

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/04/2012
NAME OF PROVIDER OR SUPPLIER  MAXIM HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD STE 630 EVANSVILLE, IN 47715		
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G0000	<p>This was a federal home health complaint investigation.</p> <p>Complaint Number IN000113096 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey Date: 9-4-12</p> <p>Facility #: 012153</p> <p>Medicaid Vendor #: 200484160E</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>September 10, 2012</p>	G0000			

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

TITLE

(X6) DATE

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

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G0107	<p><b>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</b></p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure it had maintained documentation of complaint investigations in 11 (patients #s 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) of 11 incident reports reviewed creating the potential to affect all of the agency's 103 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records included 3 (patients # 2, 6, and 7) incident reports of patients and/or family members alleging "suspected abuse / neglect / endangerment by . . . Maxim employee." The agency failed to provide documentation of the investigation of the complaints of abuse / neglect / endangerment.</li> <li>2. The agency's administrative records included 3 (patients # 8, 19, and 10)</li> </ol>	G0107	G 0107 All complaints/allegations of abuse, neglect, theft/exploitation, etc. will be reviewed on a weekly basis during the office weekly meetings. The Administrator and DOCS will be responsible for ensuring all complaints are followed up on and documented with a resolution. All investigative materials shall be maintained in the Administrator or DOCS office. The deficiency will be corrected by 10/4/2012.	10/04/2012	

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	<p>incident reports of patients and/or family members alleging "property loss / breakage / theft . . . controlled substances." The agency failed to provide documentation of the investigation of complaints of theft of medications.</p> <p>3. The agency's administrative records included 2 (patients # 11 and 12) incident reports of patients and/or family members alleging "property loss / breakage / theft . . . patient personal property." The agency failed to provide documentation of the investigation of complaints of theft of personal property.</p> <p>4. The agency's administrative records included 1 (patient number 13) incident report of patients and/or family members alleging "other allegation that employee smoking marijuana." The agency failed to provide documentation of the investigation of the complaint regarding illegal drug use in the home.</p> <p>5. The agency's administrative records included 1 (patient number 14) incident report of patients and/or family members alleging "other allegation of privacy violation." The agency failed to provide documentation of the investigation of the complaint regarding privacy violation.</p> <p>6. The agency's administrative records</p>			

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	<p>included 1 (patient number 5) incident report of patient and/or family members complaints regarding the nurse's competency to maintain the patient's tracheotomy. The incident report identifies the tracheotomy tube "became dislodged" and the parent was concerned "that nurse did not recognize tracheostomy [sic] was dislodged." The agency failed to provide documentation of the investigation of the complaint regarding the nurse's competence.</p> <p>7. During the entrance conference, on 9-4-12 at 11:45 AM, a request was made to the administrator, employee A, and the supervising nurse, employee B, for the agency's complaint documentation.</p> <p>A. On 9-4-12 at 1:00 PM, the supervising nurse, employee B, indicated there was other documentation regarding the agency's investigation of complaints in addition to the "Grievance Log" that had been provided to the surveyor. The employee indicated the documentation was on the computer and that there were incident reports. A request was made at this time to see the additional documentation.</p> <p>B. On 9-4-12 at 1:20 PM, the administrator, employee A, indicated the incident reports were "at corporate." A</p>				

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	<p>request was made to see any documentation of complaint investigations.</p> <p>C. On 9-4-12 at 1:35 PM, the administrator, employee A, indicated the incident reports investigations would be provided to the surveyor but that "they probably will not have what you need." A request was made to provide documentation of the investigation of complaints received by the agency.</p> <p>D. On 9-4-12 at 2:02 PM, the administrator, employee A, stated, "I've called them [corporate office] and sent e-mails that you want the incident report investigations."</p> <p>E. On 9-4-12 at 2:10 PM, the administrator, employee A, stated, "I received an e-mail and will get those IRs [incident reports] to you as soon as I get them."</p> <p>F. The incident reports were received at 2:30 PM on 9-4-12. The reports failed to include documentation of the investigation of the complaints and allegations.</p> <p>G. The supervising nurse, employee B, stated, on 9-4-12 at 2:55 PM, "We have investigative reports. I cannot give</p>						

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	<p>them to you."</p> <p>H. On 9-4-12 at 4:01 PM, the complaint investigation documentation was requested from the administrator, employee A. The administrator stated, "Our attorneys will not let me give you the [investigative] reports."</p> <p>8. The agency's 6-21-12 "Grievance and Complaints" policy number HH-ERR-005.2 states, "The DOCS [director of clinical services], clinical designee or AM [accounts manager] shall enter the grievance in the system of record. A recording of all investigative activities, outcomes, and analyses shall be included in the report. The documentation shall be maintained in the Grievance Binder. As necessary, the DOCS, clinical designee or AM may create an Incident Report."</p>				

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G0157	<p><b>484.18</b> <b>ACCEPTANCE OF PATIENTS, POC, MED SUPER</b> Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Based on clinical record and agency policy review and interview, the agency failed to ensure it could provide needed services to patients that had been accepted for care in 2 (#s 1 &amp; 2 ) of 5 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 7-16-12 to 9-13-12. The plan of care identified skilled nursing (SN) was to be provided 3 to 5 days per week for 26-40 hours per week for 9 weeks and that the services would not start until approval from the payer source had been received.</p> <p>A. The record included a "Client / Facility Logging Report" dated 7-17-12 and signed electronically by the supervising nurse, employee B, that states, "Nurse [employee C] called in to inform us she would not be staffing this case as she has taken another position. I [employee B, the supervising nurse]</p>	G0157	<p><b>G 0157 Administrator, DOCS, Recruiters, Clinical Supervisors, and Personnel Coordinators will be re-educated on Maxim policy HH-CL-006. Specifically, education on section 3.5 of that policy that states "Patients will be accepted for services based on the adequacy and suitability of the personnel, resources to provide requires services, and the reasonable expectation that the patient's medical, nursing, rehabilitative, and/or social needs can be adequately met in the patient's place of residence." Re-education will be completed by 10/4/2012. Administrator, DOCS, Recruiters, Clinical Supervisors, and Personnel Coordinators will be re-educated on the process to follow to ensure availability of staff for new admissions. Once a referral is received the Administrator/DOCS will meet with the Recruiters, Clinical Supervisors, and Personnel Coordinators to check on staff availability. If staff is available, then admission is scheduled.</b></p>	10/04/2012	

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	<p>called [patient's parent] to inform [the parent] of this recent change in having an available nurse to staff case. We will continue to recruit for this position."</p> <p>B. The record included a "Client / Facility Logging Report" dated 8-14-12 and signed electronically by the supervising nurse, employee B, that states, "This case has not been staffed since admission because plans are we will staff when school starts. RN that was to staff this case has resigned which leaves no nurse available to staff case when school starts."</p> <p>C. The record included a discharge summary dated 8-20-12 that states, "Admitted client on 7-16-12. Nurse scheduled to do visit called and quit. Unable to find another nurse on such short notice. Family . . . requested discharge."</p> <p>D. The supervising nurse, employee B, indicated, on 9-4-12 at 2:20 PM, the agency did not have another nurse available to provide services to this patient.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 7-28-12 to 9-25-12 that identified that SN was to be</p>		<p><b>If staff is not available then referral is declined at that time. Re-education will be completed by 10/4/2012. Administrator, DOCS, Recruiters, Clinical Supervisors, and Personnel Coordinators will be re-educated on the process to follow if staff becomes unavailable. If the client is not a current client, then we will not admit and decline the referral. If client is an active client and staff becomes unavailable we will 1. Check availability of all active field staff 2. Communicate to family if additional staff is available or not and 3. Recruit new staff for open shifts. Re-education will be completed by 10/4/2012.</b></p>				

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	<p>provided 4 to 6 days per week and 27 to 45 hours per week for 9 weeks. The plan of care also states, "Client also has 60 hours per month of respite waiver nursing for 9 weeks."</p> <p>A. The record failed to evidence any SN services had been provided the week of 8-5-12. The record included a "Missed Visit / Shift Notification" note dated 8-15-12 that identified SN visits had not been provided on 8-6-12, 8-7-12, and 8-8-12 due to "employee availability."</p> <p>B. The record included a "Communication Note", signed and dated by employee D, the alternate supervising nurse, on 7-27-12 that states, "This case is not currently staffed due to care related staffing issues."</p> <p>C. The supervising nurse, employee B, stated, on 9-4-12 at 2:45 PM, "There was no nurse available [to provide services to the patient]."</p> <p>3. The agency's 2-15-11 "Acceptance and/or Admission of Patients" policy number HH-CL-006 states, "Patients will be accepted for service based on the adequacy and suitability of the personnel, resources to provide required services, and the reasonable expectation that the patient's medical, nursing, rehabilitative,</p>				

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	and/or social needs can be adequately met in the patient's place of residence."			

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G0158	<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 clinical record and agency policy review and interview, the agency failed to ensure medications had been administered and assessments had been completed as ordered by the physician on the written plan of care in 2 (#s 3 &amp; 4) of 5 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 7-25-12 to 9-22-12. The plan of care identified the skilled nurse (SN) was to administer medications as ordered by the physician.</p> <p>A. The plan identified the following medications were to be administered daily: Baclofen 1233.3 micrograms (mcg) per day per automatic pump, Artane 2 milligram (mg) tab 1 1/2 tabs daily in pm, Baclofen 10 mg tab, 1 1/2 tabs daily in pm, Rhinocort 180 mcg/act, instill 1 spray into each nostril daily, Claritin 5mg/5 milliliters (ml) give 10 ml daily, Jolessa 0.15/0.03 mg tab give 1 tab once daily, Melatonin, 1mg/ml, give 3-5</p>	G0158	G 0158 The Director of Clinical Services educated Clinical Supervisors on 9/13/12 the process to review field staff notes in the areas of assessments and medication administration to assure assessments and medication administration are documented correctly per physician order. The proof of education is documented on meeting agenda dated 9/13/12. The Clinical Supervisors audit 100% of field staff notes on a ongoing basis and will identify assessments and medication administration documented that have not followed the plan of care as directed by physician order. The Clinical Supervisors upon identification of field staff not following the plan of care as directed by physician order will contact field staff skilled nurse, provide education and log that education into the system of record. In the event when re-education has been required the Clinical Supervisor will identify improvements then log into system of record demonstrating successful re-education has occurred in regards to correct documentation of assessments and medication	10/04/2012			

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	<p>ml at bedtime, Zolpidem Tartrate 10 mg tab give 1 tab daily at bedtime, Bactroban thin film apply thin film to bilateral nostrils daily, Saline nasal spray 1 spray instill one spray into each nostril 2 times daily, Valium 5mg/5ml liquid give 6-8 ml three times daily, Artane 2 mg tab give 4 mgs (2 tabs) 2 times daily in am and pm, Baclofen 10 mg tab take 1 tab twice daily in am and pm, Zanaflex 2 mg tab give 1 tab three times daily, and Neurontin 250 mg/5ml suspension three times daily.</p> <p>B. A SN visit note dated 7-31-12 evidenced employee D, a registered nurse, provided care to the patient from 8:00 AM to 3:00 PM. The medication administration record (MAR) dated 7-31-12 failed to evidence the nurse had administered the morning and afternoon medications of Bactroban thin film and Claritin as ordered by the physician.</p> <p>C. A SN visit note dated 8-2-12 evidenced employee D, a registered nurse, provided care to the patient from 5:30 PM to 8:30 PM. The record failed to evidence any medications had been administered by the nurse on this date.</p> <p>D. A SN visit note dated 8-3-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00 AM to 11:00 AM. The MAR dated</p>		<p>administration as directed by physician. If no improvements have been made the Clinical Supervisor will inform Director of Clinical Services and an individual performance improvement will be initiated for those skilled nurses at that time and logged into the system of record. To ensure that this deficiency does not recur the Director of Clinical Services will audit 10% of the medical records per quarter for documentation that assessments and medication administration has been conducted and documented per physician order. The Director of Clinical Services will formulate mailer and send to all Active Skilled nurses and Clinical Supervisors for education in regards to how to properly document assessments and medication administration as directed per physician order and log that mailer sent into individual employee system of record.</p>				

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	<p>8-3-12 failed to evidence the nurse had administered the daily morning medications of Bactroban thin film, Claritin, Rhinocort, Artane, Saline nasal spray, and Zanaflex.</p> <p>E. A SN visit notes dated 8-7-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00 AM to 3:00 PM and again from 5:30 PM to 8:30 PM. The MAR dated 8-7-12 failed to evidence the nurse had administered the daily morning and evening medications of Bactroban thin film, Claritin, Rhinocort,, Artane, Baclofen 10 mg tab, and Saline nasal spray.</p> <p>F. A SN visit note dated 8-14-12 evidenced employee D, a registered nurse, had provided care to the patient from 6:55 AM to 2:00 PM. The MAR dated 8-14-12 failed to evidence the nurse had administered the morning medications of Bactroban thin film, Claritin, Rhinocort, Artane 2 mg, and Saline nasal spray.</p> <p>G. The supervising nurse, employee B, indicated, on 9-4-12 at 3:30 PM, the record did not include documentation the nurse had administered the medications as ordered on the plan of care. The supervising nurse stated, "They may have been given by the patient's parent. There</p>						

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	<p>is no way to tell on the MAR if the medications were given or not."</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 8-22-12 to 10-20-12 that states, "SN 5-7 days a week, 72-120 hours/month . . . Monitor and document pain assessment at least every two hours."</p> <p>A. A SN visit note, signed and dated by employee F, a registered nurse, on 8-22-12, failed to evidence any pain assessments had been completed. The note evidenced the nurse provided care to the patient from 8:35 AM to 4:10 PM.</p> <p>B. A SN visit note, signed and dated by employee F, a registered nurse, on 8-23-12, failed to evidence any pain assessments had been completed after the nurse's arrival at 8:00 AM at which time the nurse charted "no pain." The note evidenced the nurse had provided care to the patient from 8:00 AM to 4:05 PM.</p> <p>C. A SN visit note, signed and dated by employee F, a registered nurse, on 8-24-12, evidenced the nurse provided care to the patient from 8:02 AM to 4:05 PM. The note failed to evidence the nurse had assessed the patient's pain at least every 2 hours. The note evidenced the</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>nurse assessed the patient's pain at 1:00 PM and 1:30 PM only.</p> <p>D. A SN visit note, signed and dated by employee G, a licensed practical nurse (LPN) on 8-25-12, failed to evidence the nurse had assessed the patient's pain at least every 2 hours. The note evidenced a pain assessment had been completed at 8:00 AM upon the nurse's arrival to the home and not again until 11:00 AM. The note evidenced a pain assessment had been completed at 1:30 PM with no further assessment documented. The note evidenced the LPN provided care to the patient from 8:00 AM to 4:00 PM.</p> <p>E. The supervising nurse, employee B, stated, on 9-4-12 at 4:10 PM, "I know the pain assessments were not done every 2 hours."</p> <p>3. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care (485) is the physician's order for home care services."</p>				

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G0170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the registered nurse failed to ensure medications had been administered and assessments had been completed as ordered by the physician on the written plan of care in 2 (#s 3 &amp; 4) of 5 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 7-25-12 to 9-22-12. The plan of care identified the skilled nurse (SN) was to administer medications as ordered by the physician.</p> <p>A. The plan identified the following medications were to be administered daily: Baclofen 1233.3 micrograms (mcg) per day per automatic pump, Artane 2 milligram (mg) tab 1 1/2 tabs daily in pm, Baclofen 10 mg tab, 1 1/2 tabs daily in pm, Rhinocort 180 mcg/act, instill 1 spray into each nostril daily, Claritin 5mg/5 milliliters (ml) give 10 ml daily, Jolessa 0.15/0.03 mg tab give 1 tab once daily, Melatonin, 1mg/ml, give 3-5 ml at bedtime, Zolpidem Tartrate 10 mg tab give 1 tab daily at bedtime, Bactroban</p>	G0170	G 0170 The Director of Clinical Services educated Clinical Supervisors on 9/13/12 the process to review field staff notes in the areas of assessments and medication administration to assure assessments and medication administration are documented correctly per physician order. The proof of education is documented on meeting agenda dated 9/13/12. The Clinical Supervisors audit 100% of field staff notes on a ongoing basis and will identify assessments and medication administration documented that have not followed the plan of care as directed by physician order. The Clinical Supervisors upon identification of field staff not following the plan of care as directed by physician order will contact field staff skilled nurse, provide education and log that education into the system of record. In the event when re-education has been required the Clinical Supervisor will identify improvements then log into system of record demonstrating successful re-education has occurred in regards to correct documentation of assessments and medication administration as directed by physician. If no improvements have been made the Clinical	10/04/2012			

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	<p>thin film apply thin film to bilateral nostrils daily, Saline nasal spray 1 spray instill one spray into each nostril 2 times daily, Valium 5mg/5ml liquid give 6-8 ml three times daily, Artane 2 mg tab give 4 mgs (2 tabs) 2 times daily in am and pm, Baclofen 10 mg tab take 1 tab twice daily in am and pm, Zanaflex 2 mg tab give 1 tab three times daily, and Neurontin 250 mg/5ml suspension three times daily.</p> <p>B. A SN visit note dated 7-31-12 evidenced employee D, a registered nurse, provided care to the patient from 8:00 AM to 3:00 PM. The medication administration record (MAR) dated 7-31-12 failed to evidence the nurse had administered the morning and afternoon medications of Bactroban thin film and Claritin as ordered by the physician.</p> <p>C. A SN visit note dated 8-2-12 evidenced employee D, a registered nurse, provided care to the patient from 5:30 PM to 8:30 PM. The record failed to evidence any medications had been administered by the nurse on this date.</p> <p>D. A SN visit note dated 8-3-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00 AM to 11:00 AM. The MAR dated 8-3-12 failed to evidence the nurse had administered the daily morning</p>		Supervisor will inform Director of Clinical Services and an individual performance improvement will be initiated for those skilled nurses at that time and logged into the system of record. To ensure that this deficiency does not recur the Director of Clinical Services will audit 10% of the medical records per quarter for documentation that assessments and medication administration has been conducted and documented per physician order. The Director of Clinical Services will formulate mailer and send to all Active Skilled nurses and Clinical Supervisors for education in regards to how to properly document assessments and medication administration as directed per physician order and log that mailer sent into individual employee system of record.				

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	<p>medications of Bactroban thin film, Claritin, Rhinocort, Artane, Saline nasal spray, and Zanaflex.</p> <p>E. A SN visit notes dated 8-7-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00 AM to 3:00 PM and again from 5:30 PM to 8:30 PM. The MAR dated 8-7-12 failed to evidence the nurse had administered the daily morning and evening medications of Bactroban thin film, Claritin, Rhinocort,, Artane, Baclofen 10 mg tab, and Saline nasal spray.</p> <p>F. A SN visit note dated 8-14-12 evidenced employee D, a registered nurse, had provided care to the patient from 6:55 AM to 2:00 PM. The MAR dated 8-14-12 failed to evidence the nurse had administered the morning medications of Bactroban thin film, Claritin, Rhinocort, Artane 2 mg, and Saline nasal spray.</p> <p>G. The supervising nurse, employee B, indicated, on 9-4-12 at 3:30 PM, the record did not include documentation the nurse had administered the medications as ordered on the plan of care. The supervising nurse stated, "They may have been given by the patient's parent. There is no way to tell on the MAR if the medications were given or not."</p>				

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	<p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 8-22-12 to 10-20-12 that states, "SN 5-7 days a week, 72-120 hours/month . . . Monitor and document pain assessment at least every two hours."</p> <p>A. A SN visit note, signed and dated by employee F, a registered nurse, on 8-22-12, failed to evidence any pain assessments had been completed. The note evidenced the nurse provided care to the patient from 8:35 AM to 4:10 PM.</p> <p>B. A SN visit note, signed and dated by employee F, a registered nurse, on 8-23-12, failed to evidence any pain assessments had been completed after the nurse's arrival at 8:00 AM at which time the nurse charted "no pain." The note evidenced the nurse had provided care to the patient from 8:00 AM to 4:05 PM.</p> <p>C. A SN visit note, signed and dated by employee F, a registered nurse, on 8-24-12, evidenced the nurse provided care to the patient from 8:02 AM to 4:05 PM. The note failed to evidence the nurse had assessed the patient's pain at least every 2 hours. The note evidenced the nurse assessed the patient's pain at 1:00 PM and 1:30 PM only.</p>						

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	<p>D. A SN visit note, signed and dated by employee G, a licensed practical nurse (LPN) on 8-25-12, failed to evidence the nurse had assessed the patient's pain at least every 2 hours. The note evidenced a pain assessment had been completed at 8:00 AM upon the nurse's arrival to the home and not again until 11:00 AM. The note evidenced a pain assessment had been completed at 1:30 PM with no further assessment documented. The note evidenced the LPN provided care to the patient from 8:00 AM to 4:00 PM.</p> <p>E. The supervising nurse, employee B, stated, on 9-4-12 at 4:10 PM, "I know the pain assessments were not done every 2 hours."</p> <p>3. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care (485) is the physician's order for home care services."</p>				

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N0450	<p>410 IAC 17-12-1(c)(7) Home health agency administration/management Rule 12 Sec. 1(c)(7) The administrator, who may also be the supervising physician or registered nurse required by subsection (d) of this rule, shall do the following: (7) Upon request, make available to the Commissioner or his or her designated agent all: (A) reports; (B) records; (C) minutes; (D) documentation; (E) information; and (F) files; required to determine compliance within seventy-two (72) hours of the request or, in the event the request is made in conjunction with a survey, by the time the surveyor exits the home health agency, whichever is sooner.</p> <p>Based on administrative record review and interview, the administrator failed to make all documentation related to complaint investigations available to the surveyor in 11 ( patients #s 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) of 11 incident reports reviewed.</p> <p>The findings include:</p> <p>1. The agency's administrative records included 3 (patients # 2, 6, and 7) incident reports of patients and/or family members alleging "suspected abuse / neglect / endangerment by . . . Maxim employee." The agency failed to provide</p>	N0450	N 0450 All complaints/allegations of abuse, neglect, theft/exploitation, etc. will be reviewed on a weekly basis during the office weekly meetings. The Administrator and DOCS will be responsible for ensuring all complaints are followed up on and documented with a resolution. All investigative materials shall be maintained in the Administrator or DOCS office. The deficiency will be corrected by 10/4/2012.	10/04/2012			

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	<p>documentation of the investigation of the complaints of abuse / neglect / endangerment.</p> <p>2. The agency's administrative records included 3 (patients # 8, 19, and 10) incident reports of patients and/or family members alleging "property loss / breakage / theft . . . controlled substances." The agency failed to provide documentation of the investigation of complaints of theft of medications.</p> <p>3. The agency's administrative records included 2 (patients # 11 and 12) incident reports of patients and/or family members alleging "property loss / breakage / theft . . . patient personal property." The agency failed to provide documentation of the investigation of complaints of theft of personal property.</p> <p>4. The agency's administrative records included 1 (patient number 13) incident report of patients and/or family members alleging "other allegation that employee smoking marijuana." The agency failed to provide documentation of the investigation of the complaint regarding illegal drug use in the home.</p> <p>5. The agency's administrative records included 1 (patient number 14) incident report of patients and/or family members</p>			

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	<p>alleging "other allegation of privacy violation." The agency failed to provide documentation of the investigation of the complaint regarding privacy violation.</p> <p>6. The agency's administrative records included 1 (patient number 5) incident report of patient and/or family members complaints regarding the nurse's competency to maintain the patient's tracheotomy. The incident report identifies the tracheotomy tube "became dislodged" and the parent was concerned "that nurse did not recognize tracheostomy [sic] was dislodged." The agency failed to provide documentation of the investigation of the complaint regarding the nurse's competence.</p> <p>7. During the entrance conference, on 9-4-12 at 11:45 AM, a request was made to the administrator, employee A, and the supervising nurse, employee B, for the agency's complaint documentation.</p> <p>A. On 9-4-12 at 1:00 PM, the supervising nurse, employee B, indicated there was other documentation regarding the agency's investigation of complaints in addition to the "Grievance Log" that had been provided to the surveyor. The employee indicated the documentation was on the computer and that there were incident reports. A request was made at</p>			

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	<p>this time to see the additional documentation.</p> <p>B. On 9-4-12 at 1:20 PM, the administrator, employee A, indicated the incident reports were "at corporate." A request was made to see any documentation of complaint investigations.</p> <p>C. On 9-4-12 at 1:35 PM, the administrator, employee A, indicated the incident reports investigations would be provided to the surveyor but that "they probably will not have what you need." A request was made to provide documentation of the investigation of complaints received by the agency.</p> <p>D. On 9-4-12 at 2:02 PM, the administrator, employee A, stated, "I've called them [corporate office] and sent e-mails that you want the incident report investigations."</p> <p>E. On 9-4-12 at 2:10 PM, the administrator, employee A, stated, "I received an e-mail and will get those IRs [incident reports] to you as soon as I get them."</p> <p>F. The incident reports were received at 2:30 PM on 9-4-12. The reports failed to include documentation of the</p>				

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	<p>investigation of the complaints and allegations.</p> <p>G. The supervising nurse, employee B, stated, on 9-4-12 at 2:55 PM, "We have investigative reports. I cannot give them to you."</p> <p>H. On 9-4-12 at 4:01 PM, the complaint investigation documentation was requested from the administrator, employee A. The administrator stated, "Our attorneys will not let me give you the [investigative] reports."</p>			

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N0514	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure it had maintained documentation of complaint investigations in 11 (patients #s 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) of 11 incident reports reviewed creating the potential to affect all of the agency's 103 current patients.</p> <p>The findings include:</p> <p>1. The agency's administrative records included 3 (patients # 2, 6, and 7) incident reports of patients and/or family members alleging "suspected abuse / neglect / endangerment by . . . Maxim employee." The agency failed to provide documentation of the investigation of the complaints of abuse / neglect /</p>	N0514	N 0514 All complaints/allegations of abuse, neglect, theft/exploitation, etc. will be reviewed on a weekly basis during the office weekly meetings. The Administrator and DOCS will be responsible for ensuring all complaints are followed up on and documented with a resolution. All investigative materials shall be maintained in the Administrator or DOCS office. The deficiency will be corrected by 10/4/2012.	10/04/2012			

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	<p>endangerment.</p> <p>2. The agency's administrative records included 3 (patients # 8, 19, and 10) incident reports of patients and/or family members alleging "property loss / breakage / theft . . . controlled substances." The agency failed to provide documentation of the investigation of complaints of theft of medications.</p> <p>3. The agency's administrative records included 2 (patients # 11 and 12) incident reports of patients and/or family members alleging "property loss / breakage / theft . . . patient personal property." The agency failed to provide documentation of the investigation of complaints of theft of personal property.</p> <p>4. The agency's administrative records included 1 (patient number 13) incident report of patients and/or family members alleging "other allegation that employee smoking marijuana." The agency failed to provide documentation of the investigation of the complaint regarding illegal drug use in the home.</p> <p>5. The agency's administrative records included 1 (patient number 14) incident report of patients and/or family members alleging "other allegation of privacy violation." The agency failed to provide</p>			

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	<p>documentation of the investigation of the complaint regarding privacy violation.</p> <p>6. The agency's administrative records included 1 (patient number 5) incident report of patient and/or family members complaints regarding the nurse's competency to maintain the patient's tracheotomy. The incident report identifies the tracheotomy tube "became dislodged" and the parent was concerned "that nurse did not recognize tracheostomy [sic] was dislodged." The agency failed to provide documentation of the investigation of the complaint regarding the nurse's competence.</p> <p>7. During the entrance conference, on 9-4-12 at 11:45 AM, a request was made to the administrator, employee A, and the supervising nurse, employee B, for the agency's complaint documentation.</p> <p>A. On 9-4-12 at 1:00 PM, the supervising nurse, employee B, indicated there was other documentation regarding the agency's investigation of complaints in addition to the "Grievance Log" that had been provided to the surveyor. The employee indicated the documentation was on the computer and that there were incident reports. A request was made at this time to see the additional documentation.</p>			

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	<p>B. On 9-4-12 at 1:20 PM, the administrator, employee A, indicated the incident reports were "at corporate." A request was made to see any documentation of complaint investigations.</p> <p>C. On 9-4-12 at 1:35 PM, the administrator, employee A, indicated the incident reports investigations would be provided to the surveyor but that "they probably will not have what you need." A request was made to provide documentation of the investigation of complaints received by the agency.</p> <p>D. On 9-4-12 at 2:02 PM, the administrator, employee A, stated, "I've called them [corporate office] and sent e-mails that you want the incident report investigations."</p> <p>E. On 9-4-12 at 2:10 PM, the administrator, employee A, stated, "I received an e-mail and will get those IRs [incident reports] to you as soon as I get them."</p> <p>F. The incident reports were received at 2:30 PM on 9-4-12. The reports failed to include documentation of the investigation of the complaints and allegations.</p>				

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	<p>G. The supervising nurse, employee B, stated, on 9-4-12 at 2:55 PM, "We have investigative reports. I cannot give them to you."</p> <p>H. On 9-4-12 at 4:01 PM, the complaint investigation documentation was requested from the administrator, employee A. The administrator stated, "Our attorneys will not let me give you the [investigative] reports."</p> <p>8. The agency's 6-21-12 "Grievance and Complaints" policy number HH-ERR-005.2 states, "The DOCS [director of clinical services], clinical designee or AM [accounts manager] shall enter the grievance in the system of record. A recording of all investigative activities, outcomes, and analyses shall be included in the report. The documentation shall be maintained in the Grievance Binder. As necessary, the DOCS, clinical designee or AM may create an Incident Report."</p>				

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N0520	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure it could provide needed services to patients that had been accepted for care in 2 (#s 1 &amp; 2 ) of 5 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 7-16-12 to 9-13-12. The plan of care identified skilled nursing (SN) was to be provided 3 to 5 days per week for 26-40 hours per week for 9 weeks and that the services would not start until approval from the payer source had been received.</p> <p>A. The record included a "Client / Facility Logging Report" dated 7-17-12 and signed electronically by the supervising nurse, employee B, that states, "Nurse [employee C] called in to inform us she would not be staffing this case as she has taken another position. I [employee B, the supervising nurse]</p>	N0520	<p>N 0520 <b>Administrator, DOCS, Recruiters, Clinical Supervisors, and Personnel Coordinators will be re-educated on Maxim policy HH-CL-006. Specifically, education on section 3.5 of that policy that states "Patients will be accepted for services based on the adequacy and suitability of the personnel, resources to provide requires services, and the reasonable expectation that the patient's medical, nursing, rehabilitative, and/or social needs can be adequately met in the patient's place of residence." Re-education will be completed by 10/4/2012. Administrator, DOCS, Recruiters, Clinical Supervisors, and Personnel Coordinators will be re-educated on the process to follow to ensure availability of staff for new admissions. Once a referral is received the Administrator/DOCS will meet with the Recruiters, Clinical Supervisors, and Personnel Coordinators to check on staff availability. If staff is available, then admission is scheduled.</b></p>	10/04/2012			

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	<p>called [patient's parent] to inform [the parent] of this recent change in having an available nurse to staff case. We will continue to recruit for this position."</p> <p>B. The record included a "Client / Facility Logging Report" dated 8-14-12 and signed electronically by the supervising nurse, employee B, that states, "This case has not been staffed since admission because plans are we will staff when school starts. RN that was to staff this case has resigned which leaves no nurse available to staff case when school starts."</p> <p>C. The record included a discharge summary dated 8-20-12 that states, "Admitted client on 7-16-12. Nurse scheduled to do visit called and quit. Unable to find another nurse on such short notice. Family . . . requested discharge."</p> <p>D. The supervising nurse, employee B, indicated, on 9-4-12 at 2:20 PM, the agency did not have another nurse available to provide services to this patient.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 7-28-12 to 9-25-12 that identified that SN was to be</p>		<p><b>If staff is not available then referral is declined at that time. Re-education will be completed by 10/4/2012. Administrator, DOCS, Recruiters, Clinical Supervisors, and Personnel Coordinators will be re-educated on the process to follow if staff becomes unavailable. If the client is not a current client, then we will not admit and decline the referral. If client is an active client and staff becomes unavailable we will 1. Check availability of all active field staff 2. Communicate to family if additional staff is available or not and 3. Recruit new staff for open shifts. Re-education will be completed by 10/4/2012.</b></p>		

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	<p>provided 4 to 6 days per week and 27 to 45 hours per week for 9 weeks. The plan of care also states, "Client also has 60 hours per month of respite waiver nursing for 9 weeks."</p> <p>A. The record failed to evidence any SN services had been provided the week of 8-5-12. The record included a "Missed Visit / Shift Notification" note dated 8-15-12 that identified SN visits had not been provided on 8-6-12, 8-7-12, and 8-8-12 due to "employee availability."</p> <p>B. The record included a "Communication Note", signed and dated by employee D, the alternate supervising nurse, on 7-27-12 that states, "This case is not currently staffed due to care related staffing issues."</p> <p>C. The supervising nurse, employee B, stated, on 9-4-12 at 2:45 PM, "There was no nurse available [to provide services to the patient]."</p> <p>3. The agency's 2-15-11 "Acceptance and/or Admission of Patients" policy number HH-CL-006 states, "Patients will be accepted for service based on the adequacy and suitability of the personnel, resources to provide required services, and the reasonable expectation that the patient's medical, nursing, rehabilitative,</p>			

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	and/or social needs can be adequately met in the patient's place of residence."			

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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 and agency policy review and interview, the agency failed to ensure medications had been administered and assessments had been completed as ordered by the physician on the written plan of care in 2 (#s 3 &amp; 4) of 5 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 7-25-12 to 9-22-12. The plan of care identified the skilled nurse (SN) was to administer medications as ordered by the physician.</p> <p>A. The plan identified the following medications were to be administered daily: Baclofen 1233.3 micrograms (mcg) per day per automatic pump, Artane 2 milligram (mg) tab 1 1/2 tabs daily in pm, Baclofen 10 mg tab, 1 1/2 tabs daily in pm, Rhinocort 180 mcg/act, instill 1 spray into each nostril daily, Claritin 5mg/5 milliliters (ml) give 10 ml daily, Jolessa 0.15/0.03 mg tab give 1 tab once daily, Melatonin, 1mg/ml, give 3-5</p>	N0522	N 0522 The Director of Clinical Services educated Clinical Supervisors on 9/13/12 the process to review field staff notes in the areas of assessments and medication administration to assure assessments and medication administration are documented correctly per physician order. The proof of education is documented on meeting agenda dated 9/13/12. The Clinical Supervisors audit 100% of field staff notes on a ongoing basis and will identify assessments and medication administration documented that have not followed the plan of care as directed by physician order. The Clinical Supervisors upon identification of field staff not following the plan of care as directed by physician order will contact field staff skilled nurse, provide education and log that education into the system of record. In the event when re-education has been required the Clinical Supervisor will identify improvements then log into system of record demonstrating successful re-education has occurred in regards to correct documentation of assessments and medication	10/04/2012			

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	<p>ml at bedtime, Zolpidem Tartrate 10 mg tab give 1 tab daily at bedtime, Bactroban thin film apply thin film to bilateral nostrils daily, Saline nasal spray 1 spray instill one spray into each nostril 2 times daily, Valium 5mg/5ml liquid give 6-8 ml three times daily, Artane 2 mg tab give 4 mgs (2 tabs) 2 times daily in am and pm, Baclofen 10 mg tab take 1 tab twice daily in am and pm, Zanaflex 2 mg tab give 1 tab three times daily, and Neurontin 250 mg/5ml suspension three times daily.</p> <p>B. A SN visit note dated 7-31-12 evidenced employee D, a registered nurse, provided care to the patient from 8:00 AM to 3:00 PM. The medication administration record (MAR) dated 7-31-12 failed to evidence the nurse had administered the morning and afternoon medications of Bactroban thin film and Claritin as ordered by the physician.</p> <p>C. A SN visit note dated 8-2-12 evidenced employee D, a registered nurse, provided care to the patient from 5:30 PM to 8:30 PM. The record failed to evidence any medications had been administered by the nurse on this date.</p> <p>D. A SN visit note dated 8-3-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00 AM to 11:00 AM. The MAR dated</p>		<p>administration as directed by physician. If no improvements have been made the Clinical Supervisor will inform Director of Clinical Services and an individual performance improvement will be initiated for those skilled nurses at that time and logged into the system of record. To ensure that this deficiency does not recur the Director of Clinical Services will audit 10% of the medical records per quarter for documentation that assessments and medication administration has been conducted and documented per physician order. The Director of Clinical Services will formulate mailer to be sent to all Active Skilled nurses and Clinical Supervisors for education in regards to how to properly document assessments and medication administration as directed per physician order and log that mailer sent into individual employee system of record.</p>				

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	<p>8-3-12 failed to evidence the nurse had administered the daily morning medications of Bactroban thin film, Claritin, Rhinocort, Artane, Saline nasal spray, and Zanaflex.</p> <p>E. A SN visit notes dated 8-7-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00 AM to 3:00 PM and again from 5:30 PM to 8:30 PM. The MAR dated 8-7-12 failed to evidence the nurse had administered the daily morning and evening medications of Bactroban thin film, Claritin, Rhinocort,, Artane, Baclofen 10 mg tab, and Saline nasal spray.</p> <p>F. A SN visit note dated 8-14-12 evidenced employee D, a registered nurse, had provided care to the patient from 6:55 AM to 2:00 PM. The MAR dated 8-14-12 failed to evidence the nurse had administered the morning medications of Bactroban thin film, Claritin, Rhinocort, Artane 2 mg, and Saline nasal spray.</p> <p>G. The supervising nurse, employee B, indicated, on 9-4-12 at 3:30 PM, the record did not include documentation the nurse had administered the medications as ordered on the plan of care. The supervising nurse stated, "They may have been given by the patient's parent. There</p>						

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	<p>is no way to tell on the MAR if the medications were given or not."</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 8-22-12 to 10-20-12 that states, "SN 5-7 days a week, 72-120 hours/month . . . Monitor and document pain assessment at least every two hours."</p> <p>A. A SN visit note, signed and dated by employee F, a registered nurse, on 8-22-12, failed to evidence any pain assessments had been completed. The note evidenced the nurse provided care to the patient from 8:35 AM to 4:10 PM.</p> <p>B. A SN visit note, signed and dated by employee F, a registered nurse, on 8-23-12, failed to evidence any pain assessments had been completed after the nurse's arrival at 8:00 AM at which time the nurse charted "no pain." The note evidenced the nurse had provided care to the patient from 8:00 AM to 4:05 PM.</p> <p>C. A SN visit note, signed and dated by employee F, a registered nurse, on 8-24-12, evidenced the nurse provided care to the patient from 8:02 AM to 4:05 PM. The note failed to evidence the nurse had assessed the patient's pain at least every 2 hours. The note evidenced the</p>			

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	<p>nurse assessed the patient's pain at 1:00 PM and 1:30 PM only.</p> <p>D. A SN visit note, signed and dated by employee G, a licensed practical nurse (LPN) on 8-25-12, failed to evidence the nurse had assessed the patient's pain at least every 2 hours. The note evidenced a pain assessment had been completed at 8:00 AM upon the nurse's arrival to the home and not again until 11:00 AM. The note evidenced a pain assessment had been completed at 1:30 PM with no further assessment documented. The note evidenced the LPN provided care to the patient from 8:00 AM to 4:00 PM.</p> <p>E. The supervising nurse, employee B, stated, on 9-4-12 at 4:10 PM, "I know the pain assessments were not done every 2 hours."</p> <p>3. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care (485) is the physician's order for home care services."</p>				

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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 and agency policy review and interview, the registered nurse failed to ensure medications had been administered and assessments had been completed as ordered by the physician on the written plan of care in 2 (#s 3 &amp; 4) of 5 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 7-25-12 to 9-22-12. The plan of care identified the skilled nurse (SN) was to administer medications as ordered by the physician.</p> <p>A. The plan identified the following medications were to be administered daily: Baclofen 1233.3 micrograms (mcg) per day per automatic pump, Artane 2 milligram (mg) tab 1 1/2 tabs daily in pm, Baclofen 10 mg tab, 1 1/2 tabs daily in pm, Rhinocort 180 mcg/act, instill 1 spray into each nostril daily, Claritin 5mg/5 milliliters (ml) give 10 ml daily, Jolessa 0.15/0.03 mg tab give 1 tab</p>	N0537	N 0537 The Director of Clinical Services educated Clinical Supervisors on 9/13/12 the process to review field staff notes in the areas of assessments and medication administration to assure assessments and medication administration are documented correctly per physician order. The proof of education is documented on meeting agenda dated 9/13/12. The Clinical Supervisors audit 100% of field staff notes on a ongoing basis and will identify assessments and medication administration documented that have not followed the plan of care as directed by physician order. The Clinical Supervisors upon identification of field staff not following the plan of care as directed by physician order will contact field staff skilled nurse, provide education and log that education into the system of record. In the event when re-education has been required the Clinical Supervisor will identify improvements then log into system of record demonstrating successful re-education has occurred in regards to correct documentation of assessments and medication	10/04/2012			

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	<p>once daily, Melatonin, 1mg/ml, give 3-5 ml at bedtime, Zolpidem Tartrate 10 mg tab give 1 tab daily at bedtime, Bactroban thin film apply thin film to bilateral nostrils daily, Saline nasal spray 1 spray instill one spray into each nostril 2 times daily, Valium 5mg/5ml liquid give 6-8 ml three times daily, Artane 2 mg tab give 4 mgs (2 tabs) 2 times daily in am and pm, Baclofen 10 mg tab take 1 tab twice daily in am and pm, Zanaflex 2 mg tab give 1 tab three times daily, and Neurontin 250 mg/5ml suspension three times daily.</p> <p>B. A SN visit note dated 7-31-12 evidenced employee D, a registered nurse, provided care to the patient from 8:00 AM to 3:00 PM. The medication administration record (MAR) dated 7-31-12 failed to evidence the nurse had administered the morning and afternoon medications of Bactroban thin film and Claritin as ordered by the physician.</p> <p>C. A SN visit note dated 8-2-12 evidenced employee D, a registered nurse, provided care to the patient from 5:30 PM to 8:30 PM. The record failed to evidence any medications had been administered by the nurse on this date.</p> <p>D. A SN visit note dated 8-3-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00</p>		<p>administration as directed by physician. If no improvements have been made the Clinical Supervisor will inform Director of Clinical Services and an individual performance improvement will be initiated for those skilled nurses at that time and logged into the system of record. To ensure that this deficiency does not recur the Director of Clinical Services will audit 10% of the medical records per quarter for documentation that assessments and medication administration has been conducted and documented per physician order. The Director of Clinical Services will formulate mailer to be sent to all Active Skilled nurses and Clinical Supervisors for education in regards to how to properly document assessments and medication administration as directed per physician order and log that mailer sent into individual employee system of record.</p>		

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	<p>AM to 11:00 AM. The MAR dated 8-3-12 failed to evidence the nurse had administered the daily morning medications of Bactroban thin film, Claritin, Rhinocort, Artane, Saline nasal spray, and Zanaflex.</p> <p>E. A SN visit notes dated 8-7-12 evidenced employee D, a registered nurse, had provided care to the patient from 8:00 AM to 3:00 PM and again from 5:30 PM to 8:30 PM. The MAR dated 8-7-12 failed to evidence the nurse had administered the daily morning and evening medications of Bactroban thin film, Claritin, Rhinocort,, Artane, Baclofen 10 mg tab, and Saline nasal spray.</p> <p>F. A SN visit note dated 8-14-12 evidenced employee D, a registered nurse, had provided care to the patient from 6:55 AM to 2:00 PM. The MAR dated 8-14-12 failed to evidence the nurse had administered the morning medications of Bactroban thin film, Claritin, Rhinocort, Artane 2 mg, and Saline nasal spray.</p> <p>G. The supervising nurse, employee B, indicated, on 9-4-12 at 3:30 PM, the record did not include documentation the nurse had administered the medications as ordered on the plan of care. The supervising nurse stated, "They may have</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/04/2012
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	<p>been given by the patient's parent. There is no way to tell on the MAR if the medications were given or not."</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 8-22-12 to 10-20-12 that states, "SN 5-7 days a week, 72-120 hours/month . . . Monitor and document pain assessment at least every two hours."</p> <p>A. A SN visit note, signed and dated by employee F, a registered nurse, on 8-22-12, failed to evidence any pain assessments had been completed. The note evidenced the nurse provided care to the patient from 8:35 AM to 4:10 PM.</p> <p>B. A SN visit note, signed and dated by employee F, a registered nurse, on 8-23-12, failed to evidence any pain assessments had been completed after the nurse's arrival at 8:00 AM at which time the nurse charted "no pain." The note evidenced the nurse had provided care to the patient from 8:00 AM to 4:05 PM.</p> <p>C. A SN visit note, signed and dated by employee F, a registered nurse, on 8-24-12, evidenced the nurse provided care to the patient from 8:02 AM to 4:05 PM. The note failed to evidence the nurse had assessed the patient's pain at least</p>				

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	<p>every 2 hours. The note evidenced the nurse assessed the patient's pain at 1:00 PM and 1:30 PM only.</p> <p>D. A SN visit note, signed and dated by employee G, a licensed practical nurse (LPN) on 8-25-12, failed to evidence the nurse had assessed the patient's pain at least every 2 hours. The note evidenced a pain assessment had been completed at 8:00 AM upon the nurse's arrival to the home and not again until 11:00 AM. The note evidenced a pain assessment had been completed at 1:30 PM with no further assessment documented. The note evidenced the LPN provided care to the patient from 8:00 AM to 4:00 PM.</p> <p>E. The supervising nurse, employee B, stated, on 9-4-12 at 4:10 PM, "I know the pain assessments were not done every 2 hours."</p> <p>3. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care (485) is the physician's order for home care services."</p>						