

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2016
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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G 0000  Bldg. 00	<p>This was a Federal home health recertification survey.</p> <p>Survey Dates: 1-21-16, 1-25-16, 1-26-15, and 1-27-16 Partial extended on 1-25-16</p> <p>Facility #: 005998</p> <p>Medicaid Vendor #: 200217590</p> <p>Provider #: 15K007</p> <p>Census: 28 skilled 24 home health aide only 28 attendant care</p>	G 0000		
G 0121  Bldg. 00	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, record review, and interview, the agency failed to ensure staff had provided care in accordance with the agency's own infection control and gastrostomy tube policies and procedures in 5 (#s 1, 2, 3, 4, and 5) of 5 home visit observations completed.</p> <p>The findings include:</p>	G 0121	G121The administrator willinservice and train all staff on accepted standards of practice regarding:Universal Precautions and Infection control as defined by CDC Guidelines for Hand Hygiene in Health Care Settings (MMWR October 25,2002) and CDC Guideline for Isolation Precautions: Preventing Transmissionof Infectious Agents	02/18/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>1. Employee H, a registered nurse (RN), was observed to administer medications and feedings per a gastrostomy tube (G-tube) to patient number 1 on 1-21-16 at 2:35 PM. The RN was observed to prepare medications for administration per the G-tube. The RN removed her gloves after preparing the medications and failed to cleanse her hands. The patient arrived home per school bus and the RN assisted the patient into the home per wheelchair.</p> <p>A. After bringing the patient into the kitchen, the RN washed her hands, donned gloves and prepared the tube feeding. The RN removed her gloves and was not observed to cleanse her hands. The RN pushed the patient in the wheelchair to the patient's bedroom, removed the patient's coat and scarf, washed her hands, and donned clean gloves. The RN then administered 4 different medications per the G-tube.</p> <p>B. The RN was observed to prime the pump for the tube feeding and start the feeding. The RN was not observed to check for residual (removal and return of stomach contents with suction to ensure that minimal residue remains from the previous feeding. Excess residual volume may indicate an obstruction or</p>		<p>in Healthcare Settings (2007). Infection control will be added and monitored through Quality Assurance program. All staff will be supervised providing direct patient care to ensure that guidelines are being followed as instructed. During supervisory visits, patients will be asked about staff adherence to infection control and hand washing policy. All staff will return demonstrate training received and will sign written statements regarding the value of, and support for the adherence to recommended infection control/hand hygiene practices. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>other problem) prior to starting the tube feeding.</p> <p>C. The RN indicated she checked the placement of the feeding tube "every other time. With MicKeys you know that it is in. You look at it and see that it does not appear to be dislodged."</p> <p>3. Employee B, an RN, was observed to provide care to patient number 3 on 1-25-16 at 10:40 AM. The RN drained the patient's bladder per an opening created by a Monti procedure (a surgical procedure in which part of the gastrointestinal tract is used to create a conduit between the skin surface and the urinary bladder.) The opening was observed on the patient's lower abdomen. Without cleansing the skin around the opening, the RN inserted the catheter and drained the patient's bladder. This practice created the potential for the introduction of pathogens (disease causing germs) from the surface of the patient's skin into the opening.</p> <p>The RN removed her gloves, cleansed her hands, and carried the patient into the bathroom and placed the patient onto the commode. The RN donned clean gloves without cleansing her hands. The RN then performed a MACE procedure (a catheter is inserted into an opening in the</p>			

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	<p>patient's abdomen to infuse fluid and empty the bowel.) The RN was not observed to cleanse the opening prior to inserting the catheter.</p> <p>4. Employee F, a home health aide, was observed to provide a shower bath to patient number 4 on 1-26-15 at 8:30 AM. The aide assisted the patient into the shower onto a shower bench. The patient was observed to wash the upper front of the body and the front perineal area. The aide assisted the patient to stand, and using the same bath sponge as the patient used to wash the front perineal area, washed the patient's buttocks and rear perineal area. Without cleansing her hands or changing her gloves, the aide then used the same bath sponge to wash the patient's legs and feet.</p> <p>After the bath was complete the aide placed the patient's shoes with a brace onto the patient and assisted the patient out of the shower and into a wheelchair to dry the patient. The aide was not observed to change her gloves or cleanse her hands.</p> <p>5. On 1-26-16 at 9:10 AM, employee A, an RN, was observed to perform an assessment on patient number 5. The RN was observed to touch the patient's ankles and feet to check for swelling. Without</p>			

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	<p>cleansing her hands, the RN then reached into her nursing bag and retrieved her computer to record the findings.</p> <p>6. The above-stated observations were discussed with the administrator and director of nursing on 1-27-16 at 2:50 PM. The administrator and director indicated the employees had not provided care in accordance with the agency's policies and procedures.</p> <p>7. The agency's undated "Button Gastrostomy Care and Feeding" policy number E-165 states, "Check for residual by attaching a syringe to the tube and gently pulling back on the plunger. If residual is within acceptable limits per order, give the aspirate back to the child."</p> <p>8. The agency's 12-1-09 "Infection Control/Infections among Employees" policy number 152M states, "All NAN [Need A Nurse] employees adhere to infection control guidelines and set forth by CDC/MMWR guidelines."</p> <p>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean</p>			

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	<p>hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p>			

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G 0158  Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on record review and interview, the agency failed to ensure care and services had been provided as ordered by the physician in 3 (#s 3, 8, and 9) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 12-9-15 to 2-6-16. The plan of care states, "Assess VS [vital signs] &amp; all body systems , , , s/s [signs and symptoms] complications necessitating medical attention . . . Assess cardiovascular status, Assess, Perform Measures to recognize Cardiac Dysfunction . . . Assess for signs and symptoms of UTI [urinary tract infection] . . . Cath on time . . . flush with gentamicin solution every Tuesday and Friday at 3:15 PM . . . Goals The patient's weight will be maintained between 84 and 94 for this cert period."</p>	G 0158	G158 The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care. Nurses must review all written plans of care before care is being provided. All care provided must be documented in the clinical record. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	02/18/2016

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	<p>A. The plan of care identified the physician had prescribed a blood pressure lowering medication, the patient is catheterized 4 times per day, and has a pressure ulcer.</p> <p>B. Skilled nurse visit notes, dated 12-10-15, 12-11-15, 12-14-15, 12-15-15, 12-16-15, 12-17-15, 12-18-15, 12-21-15, 12-22-15, 12-23-15, 1-4-16, 1-5-16, 1-7-16, 1-8-16, 1-11-16, 1-12-16, 1-13-16, 1-14-16, 1-8-16, 1-19-16, 1-20-16, and 1-21-16, failed to evidence the nurse had obtained the patient's temperature, blood pressure, or weight during the visits.</p> <p>C. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 12-29-15 to 2-26-16 that states, "SNV [skilled nurse visits] 2-4 x week x's 9 weeks [2 to 4 times per week for 9 weeks] . . . SN [skilled nurse] to assess all body systems and VS . . . s/s of complications requiring medical attention . . . Assess Perform WOUND care as follows: Bactroban</p>			

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	<p>(only use when wounds appear to be infected), clinical trial cream and aquafor as directed by [parent]. Mepilex foam dressing pads to excoriated areas of extremities. Wrap feet legs, arms, hands, and fingers with one layer of Vaseline gauze, apply Telfa pads to knees. Cover all Vaseline gauze with one layer of soft roll, elastomull to hands/fingers, stretch gauze to secure and protect . . . For blisters, use sterile needle to lance, and roll soft gauze gently across blister to drain fluid. Assess S/S complications, infections to include: elevated temp &gt; [greater than] 100 and purulent drainage.</p> <p>A. A SN visit note dated 12-30-15 failed to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed.</p> <p>B. A SN visit note dated 1-5-16 failed to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed. The note states, "opened dressings."</p> <p>C. A SN visit note dated 1-6-16 failed to evidence the nurse had obtained the patient's temperature. The note states,</p>			

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	<p>"cleaned area from dressing change performed by mom prior to arrival. opened pads."</p> <p>D. SN visit notes dated 1-11-16, and 1-12-16, failed to evidence the nurse had obtained the patient's temperature or completed a skin assessment. The note failed to evidence any dressing changes had been completed.</p> <p>E. A SN visit note dated 1-18-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment. The note states, "Dressings opened."</p> <p>F. SN visit notes dated 1-19-16 and 1-20-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment or dressing changes.</p> <p>G. A SN visit note dated 1-25-16 failed to evidence the nurse had obtained the patient's temperature. The note states, "Report for [parent] . . . being treated for strep infection in skin sores . . . assisted [parent] with dressing changes on legs."</p> <p>H. The administrator stated, on 1-27-16 at 1:15 PM, "The patient has gauze wraps all over the body all the time. What goes under the gauze</p>			

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	<p>depends on what [the parent] wants. The dressings vary according to the areas. The frequency of the dressing changes are determined by [the parent]. [The parent] is not cooperative with nursing care. The care is very much self-directed by the [parent]. We can only do what the [parent] allows. [The parent] will not allow dressing changes. The local physician is aware and says to do whatever [parent] wants."</p> <p>I. Employee H, a registered nurse, stated, on 1-27-16 at 2:45 PM, "I have been with the patient approximately 1 year. The [parent] is very controlling and protective of the patient. I have explained to [the parent] the nurses are capable of doing the dressing changes. [The parent] is not willing to let us come in and do. We are trying to maintain a relationship with the [parent], we do not want to push. We go at the [parent's] pace."</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 11-6-15 to 1-4-16. The plan of care states, "Assess VS &amp; all body systems."</p> <p>A. A SN visit note dated 11-29-15 failed to evidence the nurse had obtained the patient's temperature or blood</p>			

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G 0159 Bldg. 00	<p>pressure.</p> <p>B. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure plans of care included specific frequencies for visits and treatments to be provided in 4 (#s 1, 3, &amp; 6) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 12-29-15 to 2-26-16. The plan of care identifies the skilled nurse (SN) was to provide "in home therapeutic exercise program, including ROM [range of motion],</p>	G 0159	The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care and that the plan of care will be developed in consultation with all staff providing care and include all treatments. Nurses must review all written plans of care before care is being provided. All care	02/18/2016

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	<p>gait/stander training and Dev exercises." The plan failed to specify the length and number of times the exercises were to be performed.</p> <p>The plan identifies the SN was to provide "chest physiotherapy." The plan failed to specify the duration of the therapy or the number of times per day the therapy was to be completed.</p> <p>2. Clinical record number 3 included a plan of care established by the physician for the certification period 2-9-15 to 2-6-16. The plan included orders for the skilled nurse to "Assess Perform Instruct Pt/Cg [patient/caregiver] wound care." The plan failed to specify the location of the wound.</p> <p>3. Clinical record number 6 included a plan of care established by the physician for the certification period 12-18-15 to 2-15-16. The plan of care failed to include a specific frequency for skilled nurse services to be provided.</p> <p>The plan failed to evidence specific orders for central venous catheter dressing changes. The plan states, "CVC dressing changes prn. See hospital protocols."</p> <p>4. The administrator and supervising</p>		<p>provided must be documented in the clinical record. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	

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G 0170  Bldg. 00	<p>nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 AM.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview, the agency failed to ensure nursing care and services had been provided as ordered by the physician in 3 (#s 3, 8, and 9) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 12-9-15 to 2-6-16. The plan of care states, "Assess VS [vital signs] &amp; all body systems , , , s/s [signs and symptoms] complications necessitating medical attention . . . Assess cardiovascular status, Assess, Perform Measures to recognize Cardiac Dysfunction . . . Assess for signs and symptoms of UTI [urinary tract infection] . . . Cath on time . . . flush with gentamicin solution every Tuesday and Friday at 3:15 PM . . . Goals The patient's weight will be maintained</p>	G 0170	The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care. Nurses must review all written plans of care/physicians' orders before care is being provided. All care provided must be documented in the clinical record. If services are interrupted or do not comply with the written plan of care, documentation must be generated to reflect these changes. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	02/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2016	
NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712			
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	<p>between 84 and 94 for this cert period."</p> <p>A. The plan of care identified the physician had prescribed a blood pressure lowering medication, the patient is catheterized 4 times per day, and has a pressure ulcer.</p> <p>B. Skilled nurse visit notes, dated 12-10-15, 12-11-15, 12-14-15, 12-15-15, 12-16-15, 12-17-15, 12-18-15, 12-21-15, 12-22-15, 12-23-15, 1-4-16, 1-5-16, 1-7-16, 1-8-16, 1-11-16, 1-12-16, 1-13-16, 1-14-16, 1-8-16, 1-19-16, 1-20-16, and 1-21-16, failed to evidence the nurse had obtained the patient's temperature, blood pressure, or weight during the visits.</p> <p>C. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 12-29-15 to 2-26-16 that states, "SNV [skilled nurse visits] 2-4 x week x's 9 weeks [2 to 4 times per week for 9 weeks] . . . SN [skilled nurse] to assess all body systems and VS . . . s/s of complications requiring medical attention . . . Assess Perform</p>						

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	<p>WOUND care as follows: Bactroban (only use when wounds appear to be infected), clinical trial cream and aquafor as directed by [parent]. Mepilex foam dressing pads to excoriated areas of extremities. Wrap feet legs, arms, hands, and fingers with one layer of Vaseline gauze, apply Telfa pads to knees. Cover all Vaseline gauze with one layer of soft roll, elastomull to hands/fingers, stretch gauze to secure and protect . . . For blisters, use sterile needle to lance, and roll soft gauze gently across blister to drain fluid. Assess S/S complications, infections to include: elevated temp &gt; [greater than] 100 and purulent drainage.</p> <p>A. A SN visit note dated 12-30-15 failed to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed.</p> <p>B. A SN visit note dated 1-5-16 failed to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed. The note states, "opened dressings."</p> <p>C. A SN visit note dated 1-6-16 failed to evidence the nurse had obtained the</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	<p>patient's temperature. The note states, "cleaned area from dressing change performed by mom prior to arrival. opened pads."</p> <p>D. SN visit notes dated 1-11-16, and 1-12-16, failed to evidence the nurse had obtained the patient's temperature or completed a skin assessment. The note failed to evidence any dressing changes had been completed.</p> <p>E. A SN visit note dated 1-18-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment. The note states, "Dressings opened."</p> <p>F. SN visit notes dated 1-19-16 and 1-20-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment or dressing changes.</p> <p>G. A SN visit note dated 1-25-16 failed to evidence the nurse had obtained the patient's temperature. The note states, "Report for [parent] . . . being treated for strep infection in skin sores . . . assisted [parent] with dressing changes on legs."</p> <p>H. The administrator stated, on 1-27-16 at 1:15 PM, "The patient has gauze wraps all over the body all the</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	<p>time. What goes under the gauze depends on what [the parent] wants. The dressings vary according to the areas. The frequency of the dressing changes are determined by [the parent]. [The parent] is not cooperative with nursing care. The care is very much self-directed by the [parent]. We can only do what the [parent] allows. [The parent] will not allow dressing changes. The local physician is aware and says to do whatever [parent] wants."</p> <p>I. Employee H, a registered nurse, stated, on 1-27-16 at 2:45 PM, "I have been with the patient approximately 1 year. The [parent] is very controlling and protective of the patient. I have explained to [the parent] the nurses are capable of doing the dressing changes. [The parent] is not willing to let us come in and do. We are trying to maintain a relationship with the [parent], we do not want to push. We go at the [parent's] pace."</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 11-6-15 to 1-4-16. The plan of care states, "Assess VS &amp; all body systems."</p> <p>A. A SN visit note dated 11-29-15 failed to evidence the nurse had obtained</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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G 0236  Bldg. 00	<p>the patient's temperature or blood pressure.</p> <p>B. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p> <p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on record review and interview, the agency failed to ensure skilled nurse visit notes had been completed in their entirety in 1 (# 6) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a skilled nurse visit note dated 1-18-16. The head, musculoskeletal, skin condition, gastrointestinal, and genitourinary portions of the visit note</p>	G 0236	G236 The administrator will re-train all staff (via inservice) on all care being provided must be reflective in the clinical record and follow a written plan of care. Nurses must submit clinical record notes weekly and notes will be incorporated into the clinical record within 14 days or skilled care. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible	02/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2016
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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G 0338 Bldg. 00	<p>had been left blank.</p> <p>The record included a skilled nurse visit note dated 1-22-16. The head, musculoskeletal, skin condition, gastrointestinal, and genitourinary portions of the visit note had been left blank.</p> <p>2. The administrator indicated, on 1-27-16 at 1:15 PM, the visit notes were incomplete.</p> <p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. Based on record review and interview, the agency failed to ensure updates to the comprehensive assessments were</p>	G 0338	<p>for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur IDR request G236: Pt notes in question were 1) in electronic format 2) pending submission for completion-not chart ready; 3) in compliance with Federal G236 and State 436. 17-15-1 regulations 4) in compliance with agency policy. Dates of service for the notes in question were 1-18-16; 1-22-16. Dates of survey 1-21-16; 1-25-16; 1-26-16; 1-27-16. Clinical notes in question were partially completed but not completed nor chart ready. Within compliance of federal standard G236 and state standard 436 IAC 17-15-1. 'Clinical notes shall be written the day of service is rendered and incorporated within fourteen days.' Please also note 1-18-16 &amp; 1-22-16 were both snow days that required school closings. ISDH survey began 1-21-16.</p> <p>The administrator will re-train all staff (via inservice) on all patients' comprehensive assessments be updated and revised every 60</p>	02/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2016
NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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	<p>complete in 3 (#s 2, 7, and 8) of 9 records of patients on service for greater than 60 days.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a follow-up comprehensive assessment dated 12-3-15. The assessment failed to evidence the patient's weight or changes in the weight had been assessed.</li> <li>2. Clinical record 7 included a follow-up comprehensive assessment dated 12-21-15. The assessment identifies the patient has pain "daily, but not constantly." The assessment failed to evidence the intensity, location, onset date, precipitating factors, effectiveness of current pain management, progress towards pain goal, or effective relief measures.</li> <li>3. Clinical record number 8 included a follow-up assessment dated 12-29-15. The assessment failed to include a complete assessment of the patient's urinary status. The assessment states, "routine voiding pattern."</li> </ol> <p>The assessment failed to evidence a complete assessment of the patient's integumentary status. The assessment states, "generalized excoriations,</p>		<p>days or more frequently if patients' conditions warrants and that all systems assessment will be included in the comprehensive assessment document. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur and address all systems</p>		

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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N 0000 Bldg. 00	<p>blistering, and scabbing d/t EB [Epidermolysis bullosa]."</p> <p>4. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p>	N 0000		
N 0470 Bldg. 00	<p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 1-21-16, 1-25-16, 1-26-15, and 1-27-16</p> <p>Facility #: 005998</p> <p>Medicaid Vendor #: 200217590</p> <p>Provider #: 15K007</p> <p>Census: 28 skilled 24 home health aide only 28 attendant care</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in</p>			

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	<p>compliance with applicable federal and state laws.</p> <p>Based on observation, record review, and interview, the agency failed to ensure staff had provided care in accordance with the agency's own infection control and gastrostomy tube policies and procedures in 5 (#s 1, 2, 3, 4, and 5) of 5 home visit observations completed.</p> <p>The findings include:</p> <p>1. Employee H, a registered nurse (RN), was observed to administer medications and feedings per a gastrostomy tube (G-tube) to patient number 1 on 1-21-16 at 2:35 PM. The RN was observed to prepare medications for administration per the G-tube. The RN removed her gloves after preparing the medications and failed to cleanse her hands. The patient arrived home per school bus and the RN assisted the patient into the home per wheelchair.</p> <p>A. After bringing the patient into the kitchen, the RN washed her hands, donned gloves and prepared the tube feeding. The RN removed her gloves and was not observed to cleanse her hands. The RN pushed the patient in the wheelchair to the patient's bedroom, removed the patient's coat and scarf, washed her hands, and donned clean</p>	N 0470	<p>The administrator willinservice and re-train all staff on accepted standards of practice regarding:Universal Precautions and Infection control as defined by CDC Guidelines for Hand Hygiene in Health Care Settings (MMWR October 25,2002) and CDC Guideline for Isolation Precautions: Preventing Transmissionof Infectious Agents in Healthcare Settings (2007). Infection control will be monitored through Quality Assurance programAll staffwill be supervised providing direct patient care to ensure thatguidelines are being followed as instructed. During supervisory visits,patients will be asked about staff adherence to infection control/hand washing policy. All staff will sign statements regarding the value of, and support for the adherence to recommendedhand hygiene practices. Theadministrator will be responsible for monitoring these corrective actions toensure that this deficiency is corrected and will not recur</p>	02/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2016	
NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712			
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	<p>gloves. The RN then administered 4 different medications per the G-tube.</p> <p>B. The RN was observed to prime the pump for the tube feeding and start the feeding. The RN was not observed to check for residual (removal and return of stomach contents with suction to ensure that minimal residue remains from the previous feeding. Excess residual volume may indicate an obstruction or other problem) prior to starting the tube feeding.</p> <p>C. The RN indicated she checked the placement of the feeding tube "every other time. With MicKeys you know that it is in. You look at it and see that it does not appear to be dislodged."</p> <p>3. Employee B, an RN, was observed to provide care to patient number 3 on 1-25-16 at 10:40 AM. The RN drained the patient's bladder per an opening created by a Monti procedure (a surgical procedure in which part of the gastrointestinal tract is used to create a conduit between the skin surface and the urinary bladder.) The opening was observed on the patient's lower abdomen. Without cleansing the skin around the opening, the RN inserted the catheter and drained the patient's bladder. This practice created the potential for the</p>						

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	<p>introduction of pathogens (disease causing germs) from the surface of the patient's skin into the opening.</p> <p>The RN removed her gloves, cleansed her hands, and carried the patient into the bathroom and placed the patient onto the commode. The RN donned clean gloves without cleansing her hands. The RN then performed a MACE procedure (a catheter is inserted into an opening in the patient's abdomen to infuse fluid and empty the bowel.) The RN was not observed to cleanse the opening prior to inserting the catheter.</p> <p>4. Employee F, a home health aide, was observed to provide a shower bath to patient number 4 on 1-26-15 at 8:30 AM. The aide assisted the patient into the shower onto a shower bench. The patient was observed to wash the upper front of the body and the front perineal area. The aide assisted the patient to stand, and using the same bath sponge as the patient used to wash the front perineal area, washed the patient's buttocks and rear perineal area. Without cleansing her hands or changing her gloves, the aide then used the same bath sponge to wash the patient's legs and feet.</p> <p>After the bath was complete the aide placed the patient's shoes with a brace</p>			

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	<p>onto the patient and assisted the patient out of the shower and into a wheelchair to dry the patient. The aide was not observed to change her gloves or cleanse her hands.</p> <p>5. On 1-26-16 at 9:10 AM, employee A, an RN, was observed to perform an assessment on patient number 5. The RN was observed to touch the patient's ankles and feet to check for swelling. Without cleansing her hands, the RN then reached into her nursing bag and retrieved her computer to record the findings.</p> <p>6. The above-stated observations were discussed with the administrator and director of nursing on 1-27-16 at 2:50 PM. The administrator and director indicated the employees had not provided care in accordance with the agency's policies and procedures.</p> <p>7. The agency's undated "Button Gastrostomy Care and Feeding" policy number E-165 states, "Check for residual by attaching a syringe to the tube and gently pulling back on the plunger. If residual is within acceptable limits per order, give the aspirate back to the child."</p> <p>8. The agency's 12-1-09 "Infection Control/Infections among Employees" policy number 152M states, "All NAN</p>			

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	<p>[Need A Nurse] employees adhere to infection control guidelines and set forth by CDC/MMWR guidelines."</p> <p>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2016
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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N 0522 Bldg. 00	<p>delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to ensure care and services had been provided as ordered by the physician in 3 (#s 3, 8, and 9) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 12-9-15 to 2-6-16. The plan of care states, "Assess VS [vital signs] &amp; all body systems , , , s/s [signs and symptoms] complications</p>	N 0522	The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care. Nurses must review all written plans of care before care is being provided. All care provided must be documented in the clinical record. 10% of all charts will be audited	02/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2016
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	<p>necessitating medical attention . . . Assess cardiovascular status, Assess, Perform Measures to recognize Cardiac Dysfunction . . . Assess for signs and symptoms of UTI [urinary tract infection] . . . Cath on time . . . flush with gentamicin solution every Tuesday and Friday at 3:15 PM . . . Goals The patient's weight will be maintained between 84 and 94 for this cert period."</p> <p>A. The plan of care identified the physician had prescribed a blood pressure lowering medication, the patient is catheterized 4 times per day, and has a pressure ulcer.</p> <p>B. Skilled nurse visit notes, dated 12-10-15, 12-11-15, 12-14-15, 12-15-15, 12-16-15, 12-17-15, 12-18-15, 12-21-15, 12-22-15, 12-23-15, 1-4-16, 1-5-16, 1-7-16, 1-8-16, 1-11-16, 1-12-16, 1-13-16, 1-14-16, 1-8-16, 1-19-16, 1-20-16, and 1-21-16, failed to evidence the nurse had obtained the patient's temperature, blood pressure, or weight during the visits.</p> <p>C. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p>		<p>quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	

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	<p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 12-29-15 to 2-26-16 that states, "SNV [skilled nurse visits] 2-4 x week x's 9 weeks [2 to 4 times per week for 9 weeks] . . . SN [skilled nurse] to assess all body systems and VS . . . s/s of complications requiring medical attention . . . Assess Perform WOUND care as follows: Bactroban (only use when wounds appear to be infected), clinical trial cream and aquafor as directed by [parent]. Mepilex foam dressing pads to excoriated areas of extremities. Wrap feet legs, arms, hands, and fingers with one layer of Vaseline gauze, apply Telfa pads to knees. Cover all Vaseline gauze with one layer of soft roll, elastomull to hands/fingers, stretch gauze to secure and protect . . . For blisters, use sterile needle to lance, and roll soft gauze gently across blister to drain fluid. Assess S/S complications, infections to include: elevated temp &gt; [greater than] 100 and purulent drainage.</p> <p>A. A SN visit note dated 12-30-15 failed to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed.</p> <p>B. A SN visit note dated 1-5-16 failed</p>			

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	<p>to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed. The note states, "opened dressings."</p> <p>C. A SN visit note dated 1-6-16 failed to evidence the nurse had obtained the patient's temperature. The note states, "cleaned area from dressing change performed by mom prior to arrival. opened pads."</p> <p>D. SN visit notes dated 1-11-16, and 1-12-16, failed to evidence the nurse had obtained the patient's temperature or completed a skin assessment. The note failed to evidence any dressing changes had been completed.</p> <p>E. A SN visit note dated 1-18-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment. The note states, "Dressings opened."</p> <p>F. SN visit notes dated 1-19-16 and 1-20-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment or dressing changes.</p> <p>G. A SN visit note dated 1-25-16</p>			

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	<p>failed to evidence the nurse had obtained the patient's temperature. The note states, "Report for [parent] . . . being treated for strep infection in skin sores . . . assisted [parent] with dressing changes on legs."</p> <p>H. The administrator stated, on 1-27-16 at 1:15 PM, "The patient has gauze wraps all over the body all the time. What goes under the gauze depends on what [the parent] wants. The dressings vary according to the areas. The frequency of the dressing changes are determined by [the parent]. [The parent] is not cooperative with nursing care. The care is very much self-directed by the [parent]. We can only do what the [parent] allows. [The parent] will not allow dressing changes. The local physician is aware and says to do whatever [parent] wants."</p> <p>I. Employee H, a registered nurse, stated, on 1-27-16 at 2:45 PM, "I have been with the patient approximately 1 year. The [parent] is very controlling and protective of the patient. I have explained to [the parent] the nurses are capable of doing the dressing changes. [The parent] is not willing to let us come in and do. We are trying to maintain a relationship with the [parent], we do not want to push. We go at the [parent's] pace."</p>			

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N 0524 Bldg. 00	<p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 11-6-15 to 1-4-16. The plan of care states, "Assess VS &amp; all body systems."</p> <p>A. A SN visit note dated 11-29-15 failed to evidence the nurse had obtained the patient's temperature or blood pressure.</p> <p>B. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted.</p>			
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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	<p>(viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure plans of care included specific frequencies for visits and treatments to be provided in 4 (#s 1, 3, &amp; 6) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 12-29-15 to 2-26-16. The plan of care identifies the skilled nurse (SN) was to provide "in home therapeutic exercise program, including ROM [range of motion], gait/stander training and Dev exercises." The plan failed to specify the length and number of times the exercises were to be performed.</p> <p>The plan identifies the SN was to provide "chest physiotherapy." The plan failed to specify the duration of the therapy or the number of times per day the therapy was to be completed.</p> <p>2. Clinical record number 3 included a</p>	N 0524	The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care and that the plan of care will be developed in consultation with all staff providing care and include all treatments. Nurses must review all written plans of care before care is being provided. All care provided must be documented in the clinical record. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for	02/18/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2016
NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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N 0537  Bldg. 00	<p>plan of care established by the physician for the certification period 2-9-15 to 2-6-16. The plan included orders for the skilled nurse to "Assess Perform Instruct Pt/Cg [patient/caregiver] wound care." The plan failed to specify the location of the wound.</p> <p>3. Clinical record number 6 included a plan of care established by the physician for the certification period 12-18-15 to 2-15-16. The plan of care failed to include a specific frequency for skilled nurse services to be provided.</p> <p>The plan failed to evidence specific orders for central venous catheter dressing changes. The plan states, "CVC dressing changes prn. See hospital protocols."</p> <p>4. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 AM.</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a</p>		<p>monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>		

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	<p>registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on record review and interview, the agency failed to ensure nursing care and services had been provided as ordered by the physician in 3 (#s 3, 8, and 9) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 12-9-15 to 2-6-16. The plan of care states, "Assess VS [vital signs] &amp; all body systems , , , s/s [signs and symptoms] complications necessitating medical attention . . . Assess cardiovascular status, Assess, Perform Measures to recognize Cardiac Dysfunction . . . Assess for signs and symptoms of UTI [urinary tract infection] . . . Cath on time . . . flush with gentamicin solution every Tuesday and Friday at 3:15 PM . . . Goals The patient's weight will be maintained between 84 and 94 for this cert period."</p> <p>A. The plan of care identified the physician had prescribed a blood pressure lowering medication, the patient is catheterized 4 times per day, and has a pressure ulcer.</p>	N 0537	<p>The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care. Nurses must review all written plans of care/physicians' orders before care is being provided. All care provided must be documented in the clinical record. If services are interrupted or do not comply with the written plan of care, documentation must be generated to reflect these changes. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	02/18/2016

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	<p>B. Skilled nurse visit notes, dated 12-10-15, 12-11-15, 12-14-15, 12-15-15, 12-16-15, 12-17-15, 12-18-15, 12-21-15, 12-22-15, 12-23-15, 1-4-16, 1-5-16, 1-7-16, 1-8-16, 1-11-16, 1-12-16, 1-13-16, 1-14-16, 1-8-16, 1-19-16, 1-20-16, and 1-21-16, failed to evidence the nurse had obtained the patient's temperature, blood pressure, or weight during the visits.</p> <p>C. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 12-29-15 to 2-26-16 that states, "SNV [skilled nurse visits] 2-4 x week x's 9 weeks [2 to 4 times per week for 9 weeks] . . . SN [skilled nurse] to assess all body systems and VS . . . s/s of complications requiring medical attention . . . Assess Perform WOUND care as follows: Bactroban (only use when wounds appear to be infected), clinical trial cream and aquafor as directed by [parent]. Mepilex foam dressing pads to excoriated areas of extremities. Wrap feet legs, arms, hands, and fingers with one layer of Vaseline gauze, apply Telfa pads to knees. Cover</p>			

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	<p>all Vaseline gauze with one layer of soft roll, elastomull to hands/fingers, stretch gauze to secure and protect . . . For blisters, use sterile needle to lance, and roll soft gauze gently across blister to drain fluid. Assess S/S complications, infections to include: elevated temp &gt; [greater than] 100 and purulent drainage.</p> <p>A. A SN visit note dated 12-30-15 failed to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed.</p> <p>B. A SN visit note dated 1-5-16 failed to evidence the nurse had obtained the patient's temperature. The note failed to evidence an assessment of the skin or that any dressing changes had been completed. The note states, "opened dressings."</p> <p>C. A SN visit note dated 1-6-16 failed to evidence the nurse had obtained the patient's temperature. The note states, "cleaned area from dressing change performed by mom prior to arrival. opened pads."</p> <p>D. SN visit notes dated 1-11-16, and 1-12-16, failed to evidence the nurse had obtained the patient's temperature or</p>			

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	<p>completed a skin assessment. The note failed to evidence any dressing changes had been completed.</p> <p>E. A SN visit note dated 1-18-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment. The note states, "Dressings opened."</p> <p>F. SN visit notes dated 1-19-16 and 1-20-16 failed to evidence the nurse had obtained the patient's temperature or had completed a skin assessment or dressing changes.</p> <p>G. A SN visit note dated 1-25-16 failed to evidence the nurse had obtained the patient's temperature. The note states, "Report for [parent] . . . being treated for strep infection in skin sores . . . assisted [parent] with dressing changes on legs."</p> <p>H. The administrator stated, on 1-27-16 at 1:15 PM, "The patient has gauze wraps all over the body all the time. What goes under the gauze depends on what [the parent] wants. The dressings vary according to the areas. The frequency of the dressing changes are determined by [the parent]. [The parent] is not cooperative with nursing care. The care is very much self-directed by the [parent]. We can only do what the</p>			

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	<p>[parent] allows. [The parent] will not allow dressing changes. The local physician is aware and says to do whatever [parent] wants."</p> <p>I. Employee H, a registered nurse, stated, on 1-27-16 at 2:45 PM, "I have been with the patient approximately 1 year. The [parent] is very controlling and protective of the patient. I have explained to [the parent] the nurses are capable of doing the dressing changes. [The parent] is not willing to let us come in and do. We are trying to maintain a relationship with the [parent], we do not want to push. We go at the [parent's] pace."</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 11-6-15 to 1-4-16. The plan of care states, "Assess VS &amp; all body systems."</p> <p>A. A SN visit note dated 11-29-15 failed to evidence the nurse had obtained the patient's temperature or blood pressure.</p> <p>B. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p>			

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N 0541  Bldg. 00	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a)(1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on record review and interview, the agency failed to ensure updates to the comprehensive assessments were complete in 3 (#s 2, 7, and 8) of 9 records of patients on service for greater than 60 days.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a follow-up comprehensive assessment dated 12-3-15. The assessment failed to evidence the patient's weight or changes in the weight had been assessed.</li> <li>2. Clinical record 7 included a follow-up comprehensive assessment dated 12-21-15. The assessment identifies the patient has pain "daily, but not constantly." The assessment failed to evidence the intensity, location, onset date, precipitating factors, effectiveness of current pain management, progress towards pain goal, or effective relief measures.</li> </ol>	N 0541	The administrator will re-train all staff (via inservice) on all patients' comprehensive assessments be updated and revised every 60 days or more frequently if patients' conditions warrants and that all systems assessment will be included in the comprehensive assessment document. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these	02/18/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2016	
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N 0608 Bldg. 00	<p>3. Clinical record number 8 included a follow-up assessment dated 12-29-15. The assessment failed to include a complete assessment of the patient's urinary status. The assessment states, "routine voiding pattern."</p> <p>The assessment failed to evidence a complete assessment of the patient's integumentary status. The assessment states, "generalized excoriations, blistering, and scabbing d/t EB [Epidermolysis bullosa]."</p> <p>4. The administrator and supervising nurse were unable to provide any additional documentation and/or information when asked on 1-27-16 at 1:15 PM.</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes</p>		corrective actions to ensure that this deficiency is corrected and will not recur and address all systems				

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	<p>contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on record review and interview, the agency failed to ensure skilled nurse visit notes had been completed in their entirety in 1 (# 6) of 10 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a skilled nurse visit note dated 1-18-16. The head, musculoskeletal, skin condition, gastrointestinal, and genitourinary portions of the visit note had been left blank.</p> <p>The record included a skilled nurse visit note dated 1-22-16. The head, musculoskeletal, skin condition, gastrointestinal, and genitourinary portions of the visit note had been left blank.</p> <p>2. The administrator indicated, on 1-27-16 at 1:15 PM, the visit notes were incomplete.</p>	N 0608	<p>The administrator will re-train all staff (via inservice) on all care being provided must be reflective in the clinical record and follow a written plan of care. Nurses must submit clinical record notes weekly and notes will be incorporated into the clinical record within 14 days or skilled care. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. IDR request N0608: Pt notes in question were 1) in electronic format 2) pending submission for completion-not chart ready; 3) in compliance with Federal G236 and State 436. 17-15-1 regulations 4) in compliance with agency policy.Dates of service</p>	02/18/2016	

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			for the notes in question were 1-18-16; 1-22-16. Dates of survey 1-21-16; 1-25-16;1-26-16; 1-27-16. Clinical notes in question were partially completed but not completed nor chart ready. Within compliance of state standard 436 IAC 17-15-1. 'Clinical notes shall be written the day of service is rendered and incorporated within fourteen days.' Please also note 1-18-16 & 1-22-16 were both snow days that required school closings. ISDH survey began 1-21-16.	