

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/20/2011
NAME OF PROVIDER OR SUPPLIER  VISTACARE HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 6431 S EAST ST INDIANAPOLIS, IN46227		
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L0000	<p>This visit was for a hospice federal recertification and state licensure survey.</p> <p>Survey Dates: December 19-20, 2011</p> <p>Facility Number: 003901</p> <p>Provider Number: 151586</p> <p>Medicaid Number: 200471710</p> <p>Survey Team: Kelly Ennis, BSN, RN, Team Leader Tonya Tucker, RN</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 22, 2011</p>	L0000			
L0503	<p>(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.</p> <p>Based on document review and interview, the hospice failed to ensure</p>	L0503	The Quality Manager obtained the ISDH brochure "Advanced Directives Your Right to Decide, Indiana State Department of	01/18/2012	

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>the advance directives information provided to patients on admission used the language provided in the ISDH brochure <i>Advance Directives Your Right to Decide</i>, Indiana State Department of Health, Revised May 2004.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The advance directive information provided to the patient in the Vistacare Admission Packet failed to include the Indiana State Department of Health, May 2004 revisions, which included the psychiatric advance directive statute.</li> <li>2. On December 19, 2011, at 11:30 AM, employee J, Quality Manager, Registered Nurse (RN), indicated the information included in the admission packet was given to all patients at the start of care.</li> </ol>		<p>Health, Revised May 2004" and ensured it was placed in all VistaCare Admission Packets present in the office by 12/28/11. Staff members who complete the Admission Packets were notified on 12/29/11 to bring packets in their possession to the office to have the correct brochure placed in packets no later than 1/18/12. The Quality Manager began conducting in-services on 12/29/11 on the use of the correct brochure by staff members who utilize the Admission Packets. An in-service meeting will be conducted by the Quality Manager or designee on 1/5/12 to in-service all staff not previously in-serviced on the use of the correct brochure. The Quality Manager or designee will ensure all necessary staff members have been in-serviced on or before 1/18/12. The Quality Manager or designee will audit 100% of Admission Packets per week for the next 30 days to ensure the correct brochure is present in 100% of Admission Packets. The quality Manager or designee will conduct ongoing audits of ten Admission Packets per Quarter to ensure 90% or greater compliance as part of the Quarterly Site Operations Audit. Results will be reported by the Quality Manager or designee to the Quality Assurance Performance Improvement (QAPI) Committee quarterly.</p>		

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L0530	<p>[The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:</p> <ul style="list-style-type: none"> <li>(i) Effectiveness of drug therapy</li> <li>(ii) Drug side effects</li> <li>(iii) Actual or potential drug interactions</li> <li>(iv) Duplicate drug therapy</li> <li>(v) Drug therapy currently associated with laboratory monitoring.</li> </ul> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the medication review was updated when there were medication changes in 2 of 11 active clinical records reviewed. (#5 and 7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The policy titled "Medication Administration," policy number 03-17, revised 8/30/2011, states, "Changes in the medication regimen must be included in the Plan of Care and discussed/approved by the Interdisciplinary Group (IDG). Medications are administered and documented on the Medication Profile in accordance with a specific order indicating all of the following: Name of</li> </ol>	L0530	The Medication Profile in clinical records #5 and #7 was reviewed and updated by the respective RN Case Managers (RNCM) on 1/21/11 to reflect medication changes so that it is current and accurate. An in-service to nursing staff on Policy 03-17 "Medication Administration" was conducted by the Quality Manager on 12/28/11, with twelve of twenty-four RNs present. An in-service meeting will be conducted by the Quality Manager or designee on 1/5/12 to complete the in-service for all nursing staff not previously in-serviced on Policy 03-17. The Quality Manager or designee will ensure all nursing staff members have been in-serviced on regarding policy 03-17 "Medication Administration" on or before 1/18/12. The Quality Manager or designee will conduct ongoing audits of ten charts per quarter to ensure 90% or greater	01/18/2012	

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	<p>patient, name of the medication, route, dosage, strength, dilution, frequency, duration, rate of infusion if applicable, special instructions or precautions if indicated, effective date, signature of physician. This includes administration of over-the-counter (OTC) medications and herbal compounds ... The nurse will record all medications administered to a patient in the clinical record. Each patient must have a current, accurate medication profile in the medical record."</p> <p>2. Clinical record #5, start of care 11/10/11, included a review of the Certification Period from 11/10/11 to 2/7/2012. During a home visit at an assisted living center on 12/20/2011 at 10:00 AM, patient #5 was sleeping upon arrival and could not be aroused. Employee C, Social Worker, indicated that due to increased agitation, the patient was recently placed on Haldol by the Attending Physician. Employee C indicated that shortly after being placed on the medication, the patient became less responsive, less ambulatory, and had a fall. Employee C indicated the dose prescribed by the attending physician was questioned, and the dose was then cut in half. Employee C indicated they</p>		<p>compliance as part of the Quarterly Site Operations Audit. Results will be reported by the Quality Manager or designee to the Quality Assurance Performance Improvement (QAPI) Committee quarterly.</p>	

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	<p>were monitoring the patient to make sure their responsiveness increased after the medication dose was cut in half. Review of the clinical record evidenced the following:</p> <p>A. A physician order dated 11/29/11 by the attending physician stated the following, "Rispodone [sic] 1 mg [milligram] po [by mouth] @ 8 PM daily [for] agitation" (Risperidone 1 milligram by mouth at 8 PM daily for agitation.)</p> <p>B. The "IDG [Interdisciplinary Group] Plan of Care Review" dated 11/30/11 indicated there were no "New/Changed Medications since last IDG Meeting."</p> <p>C. On 12/13/11, employee N, Licensed Practical Nurse (LPN), wrote in the "Nursing Focused Visit Note" at 1:20 PM that the patient was "very lethargic today wife with patient very upset. Pt [Patient] had a fall this AM [morning]. Spoke to [assisted living facility employee] upon entering unit who was concerned about pt not feeding [themselves] and not walking. Let her know she can hold Haloperidol. Pt to lethargic 1400 held. Advised to give HS [nighttime] pill to help [patient] eat. Wife very tearful pt has two areas above lt [left] eye and 1 on</p>			

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	<p>middle forehead. Hemotoma both areas and abrasions."</p> <p>D. The "IDG Plan of Care Review" dated 12/14/11 indicated there were "New/Changed Medications since last IDG Meeting." The medication listed was "Haldol 0.5 mg Q [every] AM and 2 PM 2 mg @ 8 PM [Haldol 0.5 milligram every morning and 2 PM and 2 milligrams at 8 PM]; Atrovent Nasal Spray 2 sprays each nostril twice dly [daily]." Under the section titled "Neuro/Cognitive/Behavioral" the "Summary of Progress Toward Goals" states, "Pt [patient] with increased aggression/agitation. Risperdol dc'd [discontinued] Haloperidol started." Under the section titled "Safety/Falls" the "Summary of Progress Toward Goals" states, "Pt with fall 12/7/11 - found on floor in common area." The Haloperidol medication change on 12/13/11 was not noted, nor was the fall on 12/13/11.</p> <p>E. Review of the record revealed no order for Haldol or Atrovent Nasal Spray.</p> <p>F. On 12/20/11 at 5 PM, employee B, RN case manager, indicated that there was no order in the hospice chart for the Haloperidol order. Employee B indicated</p>				

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	<p>they took a few days off of work that week and might have forget to get the order to place in the Hospice Facility chart. Employee B indicated they would ask the Assisted Living Facility to fax the order immediately.</p> <p>G. On 12/20/11 at 5:20 PM, the assisted living facility faxed the 2 orders. The first one was dated 12/8/11 stated, "D/C [discontinue] Risperidone [sic]. Start Haloperidol 0.5 mg @ 7 AM and 2 PM. 2 mg @ 8 PM [Haloperidol 0.5 milligram at 7 AM and 2 PM. 2 milligrams at 8 PM]. The second order dated 12/13/11 stated, "Change Haloperidol to following orders. Haloperidol 0.25 mg BID [0.25 milligrams two times per day] Haloperidol 1 mg Q HS [1 milligram every night].</p> <p>H. The "Comprehensive Assessment Drug Profile - Physician Order" dated 11/10/11 failed to evidence Risperidone, Haloperidol, or Atrovent Nasal Spray.</p> <p>I. On 12/20 at 5:40 PM, employee J, Quality Assurance Manager/RN, indicated the orders should have been in the hospice chart, the medication profile should have been updated, and the medication changes/effects should have been discussed in the IDG meeting on</p>						

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	<p>12/14/2011.</p> <p>3. Clinical record #7, start of care 10/21/11, included a review of the Certification Period from 10/21/11 to 1/20/2012. Review of the clinical record evidenced the following:</p> <p>A. On 12/14/11, employee P, RN, wrote in the "Nursing Focused Visit Note" that "Pt [patient] states [they] have not had a BM [bowel movement] x [for] 10 days, has taken an extra Colace today. This writer will request liquid form of Colace to be delivered, pt states this would be easier to take."</p> <p>B. On 12/16/11, employee P, RN, wrote in the "Nursing Focused Visit Note" that "Pt states she has not had a BM for 12 days, although [pt] seems somewhat unsure of number of days ... Pt has taken liquid Colace on 12/15/11."</p> <p>C. Review of the record revealed no order for liquid Colace.</p> <p>D. The "Comprehensive Assessment Drug Profile - Physician Order" dated 10/21/11 and the "Comprehensive Assessment Drug Profile Continuation" dated 12/9/11 failed to evidence liquid</p>				

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L0554	<p>Colace.</p> <p>E. On 12/20/11 at 5:45 PM, employee J, RN, indicated no order for liquid colace was found in the record and the drug profile should have been updated when liquid Colace was added.</p> <p>The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-</p> <p>(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the interdisciplinary group maintained responsibility for directing, coordinating, and supervising the care and services provided in 2 of 11 active clinical records reviewed. (#5 and 7)</p> <p>Findings include:</p>	L0554	<p>The Medication Profile in clinical records #5 and #7 was reviewed and updated by the respective RN Case Managers on 12/21/11 to reflect medication changes so that it is current and accurate. The next scheduled IDG Plan of Care Review for the patient in clinical record #5 on 1/11/12 will include updates on the information sited as lacking on the 12/14/11 IDG Plan of Care Review, in addition to current updates. An in-service to nursing</p>	01/18/2012	

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	<p>1. The policy titled "Medication Administration," policy number 03-17, revised 8/30/2011, states, "Changes in the medication regimen must be included in the Plan of Care and discussed/approved by the Interdisciplinary Group (IDG). Medications are administered and documented on the Medication Profile in accordance with a specific order indicating all of the following: Name of patient, name of the medication, route, dosage, strength, dilution, frequency, duration, rate of infusion if applicable, special instructions or precautions if indicated, effective date, signature of physician. This includes administration of over-the-counter (OTC) medications and herbal compounds ... The nurse will record all medications administered to a patient in the clinical record. Each patient must have a current, accurate medication profile in the medical record."</p> <p>2. The policy titled "Interdisciplinary Group (IDG) Meeting," policy number 03-11, revised 8/30/2011, states, "The IDG will ensure that they maintain responsibility for directing, coordinating, and supervising the care and services provided ... There is ongoing sharing of</p>		<p>staff on Policy 03-17 "Medication Administration" was conducted by the Quality Manager on 12/28/11, with twelve of twenty-four RNs present. An in-service meeting will be conducted by the Quality Manager or designee on 1/5/12 to complete the in-service for all nursing staff not previously in-serviced on Policy 03-17. Any remaining nursing staff will be in-serviced regarding policy 03-17 "Medication Administration" by the Quality Manager or designee on or before 1/18/12. An in-service for all IDG members on Policy 03-11, "Interdisciplinary Group Meeting", was conducted for twenty-three IDG members by the Quality Manager on 12/28/11. An in-service meeting will be conducted by the Quality Manager or designee on 1/5/12 to in-service all IDG members not previously in-serviced on Policy 03-11. All remaining IDG members will be in-serviced on Policy 03-11 by the Quality Manager or designee on or before 1/18/12. All IDG members will be instructed to document changes and discussions regarding said changes on the IDG Plan of Care Review to facilitate sharing of information among all disciplines providing care and services in all settings. All RNs will be instructed to obtain orders for all medications and to keep the Medication Profile updated and current. The Quality Manager or designee will conduct</p>				

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	<p>information among all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement."</p> <p>3. Clinical record #5, start of care 11/10/11, included a review of the Certification Period from 11/10/11 to 2/7/2012. During a home visit at an assisted living center on 12/20/2011 at 10:00 AM, patient #5 was sleeping upon arrival and could not be aroused. Employee C, Social Worker, indicated that due to increased agitation, the patient was recently placed on Haldol by the Attending Physician. Employee C indicated that shortly after being placed on the medication, the patient became less responsive, less ambulatory, and had a fall. Employee C indicated the dose prescribed by the attending physician was questioned, and the dose was then cut in half. Employee C indicated they were monitoring the patient to make sure their responsiveness increased after the medication dose was cut in half. Review of the clinical record evidenced the following:</p> <p>A. A physician order dated 11/29/11 by the attending physician stated the following, "Rispodone [sic] 1 mg</p>		ongoing audits of ten charts per quarter to ensure 90% or greater compliance as part of the Quarterly Site Operations Audit. Results will be reported by the Quality Manager or designee to the Quality Assurance Performance Improvement (QAPI) Committee quarterly.		

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	<p>[milligram] po [by mouth] @ 8 PM daily [for] agitation" (Risperidone 1 milligram by mouth at 8 PM daily for agitation.)</p> <p>B. The "IDG [Interdisciplinary Group] Plan of Care Review" dated 11/30/11 indicated there were no "New/Changed Medications since last IDG Meeting."</p> <p>C. On 12/13/11, employee N, Licensed Practical Nurse (LPN), wrote in the "Nursing Focused Visit Note" at 1:20 PM that the patient was "very lethargic today wife with patient very upset. Pt [Patient] had a fall this AM [morning]. Spoke to [assisted living facility employee] upon entering unit who was concerned about pt not feeding [themselves] and not walking. Let her know she can hold Haloperidol. Pt to lethargic 1400 held. Advised to give HS [nighttime] pill to help [patient] eat. Wife very tearful pt has two areas above lt [left] eye and 1 on middle forehead. Hemotoma both areas and abrasions."</p> <p>D. The "IDG Plan of Care Review" dated 12/14/11 indicated there were "New/Changed Medications since last IDG Meeting." The medication listed was "Haldol 0.5 mg Q [every] AM and 2 PM 2 mg @ 8 PM [Haldol 0.5 milligram every</p>				

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	<p>morning and 2 PM and 2 milligrams at 8 PM]; Atrovent Nasal Spray 2 sprays each nostril twice dly [daily]." Under the section titled "Neuro/Cognitive/Behavioral" the "Summary of Progress Toward Goals" states, "Pt [patient] with increased aggression/agitation. Risperdol dc'd [discontinued] Haloperidol started." Under the section titled "Safety/Falls" the "Summary of Progress Toward Goals" states, "Pt with fall 12/7/11 - found on floor in common area." The Haloperidol medication change on 12/13/11 was not noted, nor was the fall on 12/13/11.</p> <p>E. Review of the record revealed no order for Haldol or Atrovent Nasal Spray.</p> <p>F. On 12/20/11 at 5 PM, employee B, RN case manager, indicated that there was no order in the hospice chart for the Haloperidol order. Employee B indicated they took a few days off of work that week and might have forget to get the order to place in the Hospice Facility chart. Employee B indicated they would ask the Assisted Living Facility to fax the order immediately.</p> <p>G. On 12/20/11 at 5:20 PM, the assisted living facility faxed the 2 orders. The first</p>			

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	<p>one was dated 12/8/11 stated, "D/C [discontinue] Risperidone [sic]. Start Haloperidol 0.5 mg @ 7 AM and 2 PM. 2 mg @ 8 PM [Haloperidol 0.5 milligram at 7 AM and 2 PM. 2 milligrams at 8 PM].</p> <p>The second order dated 12/13/11 stated, "Change Haloperidol to following orders. Haloperidol 0.25 mg BID [0.25 milligrams two times per day] Haloperidol 1 mg Q HS [1 milligram every night].</p> <p>H. The "Comprehensive Assessment Drug Profile - Physician Order" dated 11/10/11 failed to evidence Risperidone, Haloperidol, or Atrovent Nasal Spray.</p> <p>I. On 12/20 at 5:40 PM, employee J, Quality Assurance Manager/RN, indicated the orders should have been in the hospice chart, the medication profile should have been updated, and the medication changes/effects should have been discussed in the IDG meeting on 12/14/2011.</p> <p>4. Clinical record #7, start of care 10/21/11, included a review of the Certification Period from 10/21/11 to 1/20/2012. Review of the clinical record evidenced the following:</p> <p>A. On 12/14/11, employee P, RN, wrote</p>				

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	<p>in the "Nursing Focused Visit Note" that "Pt [patient] states [they] have not had a BM [bowel movement] x [for] 10 days, has taken an extra Colace today. This writer will request liquid form of Colace to be delivered, pt states this would be easier to take."</p> <p>B. On 12/16/11, employee P, RN, wrote in the "Nursing Focused Visit Note" that "Pt states she has not had a BM for 12 days, although [pt] seems somewhat unsure of number of days ... Pt has taken liquid Colace on 12/15/11."</p> <p>C. Review of the record revealed no order for liquid Colace.</p> <p>D. The "Comprehensive Assessment Drug Profile - Physician Order" dated 10/21/11 and the "Comprehensive Assessment Drug Profile Continuation" dated 12/9/11 failed to evidence liquid Colace.</p> <p>E. On 12/20/11 at 5:45 PM, employee J, RN, indicated no order for liquid colace was found in the record and the drug profile should have been updated when liquid Colace was added.</p>				

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L0628	<p>(4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.</p> <p>Based on job description review, clinical record review, and interview, the hospice failed to ensure the hospice aide reported changes in the patient's condition to a registered nurse in 1 of 10 active clinical records reviewed for patients receiving Hospice Aide Services. (#7)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A job description titled "Home Health Aide/Certified Nurse Assistant," revised 3/27/2009 states, "Observe the patient, report observations and document observations and are performed ... identify need for intervention by other members of interdisciplinary team on an ongoing basis and report to primary case manager."</li> <li>2. Clinical record #7 evidenced a Hospice Aide Assignment sheet completed by employee L, Registered Nurse (RN), on 10/21/11. The Hospice Aide Assignment</li> </ol>	L0628	To ensure immediate compliance, the Patient Care Manager met with the identified Hospice Aide on 12/21/11 to instruct her on the requirement to notify the RN Case Manger of any patient changes. On 12/29/11 the Quality Manager met with the identified Hospice Aide to review her notes on clinical record # 7 regarding the failure to report pain level of three or greater to an RN. The Hospice Aide was provided a copy of the job description titled "Home Health Aide/Certified Nurse Assistant" and the expectation of documenting and reporting changes to an RN was reviewed with her again. On 12/29/11 the Quality Manager conducted an in-service for Hospice Aide staff on the job description titled "Home Health Aide/Certified Nurse Assistant" and the expectation of documenting and reporting changes to an RN. Fifteen of nineteen Hospice Aides were present. An in-service meeting will be held on 1/5/12 to in-service all Hospice Aides not previously in-serviced on the Health Aide job description. Any remaining Hospice Aides will be in-serviced	01/18/2012	

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L0678	<p>sheet included a section titled "Pain" which stated, "Ask the patient to rate their pain between 0 and 10 on each visit and report to the Hospice RN/PCM pain that is greater than or equal to 3. If the patient cannot rate their pain, indicate that he/she is unable to report."</p> <p>A. Hospice Aide Visit Note completed by employee M, Hospice Aide, on 11/3/2011 evidenced a pain rating of 6 reported. There was no evidence that a RN was notified of the pain level greater than 3.</p> <p>B. Hospice Aide Visit Note completed by employee M on 12/8/11 evidenced a pain rating of 5 reported. There was no evidence that a RN was notified of the pain level greater than 3.</p> <p>3. On 12/20/11 at 4:30 PM, Employee J, RN, indicated that pain greater than 3 should have been reported to the nurse.</p> <p>[Each patient's record must include the following:] (7) Physician orders.</p> <p>Based on policy review, clinical record review, and interview, the agency failed</p>	L0678	<p>on or before 1/18/12 by the Quality Manager or designee. The Quality Manager or designee will conduct ongoing audits of ten charts per quarter to ensure 90% or greater compliance as part of the Quarterly Site Operations Audit. Results will be reported by the Quality Manager or designee to the Quality Assurance Performance Improvement (QAPI) Committee quarterly.</p> <p>Clinical records #5 and #7 were reviewed and updated by the respective RN Case Managers on</p>	01/18/2012	

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	<p>to ensure the clinical record contained physician orders for all medications in 2 of 11 active clinical records reviewed. (#5 and 7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled, "Physician's Orders," policy number 03-10, revised 8/30/2011, states, "All care and services prescribed for a patient require an order signed by a physician. Orders must be obtained prior to the provision of services requiring such orders."</li> <li>Clinical record #5, start of care 11/10/11, included a review of the Certification Period from 11/10/11 to 2/7/2012. During a home visit at an assisted living center on 12/20/2011 at 10:00 AM, patient #5 was sleeping upon arrival and could not be aroused. Employee C, Social Worker, indicated that do to increased agitation, the patient was recently placed on Haldol by the Attending Physician. Employee C indicated that shortly after being placed on the medication, the patient became less responsive, less ambulatory, and had a fall. Employee C indicated the dose prescribed by the attending physician was questioned, and the dose was then</li> </ol>		<p>12/21/11 to include physician orders for the medications identified as lacking a physician's order (Haldol, Atrovent Nasal Spray and liquid Colace). On 12/28/11 the Quality Manager conducted an in-service to nursing staff on Policy 03-10 "Physician's Orders", with twelve of twenty-four RNs present. An in-service meeting will be conducted by the Quality Manager or designee on 1/5/12 to in-service all nursing staff not previously in-serviced on Policy 03-10. The Quality Manager will ensure all nursing staff will be in-serviced regarding policy 03-10 "Physician's Orders" on or before 1/18/12. The Quality Manager or designee will conduct ongoing audits of ten charts per quarter to ensure 90% or greater compliance as part of the Quarterly Site Operations Audit. Results will be reported by the Quality Manager or designee to the Quality Assurance Performance Improvement (QAPI) Committee quarterly.</p>		

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	<p>cut in half. Employee C indicated they were monitoring the patient to make sure their responsiveness increased after the medication dose was cut in half. Review of the clinical record evidenced the following:</p> <p>A. The "IDG Plan of Care Review" dated 12/14/11, indicated there were "New/Changed Medications since last IDG Meeting." The medication listed was "Haldol 0.5 mg Q AM and 2 PM 2 mg @ 8 PM [Haldol 0.5 milligram every morning and 2 PM and 2 milligrams at 8 PM]; Atrovent Nasal Spray 2 sprays each nostril twice dly [daily]." Under the section titled "Neuro/Cognitive/Behavioral" the "Summary of Progress Toward Goals" states, "Pt [patient] with increased aggression/agitation. Risperdol dc'd [discontinued] Haloperidol started." Under the section titled "Safety/Falls" the "Summary of Progress Toward Goals" states, "Pt with fall 12/7/11 - found on floor in common area." The Haloperidol medication change on 12/13/11 was not noted, nor was the fall on 12/13/11.</p> <p>B. Review of the record revealed no order for Haldol or Atrovent Nasal Spray.</p>			

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	<p>C. On 12/20/11 at 5 PM, employee B, RN case manager, indicated that there was no order in the hospice chart for the Haloperidol order. Employee B indicated they took a few days off of work that week and might have forget to get the order to place in the Hospice Facility chart. Employee B indicated they would ask the Assisted Living Facility to fax the order immediately.</p> <p>D. On 12/20/11 at 5:20 PM, the assisted living facility faxed the 2 orders. The first one was dated 12/8/11 stated, "D/C [discontinue] Resperidone [sic]. Start Haloperidol 0.5 mg @ 7 AM and 2 PM. 2 mg @ 8 PM [Haloperidol 0.5 milligram at 7 AM and 2 PM. 2 milligrams at 8 PM]. The second order dated 12/13/11 stated, "Change Haloperidol to following orders. Haloperidol 0.25 mg BID [0.25 milligrams two times per day] Haloperidol 1 mg Q HS [1 milligram every night].</p> <p>E. On 12/20 at 5:40 PM, employee J, Quality Assurance Manager/RN, indicated the orders should have been in the hospice chart, the medication profile should have been updated and the medication changes/effects should have been discussed in the IDG meeting on 12/14/2011.</p>				

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	<p>3. Clinical record #7, start of care 10/21/11, included a review of the Certification Period from 10/21/11 to 1/20/2012. Review of the clinical record evidenced the following:</p> <p>A. On 12/14/11, employee P, RN, wrote in the "Nursing Focused Visit Note" that "Pt [patient] states [they] have not had a BM [bowel movement] x 10 days, has taken an extra Colace today. This writer will request liquid form of Colace to be delivered, pt states this would be easier to take."</p> <p>B. On 12/16/11, employee P, RN, wrote in the "Nursing Focused Visit Note" that "Pt states she has not had a BM for 12 days, although [pt] seems somewhat unsure of number of days ... Pt has taken liquid Colace on 12/15/11."</p> <p>C. Review of the record revealed no order for liquid Colace.</p> <p>D. On 12/20/11 at 5:45 PM, employee J, RN, indicated no order for liquid colace was found in the record and the drug profile should have been updated when liquid Colace was added.</p>			

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

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