

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/04/2012	
NAME OF PROVIDER OR SUPPLIER FIRST CHOICE IN HOME SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 2064 N OLD BRUCEVILLE RD VINCENNES, IN 47591			
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N0000	<p>This was a home health State re-licensure survey.</p> <p>Facility #: 010921</p> <p>Survey Dates: 12-3-12 and 12-4-12</p> <p>Medicaid Vendor #: N/A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">December 5, 2012</p>			N0000			

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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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had administered medications in accordance with the medical plan of care in 2 (#s 2 and 5) of 5 records reviewed creating the potential to affect all of the agency's 9 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a medical plan of care established by the physician for the certification period 10-3-12 to 12-1-12. The plan identified 17 medications had been ordered by the physician. The plan evidenced the skilled nurse was to provide services 3 to 5 times per week and states, "Respite nursing to . . . Administer meds [medications]."</p> <p>A. Skilled nurse visit notes, dated 10-3-12, 10-5-12, 10-8-12, 10-9-12, 10-10-12, 10-11-12, 10-12-12, 10-15-12, 10-16-12, 10-17-12, 10-18-12, 10-19-12, 10-22-12, 10-23-12, 10-24-12, 10-25-12, 10-26-12, 10-29-12, 10-30-12, 10-31-12, 11-1-12, 11-2-12, 11-5-12, 11-6-12,</p>	N0522	A medication administration form has been developed by the R.N. Supervisor. The R.N. Supervisor has inserviced all nursing staff on the use of the form and the requirements for medication administration in compliance with the medical plan of care. The R.N. Supervisor will review the medication administration form weekly to assure medications are being administered as ordered. The R.N. Supervisor will be responsible for monitoring these corrective actions to assure the deficiency is corrected and will not recur.	12/16/2012			

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	<p>11-7-12, 11-8-12, 11-9-12, 11-12-12, 11-13-12, 11-14-12, 11-15-12, 11-16-12, 11-18-12, 11-19-12, 11-20-12, 11-21-12, and 11-23-12, failed to evidence the skilled nurse had administered any medications to the patient.</p> <p>B. A home visit was made to patient number 2 on 12-4-12 at 9:20 AM Central time with employee C, the registered nurse. Employee C indicated she does administer medications to the patient. The employee stated, "I give 4 medications to the patient. And sometimes more if they are in the med planner then [the parent] has not given them. I usually chart when I give the meds in the nurse's note."</p> <p>2. Clinical record number 5 included a medical plan of care established by the physician for the certification period 11-3-12 to 1-1-13. The plan of care identified 11 medications had been ordered by the physician. The plan states, "Respite nursing 1-7 hours 2-6 times per wk [week] X 60 days . . . SN . . . administer meds."</p> <p>A. The plan of care identified Albuterol 2.5 milligrams (mg) 1 vial per nebulizer 4 times per day, Budesonide 0.5 mg per nebulizer 2 times per day, and Pulmozyme 1 vial per nebulizer 2 times</p>						

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	<p>per day were to be administered.</p> <p>B. Skilled nurse visit notes, dated 11-3-12, 11-6-12, 11-8-12, 11-9-12, 11-15-12, 11-16-12, 11-17-12, 11-27-12, 11-29-12, and 12-1-12, evidenced the registered nurse had administered the Albuterol but failed to evidence any other medications had been administered as ordered.</p> <p>C. The skilled nurse visit notes listed above evidenced the skilled nurse had administered the Albuterol with "vest CPT" each time. The plan of care failed to evidence an order for the "vest CPT" treatment.</p> <p>D. A skilled nurse visit note dated 11-20-12 evidenced the skilled nurse had applied a topical medication, Desitin, and a dressing to the patient's gastrostomy tube insertion site. The clinical record failed to include an order for the Desitin and the application of a dressing to the insertion site.</p> <p>3. The administrator, employee A, stated, on 12-3-12 at 12:15 PM Central time, "We do not keep separate medication administration records. It should be in the skilled nurse notes when medications are administered."</p>						

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	4. The supervising nurse, employee B, was unable to provide any additional documentation and/or information when asked on 12-4-12 at 11:15 AM Central time.			

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N0527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had informed the physician of a change in the patient's skin integrity in 1 (#5) of 5 records reviewed creating the potential to affect all of the agency's 9 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 5 included a skilled nurse visit note signed and dated by employee J on 11-20-12. The note evidenced the nurse had started the patient's gastrostomy tube feeding and stated, "Site red & inflammed [sic] Desitin and drsg [dressing] applied." <p>The record failed to evidence the RN had informed the physician of the condition of the patient's gastrostomy tube insertion site and had obtained an order for the topical medication and the application of the dressing.</p> <ol style="list-style-type: none"> 2. The supervising nurse, employee B, was unable to provide any additional 	N0527	<p>The R.N. Supervisor has inserviced all nursing staff on the requirment for alerting physician to any and all medical changes, including simple medical issues. This inservice has also covered the need for orders for OTC as well as prescription medications. The R.N. Supervisor will review Nursing documentation weekly to assure all medical changes are reported to the physician and orders for all medications have been obtained. The R.N. Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/13/2012			

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	documentation and/or information when asked on 12-4-12 at 11:15 AM Central time.			

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had administered medications in accordance with the medical plan of care in 2 (#s 2 and 5) of 5 records reviewed creating the potential to affect all of the agency's 9 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a medical plan of care established by the physician for the certification period 10-3-12 to 12-1-12. The plan identified 17 medications had been ordered by the physician. The plan evidenced the skilled nurse was to provide services 3 to 5 times per week and states, "Respite nursing to . . . Administer meds [medications]."</p> <p>A. Skilled nurse visit notes, dated 10-3-12, 10-5-12, 10-8-12, 10-9-12, 10-10-12, 10-11-12, 10-12-12, 10-15-12, 10-16-12, 10-17-12, 10-18-12, 10-19-12, 10-22-12, 10-23-12, 10-24-12, 10-25-12, 10-26-12, 10-29-12, 10-30-12, 10-31-12, 11-1-12, 11-2-12, 11-5-12, 11-6-12,</p>	N0537	<p>A medication administration form has been developed by the R.N. Supervisor. The R.N. Supervisor has inserviced all nursing staff on the use of this form and the requirements for medication administration in compliance with the medical plan of care. The inservice also included the rule for physician's orders for all medications, including OTC medications and the rule for physician's orders for all treatments administered to clients during the course of care. The R.N. Supervisor will review all medication administration forms and nursing notes each week to assure that medications are being administered according to the medical plan of care and that physician's orders are present for all medications and treatments being administered by nursing staff. The R.N. Supervisor will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.</p>	12/16/2012			

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	<p>per day were to be administered.</p> <p>B. Skilled nurse visit notes, dated 11-3-12, 11-6-12, 11-8-12, 11-9-12, 11-15-12, 11-16-12, 11-17-12, 11-27-12, 11-29-12, and 12-1-12, evidenced the registered nurse had administered the Albuterol but failed to evidence any other medications had been administered as ordered.</p> <p>C. The skilled nurse visit notes listed above evidenced the skilled nurse had administered the Albuterol with "vest CPT" each time. The plan of care failed to evidence an order for the "vest CPT" treatment.</p> <p>D. A skilled nurse visit note dated 11-20-12 evidenced the skilled nurse had applied a topical medication, Desitin, and a dressing to the patient's gastrostomy tube insertion site. The clinical record failed to include an order for the Desitin and the application of a dressing to the insertion site.</p> <p>3. The administrator, employee A, stated, on 12-3-12 at 12:15 PM Central time, "We do not keep separate medication administration records. It should be in the skilled nurse notes when medications are administered."</p>						

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	4. The supervising nurse, employee B, was unable to provide any additional documentation and/or information when asked on 12-4-12 at 11:15 AM Central time.			

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N0546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had informed the physician of a change in the patient's skin integrity in 1 (#5) of 5 records reviewed creating the potential to affect all of the agency's 9 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a skilled nurse visit note signed and dated by employee J on 11-20-12. The note evidenced the nurse had started the patient's gastrostomy tube feeding and stated, "Site red & inflamed [sic] Desitin and drsg [dressing] applied."</p> <p>The record failed to evidence the RN had informed the physician of the condition of the patient's gastrostomy tube insertion site and had obtained an order</p>	N0546	The R.N. Supervisor has inserviced all nursing staff on the requirement for alerting the physician to any change in condition, including simple medical issues. The inservice also included obtaining physician's orders for even simple medical issues and orders including OTC medications or treatments. The R.N. Supervisor will review all nursing documentation each week to assure any changes in condition have been reported to the physician and orders obtained and written as needed. The R.N. Supervisor will be responsible for monitoring these corrective actions to assure the deficiency is corrected and will not recur.	12/13/2012			

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	<p>for the topical medication and the application of the dressing.</p> <p>2. The supervising nurse, employee B, was unable to provide any additional documentation and/or information when asked on 12-4-12 at 11:15 AM Central time.</p>			