

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER CAREGIVERS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3536 WASHINGTON BLVD INDIANAPOLIS, IN 46205
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G000000	<p>This was a home health federal complaint investigation.</p> <p>Complaint #IN00157203 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey Date: October 29-31, 2014</p> <p>Facility #005941</p> <p>Surveyor: Nina Koch , R.N, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 12, 2014</p>	G000000		
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>			

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>Based on interview and review of clinical records and agency policy, the registered nurse (RN) failed to provide care as ordered in the plan of care for 1 (#1) of 3 clinical records reviewed creating the potential to affect all of the agency's patients 446 skilled nursing patients.</p> <p>Findings:</p> <p>1. Clinical record number one, start of care 8/1/2014, included a plan of care established by the patient's physician for the certification period 8/1/2014 through 9/29/2014 that identified the patient's diagnoses were stage two pressure ulcer, abnormal loss of weight, and dementia. The physician orders for wound care identified the nurse was to assess the wound for location, size, stage, drainage, wound bed, and periwound. The very elderly patient was admitted to the hospital on 8/24/2014 with diagnoses, sepsis, urinary tract infection, worsening left decubitus ulcer, and adult failure to thrive.</p> <p>2. The skilled nursing notes completed 8/7/2014 through 8/21/2014 by employee C, a RN, failed to evidence an assessment of the size, stage, drainage, wound bed, or periwound.</p>	G000158	<p>G 158 and N 522 Follows a written POC. Correction Response: Failure to provide care as ordered in the plan of care.</p> <p>C1. The Clinical Operation Manager/designee will in services the skilled staff beginning 11/05/2014, to follow clinical policies to document in the clinical records, color, amount and odor of drainage and presence of necrotic debris, measure wound perimeter with disposable device, assess for undermining and tunneling by inserting a sterile swab into the wound bed, note condition of wound bed and surrounding skin. If necrotic tissue adheres to the wound, notify the physician and document in the clinical records. Completion of all staff in services by 11/05/2014.</p> <p>C2. Beginning immediately chart audits will be completed on all pressure wound care patients to assure compliance to the clinical policy C160 "Management of Pressure Ulcer Dressing Change" and that wounds that are deteriorating be notified to the physician and documented. Completion date of Chart audits will be 12/01/2014.</p> <p>C3. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	11/05/2014

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G000176	<p>3. At 2:39 PM on October 30, 2014, employee C, (RN), stated, "I measured the wound weekly but did not write it down." Employee A, the agency's administrator, indicated on October 30, 2014, at 2:45 PM that the wounds should be measured weekly and documented in the clinical record per agency policy.</p> <p>4. Agency policy C160, titled Pressure Ulcer Dressing Change, dated April 2008, states " Procedure: ... Note color, amount and odor of drainage and presence of necrotic debris ... Measure wound perimeter with disposable device ... Assess for undermining and tunneling by inserting a sterile swab into the wound bed ... Note condition of wound bed and surrounding skin. (If necrotic tissue adheres to the wound, notify the physician or wound care specialist.)"</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p>	G000176	G 176 and N544 – Duties of the	11/05/2014

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	<p>Based on interview and review of clinical records and agency policy, the registered nurse (RN) failed to prepare clinical notes documenting that care was provided as ordered in the plan of care for 1 (#1) of 3 clinical records reviewed creating the potential to affect all of the agency's patients 446 skilled nursing patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record number one, start of care 8/1/2014, included a plan of care established by the patient's physician for the certification period 8/1/2014 through 9/29/2014 that identified the patient's diagnoses were stage two pressure ulcer, abnormal loss of weight, and dementia. The physician orders for wound care identified the nurse was to assess the wound for location, size, stage, drainage, wound bed, and periwound. The very elderly patient was admitted to the hospital on 8/24/2014 with diagnoses, sepsis, urinary tract infection, worsening left decubitus ulcer, and adult failure to thrive. 2. The skilled nursing notes completed 8/7/2014 through 8/21/2014 by employee C, a RN, failed to evidence an assessment of the size, stage, drainage, wound bed, 		<p>Registered Nurse - The RN prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes of the patient's condition and needs.</p> <p>C1. The Clinical Operation Manager/designee will in service a RN staff beginning 11/05/2014 to assess the size, stage, drainage, wound bed or peri-wound weekly and document in the clinical record.</p> <p>All staff in services and will be completed by 11/05/2014 chart audits will be completed on all wound care patients to assure compliance to the clinical policy C160 "Management of Pressure Ulcer Dressing Change" and that wounds that are deteriorating be notified to the physician and documented.</p> <p>C2. Beginning immediately, C3. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>	

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N000000	<p>or periwound.</p> <p>3. At 2:39 PM on October 30, 2014, employee C, (RN), stated, "I measured the wound weekly but did not write it down." Employee A, the agency's administrator, indicated on October 30, 2014, at 2:45 PM that the wounds should be measured weekly and documented in the clinical record per agency policy.</p> <p>4. Agency policy C160, titled Pressure Ulcer Dressing Change, dated April 2008, states " Procedure: ... Note color, amount and odor of drainage and presence of necrotic debris ... Measure wound perimeter with disposable device ... Assess for undermining and tunneling by inserting a sterile swab into the wound bed ... Note condition of wound bed and surrounding skin. (If necrotic tissue adheres to the wound, notify the physician or wound care specialist.)"</p>	N000000		

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N000522	<p>This was a home health state complaint investigation.</p> <p>Complaint #IN00157203 - Substantiated: State deficiencies related to the allegation are cited.</p> <p>Survey Date: October 29-31, 2014</p> <p>Facility #005941</p> <p>Surveyor: Nina Koch , R.N, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 12, 2014</p> <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:</p> <p>Based on interview and review of clinical records and agency policy, the registered nurse (RN) failed to provide care as ordered in the plan of care for 1 (#1) of 3</p>	N000522	G 158 and N 522 Follows a written POC. Correction Response: Failure to provide care as ordered in the plan of care. C1. The Clinical Operation	12/01/2014

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	<p>clinical records reviewed creating the potential to affect all of the agency's patients 446 skilled nursing patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record number one, start of care 8/1/2014, included a plan of care established by the patient's physician for the certification period 8/1/2014 through 9/29/2014 that identified the patient's diagnoses were stage two pressure ulcer, abnormal loss of weight, and dementia. The physician orders for wound care identified the nurse was to assess the wound for location, size, stage, drainage, wound bed, and periwound. The very elderly patient was admitted to the hospital on 8/24/2014 with diagnoses, sepsis, urinary tract infection, worsening left decubitus ulcer, and adult failure to thrive. The skilled nursing notes completed 8/7/2014 through 8/21/2014 by employee C, a RN, failed to evidence an assessment of the size, stage, drainage, wound bed, or periwound. At 2:39 PM on October 30, 2014, employee C, (RN), stated, "I measured the wound weekly but did not write it down." Employee A, the agency's administrator, indicated on October 30, 		<p>Manage/designee will in services the skilled staff beginning 11/05/2014, to follow clinical policies to document in the clinical records, color, amount and odor of drainage and presence of necrotic debris, measure wound perimeter with disposable device, assess for undermining and tunneling by inserting a sterile swab into the wound bed, note condition of wound bed and surrounding skin. If necrotic tissue adheres to the wound, notify the physician and document in the clinical records. Completion of all staff in services by 11/05/2014.</p> <p>C2. Beginning immediately chart audits will be completed on all pressure wound care patients to assure compliance to the clinical policy C160 "Management of Pressure Ulcer Dressing Change" and that wounds that are deteriorating be notified to the physician and documented. Completion date of Chart audits will be 12/01/2014.</p> <p>C3. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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N000544	<p>2014, at 2:45 PM that the wounds should be measured weekly and documented in the clinical record per agency policy.</p> <p>4. Agency policy C160, titled Pressure Ulcer Dressing Change, dated April 2008, states " Procedure: ... Note color, amount and odor of drainage and presence of necrotic debris ... Measure wound perimeter with disposable device ... Assess for undermining and tunneling by inserting a sterile swab into the wound bed ... Note condition of wound bed and surrounding skin. (If necrotic tissue adheres to the wound, notify the physician or wound care specialist.)"</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on interview and review of clinical records and agency policy, the registered nurse (RN) failed to prepare clinical notes documenting that care was provided as ordered in the plan of care for 1 (#1) of 3 clinical records reviewed</p>	N000544	G 176 and N544 – Duties of the Registered Nurse - The RN prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes of the patient's condition and needs.	11/05/2014

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	<p>creating the potential to affect all of the agency's patients 446 skilled nursing patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record number one, start of care 8/1/2014, included a plan of care established by the patient's physician for the certification period 8/1/2014 through 9/29/2014 that identified the patient's diagnoses were stage two pressure ulcer, abnormal loss of weight, and dementia. The physician orders for wound care identified the nurse was to assess the wound for location, size, stage, drainage, wound bed, and periwound. The very elderly patient was admitted to the hospital on 8/24/2014 with diagnoses, sepsis, urinary tract infection, worsening left decubitus ulcer, and adult failure to thrive. 2. The skilled nursing notes completed 8/7/2014 through 8/21/2014 by employee C, a RN, failed to evidence an assessment of the size, stage, drainage, wound bed, or periwound. 3. At 2:39 PM on October 30, 2014, employee C, (RN), stated, "I measured the wound weekly but did not write it down." Employee A, the agency's administrator, indicated on October 30, 		<p>C1. The Clinical Operation Manager/designee will in service a RN staff beginning 11/05/2014 to assess the size, stage, drainage, wound bed or peri-wound weekly and document in the clinical record. All staff in services and will be completed by 11/05/2014 chart audits will be completed on all wound care patients to assure compliance to the clinical policy C160 "Management of Pressure Ulcer Dressing Change" and that wounds that are deteriorating be notified to the physician and documented.</p> <p>C2. Beginning immediately, C3. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>	

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