

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER 1ST OPTION ADULT DAY SERVICES & HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6111 HARRISON STREET SUITE 304 MERRILLVILLE, IN 46411
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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
G000000	<p>This visit was a Home Health Initial Medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: July 30, 31, August 1, 2, 2013. Partial Extended Dates: August 1, 2, 2013.</p> <p>Facility Number: 12812.</p> <p>Unduplicated census: 19.</p> <p>Surveyor: Janet Brandt, RN, PHNS.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 9, 2013</p>	G000000		

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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G000158	<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.</p> <p>Based on policy review, observation, clinical record review, and staff interview, the agency failed to ensure there were orders for wound care provided in 1 of 11 active records reviewed (#6) of patients receiving skilled nursing service with the potential to affect all the patients of the agency receiving skilled nurse services.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record #6, start of care (SOC) 9-16-12, included a plan of care for the certification period 7-8-13 to 9-5-13 with orders for the skilled nurse to perform wound care 3 times weekly with the option of dropping to 2 visits weekly as wound healing improved. The Plan of Care (POC) described the location of the wound as the right inner ankle and described the wound as a diabetic ulcer. The skilled nurse was to cleanse the wound with NS (normal saline) and apply Silvadene cream. 2. On 8-1-13 at 9:30 AM CST, on a home visit to patient #6, Employee B was 	G000158	<p>G 0158 Corrective Measures: The agency continues to follow its policy regarding wound care. Employee B was misunderstood as evidence by doctor's order prior to wound treatment. However, where such order is omitted in POC, was a human error. Effective immediately, the DON has in-serviced RNs to ensure that physician order on wound care is reflected in all patients POC and such order is constantly updated in the POC. 2. All nursing staff has been in-serviced in addition to photographing wounds to also document /chart wound measurements as the effective means to determining whether the wound is increasing or decreasing in size. The administrator has directed the DON with immediate effect to take charge of this responsibility and ensure that patient's chart is regularly monitored in order to avoid the reoccurrence of this deficiency. 3. Employee B may have been misunderstood, the agency has a comprehensive and specific policy on wound care treatment; evidence by policy # G 100 – 260. The agency will continue to adhere to its policy in</p>	08/12/2013

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	<p>observed assessing a wound on the right great toe after removing a dressing from the toe. When asked what was being done, Employee B indicated having cleansed the wound with Betadine, applied gentamycin cream, covered the wound with 4X4 gauze and then wrapped the extremity in kerlix. Employee B then moved to a 2nd wound on the left foot by the arch of the foot and performed wound care indicating having cleansed the 2nd wound with betadine, applied gentamycin cream, covered the 2nd wound with 4x4 gauze and wrapped with kerlix.</p> <p>Employee B indicated the physician was aware of the 2 wounds and the treatment Employee B performed was according to a physician order received 6-24-13. Employee B indicated that the physician ordered POC for 7-8-13 to 9-5-13 was not updated to include the 2nd open area or the change in treatment. Employee B indicated taking pictures of the wounds to determine if the wounds were increasing or decreasing in size and, therefore, did not do wound measurements. Employee B indicated there was no policy specific to wound care other than the plan for treatment being specific to the patient as mentioned in the policy, "C-480, undated, Plan of Treatment."</p> <p>3. Agency policy C-480,undated, "Plan</p>		<p>the treatment of wounds. The DON will see to it that the agency policy is followed at all times.</p>				

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	of Treatment" states under "Special Instructions" that an individualized plan of care signed by the physician must be provided for each agency patient and the plan of care needs to include all pertinent diagnosis, with treatments specified as well as the supplies and equipment needed to perform the treatments listed on the plan of care.			

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G000159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on policy review, observation, clinical record review, and staff interview, the agency failed to ensure the plan of care contained orders for the care of all wounds in 1 of 11 active records reviewed (#6) and certification periods were dated correctly in 6 of 10 records reviewed (#1-6) of patients receiving services longer than 60 days with the potential to affect all the patients of the agency.</p> <p>Findings:</p> <p>1. Clinical record #6, start of care (SOC) 9-16-12, included a plan of care for the certification period 7-8-13 to 9-5-13 with orders for the skilled nurse to perform wound care 3 times weekly with the option of dropping to 2 visits weekly as wound healing improved. The Plan of Care (POC) described the location of the wound as the right inner ankle and described the wound as a diabetic ulcer.</p>	G000159	G 0159 Corrective Measures: 1. Clinical record # 6 contained all orders for wound care as directed by the doctor. In any case, the DON has in-services RNs to ensure that all wound care ordered by the physician is well documented in the POC. The DON will regularly monitor patient chart/POC to make sure that doctor's wound care order and precise treatment solution is accurately documented, description and location of the wound is clearly stated. A. Nursing staff has been in-serviced by the DON to immediately follow the Healthcare Provider Solutions 60 Day Episodes for more accuracy. (Copy attached) thus; Day 61 is to be used as the start date for the next certification period. However, the agency will continue to follow its policy to recertify patient 5 days prior to the end of episode, policy # C- 155 (copy attached). The DON has been assigned the responsibility of	08/12/2013			

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	<p>The skilled nurse was to cleanse the wound with NS (normal saline) and apply Silvadene cream.</p> <p>A. On 8-1-13 at 9:30 AM CST, on a home visit to patient #6, Employee B was observed assessing a wound on the right great toe after removing a dressing from the toe. When asked what was being done, Employee B indicated having cleansed the wound with Betadine, applied gentamycin cream, covered the wound with 4X4 gauze and then wrapped the extremity in kerlix. Employee B then moved to a 2nd wound on the left foot by the arch of the foot and performed wound care indicating having cleansed the 2nd wound with betadine, applied gentamycin cream, covered the 2nd wound with 4x4 gauze and wrapped with kerlix.</p> <p>Employee B indicated the physician was aware of the 2 wounds and the treatment Employee B performed was according to a physician order received 6-24-13. Employee B indicated that the physician ordered POC for 7-8-13 to 9-5-13 was not updated to include the 2nd open area or the change in treatment. Employee B indicated taking pictures of the wounds to determine if the wounds were increasing or decreasing in size and, therefore, did not do wound measurements. Employee B indicated there was no policy specific</p>		<p>ensuring that this policy is meticulously followed accordingly. B. Nursing staff has been in-serviced by the DON to immediately follow the Healthcare Provider Solutions 60 Day Episodes for more accuracy. (Copy attached) thus; Day 61 is to be used as the start date for the next certification period. However, the agency will continue to follow its policy to recertify patient 5 days prior to the end of episode, policy # C- 155 (copy attached). The DON has been assigned the responsibility of ensuring that this policy is meticulously followed accordingly. C. Nursing staff has been trained by the DON to immediately follow the Healthcare Provider Solutions 60 Day Episodes for more accuracy. (Copy attached) thus; Day 61 is to be used as the start date for the next certification period. However, the agency will continue to follow its policy to recertify patient 5 days prior to the end of episode, policy # C- 155 (copy attached). The DON has been assigned the responsibility of monitoring this and ensuring that this policy is meticulously followed accordingly. This will avoid the reoccurrence of this deficiency D. Nursing staff has been in-serviced by the DON to immediately follow the Healthcare Provider Solutions 60 Day Episodes for more accuracy. (Copy attached) thus; Day 61 is to</p>				

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	<p>to wound care other than the plan for treatment being specific to the patient as mentioned in the policy, "C-480, undated, Plan of Treatment."</p> <p>B. Agency policy C-480, undated, "Plan of Treatment" states under "Special Instructions" that an individualized plan of care signed by the physician must be provided for each agency patient and the plan of care needs to include all pertinent diagnosis, with treatments specified as well as the supplies and equipment needed to perform the treatments listed on the plan of care.</p> <p>2. In review of clinical records with Employee B on 8-2-13 at 12:30 PM Employee B indicated awareness of having to complete a comprehensive assessment on agency patients every 60 days with the purpose of identifying patient decline or improvement and to verify the patient's eligibility for home care services for the next 60 day certification period. The assessment could have been completed on days 56-60, the last 5 days of the certification period. Employee B indicated that all updated comprehensive assessments were completed on day 60 for agency patients. Employee B indicated that Day 60 was also used as the 1st day of the subsequent certification period. Employee B</p>		<p>be used as the start date for the next certification period. However, the agency will continue to follow its policy to recertify patient 5 days prior to the end of episode, policy # C- 155 (copy attached). The DON has been assigned the responsibility of ensuring that this policy is meticulously followed accordingly. E. Nursing staff has been trained by the DON to immediately follow the Healthcare Provider Solutions 60 Day Episodes for more accuracy. (Copy attached) thus; Day 61 is to be used as the start date for the next certification period. However, the agency will continue to follow its policy to recertify patient 5 days prior to the end of episode, policy # C- 155 (copy attached). The DON has been assigned the responsibility of ensuring that this policy is meticulously followed accordingly. F. Nursing staff has been in-serviced by the DON to immediately follow the Healthcare Provider Solutions 60 Day Episodes for more accuracy. (Copy attached) thus; Day 61 is to be used as the start date for the next certification period. However, the agency will continue to follow its policy to recertify patient 5 days prior to the end of episode, policy # C- 155 (copy attached). The DON has been assigned the responsibility of ensuring that this policy is meticulously followed</p>	

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	<p>indicated not being aware that Day 61 was to be used as the start date for the next certification period and using Day 60 as both the last day and the first day of the 60 day cycle could cause billing issues.</p> <p>A. Clinical record #1 had a SOC (start of care) of 2-15-13, with an initial certification period of 2-15-13 to 4-15-13 identified a recertification assessment was completed on 4-15-13, or Day 60, and the certification period was also started on Day 60, 4-15-13 to 6-13-13. The next recertification assessment was completed on Day 60, 6-13-13. The subsequent certification period was also started on Day 60, 6-13-13 to 8-11-13.</p> <p>B. Clinical record #2, SOC 1-30-13, with an initial certification period 1-30-13 to 3-30-13 identified a recertification assessment was completed on Day 60, 3-30-13 and subsequent certification period also started on Day 60, 3-30-13 to 5-28-13. The next recertification assessment was completed on Day 60, 5-28-13, and the subsequent certification period was started on Day 60, 5-28-13 to 7-26-13. The current certification period starts 7-26-13 and goes to 9-23-13. The recertification assessment was completed on Day 60, 7-26-13.</p> <p>C. Clinical record #3, SOC 3-29-13,</p>		accordingly.				

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	<p>certification period 5-27-13 to 7-25-13 had a recertification assessment completed on Day 60, 5-27-13. The subsequent certification period was started on Day 60, 5-27-13 to 7-25-13.</p> <p>D. Clinical record #4, SOC 9-5-12, certification period 6-27-13 to 8-25-13 had a recertification assessment completed on Day 60, 6-27-13, with Day 1 of the subsequent certification period also documented as 6-27-13.</p> <p>E. Clinical record #5, SOC 3-15-13, had an initial comprehensive assessment completed 3-15-13. A recertification assessment was completed on Day 60 of the initial certification period, 5-13-13, and Day 1 of the subsequent certification period was also 5-13-13. The next recertification assessment was completed on Day 60, 7-11-13 and the next certification period started on Day 60, 7-11-13.</p> <p>F. Clinical record #6, SOC 9-6-12, certification period 7-8-13 to 9-5-13 had recertification assessments completed on Day 60 of every 2 month period, with day 1 of each succeeding certification period starting on Day 60 instead of on Day 61.</p>			

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G000173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on observation, clinical record review, and staff interview, the agency failed to ensure the registered nurse included previous wound orders on the plan of care for the certification period beginning 7/8/13 in 1 of 11 active records reviewed (#6) of patients receiving skilled nursing service with the potential to affect all the patients of the agency receiving skilled nurse services.</p> <p>Findings:</p> <p>1. Clinical record #6, start of care (SOC) 9-16-12, included a plan of care for the certification period 7-8-13 to 9-5-13 with orders for the skilled nurse to perform wound care 3 times weekly with the option of dropping to 2 visits weekly as wound healing improved. The Plan of Care (POC) described the location of the wound as the right inner ankle and described the wound as a diabetic ulcer. The skilled nurse was to cleanse the wound with NS (normal saline) and apply Silvadene cream.</p> <p>2. On 8-1-13 at 9:30 AM CST, on a home visit to patient #6, Employee B was observed assessing a wound on the right great toe after removing a dressing from</p>	G000173	<p>G 0173 Corrective Measures: 1. The agency continues to follow its policy regarding wound care. Employee B was misunderstood as evidence by doctor's order prior to wound treatment. However, where such order is omitted in POC, was a human error. Effective immediately, the DON has in-serviced RNs to ensure that physician order on wound care is reflected in all patients POC and such order is constantly updated in the POC during recertification period. 2 . All nursing staff has been in-serviced in addition to photographing wounds to also to document /chart wound measurements as the effective means to determine whether the wound is increasing or decreasing in size. The administrator has directed the DON with immediate effect to take charge of this responsibility and ensure that patient's chart is regularly monitored in order to avoid the reoccurrence.</p>	08/13/2013			

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	<p>the toe. When asked what was being done, Employee B indicated having cleansed the wound with Betadine, applied gentamycin cream, covered the wound with 4X4 gauze and then wrapped the extremity in kerlix. Employee B then moved to a 2nd wound on the left foot by the arch of the foot and performed wound care indicating having cleansed the 2nd wound with betadine, applied gentamycin cream, covered the 2nd wound with 4x4 gauze and wrapped with kerlix.</p> <p>Employee B indicated the physician was aware of the 2 wounds and the treatment Employee B performed was according to a physician order received 6-24-13. Employee B indicated that the physician ordered POC for 7-8-13 to 9-5-13 was not updated to include the 2nd open area or the change in treatment. Employee B indicated taking pictures of the wounds to determine if the wounds were increasing or decreasing in size and, therefore, did not do wound measurements.</p>						

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G000175	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>Based on interview and review of clinical record review, the agency failed to ensure the nurse implemented a social service referral in 1 of 11 records reviewed (#2) with the potential to affect all the agency's patients.</p> <p>Findings:</p> <p>1. Review of clinical record #2, Start of Care (SOC) 1-30-13, had a plan of care for the certification period 5-28-13 to 7-26-13 with physician orders for the skilled nurse (SN) to assess and observe vital signs and notify the physician of any significant changes in blood pressure, heart rate, temperature, weight or overall patient status. The patient diagnosis included cerebral vascular accident (CVA), Hypertension, Vertigo, Gastroesophageal Reflux (GERD). The SN was also to instruct the patient as needed regarding cardiovascular function, diagnosis, medications, diet, and was to monitor the patient for self care deficits and instruct the patient regarding available community resources/support systems available to maintain the patient's ability to remain independent in the home</p>	G000175	G 0175 Corrective Measures: 1. The administrator has the reminded all nursing employees to always review their job description in order to render complete health care services to patients. The DON has in-serviced RNs to undertake not only a comprehensive medical assessment of patient during admission; also take note/assess the social conditions of patients and where appropriate or there is need for social services inform the patient's physician of such need. RNs will continue to inform patients of available community resources they can utilize for optimum wellness. The DON will be responsible for the implementation of this policy to avoid its reoccurrence. 2. The DON has informed this patient's physician of the need to have the her evaluated for social services. Once a referral is obtained, the agency social worker will evaluate patient condition and initiate needed services. Social worker will inform patient of available community resources which she can access for a better health outcome. The DON will monitor and ensure that the physician order is followed. 3. Effective immediately, the DON has in-service the RNs to instruct	08/13/2013			

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	<p>2. In an interview with the patient on 8-1-13 at 10:00 AM CST, the patient indicated that at the age of 86, fatigue and weakness occasionally were somewhat of an issue as far as getting things done but the dizziness that had been ongoing since a prior "stroke" interfered with the completion of daily activities like making meals, bathing, writing checks and going to the grocery store. The patient indicated living alone in the house and expressed a need for help, indicated having limited financial resources and not knowing "where to go for information." Patient indicated not having received any information from the nurse regarding community resources that might be available, i.e., "Meals on Wheels", etc. and had not had a visit from the agency social worker. The patient indicated using a rolling walker to maintain balance walking around the house and being afraid of bathing due to episodes of "dizziness."</p> <p>3. In an interview with the Employee B on 8-2-13 at 11:15 AM, Employee B indicated the agency used a social worker for teaching residents about community resources and evaluating patient needs as far as community programs, Employee B indicated the agency had a social worker available but no referral for consult had been considered and no teaching had been</p>		<p>patients regarding community resources and support systems available that they can utilize when the need arises. And where appropriate to obtain a referral for social service. The DON will monitor/supervise the RNs to ensure compliance.</p>				

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	<p>done with the patient regarding available community services / resources.</p> <p>Employee B indicated having done some tasks for the patient like writing checks to pay bills and taking the checks to the mail box to assist the patient, but it had not occurred to Employee B that patient #1 would have benefited from more help.</p> <p>Employee B indicated the physician had included as part of the POC that the nurse was to instruct the patient regarding community resources and support systems available, that the part of the plan of care related to that issue had not been followed in that no instruction had been given to the patient related to community services and resources even though the patient may have benefited from the information.</p> <p>Employee B indicated a social worker referral was not obtained.</p>			

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G000332	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on agency document and clinical record review and staff interview, the agency failed to ensure an initial assessment of a patient was completed within forty-eight (48) hours of the physician referral for home care services for 1 of 11 (#3) patient records reviewed with the potential to affect all patients new patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the medical record for patient #3, Start of Care (SOC) 3-29-13, had a plan of care that included skilled nursing visits to be completed 1 time weekly for 9 weeks for skilled assessment. The clinical record had documentation of an initial and comprehensive assessment of the patient completed on 3-29-13. Agency document titled "1st Option Intake/Referral Form" dated 3-25-13, completed by Employee B, identified the patient was referred on 3-25-13. Interview on 7-30-13 with Employee B 	G000332	<p>G 0332 Corrective Measures: 1. The agency consistently followed its admission policy of 48 hours of initial assessment of patient immediately following physician order. Clinical record # 3 sighted is hereby attached as evidenced by agency compliance with its policy; admission policy – C 140 (copy attached) 2. The intake of 3/25/2013 and visit of 3/29/2013; the agency was unable to follow its 48 hours policy of initial patient assessment per patient request. Client wanted visit on 3/29/2013 same day of her husband nursing weekly visit. Patient alert and oriented X 3, able to make her own health care decisions. Patient request/decision respected by the agency. The administrator directed the DON to continue to in-service clinical staff to always adhere strictly to the agency policy of making initial home visit within the 48 hours' time frame following physician referral. This takes immediate effect. The DON will oversee the implementation of the policy. 3. Employee B was confirming the actual agency policy practice once a patient is referred to the agency. The agency will continue to stick to its 48 hours of initial patient assessment as soon as</p>	08/12/2013
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	at 3:00 PM CST, Employee B indicated that the agency policy was to follow federal/state guidelines related to when the initial assessment was done and stated, "When the agency receives a referral, we see the patient within 24-48 hours as I indicated during the entrance meeting earlier."		referral is received.	

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G000337	<p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on interview, clinical record review, and policy review, the agency failed to ensure the medication profile was updated at least every 60 days in 1 of 11 (#2) clinical records reviewed with the potential to affect all patients at this agency</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 1-28-13, included a Medication Profile" which listed the medication, dose and frequency the patient was taking the medication. The "Medication Profile" document had been initiated with the start of care with the next documented review done 3-30-13 and then 5-25-13 for certification period 5-28-13 to 7-26-13. The medication profile had not been completed and/or updated for the current certification period of 7-26-13 to 9-23-13.</p>	G000337	<p>G 0337 Corrective Measures: 1. The agency always adheres to its policy of medication update. For clinical record # 2; re-certification period 7/2/2013 to 9/23/2013, medication profile update was unintentionally missed. The record has been immediately updated. The administrator has instructed the DON to always cross check patient chart at the end of each 60 day episode to ensure that medication profile is updated and periodically review the charts for accuracy. 2. The DON has in-serviced RNs to make sure that all patients' medication profile is constantly updated and appropriately documented at all times following 60 day episode. 3. The agency will continue to follow its medication profile update policy. The DON will ensure that RNs follow the agency policy and update any change in medication profile. The DON will be responsible to monitor clinical staff compliance to this policy to prevent the reoccurrence of the deficiency.</p>	08/12/2013			

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	<p>2. Employee B, on 8-2-13 at 12:30 PM, indicated there was no documentation available that the medication profile had been updated for the current certification period of 7-26-13 to 9-23-13. Employee B indicated the agency had not followed its own policy to update the medication profile every 60 days, and as needed, with newly ordered drugs, medication changes, and discontinued medicines.</p> <p>3. Review of agency policy, "C-600 /Medication Profile" undated document, states under, "Special Instructions: ... #10. The Medication Profile shall be reviewed by a Registered Nurse every 60 days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation and, at a minimum every 60 days thereafter."</p>			