /COBAN . . . PT [patient] DID NOT WANT COBAN ON LLE [left lower extremity], SN ED [educated] PT THAT THE DRSG [dressing] NEEDS</p> |               |   |                      |

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|                    | <p>TO BE SECURE AND THE EDEMA NEEDS TO BE RELIEVED WITH COBAN."</p> <p>1.) The record failed to evidence an order for the application of the coban to the wound.</p> <p>2.) The Clinical Manager stated, on 12-5-11 at 1:10 PM, "There is no order for the Coban."</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 10-22-11 to 12-20-11. The plan of care states, "Wound Vac @ 125 mmHg cont [continuous]."</p> <p>A. Skilled nurse visit notes, dated 10-24-11, 10-26-11, 10-28-11, 11-2-11, 11-4-11, 11-7-11, 11-9-11, 11-11-11, 11-21-11, 11-23-11, and 11-25-11, evidenced the wound vac pressure was 75 mmHg.</p> <p>B. Skilled nurse visit notes, dated 11-16-11 and 11-18-11, failed to evidence at what pressure the wound vac had been set.</p> <p>C. The Clinical Manager, employee B, stated, on 12-5-11 at 1:15 PM, "There must have been a typing error on the plan</p> |               |   |                      |

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|  | <p>of care."</p> <p>6. Clinical record number 14 included a plan of care established by the physician for the certification period 11-06-11 to 01-04-12. The plan of care states, "SN for wound care 3X/week and prn. SN to cleanse/irrigate left 4th toe amputation site and left plantar medial wound with 1/4 str Dakins solution, rinse periwound with normal saline, apply santyl ointment to yellow sloughing tissue, cover/pack wounds with black granufoam, apply wound vac at 125 mmHg cont."</p> <p>A. Skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, failed to evidence the skilled nurse had used the Dakins solution as ordered.</p> <p>B. A skilled nurse visit note dated 11-25-11 evidenced the wound vac pressure was set at 120 mmHg.</p> <p>C. The Clinical Manager indicated, on 12-5-11 at 3:30 PM, skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, did not evidence the Dakins solution had been used and that the pressure setting on 11-25-11 was not as ordered.</p> <p>7. Clinical record number 16 included a skilled nurse visit note dated 11-15-11</p> |   |   |                      |   |

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|--------------------|--|---------------|---|----------------------|
|                    | <p>that states, "SN OUT TO SEE PT. CATHFLO ACTIVASE 2 mg X 1 USED WITH SUCCESS AFTER 30 MIN."</p> <p>A. The record failed to include a physician order for the use of the Cathflo Activase.</p> <p>B. The Clinical Manager indicated, on 12-6-11 at 9:20 AM, the order for the use of the Cathflo Activase was from the pharmacy.</p> <p>C. The agency's 03-02-10 "Adult &amp; Pediatric: Dec clotting Central Venous Catheters" policy number 421.33 states, "Use of Cathflo . . . An order is to be written per this policy for the use of Cathflo. The order will be written as: Cathflo 2 mg / 2 mL IV, instill 2 mg per _____ occluded lumen(s). May repeat one (1) time if needed."</p> <p>8. Clinical record number 19 included skilled nurse visit notes, dated 5-20-11, 5-21-11, and 5-22-11, that evidenced the skilled nurse had applied Mepilex to the patient's left lower extremity wound. The record failed to evidence an order for the application of the Mepilex.</p> <p>A. The record included a physician order dated 5-23-11 that states, "Wound # 3 Bilat [bilateral] legs Cleanse wound</p> |               |   |                      |

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| N0527  | <p>and periwound with Normal Saline.<br/>Apply to wound bed (Primary dressing) Mepilex. Cover with ABD."</p> <p>B. Skilled nurse visit notes, dated 5-24-11, 5-25-11, 5-26-11, and 5-27-11, failed to evidence the Mepilex had been applied.</p> <p>9. The Director, employee A, and the Clinical Manager, employee B, were unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> <p>Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review, observation, and interview, the agency failed to ensure the physician had been provided significant information related to patient needs in 4 (#s 3, 6, 11, and 13) of 20 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a skilled nurse (SN) admit visit note dated</p> | N0527   | The Clinical and Rehab Manager will educate the nursing and therapy clinical field staff on the importance of communicating significant information related to patient needs to the physician in order to reveiw and update the plan of care.10% of all clinical records will be audited quarterly for evidence that the clinical staff has communicated significant information related to patient needs to the physicians and that the plan of care has | 01/04/2012           |   |

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|  | <p>11-8-11 that identified the patient had pain in the "hands" that was "acute" and "aches/burns" and was "on-off."</p> <p>A. The record included a physical therapy (PT) evaluation visit note dated 11-9-11 that identified the patient had pain in the right hand that was an "ache in the the surface of [the patient's] palm and into fingers. Dx [diagnosed] with gouty arthritis." The note identifies the patient's highest level of pain was an 8 on a scale of 1 to 10, was constant, and the lowest level of pain relief was a 4 and that the relief level of the pain was not acceptable.</p> <p>B. The record included an occupational therapy (OT) initial evaluation visit note dated 11-14-11 that identified the patient had pain the right hand that was "intermittent", was a 4 on a scale of 1 to 10, and that the patient "wears glove on R hand to keep it warm."</p> <p>C. The record included a SN visit note dated 11-17-11 that states, "Pt [patient] c/o [complains of] increased pain in wrist. P.T./O.T. aware. Pt instructed to set apt [appointment] with PCP [primary care giver] for follow up."</p> <p>D. The record included an OT visit note dated 11-17-11 that identified the patient had pain in the "R [right] hand</p> |   | <p>been reviewed and updated accordingly. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p> |                      |   |

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|  | <p>over median N [nerve] distribution unable to rate . . . sharp, jabbing pain w [with] /movement."</p> <p>E. The record included a SN visit note dated 11-21-11 that identified the patient had pain in the "rt wrist" that was "chronic", a 6 on a scale of 1 to 10, with the best response to control measures being a 5, that the pain was an "ache", and prevented the patient from "lifting objects."</p> <p>F. The record included an OT visit note dated 11-22-11 that states the patient had pain the the "R hand over median N distribution unable to rate . . . sharp, jabbing pain w/movement."</p> <p>G. The record included a PT visit note dated 11-25-11 that states, "Pt is c/o pain in R hand and states OT feels [the patient] has carpal tunnel syndrome. [The patient] has a splint for this that was given to [the patient] in ECF [extended care facility], but we were unable to find it today."</p> <p>H. The record included a SN visit note dated 11-28-11 that identified the patient has pain in the "Rt hand" that is "chronic", a 6 on a scale of 1 to 10, "ache/tender", "constant", and worsened "with activity."</p> <p>I. The record included an OT note</p> |   |   |                      |   |

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|  | <p>dated 11-29-11 that states, "Location of pain: R hand over median N distribution . . . says it is numb more than painful." The note states further, "Pt. has obtained a wrist splint which [the patient] says offers some relief of symptoms in [the patient's] R hand. Tried using soft sock aid for donning TED hose, but pt does not have the hand strength to get the stocking on the device or to pull it up."</p> <p>J. A home visit was made to patient number 3 with the occupational therapist on 11-29-11 at 1:15 PM. The patient indicated to the therapist the patient had found the splint from another time and had decided to start wearing it. The therapist checked the splint for proper fit. Observation noted the occupational therapist work with the patient to use a soft sock aid. The patient indicated the pain in the right hand prevented getting the stocking on the device and pulling it up.</p> <p>K. The record failed to evidence the skilled nurse nor the occupational or physical therapists had informed the physician of the patient's complaints regarding pain and numbness in the right wrist, the inability to use assistive devices, and the use of the splint by the patient.</p> |   |   |                      |   |

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|  | <p>L. The Director, employee A, indicated, on 12-5-11 at 1:25 PM, the record did not evidence any documentation the nurse or therapists had informed the physician of the patient's complaints of pain or use of the splint.</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1 hr X [times/for] 4 days . . . Pt stated [the patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms occurred, we would need to page MD on call. SN instr on all possible side effects of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10</p> |   |   |                      |   |

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|  | <p>milligram (mg) dose pack over 30 days starting 11-27-11.</p> <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>E. A PT visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking predinsone and seeing some bizarre things . . . hair on everything, bugs, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the</p> |   |   |                      |   |

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|  | <p>patient's reports of seeing things. In retrospect, I should have called the doctor."</p> <p>G. The Director, employee A, indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> <p>3. Clinical record number 11 included a PT "agency admit" visit note dated 11-23-11 that identified the patient needed assistance with understanding and setting up medications. The note states, "States [the patient] does not understand [the patient's] medications or how to set them up. PT has obtained orders for nursing for med set up and education. [The patient] has not taken [the patient's] insulin and [the patient's] BS [blood sugar] was 271."</p> <p>A. The record included a SN visit note dated 11-26-11 that states, "I sat down with [the patient] and made [the patient] tell me what insulins [the patient] was on and when to take them. At first [the patient] really couldn't tell me much of anything about [the patient's] meds except [the patient] didn't have them all and didn't have the money to get them . . . I had [the patient] fill [the patient's] pillboxes with what medcs [medicines]</p> |   |   |                      |   |

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|                    | <p>[the patient] has and told [the patient] when the social worker comes and figures out a way for [the patient] to get the remaining meds, a nurse can help [the patient] fill the pillboxes with the rest of the meds . . . I feel that it is best to have [the patient] do as much for [the patient's] self b/c [because] [the patient] is overwhelmed and has I just want to give up attitude." The note states, "Plan for Next Visit: F/U [follow-up] med ed [education] and diabetic ed."</p> <p>B. The record failed to evidence the physician had been notified of the continued need for skilled nursing for medication and diabetic education.</p> <p>4. Clinical record number 13 included a plan of care, established by the physician for the certification period 10-8-11 to 12-6-11 that identified the principal diagnosis as diabetes mellitus type II without complications.</p> <p>A. The record included a SN visit note dated 10-19-11 that states, "Glucometer Reading: 267." A SN visit note dated 10-21-11 evidenced the patient's glucometer reading was 358.</p> <p>B. A SN visit note dated 10-25-11 states, "Pt has had some HI blood sugars and states [the patient] is sure [the patient]</p> |               |   |                      |

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|  | <p>has a UTI [urinary tract infection]. States [the patient] is to see Dr. [name] today as well."</p> <p>C. A SN visit note dated 10-31-11 evidenced the glucometer reading was 315. A SN visit note dated 11-7-11 states, "Pt states [the patient] has felt bad all weekend. States [the patient] has not been eating or drinking like [the patient] should because [the patient] has had vomiting and diarrhea. States [the patient] had some blood in the stool the other day. Pts blood pressure is up. Instructed on the need to go to ER [emergency room] if [the patient] is unable to keep anything down and is not taking meds. Pt verbalized understanding and states [the patient] thinks [the patient] will go in a bit if not better."</p> <p>D. A SN visit note dated 11-11-11 states, "Glucometer Reading: 307 . . . Pt states [the patient] has been having N/V [nausea, vomiting] and diarrhea today and [the patient] is going to call Dr. today and see if [the patient] needs to go back to hospital. Pt states [the patient] has been having some issues with [the patient's] children and I think [the patient] has been putting off calling MD b/c [the patient] feels [the patients] needs to tend to the kids. Appetite poor. Pt eating few crackers and still [the patient's] BS was</p> |   |   |  |  |   |  |

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|  | <p>307. I asked if I could just call Dr. to expedite things and [the patient] said no, I'll do it."</p> <p>E. A SN visit note dated 11-15-11 states, "Pt states [the patient] has continued to be sick but is improving. States [the patient] is not eating much due to nausea . . . States [the patient's] bladder is bothering [the patient] again . . . Pt states [the patient] has informed Dr. [name]."</p> <p>F. A SN visit note dated 11-23-11 states, "Pt states [the patient] went to the ER at IU med center over the weekend . . . Pt states [the patient's] blood sugar was high. Pt states [the patient] was given an IV and released within a few hours. Pt states [the patient] also received antibiotics IV due to UTI. Blood sugar is hi today. Instructed pt to call MD if next reading is also hi."</p> <p>G. The record failed to evidence the SN had informed and communicated with the physician regarding the patient's high blood sugar readings and complaints of urinary tract infection symptoms.</p> <p>H. The Director, employee A, stated, on 12-5-11 at 3:00 PM, "Everybody knows this patient and know that the patient is noncompliant. The nurse did</p> |   |   |                      |   |

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| N0537  | <p>not document conversations with the doctor and case manager."</p> <p>5. The Director, employee A, and the Clinical Manager, employee B, were unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> <p>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:<br/>Based on clinical record and agency policy review and interview, the agency failed to ensure the skilled nurse had provided treatments and visits as ordered by the physician on the plan of care in 8 (#s 1, 7, 9, 10, 12, 14, 16, and 19) of 20 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a skilled nurse visit note dated 11-25-11 that identified wound care had been completed on a wound on the patient's "right thigh proximal." The note states, "Wound Dressing applied (specify type): POLYMEM SECURED WITH COVEROLL." The record failed to include an order for wound care to the</p> | N0537   | <p>The Clinical Manager will in-service the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. The nursing staff will also be educated on wound care treatments and documentation. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. The audit will include a review a wound care treatments and documentation. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected</p> | 01/04/2012           |   |

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|  | <p>right proximal thigh.</p> <p>A. The record included a physician order dated 10-25-11 that states, "Rt [right] LE [lower extremity] thigh trauma wound: cleanse with NS [normal saline] apply Bacitracin, apply ABD pads, secure with tape/coverroll daily."</p> <p>B. A skilled nurse visit note dated 11-3-11 failed to evidence Bacitracin had been applied to the right thigh trauma wound.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period 10-23-11 to 12-21-11 that states, "Apply Smith Nephew's negative pressure wound vac using black foam. Set @ 120 mmHg [millimeters of mercury] continuous suction."</p> <p>A. A skilled nurse visit note dated 10-24-11 evidenced documentation the skilled nurse had completed the dressing change and had set the pressure at 75 mmHg.</p> <p>B. The Director, employee A, indicated, on 12-5-11 at 1:30 PM, that the order was for 120 mmHg. The Director stated, "I don't know why the skilled nurse (SN) put 75 [on the 10-24-11 skilled</p> |   | and will not recur.   |                      |   |

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|                    | <p>nurse visit note]."</p> <p>3. Clinical record number 9 included a physician order dated 10-8-11 that states, "SN 1 week 1; 7 week 6, [one time week 1 and 7 times a week for 6 weeks] 4 [visits] as needed." The record failed to evidence any skilled nurse visits had been provided on 10-26-11.</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 11-12-11 to 01-10-12. The plan of care states, "Wound Care: Cleanse with 1/4 str [strength] Dakins pack wd [wound] with dakins moist gauze. Cover with soft gauze and tape to secure.</p> <p>A. A skilled nurse visit note dated 11-12-11 states, "Wound packed (specify packing material): moist soft gauze." The note failed to evidence the wound had been packed with Dakins moist gauze."</p> <p>B. The record included a skilled nurse visit note dated 11-13-11 that states, "Wound dressing applied (specify type): MOISTENED 1/4 STR [strength] DAIKINS [sic] SOLUTION 4 X 4/ABD [type of dressing] /KERLEX [type of dressing] /COBAN . . . PT [patient] DID NOT WANT COBAN ON LLE [left lower extremity], SN ED [educated] PT</p> |               |   |                      |

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|  | <p>THAT THE DRSG [dressing] NEEDS TO BE SECURE AND THE EDEMA NEEDS TO BE RELIEVED WITH COBAN."</p> <p>1.) The record failed to evidence an order for the application of the coban to the wound.</p> <p>2.) The Clinical Manager stated, on 12-5-11 at 1:10 PM, "There is no order for the Coban."</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 10-22-11 to 12-20-11. The plan of care states, "Wound Vac @ 125 mmHg cont [continuous]."</p> <p>A. Skilled nurse visit notes, dated 10-24-11, 10-26-11, 10-28-11, 11-2-11, 11-4-11, 11-7-11, 11-9-11, 11-11-11, 11-21-11, 11-23-11, and 11-25-11, evidenced the wound vac pressure was 75 mmHg.</p> <p>B. Skilled nurse visit notes, dated 11-16-11 and 11-18-11, failed to evidence at what pressure the wound vac had been set.</p> <p>C. The Clinical Manager, employee B, stated, on 12-5-11 at 1:15 PM, "There</p> |   |   |                      |   |

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|                    | <p>must have been a typing error on the plan of care."</p> <p>6. Clinical record number 14 included a plan of care established by the physician for the certification period 11-06-11 to 01-04-12. The plan of care states, "SN for wound care 3X/week and prn. SN to cleanse/irrigate left 4th toe amputation site and left plantar medial wound with 1/4 str Dakins solution, rinse periwound with normal saline, apply santyl ointment to yellow sloughing tissue, cover/pack wounds with black granufoam, apply wound vac at 125 mmHg cont."</p> <p>A. Skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, failed to evidence the skilled nurse had used the Dakins solution as ordered.</p> <p>B. A skilled nurse visit note dated 11-25-11 evidenced the wound vac pressure was set at 120 mmHg.</p> <p>C. The Clinical Manager indicated, on 12-5-11 at 3:30 PM, skilled nurse visit notes, dated 11-7-11, 11-18-11, and 11-21-11, did not evidence the Dakins solution had been used and that the pressure setting on 11-25-11 was not as ordered.</p> <p>7. Clinical record number 16 included a</p> |               |   |                      |

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|  | <p>skilled nurse visit note dated 11-15-11 that states, "SN OUT TO SEE PT. CATHFLO ACTIVASE 2 mg X 1 USED WITH SUCCESS AFTER 30 MIN."</p> <p>A. The record failed to include a physician order for the use of the Cathflo Activase.</p> <p>B. The Clinical Manager indicated, on 12-6-11 at 9:20 AM, the order for the use of the Cathflo Activase was from the pharmacy.</p> <p>C. The agency's 03-02-10 "Adult &amp; Pediatric: Dec clotting Central Venous Catheters" policy number 421.33 states, "Use of Cathflo . . . An order is to be written per this policy for the use of Cathflo. The order will be written as: Cathflo 2 mg / 2 mL IV, instill 2 mg per _____ occluded lumen(s). May repeat one (1) time if needed."</p> <p>8. Clinical record number 19 included skilled nurse visit notes, dated 5-20-11, 5-21-11, and 5-22-11, that evidenced the skilled nurse had applied Mepilex to the patient's left lower extremity wound. The record failed to evidence an order for the application of the Mepilex.</p> <p>A. The record included a physician order dated 5-23-11 that states, "Wound #</p> |   |   |  |  |   |  |

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| N0545  | <p>3 Bilat [bilateral] legs Cleanse wound and periwound with Normal Saline. Apply to wound bed (Primary dressing) Mepilex. Cover with ABD."</p> <p>B. Skilled nurse visit notes, dated 5-24-11, 5-25-11, 5-26-11, and 5-27-11, failed to evidence the Mepilex had been applied.</p> <p>9. The Director, employee A, and the Clinical Manager, employee B, were unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> <p>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:<br/>(F) Coordinate services.<br/>Based on clinical record review and interview, the agency failed to ensure the skilled nurse had communicated with the physician and the therapist to ensure optimal care for the patients in 2 (#s 2 and 6) of 20 records reviewed creating the potential to affect all of the agency's current 141 patients.</p> | N0545   | The Clinical Manager will educate the nursing field staff on the coordination of care including the importance of communicating significant information related to patient needs to the physician and therapist in order to review and update the plan of care. 10% of all clinical records will be audited quarterly for evidence that the nursing staff has coordinated the patients care | 01/04/2012           |   |

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|  | <p>The findings include:</p> <p>1. Clinical record number 2 included a skilled nurse admission visit note dated 11-11-11. The note identified discrepancies with medications. The note states, "SN [skilled nurse] completed medication review guide. Flexeril, Colace, Pepcid, Robinul, Atrovent, Flagyl, Provigil - listed on med sheet but caregiver sts [states] pt [patient] not taking these meds. SN will call Dr. [name of physician] Monday."</p> <p>A. A skilled nurse visit note dated 11-14-11 states, "SN called Dr [name of physician]-spoke with [name] regarding complaints, It [left?] heel and med discrepancies on admission. [name] states he will talk w/Dr. [name of physician] and return call.</p> <p>B. The record failed to evidence any follow-up by the registered nurse, employee L, to ensure the medication discrepancies were resolved.</p> <p>C. The Director, employee A, stated, on 12-6-11 at 11:30 AM, "There is no documentation of follow-up by the nurse."</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1</p> |   | including communication of significant information related to patient needs to the physicians and therapist, and that the plan of care has been reviewed and updated accordingly. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. |                      |   |

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|  | <p>hr [hour] X [times/for] 4 days . . . Pt stated [the patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms occurred, we would need to page MD on call. SN instr on all possible side effects of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10 milligram (mg) dose pack over 30 days starting 11-27-11.</p> <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> |   |   |                      |   |

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|                    | <p>E. A PT (physical therapy) visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bugs, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the patient's reports of seeing things. In retrospect, I should have called the doctor."</p> <p>G. The Director, employee A, indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> |               |   |                      |

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| N0546              | <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 review, observation, and interview, the agency failed to ensure the registered nurse had provided the physician with significant information related to patient needs in 4 (#s 3, 6, 11, and 13) of 20 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a skilled nurse (SN) admit visit note dated 11-8-11 that identified the patient had pain in the "hands" that was "acute" and "aches/burns" and was "on-off."</p> <p>A. The record included a physical therapy (PT) evaluation visit note dated 11-9-11 that identified the patient had pain in the right hand that was an "ache in the the surface of [the patient's] palm and into fingers. Dx [diagnosed] with gouty arthritis." The note identifies the patient's</p> | N0546         | The Clinical and Rehab Manager will educate the nursing and therapy clinical field staff on importance of communicating significant information related to patient needs to the physician in order to review and update the plan of care. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has communicated significant information related to patient needs to the physicians and that the plan of care has been reviewed and updated accordingly. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur. | 01/04/2012           |

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|  | <p>highest level of pain was an 8 on a scale of 1 to 10, was constant, and the lowest level of pain relief was a 4 and that the relief level of the pain was not acceptable.</p> <p>B. The record included an occupational therapy (OT) initial evaluation visit note dated 11-14-11 that identified the patient had pain the right hand that was "intermittent", was a 4 on a scale of 1 to 10, and that the patient "wears glove on R hand to keep it warm."</p> <p>C. The record included a SN visit note dated 11-17-11 that states, "Pt [patient] c/o [complains of] increased pain in wrist. P.T./O.T. aware. Pt instructed to set apt [appointment] with PCP [primary care giver] for follow up."</p> <p>D. The record included an OT visit note dated 11-17-11 that identified the patient had pain in the "R [right] hand over median N [nerve] distribution unable to rate . . . sharp, jabbing pain w [with] /movement."</p> <p>E. The record included a SN visit note dated 11-21-11 that identified the patient had pain in the "rt wrist" that was "chronic", a 6 on a scale of 1 to 10, with the best response to control measures being a 5, that the pain was an "ache", and prevented the patient from "lifting</p> |   |   |                      |   |

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|                    | <p>objects."</p> <p>F. The record included an OT visit note dated 11-22-11 that states the patient had pain the the "R hand over median N distribution unable to rate . . . sharp, jabbing pain w/movement."</p> <p>G. The record included a PT visit note dated 11-25-11 that states, "Pt is c/o pain in R hand and states OT feels [the patient] has carpal tunnel syndrome. [The patient] has a splint for this that was given to [the patient] in ECF [extended care facility], but we were unable to find it today."</p> <p>H. The record included a SN visit note dated 11-28-11 that identified the patient has pain in the "Rt hand" that is "chronic", a 6 on a scale of 1 to 10, "ache/tender", "constant", and worsened "with activity."</p> <p>I. The record included an OT note dated 11-29-11 that states, "Location of pain: R hand over median N distribution . . . says it is numb more than painful." The note states further, "Pt. has obtained a wrist splint which [the patient] says offers some relief of symptoms in [the patient's] R hand. Tried using soft sock aid for donning TED hose, but pt does not have the hand strength to get the stocking on the device or to pull it up."</p> |               |   |                      |

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|  | <p>J. A home visit was made to patient number 3 with the occupational therapist on 11-29-11 at 1:15 PM. The patient indicated to the therapist the patient had found the splint from another time and had decided to start wearing it. The therapist checked the splint for proper fit. Observation noted the occupational therapist work with the patient to use a soft sock aid. The patient indicated the pain in the right hand prevented getting the stocking on the device and pulling it up.</p> <p>K. The record failed to evidence the skilled nurse nor the occupational or physical therapists had informed the physician of the patient's complaints regarding pain and numbness in the right wrist, the inability to use assistive devices, and the use of the splint by the patient.</p> <p>L. The Director, employee A, indicated, on 12-5-11 at 1:25 PM, the record did not evidence any documentation the nurse or therapists had informed the physician of the patient's complaints of pain or use of the splint.</p> <p>2. Clinical record number 6 included a SN visit note dated 11-23-11 that states, "Pt to get Solumedrol 1GM [gram] over 1 hr X [times/for] 4 days . . . Pt stated [the</p> |   |   |                      |   |

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|  | <p>patient] once had a side affect of prednisone that it made [the patient] hallucinate, but it has been like 5 years ago. SN instr [instructed] if symptoms occurred, we would need to page MD on call. SN instr on all possible side effects of medication including increased blood sugars."</p> <p>A. The record failed to evidence the SN had informed the physician of the patient's past reaction to prednisone.</p> <p>B. The SN, employee C, stated, on 12-5-11 at 10:15 AM, "No, I did not call the physician. The patient said it was 5 to 7 years ago and that [the patient] had never had IV Solumedrol before."</p> <p>C. The record included a physician order, dated 11-23-11 and signed by the SN, employee C, that evidenced the patient was to receive a prednisone 10 milligram (mg) dose pack over 30 days starting 11-27-11.</p> <p>D. The record included a PT visit note dated 11-29-11 that states, "[The patient] reports that [the patient] is taking prednisone and seeing some bizarre things . . . hair on everything, bug, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> |   |   |                      |   |

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|  | <p>E. A PT visit note dated 12-1-11 states, "[The patient] reports that [the patient] is taking predinsone and seeing some bizarre things . . . hair on everything, bugs, etc. [The patient] states [the patient] had this same problem when on prednisone in the past."</p> <p>F. The physical therapist, employee F, stated, during an interview on 12-2-11 at 10:55 AM, "The patient says if [the patient] looks at faces [the patient] sees bugs and sees hair. [The patient] said [the patient] dreaded going on the Prednisone again. [The patient] said the MD was aware but I do not know which MD [the patient] was talking about. The physician that ordered the dose pack was an associate of the patient's regular neurologist. I did not call the physician because the patient's spouse stated [the patient] had the same reaction last time. I have not talked to the nurse about the patient's reports of seeing things. In retrospect, I should have called the doctor."</p> <p>G. The Director, employee A, indicated, on 12-2-11 at 11:05 AM, that the nurse and the therapist should have notified the physician of the patient's past reaction to the prednisone and the patient's current reports of hallucinations.</p> |   |   |                      |   |

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|  | <p>3. Clinical record number 11 included a PT "agency admit" visit note dated 11-23-11 that identified the patient needed assistance with understanding and setting up medications. The note states, "States [the patient] does not understand [the patient's] medications or how to set them up. PT has obtained orders for nursing for med set up and education. [The patient] has not taken [the patient's] insulin and [the patient's] BS [blood sugar] was 271."</p> <p>A. The record included a SN visit note dated 11-26-11 that states, "I sat down with [the patient] and made [the patient] tell me what insulins [the patient] was on and when to take them. At first [the patient] really couldn't tell me much of anything about [the patient's] meds except [the patient] didn't have them all and didn't have the money to get them . . . I had [the patient] fill [the patient's] pillboxes with what medcs [medicines] [the patient] has and told [the patient] when the social worker comes and figures out a way for [the patient] to get the remaining meds, a nurse can help [the patient] fill the pillboxes with the rest of the meds . . . I feel that it is best to have [the patient] do as much for [the patient's] self b/c [because] [the patient] is overwhelmed and has I just want to give up attitude." The note states, "Plan for Next Visit: F/U [follow-up] med ed</p> |   |   |  |  |   |  |

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|  | <p>[education] and diabetic ed."</p> <p>B. The record failed to evidence the physician had been notified of the continued need for skilled nursing for medication and diabetic education.</p> <p>4. Clinical record number 13 included a plan of care, established by the physician for the certification period 10-8-11 to 12-6-11 that identified the principal diagnosis as diabetes mellitus type II without complications.</p> <p>A. The record included a SN visit note dated 10-19-11 that states, "Glucometer Reading: 267." A SN visit note dated 10-21-11 evidenced the patient's glucometer reading was 358.</p> <p>B. A SN visit note dated 10-25-11 states, "Pt has had some HI blood sugars and states [the patient] is sure [the patient] has a UTI [urinary tract infection]. States [the patient] is to see Dr. [name] today as well."</p> <p>C. A SN visit note dated 10-31-11 evidenced the glucometer reading was 315. A SN visit note dated 11-7-11 states, "Pt states [the patient] has felt bad all weekend. States [the patient] has not been eating or drinking like [the patient] should because [the patient] has had</p> |   |   |                      |   |

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|  | <p>vomiting and diarrhea. States [the patient] had some blood in the stool the other day. Pts blood pressure is up. Instructed on the need to go to ER [emergency room] if [the patient] is unable to keep anything down and is not taking meds. Pt verbalized understanding and states [the patient] thinks [the patient] will go in a bit if not better."</p> <p>D. A SN visit note dated 11-11-11 states, "Glucometer Reading: 307 . . . Pt states [the patient] has been having N/V [nausea, vomiting] and diarrhea today and [the patient] is going to call Dr. today and see if [the patient] needs to go back to hospital. Pt states [the patient] has been having some issues with [the patient's] children and I think [the patient] has been putting off calling MD b/c [the patient] feels [the patients] needs to tend to the kids. Appetite poor. Pt eating few crackers and still [the patient's] BS was 307. I asked if I could just call Dr. to expedite things and [the patient] said no, I'll do it."</p> <p>E. A SN visit note dated 11-15-11 states, "Pt states [the patient] has continued to be sick but is improving. States [the patient] is not eating much due to nausea . . . States [the patient's] bladder is bothering [the patient] again . . . Pt states [the patient] has informed Dr.</p> |   |   |                      |   |

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|  | <p>[name]."</p> <p>F. A SN visit note dated 11-23-11 states, "Pt states [the patient] went to the ER at IU med center over the weekend . . . Pt states [the patient's] blood sugar was high. Pt states [the patient] was given an IV and released within a few hours. Pt states [the patient] also received antibiotics IV due to UTI. Blood sugar is hi today. Instructed pt to call MD if next reading is also hi."</p> <p>G. The record failed to evidence the SN had informed and communicated with the physician regarding the patient's high blood sugar readings and complaints of urinary tract infection symptoms.</p> <p>H. The Director, employee A, stated, on 12-5-11 at 3:00 PM, "Everybody knows this patient and know that the patient is noncompliant. The nurse did not document conversations with the doctor and case manager."</p> <p>5. The Director, employee A, and the Clinical Manager, employee B, were unable to provide any additional documentation and/or information when asked on 12-5-11 at 11:00 AM and 1:40 PM and before the exit conference on 12-6-11 at 2:00 PM.</p> |   |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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