STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157197	A. BUILDING 00 B. WING	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEDIATRIC NURSING SPECIALISTS OF INDIANA	3500 DEPAUW BLVD STE 1041 INDIANAPOLIS, IN 46268

(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
G000000	This was a federal home health agency recertification survey. This was a partial extended survey. Survey dates: 12.1.14 to 12.5.14 Facility Number: 005359 Medicaid Number: 200852870 Surveyors: Michelle Weiss RN MSN Public Health Nurse Surveyor Nina Koch RN Public Health Nurse Surveyor Census: 65 Quality Review: Joyce Elder, MSN, BSN, RN December 11, 2014	G000000		
G000158	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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Based on clinical record review, interview, and policy review, the agency failed to ensure care and services had been provided in accordance with the physicians orders and missed visits were reported to the physician in 3 out of 10 clinical records reviewed creating the potential to affect all 65 patients receiving services in the agency (number 2, 5 and 8). Findings include: 1. Clinical record number 2, start of care 9/2/2014, contained a plan of care established by the physician for a certification period of 9/2/2014 to 10/31/2014 with orders for skilled nursing one time a week for 6 weeks. The nurse was to take VS (vital signs) to include temperature, Pulse, Respirations, and Oxygen Saturation every visit. Parameters included "Patient will have Oxygen Sat. [saturation] equal to or greater than 92%." The Durable Medical Equipment (DME) and supplies listed the pulse oximeter on the plan of care. A. Scheduled visits were completed by skilled nursing on 9/2/14, 9/9/14, 9/16/14, and 9/23/14, but there was no documentation of an oxygen saturation on the home visit records by the registered nurse (RN) on 9/2/14 or the	G000158	G 158 The Administrator and Clinical Care Manager to compare the 485 orders to the medications, equipment, and treatment modality documented in the nurse's charting to ensure the MD orders are being followed as ordered. An interim order to be sent to the MD as indicated to correct any order discrepancies. Clinical Record #2 Findings: The Administrator re-educated the field staff on Clinical Record #2 regarding reviewing the 485, following the MD orders and notify the office immediately of any order discrepancies. Clinical Record #5 Findings: The Administrator re-educated the field staff on Clinical Record #5 that the office must be notified of any changes in the patient's schedule. Any changes in the frequency/duration to be documented and communicated with the MD. Clinical Record # 5 Findings: The Administrator also re-educated the field staff regarding following the 485 as ordered. The Administrator re-educated the management nursing staff that any change in visit frequency and/or duration must be documented and communicated to the ordering Physician. The Administrator and Clinical Care Manager to re-educated the field staff as indicated regarding following the MD Plan of Care. Measures taken to correct in future: Measures taken to correct in	01/22/2015

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	Licensed Practical Nurse (LPN) on the subsequent visits. B. On 12/5/14 at 10:55 AM, employee H, the LPN, stated, "No, I didn't check the oxygen saturation because there wasn't a pulse ox [oximeter] machine there. I thought it was strange and asked the mother about it. [The patient] was on oxygen. I did not see it on the plan of care." C. On 12/3/14 at 1:00 PM, the RN, employee F, agreed there were not oxygen saturation readings on the nursing assessment documentation and stated, "I'm not sure [he/she] had a pulse oximeter." 2. Clinical record number 5, start of care 6/28//14, included a plan of care established by the physician for the certification period 10/21/14 to 12/19/14 with orders for skilled nursing (SN) 4 days a week for 11 hours days 1-5 days/week up to 55 hours / calendar week. The clinical record failed to evidence documentation of notifying the physician of a missed skilled nursing visit on 10/31/14, 11/14/14 and 11/17/14. A. In an interview with the RN administrator, employee I, on 12/4/14 at 2:35, stated, "It's always a challenge		future: The Administrator and Clinical Care Manager will audit 10% of client charts using the PI process quarterly to ensure that the nursing staff is following the MD orders. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	

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	for a company to account for everyday there, and when the family is aware that the nurse was going to be absent, they don't want a new or different nurse. It is our policy however, to notify the physician and keep documentation of that missed visit." B. During a home visit on 12/2/14 at 1:45 PM to patient 5 by LPN, employee D, the patient was observed walking from the living room approximately 25 or more feet to a bedroom/play area, to a closet, back to the bedroom and after that, to the kitchen. The LPN changed some of the patients clothes then walked with the patient into the kitchen for lunch. During the time of this observation, the patient was not wearing ankle Orthotics. 1.) Clinical record #5 evidenced a plan of care for certification period 10/21/2014 to 12/19/2014 which states, "Bilateral ankle Orthotics to be worn at all times when awake as tolerated." 2.) On 12/3/14 at 3:00 PM, employee F, RN, indicated the Orthotics were not worn during the observation and stated, "They were on the dresser in the room. The nurse had them off, probably, because the patient had taken a nap."			

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	3. Clinical record number 8, start of care 10/5/14, included a plan of care established by the physician for certification period 10/5/14 to 12/3/14 with orders for skilled nursing 03 hours per week for 9 weeks and Medicaid SN 1 hour visit 3 visits per week. The clinical record failed to evidence documentation of notifying the physician of a missed skilled nursing visit for 10/19/14. 4. Pediatric Nursing Specialists of Indiana Home Health Network policy C-200, revised July 2012, titled "Skilled Nursing Services" states, "Skilled nursing services will be provided by a registered nurse or Licensed Practical / Vocational Nurse under the supervision of the Registered Nurse and in accordance with a medically approved plan of care ... Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative procedures." 5. Pediatric Nursing Specialists of Indiana Home Care Network policy C-680, revised October 2012, titled "Clinical Documentation" states, "To document conformance to the plan of care, modifications to the plan, and interdisciplinary involvement. ... Services not provided and the reason for the missed visits will be documented and			

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	reported to the physician."			
G000159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on observation, clinical record review, agency policy review, and staff interview, the agency failed to ensure the plan of care contained types of services, equipment, and medications required for 2 out of 10 records reviewed with skilled nursing with the potential to affect all of the agency's current 65 patients (patient 3 and 10). Findings include: 1. Clinical record #3 contained a plan of	G000159	G 159 The Administrator and Clinical Care Manager to compare the 485 to the equipment orders for the patient. An interim order to be sent to the MD as needed to correct any discrepancies. The DON and CCM to re-educated the field staff as indicated regarding following the MD Plan of Care. Findings for Clinical Record #4: The Administrator re-educated the field staff that any equipment changes noted in the patient's home must be communicated with the Clinical Manager.	01/22/2015

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	care for the certification period, 11/25/14 -1/23/15 with the durable medical equipment listed as O2, (oxygen) and an LTV 950 Vent (ventilator). A. On 12/2/14 at 10:15 AM, during a home visit to patient #3, observation of the patient failed to evidence oxygen and a ventilator. The patient was stable and alert, playing, and interactive and was on room air. B. The RN, employee F, on December 3, 2014, at 9:30 AM, indicated that the most recent plan of care had not been revised to reflect that the ventilator and oxygen had been discontinued. C. Pediatric Nursing Specialists of Indiana Home Care Network policy C-660, revised 11/12, states, "The Care Plan/485 shall be reviewed, evaluated, and revised (minimally every 60 days and as needed) based upon the the client's health status and/or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress towards goals." 2. Patient number 10, start of care 8/18/2014, contained a plan of care for the certification period 8/18/2014 to 10/16/2014 that states, "Miralax G		Findings for Patient #10: The Administrator re-educated the Clinical Manager regarding documentation of Physician Orders with regards to mixing medication/fluid ratios and the amount to be administered. Findings for Patient #10: The Administrator re-educated the field staff on Patient #10 that the Physician order must be followed and to document any changes in the medication regime as they happen. The Administrator also re-educated the field staff on Patient #10 that the Clinical Manager must be notified of any order changes in medication and treatment regime. Measures taken to correct in future: The Administrator and Clinical Care Manager will audit 10% of client charts using the PI processquarterly to ensure that the nursing staff is following the MD orders. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	

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	[gastrostomy] tube 5 times a day Mix 1/2 capful in 15 ml [milliliters] of water. Administer 2 ml every 3 hours with the feeding per G-tube." A separate order from 8/19/14 states, "MiraLax NA Powder .. 1/2 capful mixed with 6 oz [ounces] fluid Orally daily as needed." An Addendum to the plan of treatment on the same date reads, "Miralax 8.5 gm [gram] G Tube PRN [as necessary]. May give daily as needed for constipation." The plan of care did not evidence the miralax to water ratio or the amount to be given daily. The plan of care is does not specify the nurse is to give 2-4 ml of the miralax mixture 5 times a day, or 15-20 mls of the miralax mixture once day. A. The treatment record evidenced the nurse has been giving the drug each day in September at approximately 9 AM in September. The medication treatment record from September states, "After small amount each feeding." In October, the treatment record identifies the dose is is to be given at 1 PM of "Miralax 1/2 cap mix c [with] 20 ml H20 [water] q [every] day via G-button." The drug was given 7 times in October. Therefore, there is an inconsistency with the medication directions listed on the plan of care. B. On December 5, 2014, at 10:00			

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	AM, the RN, employee F, indicated the plan of care should be updated to include medications that are used PRN with clear directions on the volume to mix and administer. C. Pediatric Nursing Specialists of Indiana Home Care Network policy C-635, revised 11/12, titled "Physicians Orders" states, "All orders for medications must contain the name of the drug, dosage, route of administration and directions for use ... when a nurse or therapist receives a verbal order from the physician he/she will immediately record the date, specific order, sign the interim order form and send it to the physician to amend the plan of care ... " D. Pediatric Nursing Specialists of Indiana Home Care Network policy C-700, revised 11/12, titled "Medication Profile" states the purpose of the policy is, "To provide documentation of the comprehensive assessment of all medications the client is currently taking, and identify any discrepancies between client profile and the physician and/or agency profile and identify educational opportunities for clients and caregivers. To provide documentation of changes in the medication regime as they happen, and to support changes needed in the plan of care ... "			

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G000170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review, interview, and observation, the agency failed to ensure skilled nursing services were in accordance with the plan of care for 2 our of 10 records reviewed with the potential to affect all of the agency's current 65 patients (patient 2 and 5). Findings include: 1. Clinical record number 2, start of care 9/2/2014, contained a plan of care established by the physician for a certification period of 9/2/2014 to 10/31/2014 with orders for skilled nursing one time a week for 6 weeks. The nurse was to take VS (vital signs) to include temperature, Pulse, Respirations, and Oxygen Saturation every visit. Parameters included "Patient will have Oxygen Sat. [saturation] equal to or greater than 92%." The Durable Medical Equipment (DME) and supplies listed the	G000170	G 170 The Administrator and Clinical Care Manager to compare the 485 orders to the medications,equipment, and treatment modality noted in the nurse's documentation to ensure the MD orders are being followed as ordered. An interim order to be sent to the MD as indicated to correct any order discrepancies. On-going re-education of field staff as indicated regarding following the MD Plan of Care as ordered. Findings for Clinical Record #2: The Administrator re-educated the field staff on Clinical Record 2 that any discrepancy in Physician Orders must be communicated to the office. A interim order sent to the MD to correct the order discrepancies. Findings for Clinical Record #5: The Administrator re-educated the field staff on Clinical Record # 5 that all Physician Orders must be reviewed and followed. The staff was re-educated that for any reason that the patient's Orthotics were not able to be worm it must	01/22/2015

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	pulse oximeter on the plan of care. A. Scheduled visits were completed by skilled nursing on 9/2/14, 9/9/14, 9/16/14, and 9/23/14, but there was no documentation of an oxygen saturation on the home visit records by the registered nurse (RN) on 9/2/14 or the Licensed Practical Nurse (LPN) on the subsequent visits. B. On 12/5/14 at 10:55 AM, employee H, the LPN, stated, "No, I didn't check the oxygen saturation because there wasn't a pulse ox [oximeter] machine there. I thought it was strange and asked the mother about it. [The patient] was on oxygen. I did not see it on the plan of care." C. On 12/3/14 at 1:00 PM, the RN, employee F, agreed there were not oxygen saturation readings on the nursing assessment documentation and stated, "I'm not sure [he/she] had a pulse oximeter." 2. During a home visit on 12/2/14 at 1:45 PM to patient 5 by LPN, employee D, the patient was observed walking from the living room approximately 25 or more feet to a bedroom/play area, to a closet, back to the bedroom and after that, to the kitchen. The LPN changed some of the		be documented in the nursing notes and communicated to the office. The Clinical Manager to update the MD of any noted problems in the usage of the Orthotics and an interim order obtained as indicated. Measures taken to correct in future: The Administrator and Clinical Care Manager will audit 10% of client charts using the PI process quarterly to ensure that the nursing staff is following the MD's orders The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.ollowing the MD orders.	

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	patients clothes then walked with the patient into the kitchen for lunch. During the time of this observation, the patient was not wearing ankle Orthotics. A. Clinical record #5 evidenced a plan of care for certification period 10/21/2014 to 12/19/2014 which states, "Bilateral ankle Orthotics to be worn at all times when awake as tolerated." B. On 12/3/14 at 3:00 PM, employee F, RN, indicated the Orthotics were not worn during the observation and stated, "They were on the dresser in the room. The nurse had them off, probably, because the patient had taken a nap." C. Pediatric Nursing Specialists of Indiana Home Health Network policy C-200, revised July 2012, titled "Skilled Nursing Services" states, "Skilled nursing services will be provided by a registered nurse or Licensed Practical / Vocational Nurse under the supervision of the Registered Nurse and in accordance with a medically approved plan of care ... Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative procedures."			

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N000000	This was a state home health agency relicensure survey. Survey dates were 12.1.14 to 12.5.14 Facility Number: 005359 Medicaid Number: 200852870 Surveyors: Nina Koch Public Health Nurse Surveyor Michelle Weiss RN MSN Public Health Nurse Surveyor Census: 65 Quality Review: Joyce Elder, MSN, BSN, RN December 11, 2014	N000000		
N000522	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:			

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	Based on clinical record review, interview, and policy review, the agency failed to ensure care and services had been provided in accordance with the physicians orders and missed visits were reported to the physician in 3 out of 10 clinical records reviewed creating the potential to affect all 65 patients receiving services in the agency (number 2, 5 and 8). Findings include: 1. Clinical record number 2, start of care 9/2/2014, contained a plan of care established by the physician for a certification period of 9/2/2014 to 10/31/2014 with orders for skilled nursing one time a week for 6 weeks. The nurse was to take VS (vital signs) to include temperature, Pulse, Respirations, and Oxygen Saturation every visit. Parameters included "Patient will have Oxygen Sat. [saturation] equal to or greater than 92%." The Durable Medical Equipment (DME) and supplies listed the pulse oximeter on the plan of care. A. Scheduled visits were completed by skilled nursing on 9/2/14, 9/9/14, 9/16/14, and 9/23/14, but there was no documentation of an oxygen saturation on the home visit records by the registered nurse (RN) on 9/2/14 or the	N000522	N 522 The Director of Nursing and Clinical Care Manager to compare the 485 orders to the medications,equipment, frequency & duration of visits and treatment modality noted in the nurse's documentation to ensure the MD orders are being followed as ordered. An interim order to be sent to the MD as indicated to correct any order discrepancies. Clinical Record #2 Findings: The Administrator educated the field staff nurse on Clinical Record #2 that any noted discrepancies in MD orders must be communicated to the office Clinical Manager and/or Administrator. Clinical Record #5 and Clinical Record #8: The Administrator re-educated the Clinical Care Manager that any change in the frequency and/or duration of care order must be documented and reported to the MD. Clinical Record #5 Findings: The Administrator re-educated the field staff on Clinical Record #5 regarding following the 485. If patient is unable to wear or tolerate the ordered Orthotics, the field nurse must communicate this to the Clinical Care Manager. The Clinical Care Manager to notify the MD of findings and an interim order submitted as indicated. On-going re-education of field staff will be provided as needed to ensure that the nurses are following the 485. Measures taken to correct in future: The	01/22/2015

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	157197	A. BUILDING 00 B. WING	12/05/2014

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	Licensed Practical Nurse (LPN) on the subsequent visits. B. On 12/5/14 at 10:55 AM, employee H, the LPN, stated, "No, I didn't check the oxygen saturation because there wasn't a pulse ox [oximeter] machine there. I thought it was strange and asked the mother about it. [The patient] was on oxygen. I did not see it on the plan of care." C. On 12/3/14 at 1:00 PM, the RN, employee F, agreed there were not oxygen saturation readings on the nursing assessment documentation and stated, "I'm not sure [he/she] had a pulse oximeter." 2. Clinical record number 5, start of care 6/28//14, included a plan of care established by the physician for the certification period 10/21/14 to 12/19/14 with orders for skilled nursing (SN) 4 days a week for 11 hours days 1-5 days/week up to 55 hours / calendar week. The clinical record failed to evidence documentation of notifying the physician of a missed skilled nursing visit on 10/31/14, 11/14/14 and 11/17/14. A. In an interview with the RN administrator, employee I, on 12/4/14 at 2:35, stated, "It's always a challenge		Director of Nursing and Clinical Care Manager will audit 10% of client charts using the PI process quarterly to ensure that the nursing staff is following the MD orders. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	

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	for a company to account for everyday there, and when the family is aware that the nurse was going to be absent, they don't want a new or different nurse. It is our policy however, to notify the physician and keep documentation of that missed visit." B. During a home visit on 12/2/14 at 1:45 PM to patient 5 by LPN, employee D, the patient was observed walking from the living room approximately 25 or more feet to a bedroom/play area, to a closet, back to the bedroom and after that, to the kitchen. The LPN changed some of the patients clothes then walked with the patient into the kitchen for lunch. During the time of this observation, the patient was not wearing ankle Orthotics. 1.) Clinical record #5 evidenced a plan of care for certification period 10/21/2014 to 12/19/2014 which states, "Bilateral ankle Orthotics to be worn at all times when awake as tolerated." 2.) On 12/3/14 at 3:00 PM, employee F, RN, indicated the Orthotics were not worn during the observation and stated, "They were on the dresser in the room. The nurse had them off, probably, because the patient had taken a nap."			

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	3. Clinical record number 8, start of care 10/5/14, included a plan of care established by the physician for certification period 10/5/14 to 12/3/14 with orders for skilled nursing 03 hours per week for 9 weeks and Medicaid SN 1 hour visit 3 visits per week. The clinical record failed to evidence documentation of notifying the physician of a missed skilled nursing visit for 10/19/14. 4. Pediatric Nursing Specialists of Indiana Home Health Network policy C-200, revised July 2012, titled "Skilled Nursing Services" states, "Skilled nursing services will be provided by a registered nurse or Licensed Practical / Vocational Nurse under the supervision of the Registered Nurse and in accordance with a medically approved plan of care ... Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative procedures." 5. Pediatric Nursing Specialists of Indiana Home Care Network policy C-680, revised October 2012, titled "Clinical Documentation" states, "To document conformance to the plan of care, modifications to the plan, and interdisciplinary involvement. ... Services not provided and the reason for the missed visits will be documented and			

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	reported to the physician."			
N000524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.			
	Based on observation, clinical record review, agency policy review, and staff interview, the agency failed to ensure the plan of care contained types of services, equipment, and medications required for 2 out of 10 records reviewed with skilled nursing with the potential to affect all of the agency's current 65 patients (patient 3	N000524	N-0524 The Administrator and Clinical Care Manager to compare the 485 to the equipment orders for the patient. An interim order to be sent to the MD as needed to correct any discrepancies. The DON and CCM to re-educated the field staff as indicated regarding following the MD Plan of Care.	01/22/2015

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	and 10). Findings include: 1. Clinical record #3 contained a plan of care for the certification period, 11/25/14 -1/23/15 with the durable medical equipment listed as O2, (oxygen) and an LTV 950 Vent (ventilator). A. On 12/2/14 at 10:15 AM, during a home visit to patient #3, observation of the patient failed to evidence oxygen and a ventilator. The patient was stable and alert, playing, and interactive and was on room air. B. The RN, employee F, on December 3, 2014, at 9:30 AM, indicated that the most recent plan of care had not been revised to reflect that the ventilator and oxygen had been discontinued. C. Pediatric Nursing Specialists of Indiana Home Care Network policy C-660, revised 11/12, states, "The Care Plan/485 shall be reviewed, evaluated, and revised (minimally every 60 days and as needed) based upon the the client's health status and/or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress towards goals."		Findings for Clinical Record #3: The Administrator re-educated the field staff that any equipment changes noted in the patient's home must be communicated with the Clinical Manager. The Clinical Manager to send an interim order to the MD Findings for Patient #10: The Administrator re-educated the Clinical Manager regarding documentation of Physician Orders with regards to mixing medication/fluid ratios and the amount to be administered. Findings for Patient #10: The Administrator re-educated the field staff on Patient #10 that the Physician order must be followed and to document any changes in the medication regime as they happen. The Administrator also re-educated the field staff on Patient #10 that the Clinical Manager must be notified of any order changes in and treatment regime. Measures taken to correct in future: The Administrator and Clinical Care Manager will audit 10% of client charts using the PI process quarterly to ensure that the nursing staff is following the MD orders. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	

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	2. Patient number 10, start of care 8/18/2014, contained a plan of care for the certification period 8/18/2014 to 10/16/2014 that states, "Miralax G [gastrostomy] tube 5 times a day Mix 1/2 capful in 15 ml [milliliters] of water. Administer 2 ml every 3 hours with the feeding per G-tube." A separate order from 8/19/14 states, "MiraLax NA Powder .. 1/2 capful mixed with 6 oz [ounces] fluid Orally daily as needed." An Addendum to the plan of treatment on the same date reads, "Miralax 8.5 gm [gram] G Tube PRN [as necessary]. May give daily as needed for constipation." The plan of care did not evidence the miralax to water ratio or the amount to be given daily. The plan of care is does not specify the nurse is to give 2-4 ml of the miralax mixture 5 times a day, or 15-20 mls of the miralax mixture once day. A. The treatment record evidenced the nurse has been giving the drug each day in September at approximately 9 AM in September. The medication treatment record from September states, "After small amount each feeding." In October, the treatment record identifies the dose is is to be given at 1 PM of "Miralax 1/2 cap mix c [with] 20 ml H20 [water] q [every] day via G-button." The drug was given 7 times in October. Therefore,			

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	there is an inconsistency with the medication directions listed on the plan of care. B. On December 5, 2014, at 10:00 AM, the RN, employee F, indicated the plan of care should be updated to include medications that are used PRN with clear directions on the volume to mix and administer. C. Pediatric Nursing Specialists of Indiana Home Care Network policy C-635, revised 11/12, titled "Physicians Orders" states, "All orders for medications must contain the name of the drug, dosage, route of administration and directions for use ... when a nurse or therapist receives a verbal order from the physician he/she will immediately record the date, specific order, sign the interim order form and send it to the physician to amend the plan of care ... " D. Pediatric Nursing Specialists of Indiana Home Care Network policy C-700, revised 11/12, titled "Medication Profile" states the purpose of the policy is, "To provide documentation of the comprehensive assessment of all medications the client is currently taking, and identify any discrepancies between client profile and the physician and/or agency profile and identify educational			

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	opportunities for clients and caregivers. To provide documentation of changes in the medication regime as they happen, and to support changes needed in the plan of care ... "			
N000537	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, interview, and observation, the agency failed to ensure skilled nursing services were in accordance with the plan of care for 2 our of 10 records reviewed with the potential to affect all of the agency's current 65 patients (patient 2 and 5). Findings include: 1. Clinical record number 2, start of care 9/2/2014, contained a plan of care established by the physician for a certification period of 9/2/2014 to 10/31/2014 with orders for skilled nursing one time a week for 6 weeks. The nurse was to take VS (vital signs) to include temperature, Pulse, Respirations,	N000537	N 537 The Administrator and Clinical Care Manager to compare the 485 orders to the medications,equipment, and treatment modality noted in the nurse's documentation to ensure the MD orders are being followed as ordered. An interim order to be sent to the MD as indicated to correct any order discrepancies.On-going re-education of field staff as indicated regarding following the MD Plan of Care as ordered Findings for Clinical Record #2: The Administrator re-educated the field staff on Clinical Record 2 that any discrepancy in Physician Orders must be communicated to the office. A interim order sent to the MD to correct the order discrepancies.	01/22/2015

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	and Oxygen Saturation every visit. Parameters included "Patient will have Oxygen Sat. [saturation] equal to or greater than 92%." The Durable Medical Equipment (DME) and supplies listed the pulse oximeter on the plan of care. A. Scheduled visits were completed by skilled nursing on 9/2/14, 9/9/14, 9/16/14, and 9/23/14, but there was no documentation of an oxygen saturation on the home visit records by the registered nurse (RN) on 9/2/14 or the Licensed Practical Nurse (LPN) on the subsequent visits. B. On 12/5/14 at 10:55 AM, employee H, the LPN, stated, "No, I didn't check the oxygen saturation because there wasn't a pulse ox [oximeter] machine there. I thought it was strange and asked the mother about it. [The patient] was on oxygen. I did not see it on the plan of care." C. On 12/3/14 at 1:00 PM, the RN, employee F, agreed there were not oxygen saturation readings on the nursing assessment documentation and stated, "I'm not sure [he/she] had a pulse oximeter." 2. During a home visit on 12/2/14 at 1:45 PM to patient 5 by LPN, employee D, the		Findings for Clinical Record #5: The Administrator re-educated the field staff on Clinical Record # 5 that all Physician Orders must be reviewed and followed. The staff was re-educated that for any reason that the patient's Orthotics were not able to be worm it must be documented in the nursing notes and communicated to the office. The Clinical Manager to update the MD of any noted problems in the usage of the Orthotics and an interim order obtained as indicated. Measures taken to correct in future:The Administrator and Clinical Care Manager will audit 10% of client charts using the PI process quarterly to ensure that the nursing staff is following the MD orders. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	

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	patient was observed walking from the living room approximately 25 or more feet to a bedroom/play area, to a closet, back to the bedroom and after that, to the kitchen. The LPN changed some of the patients clothes then walked with the patient into the kitchen for lunch. During the time of this observation, the patient was not wearing ankle Orthotics. A. Clinical record #5 evidenced a plan of care for certification period 10/21/2014 to 12/19/2014 which states, "Bilateral ankle Orthotics to be worn at all times when awake as tolerated." B. On 12/3/14 at 3:00 PM, employee F, RN, indicated the Orthotics were not worn during the observation and stated, "They were on the dresser in the room. The nurse had them off, probably, because the patient had taken a nap." C. Pediatric Nursing Specialists of Indiana Home Health Network policy C-200, revised July 2012, titled "Skilled Nursing Services" states, "Skilled nursing services will be provided by a registered nurse or Licensed Practical / Vocational Nurse under the supervision of the Registered Nurse and in accordance with a medically approved plan of care ... Provides services requiring specialized nursing skill and initiates appropriate			

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	preventative and rehabilitative procedures."			