

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2011
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NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE C BEDFORD, IN47421
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G0000	<p>This visit was for a home health federal initial Medicaid certification survey. This was a partial extended survey.</p> <p>Survey dates: December 5 - 7, 2011</p> <p>Facility #: 012617</p> <p>Medicaid #: NA</p> <p>Surveyor: Ingrid Miller RN, PHNS</p> <p>Census: 18</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 9, 2011</p>	G0000		
G0159	<p>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 clinical record review, policy</p>	G0159	1.Clinical Record #3, MD was	12/13/2011

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

TITLE

(X6) DATE

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

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	<p>and document review, and interview, the agency failed to ensure current medications and treatments were listed on the plan of care for 3 of 10 clinical records reviewed (Files #3, #5, #6).</p> <p>Findings include</p> <p>Regarding Clinical record #3</p> <p>1. On 12/6/11 at 10:30 AM, Employee J, a home health aide, was observed at a home visit to pour Epsom salts into a warm water foot soak.</p> <p>2. Clinical record #3, start of care (SOC) 11-11-11, included a plan of care (POC) for the certification period 11/11/11 - 1/9/12 that failed to evidence a medication / treatment order on the POC for Epsom salt warm foot soaks.</p> <p>3. On 12/7/11 at 11 AM, the administrator indicated the Epsom salt foot soaks were not listed on the POC.</p> <p>Regarding Clinical record #5</p> <p>1. Clinical record #5, SOC 11/7/11, certification period 11/7/11 - 1/9/12, evidenced a medication order for Nitrostat 0.4 mg (milligram) prn.</p> <p>2. A clinical document titled</p>		<p>contacted. A verbal order was obtained and the Medication Profile, the Plan of Treatment and the Home Health Aide assignment were updated. The patient, clinical manager and the Home Health Aide were notified via phone of the update. Clinical Record #5 the Medication Profile and the Plan of Treatment were updated to reflect the current orders. Clinical Record #6, The Plan of Treatment was updated to reflect the O2 order. 2.The Administrator in-serviced nursing staff on developing the Plan of Treatment, to reflect the ordered medications and treatments. 3.The Administrator and the Director of Nursing are responsible for correcting the deficiencies. 4. The completion date for this Plan of Correction is 12/13/11.</p>				

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	<p>"Confirmation of physician telephone/verbal orders" states, "Addition to/or change of previous orders: 1. Nitro liquid 400 mcg [micrograms] / pump spray one pump subling [sublingual] for chest pain, may repeat q [every] 5 mins. [minutes] for chest pain X [times] 3, if no relief call 911. 2. DC [discontinue] nitro stat tabs." This document was signed by Employee A, the employee and administrator, on 11/7/11.</p> <p>3. On 12/6/11 at 4:40 PM, the administrator indicated the nitro stat tablets had been discontinued and should not have been on the current POC.</p> <p>Regarding Clinical record #6</p> <p>1. Clinical record #6, SOC 11/7/11, certification period 11/7/11 - 1/5/11, failed to evidence a POC that included all medications and treatments for patient #6. Employee A, the administrator and RN, completed the initial assessment noted oxygen 2 LPM (liters per minute) via cannula per hs (bedtime). This oxygen treatment was not on the POC.</p> <p>2. The clinical record note titled "Skilled Nursing Visit note," dated 11/15/11 10:40 AM - 12:10 AM and completed by Employee K, RN, had written documentation under analysis /</p>				

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	<p>instructions / patient response: "O2 sats (saturation) 85% on arrival, O2 via nasal cannula 2 liters started, O2 sats increased to 99 after 6 minutes. Complained tightness in left chest - relieved after oxygen in use ..."</p> <p>3. On 12/6/11 at 5 PM, the administrator indicated the oxygen treatment administered was not on listed on the current POC.</p> <p>Regarding documents reviewed</p> <p>1. The agency policy titled "Medication Orders and Administration" with no effective date states, "Licensed nurses, as permitted by state law and regulations, may accept orders for and administer patient medications ... Medication orders include the following following information: medication name, dose, route, reason medication has been prescribed ... Medications identified during the initial assessment visit and throughout the certification period are documented on the initial and recertifications plans of care, as well as in the clinical visit note and the medication administration record."</p> <p>2. The agency document titled "Job Description: Registered Nurse" with no effective date states, "Complies with</p>						

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G0170	<p>documentation standards: content, frequency, times, corrections, assessments, etc." This document was signed by the administrator on 11/3/11."</p> <p>The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and interview, the agency failed to ensure the skilled nurse only provided care ordered on the plan of care for 1 of 10 clinical records reviewed (patient #6).</p> <p>Findings:</p> <p>1. Clinical record #6, SOC 11/7/11, certification period 11/7/11 - 1/5/12, failed to evidence the skilled nurse followed the plan of care (POC).</p> <p>a. The initial/comprehensive assessment signed by Employee A and dated 11/7/11 with a time in of 3 PM and time out of 5:30 PM evidenced a cardiopulmonary system review which stated, "O2 [oxygen] at 2 LPM [liters per</p>	G0170	<p>1.Clinical record #6. The Plan of Treatment was updated to reflect the current O2 orders. 2.The administrator in-serviced nursing staff on following the Plan of Treatment. 3.The Administrator and the Director of Nursing are responsible for correcting the deficiencies. 4. The completion date for this Plan of Correction is 12/13/2011.</p>	12/13/2011			

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	<p>minute] via nasal cannula per hs [bedtime]."</p> <p>b. The clinical record note titled "Skilled Nursing Visit note" dated 11/15/11 with a time in at 10:40 AM and time out at 12:10 PM and completed by Employee K, RN, under the analysis/instructions/patient response, stated, "O2 sats [saturation] 85% on arrival, O2 via nasal cannula 2 liters started, O2 sats increased to 99 after 6 minutes. Complained tightness in left chest - relieved after oxygen in use ..."</p> <p>c. The clinical record note titled "Skilled Nursing Visit note" dated 11/22/11 at 1:38 PM - 2:29 PM, and completed by Employee G, RN, evidenced the following, under the analysis / instructions / patient response, "O2 sat 87% on room air, O2 via n/c [nasal cannula] applied, O2 sat increased to 95% during medication set up."</p> <p>2. On 12/6/11 at 5 PM, the administrator indicated the skilled nurse did not follow the POC.</p>						

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G0337	<p>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 clinical record review, policy review, and interview, the agency failed to ensure current medications were accurately listed according to professional standards on the medication profile for 2 of 10 clinical records reviewed (Clinical record #2 and #6).</p> <p>Findings include</p> <p>Regarding Clinical #2</p> <p>1. Clinical record #2, start of care (SOC) and certification period 11/7/11 - 1/5/12, failed to evidence an accurate verbal order. The registered nurse (RN) initiated a telephone / verbal order due to a low blood sugar in the morning for patient #2. The plan of care (POC) with a verbal</p>	G0337	<p>1. Clinical record #2 and #6. The Medication Profile and the Plan of Treatment were updated to reflect the current order. 2. The Administrator in-serviced nursing staff on Policies and Procedures for processing verbal orders to reflect the five rights. 3. The Administrator and the Director of Nursing were responsible for correcting the deficiencies. 4. The completion date for this Plan of Correction is 12/13/11.</p>	12/13/2011

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	<p>order date of 11/7/11 indicated a medication order of Lantus Kwik pen 26 units which differed from the verbal order which stated to discontinue 29 units and the medication profile which had been altered from the original order of 26 to 20 as follows:</p> <p>2. The current POC states, "Lantus Kwik pen 26 units once each morning subcutaneous injection, diabetes." This POC was signed by the Employee A, Administrator and RN.</p> <p>3. A confirmation of physician / telephone orders with the name of clinical record #2 and the physician name states, "Stop Lantus units 29 SQ [subcutaneous]. Decrease Lantus insulin to 20 units SQ in am. Low Blood Sugar." Employee B, RN, signed and dated this verbal order 11/14/11.</p> <p>4. The medication profile with a review date of 11/7/11 originally stated, "Lantus 26 units subq [subcutaneous] q [every] am." Over the top of the 6 in the number 26, a 0 had been written. The medication profile was signed by Employee A, the administrator/RN on 11/7/11. No further additions had been made to this document.</p>						

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	<p>Regarding Clinical Record #6</p> <p>1. Clinical record #6, SOC 11-7-11, failed to evidence a complete medication profile.</p> <p>2. The medication profile addendum stated a start date of 11/8/11 for Vitamin B 12 1000 mcg (micrograms)/ml (milliliter) 1 ml q (every) month supplement. This medication was listed as a new medication and failed to list the route of administration. This addition to the medication profile was completed by the administrator, a registered nurse (RN), on 11/8/11.</p> <p>3. On 12/6/11 at 5 PM, the administrator indicated the route of the B 12 was by injection and the medication profile was not correct.</p> <p>3. The agency policy titled "Medication Orders and Administration," with no effective date states, "Licensed nurses, as permitted by state law and regulations, may accept orders for and administer patient medications ... Medication orders include the following following information: medication name, dose, route, reason medication has been prescribed ... Medications identified during the initial assessment visit and throughout the certification period are</p>			

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N0524	<p>documented on the initial and recertifications plans of care, as well as in the clinical visit note and the medication administration record."</p> <p>4. The agency document titled "Job Description: Registered Nurse," with no effective date states, "Complies with documentation standards: content, frequency, times, corrections, assessments, etc."</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p>			

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	<p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure current medications and treatments were listed on the plan of care for 3 of 10 clinical records reviewed (Files #3, #5, #6).</p> <p>Findings include</p> <p>Regarding Clinical #3</p> <p>1. On 12/6/11 at 10:30 AM, Employee J, a home health aide, was observed at a home visit to pour Epsom salts into a warm water foot soak.</p> <p>2. Clinical record #3, start of care (SOC) 11-11-11, included a plan of care (POC) for the certification period 11/11/11 - 1/9/12 that failed to evidence a medication / treatment order on the POC for Epsom salt warm foot soaks.</p> <p>3. On 12/7/11 at 11 AM, the administrator indicated the Epsom salt foot soaks were not listed on the POC.</p> <p>Regarding Clinical record #5</p> <p>1. Clinical record #5, SOC 11/7/11, certification period 11/7/11 - 1/9/12, evidenced a medication order for Nitrostat 0.4 mg (milligram) prn.</p>	N0524	<p>1.Regarding clinical record # 3, the MD was contacted, a verbal order was obtained for the Epsom Salts to be added to the foot soak. The Medication Profile, Plan of Treatment and Home Health Aide assignment sheet were updated. The client and the home health aide were notified of the update.</p> <p>Regarding clinical record #5, the Medication Profile and the Plan of Treatment were updated to reflect the current orders. Regarding clinical record #6, the Plan of Treatment was updated to reflect the O2 order. 2. The Administrator in-serviced nursing staff on updating the Medication Profile, Plan of Treatment and Home Health Aide assignment sheet to reflect the current medications and treatments. 3. The Administrator and the Director of Nursing were responsible for correcting the deficiencies. 4. The completion date for this Plan of Correction is 12/13/11.</p>	12/13/2011			

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	<p>2. A clinical document titled "Confirmation of physician telephone/verbal orders" states, "Addition to/or change of previous orders: 1. Nitro liquid 400 mcg [micrograms] / pump spray one pump subling [sublingual] for chest pain, may repeat q [every] 5 mins. [minutes] for chest pain X [times] 3, if no relief call 911. 2. DC [discontinue] nitro stat tabs." This document was signed by Employee A, the employee and administrator, on 11/7/11.</p> <p>3. On 12/6/11 at 4:40 PM, the administrator indicated the nitro stat tablets had been discontinued and should not have been on the current POC.</p> <p>Regarding Clinical record #6</p> <p>1. Clinical record #6, SOC 11/7/11, certification period 11/7/11 - 1/5/11, failed to evidence a POC that included all medications and treatments for patient #6. Employee A, the administrator and RN, completed the initial assessment noted oxygen 2 LPM (liters per minute) via cannula per hs (bedtime). This oxygen treatment was not on the POC.</p> <p>2. The clinical record note titled "Skilled Nursing Visit note," dated 11/15/11 10:40 AM - 12:10 AM and completed by Employee K, RN, had written</p>				

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	<p>documentation under analysis / instructions / patient response: "O2 sats (saturation) 85% on arrival, O2 via nasal cannula 2 liters started, O2 sats increased to 99 after 6 minutes. Complained tightness in left chest - relieved after oxygen in use ..."</p> <p>3. On 12/6/11 at 5 PM, the administrator indicated the oxygen treatment administered was not on listed on the current POC.</p> <p>Regarding documents reviewed</p> <p>1. The agency policy titled "Medication Orders and Administration" with no effective date states, "Licensed nurses, as permitted by state law and regulations, may accept orders for and administer patient medications ... Medication orders include the following following information: medication name, dose, route, reason medication has been prescribed ... Medications identified during the initial assessment visit and throughout the certification period are documented on the initial and recertifications plans of care, as well as in the clinical visit note and the medication administration record."</p> <p>2. The agency document titled "Job Description: Registered Nurse" with no</p>				

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N0537	<p>effective date states, "Complies with documentation standards: content, frequency, times, corrections, assessments, etc." This document was signed by the administrator on 11/3/11."</p> <p>Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review and interview, the agency failed to ensure the skilled nurse only provided care ordered on the plan of care for 1 of 10 clinical records reviewed (patient #6).</p> <p>Findings:</p> <p>1. Clinical record #6, SOC 11/7/11, certification period 11/7/11 - 1/5/12, failed to evidence the skilled nurse followed the plan of care (POC).</p> <p>a. The initial/comprehensive assessment signed by Employee A and dated 11/7/11 with a time in of 3 PM and time out of 5:30 PM evidenced a cardiopulmonary system review which stated, "O2 [oxygen] at 2 LPM [liters per minute] via nasal cannula per hs [bedtime]."</p> <p>b. The clinical record note titled "Skilled Nursing Visit note" dated</p>	N0537	<p>1.Regarding clinical record #6, the Plan of Treatment was reviewed. 2.The Administrator in-serviced staff on notifying the physician when O2 saturations are below the ordered parameters. 3. The Administrator and the Director of Nursing were responsible for correcting the deficiencies. 4. The completion date for this Plan of Correction is 12/13/11.</p>	12/13/2011			

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NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE C BEDFORD, IN47421
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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>11/15/11 with a time in at 10:40 AM and time out at 12:10 PM and completed by Employee K, RN, under the analysis/instructions/patient response, stated, "O2 sats [saturation] 85% on arrival, O2 via nasal cannula 2 liters started, O2 sats increased to 99 after 6 minutes. Complained tightness in left chest - relieved after oxygen in use ..."</p> <p>c. The clinical record note titled "Skilled Nursing Visit note" dated 11/22/11 at 1:38 PM - 2:29 PM, and completed by Employee G, RN, evidenced the following, under the analysis / instructions / patient response, "O2 sat 87% on room air, O2 via n/c [nasal cannula] applied, O2 sat increased to 95% during medication set up."</p> <p>2. On 12/6/11 at 5 PM, the administrator indicated the skilled nurse did not follow the POC.</p>			