

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2015
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NAME OF PROVIDER OR SUPPLIER  HOME SERVICES UNLIMITED INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7750 N MICHIGAN RD INDIANAPOLIS, IN 46268
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G000000	<p>This visit was for a home health agency partial extended recertification survey.</p> <p>Dates of survey: 1-20, 1-21, 1-22, 1-23, and 1-26-2015</p> <p>Facility #: IN009865</p> <p>Medicaid Vendor #: 200122510A</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: 763 Skilled unduplicated admissions, past twelve months 118 Home Health Aide only 881 Total 183 Active patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 2, 2015</p>	G000000		
G000116	484.10(f) HOME HEALTH HOTLINE			

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>The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>Based on observation and interview, the agency failed to provide the correct phone number of the Home Health Hotline to 3 of 8 patients who received home visits (11, 13, and 16).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During home visit on 1-22-15 at 8:30 AM for patient 16, a document was observed in the patient's home packet titled "Home Care Patients / Clients Right and Responsibilities", undated, which included a phone number for the Indiana Home Health Complaint Hotline 1-800-246-8913. This reached a fast busy signal when called.</li> <li>2. During a home visit on 1-23-15 at 10:00 AM for patient 11, a document was observed in the patient's home packet</li> </ol>	G000116	<p>Administrator reeducated clinicians and a clerical personnel to ensure that correct phone number of home health hotline is included in all patients home records. All home records have been updated to reflect the correct hotline number. Ten percent of home records will be selected and audited by clinicians each quarter to ensure that the number in the home is correct. Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	01/26/2015			

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G000143	<p>titled "Home Care Patients / Clients Right and Responsibilities", undated, which included a phone number for the Indiana Home Health Complaint Hotline 800-277-6634. This was a disconnected phone number when called.</p> <p>3. During a home visit on 1-22-15 at 1:45 PM for patient 13, a document was observed in the patient's home packet titled "Home Care Patients / Clients Right and Responsibilities", undated, which included a phone number for the Indiana Home Health Complaint Hotline 800-277-6634, which was a disconnected phone number when called.</p> <p>4. The Alternate Administrator and Alternate Director of Nursing indicated on 1-23-15 at 9:30 AM the patient packets had been recently assembled and a mistake must have been made in the hotline phone number, the correct phone number on the ISDH website is 800-246-8909, but the agency has used 800-227-6334 in the past and this reaches the complaint hotline.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p>			

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	<p>Based on clinical record review and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 1 of 10 records reviewed of patients receiving more than one agency service (10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 10, start of care 12-20-14, evidenced a plan of care for the certification period of 12-20-14 to 2-17-15 with orders for Skilled Nursing (SN), Physical Therapy (PT), and Occupational Therapy (OT) The record failed to evidence communication between the disciplines.</li> <li>2. Agency policy "Coordination of Care", copyright 2014 by Suedkamp Enterprises, Inc., states "Staff should coordinate care with the patient/family and other team members providing care, including any personnel providing care under agreement. The RN or qualified therapist case manager oversees the process. Coordination efforts also include the physician and other agencies involved."</li> </ol>	G000143	<p>Administrator in-serviced staff on standard G143 and agency policy on care coordination. All personnel furnishing services will maintain liaison between physicians, family, patient, other disciplines, and other agencies involved to ensure that efforts are coordinated effectively and objectives outlined in the Plan of Care are supported. All communications to include telephone conversations and e-mails will be included in the patient record. Ten percent of all clinical records will be audited quarterly for evidence of documentation of phone calls with all disciplines, agencies, physicians, and patient/family. Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	02/23/2015

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G000144	<p>3. The Alternate Administrator indicated on 1-23-15 at 9:30 AM the clinicians use informal means of communication such as phone calls or emails, but that these were not part of the clinical record. The clinical record failed to evidence the personnel effectively supported the patient's care plan objectives through intercommunication. The agency expectation is these communications will be incorporated into the clinical record.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on policy review, review of clinical records, and interview, the agency failed to ensure the agency personnel maintained timely liaison to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care with another agency providing services for 1 of 3 wound care patients records reviewed (1).</p> <p>Findings include:</p> <p>1. Agency policy "Coordination of</p>	G000144	The Administrator in-serviced Clinicians that agency personnel must maintain timely liaison to ensure that efforts are coordinated efficiently and support the objectives in the patients Plan of Care with any other agency providing care Coordination of care should be ongoing guiding personnel providing care and other team members. Efforts should be effectively coordinated and support outcomes and goals identified in the plan of care and recorded in the clinical record. The clinical record should contain documentation of effective interchange, reporting,	02/23/2015

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	<p>Care", copyright 2014 by Suedkamp Enterprise, states, "Coordination of care is an ongoing process among personnel providing care and other team members. Coordination efforts should be effectively coordinated and support the outcomes and goals identified in the plan of care and then recorded in the clinical record ... The clinical record should contain documentation of effective interchange, reporting, and coordination of patient care ... Coordination efforts also include the physician and other agencies involved."</p> <p>2. Clinical Record (CR) 1, start of care (SOC) 3-4-14, diagnoses included pneumonia, methicillin resistant staph aureus, varicose ulcer of lower extremity, diabetes mellitus type 2, dysphagia, mild mental retardation, anemia, osteoporosis, and gastrostomy as identified in the plan of care (POC) for certification period 8-31 to 10-29-14. The skilled nursing (SN) goal for the certification period was "Wounds will heal without Complications within cert. period." Patient lived in a residential home with 2 other developmentally delayed patients.</p> <p>A. Patient 1 received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers.</p>		<p>and coordination of care Coordination efforts also include the physician and other agencies involved Ten percent of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard G144 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>B. Patient 1 was also receiving 24 hour a day attendant care services from another agency.</p> <p>C. The clinical record failed to evidence the agency maintained liaison with the agency providing 24 hour a day attendant care services which effectively coordinated their efforts to support the objectives in the patient's plan of care.</p> <p>3. During home visit of patient 10, on 1-23-15 at 10:45 AM, start of care 12-20-14, whose clinical record included a plan of care for the certification period of 12-20-14 to 2-17-15 with orders for services from skilled nursing, physical therapy, and occupational therapy, the patient indicated she received attendant care services from another agency. The clinical record failed to evidence documentation of coordination of care between this agency and the agency providing attendant care services.</p> <p>4. On 1-26-15 at 3:30 PM, Employee E indicated there were no case conference minutes for the patients 1 and 10 to show coordination of care between the 2 agencies.</p> <p>5. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the clinical</p>			

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G000145	<p>record failed to evidence communication and interventions were effectively coordinated and implemented.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record review and interview, the agency failed to ensure the 60 day clinical summary sent to the physician included information about the patient's condition as per agency policy for 1 of 9 clinical records reviewed containing 60 day summaries (2).</p> <p>Findings include:</p> <p>1. Clinical record 2, start of care 1-9-01, contained a plan of care (POC) for the certification period 12-27-14 to 2-24-15 with orders for skilled nursing services (SN). The 60 day clinical summary in this POC regarding the previous certification period of 10-28-14 to 12-26-14 stated, " Skilled nursing sees patient one time a week to prefill insulin syringes and med set up to assist the patient in medication compliance." During the certification period, SN had assessed cardiopulmonary status,</p>	G000145	<p>The Administrator has in-serviced the nursing staff that a written summary report - 'a compilation of the pertinent factors of a patient's clinical and progress notes' - must be sent to the physician at least 60 days. No recertification will be sent out without being audited by QI Director or Director of Clinical Services for presence of 60-day summary. Data regarding the presence of 60-day summary will be tracked by clinician. Ten percent of all clinical records will be audited quarterly for evidence that a written summary was sent to the attending physician every 60 days.</p> <p>The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/23/2015

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	<p>performed diabetic foot examinations, monitored patient's compliance with medications, monitored blood sugar testing log for results and compliance, and reinforced education regarding signs and symptoms of infections to report.</p> <p>2. Agency policy "Coordination of Patient Care", copyright 2000 MED-PASS, states "A written report summarizing the patient's condition and services provided will be sent to the patient's physician at least every 60 days."</p> <p>3. The Alternate Administrator indicated on 1-26-15 at 3:30 PM, indicated the nurse had performed the assessments and interventions above (finding 1). The 60 day summary described some of the services provided by SN, but failed to contain pertinent information about the patient's condition during the certification period as required by agency policy.</p>			

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G000159	<p>484.18(a) PLAN OF CARE</p> <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.</p> <p>Based on clinical record, policy review, and interview the agency failed to ensure all durable medical equipment in the home was on the plan of care for 2 of 8 home visits whose clinical records were reviewed (11,12) and 1 of 8 patients with clinical records review only (2), failed to include all indicated safety measures for 1 of 16 clinical records reviewed (10), failed to include all the medications the patient was taking for 1 of 8 home visits whose clinical records were reviewed (9), failed to include oxygen orders for a patient using oxygen for 1 of 16 clinical records reviewed (7), and failed to ensure the plan of care accurately reflected the activities permitted for 1 of 16 clinical records reviewed (1).</p> <p>Findings include:</p> <p>1. During home visit on 1-22-15 at 3:00</p>	G000159	<p>The administrator has inserviced clinicians that 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 prefer permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. The administrator re-iterated to clinicians that 1) all durable medical equipment in the home should be on the plan of care; 2) that all safety measures are included in the clinical record 3) that all medications and oxygen are included in the patient record 4) the plan of care accurately reflects the activities permitted. Ten percent of clinical records will be reviewed quarterly for evidence of this documentation.</p>	02/23/2015

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	<p>PM of patient 12, start of care (SOC), a rolling walker and cane were observed in the home, which the patient said he/she uses, but were not listed on the plan of care (POC) for the certification period 12-29-14 to 2-26-15.</p> <p>2. During home visit on 1-23-15 at 10:00 AM of patient 11, SOC 1-2-04, a rolling walker was observed in the home, which the patient said he/she uses, but was not listed on the POC for the certification period 1-5-15 to 3-5-15.</p> <p>3. Clinical record 10, SOC 12-20-14, contained a plan of care for the certification period 12-20-14 to 2-17-15 with orders for skilled nursing, physical therapy, and occupational therapy. The patient's medication orders included aspirin 325 mg by mouth every day. The safety precaution on the plan of care failed to include bleeding precautions.</p> <p>4. On 1-23-15 at 12:30 PM, during home visit of patient 9, the patient indicated he/she had started a new medication just before start of care. The medication he/she presented was not on the POC or the patient's medication profile. Both failed to include Chlordiazepoxide [milligrams ?] 1 tablet twice a day for 7 days, then 1 tablet daily for 7 days, then stop.</p>		Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	

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	<p>5. Clinical record 7, start of care (SOC) 4-20-14, contained a plan of care for the certification period 4-20-14 to 6-18-14 with orders for skilled nursing, physical therapy, occupational therapy, and medical social worker services. Skilled nursing notes indicated the patient was using 3 liters of oxygen per nasal cannula. Oxygen precautions were implemented and instruction given. The POC failed to include an order for the oxygen use.</p> <p>6. Clinical record 2, start of care (SOC) 1-9-01, contained a plan of care for the certification period 12-27-14 to 2-24-15 with orders for skilled nursing services for skilled "observation and assessment of cardiopulmonary status, nutrition / hydration. Prepare insulin syringes, teach signs and symptoms of Wound Infection." The POC listed "chem strips" under equipment and supplies but failed to include the patient's glucometer as durable medical equipment.</p> <p>7. Clinical Record 1, SOC 3-4-14, contained a POC for certification period 8-31 to 10-29-14 which listed Complete Bedrest on the Activities Permitted section of the POC.</p> <p>On 1-26-15 at 3:30 PM, Employee E</p>			

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	<p>indicated patient 1 was able to transfer with the assist of 1 person and could be up in wheelchair. The POC was not correct and did not accurately reflect the patient's activities permitted.</p> <p>8. Agency policy, "Plan of Care", copyright 2014 Suedkamp Enterprise, states, "Each patient has an individualized plan of care (POC) based on assessments and/or physician orders. The Plan of Care is not a static document. It includes but is not limited to ... discipline specific interventions ... The written plan of care (POC) is developed following a comprehensive assessment and collaboration with the physician for orders at admission ... This minimally includes: ... i. activities permitted ... j. safety measures ... l. drugs and treatments ... n. supplies and equipment."</p> <p>10. The Alternate Administrator indicated on 1-23-15 at 9:30 AM, for clinical records 11 and 12, the POC's did not include all equipment and supplies; clinical record 10 should have included bleeding precautions as a safety measure; and clinical record 7 should have had an order authorizing the use of oxygen per nasal cannula at a physician determined flow rate. On 1-16-15 at 3:30 PM, Alternate Administrator indicated clinical</p>			

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G000173	<p>record 2 should have included glucometer as durable medical equipment.</p> <p>11. The Nursing Supervisor indicated on 1-23-15 at 1:30 PM, the medication profile failed to include all the medications patient 9 was taking.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse initiated a necessary revision to the plan of care to accurately reflect the patient's activities permitted for 1 of 16 clinical records reviewed (1), and failed to ensure the registered nurse initiated a necessary revision to the plan of care to specify the duties of the nurse in 1 of 9 active clinical records with skilled nursing services reviewed (16).</p> <p>Findings include:</p> <p>1. Clinical Record 1, start of care 3-4-14,</p>	G000173	<p>Administrator has reinserviced registered nurses that they must initiate necessary revisions to the plan of care to accurately reflect the patients activities.</p> <p>Ten percent of clinical records will be reviewed quarterly for evidence of this documentation.</p> <p>Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	02/06/2015

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	<p>contained a plan of care (POC) for certification period 8-31 to 10-29-14 which listed Complete Bedrest on the Activities Permitted section of the POC.</p> <p>On 1-26-15 at 3:30 PM, Employee E indicated the patient was able to transfer with the assist of 1 person and could be up in wheelchair. The POC was not correct and did not accurately reflect the patient's activities permitted, the registered nurse should have had the POC amended with the correct activity level.</p> <p>2. Clinical record 16, start of care 12-19-14, contained a POC for the certification period 12-19-14 to 2-16-15 with orders for skilled nursing services (SN). The order for SN states "Once every da[y] X [for] 59 das[days]". The order failed to specify the duties of the SN during the once daily visits.</p> <p>The Alternate Administrator indicated on 1-23-15 at 9:30 AM, for clinical record 16, the SN was in the patient's home for daily Lovenox injections and for supervisory visits of the home health aide. The order for SN services in the POC should have included specific interventions.</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 clinical record review and interview, the agency failed to ensure the registered nurse addressed the accumulation of flies in the patient's home for 1 of 3 patients who were receiving wound care. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 1 identified the patient was sent to the emergency room by the skilled nurse, employee D on 9-7-14 for treatment of larvae in the right leg dressing. The patient had venous stasis ulcers for which the agency was providing wound care. Flies had been observed in the patient's room by Employee D on 9-5-14, and flies had landed on the removed dressing and on the legs during the dressing change.</li> <li>2. Flies were also observed in the patient's room on 9-24-14 by Employee D but did not contaminate the wound.</li> <li>3. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the patient's home environment issue was</li> </ol>	G000175	<p>The Administrator in-serviced nurses on responsibilities of Registered Nurse to ensure that nurses initiate appropriate preventive and rehabilitative nursing procedures (eg. accumulation of flies in patient's home should be addressed immediately and efforts coordinated with all parties involved in care of patient to ensure flies are out of patient's home ASAP). Efforts should be documented in the patient record. 10% of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard G175 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/06/2015
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G000176	<p>resolved 10-8-14 when the attendant care agency made a comprehensive review of the home, implemented additional interventions, and educated attendant caregiver staff regarding the maintaining a safe and healthy home environment for patients.</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> <p>Based on clinical record review and interview, the agency failed to ensure the skilled nurse (SN), Employee D, notified the physician of a change in patient's condition for 1 of 3 wound care patients whose clinical records were reviewed (1).</p> <p>Finding include:</p> <p>1. Clinical Record 1, start of care 3-4-14, contained a plan of care for certification period 8-31 to 10-29-14. The patient received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers.</p> <p>A. Patient 1 was sent to the emergency room by SN Employee D, on 9-7-14 for treatment of larvae in the right leg dressing.</p>	G000176	<p>The Administrator in-serviced nurses that it is the responsibility of the RN to prepare clinical and progress notes, coordinate services, inform the physician and other personnel of changes in the patient's condition and needs. Clinical record will show evidence that attending physician was notified of the change in patient's condition.</p> <p>Ten percent of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard G176 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/06/2015

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G000337	<p>B. The clinical record failed to evidence the agency notified the attending physician of this change in patient's condition.</p> <p>2. On 1-26-15 at 3:45 PM, Employee B indicated the agency expectation is that the physician will be notified when a change in the patient's condition necessitates an Emergency Room visit and this did not occur.</p> <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 observation, clinical record review, review of policy, and interview, the agency failed to ensure the medication profile included all the medications the patient was taking for 1 of 8 home visits whose clinical records were reviewed (9).</p> <p>Findings include:</p>	G000337	<p>Administrator has retrained clinicians that 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 the drug therapy.</p> <p>Ten percent of clinical records will</p>	02/06/2015

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	<p>1. On 1-23-15 at 12:30 PM, during home visit of patient 9, start of care 1-13-15, with plan of care (POC) for certification period 1-13-15 to 3-13-15, the patient indicated he/she had started a new medication just before start of care. The medication he/she presented was not on the patient's medication profile. It failed to include "Chlordiazepoxide [milligrams ?] 1 tablet twice a day for 7 days, then 1 tablet daily for 7 days, then stop."</p> <p>2. Agency policy, "Plan of Care", copyright 2014 Suedkamp Enterprise, states, "Each patient has an individualized plan of care (POC) based on assessments and/or physician orders. The POC is not a static document. It includes but is not limited to ... discipline specific interventions ... The written plan of care (POC) is developed following a comprehensive assessment and collaboration with the physician for orders at admission ... This minimally includes: ... l. drugs and treatments ..."</p> <p>3. On 1-23-15 at 1:30 PM, the Nursing Supervisor, who was present during the home visit, indicated the medication profile did not include all patient 9's medications.</p>		<p>be reviewed quarterly for evidence of this documnetation. Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	

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N000000	<p>This visit was for a home health agency state re-licensure survey,</p> <p>Survey dates: 1-20, 1-21, 1-22, 1-23, and 1-26-2015</p> <p>Facility #: IN009865</p> <p>Medicaid Vendor #: 200122510A</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: 763 Skilled unduplicated admissions, past twelve months 118 Home Health Aide only 881 Total 183 Active patients</p>	N000000		

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N000462	<p>Quality Review: Joyce Elder, MSN, BSN, RN February 2, 2015</p> <p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review and interview, the agency failed to ensure personnel files included a physical examination not more than 180 days prior to direct patient contact in 1 of 4 files reviewed (A).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file A, a home health aide, evidenced the individual had been hired on 11-17-10 as a home health aide. The file evidenced a physical examination by a physician dated 1-7-11.</li> <li>2. Agency policy "Required Employee Health Screening", copyright 2014</li> </ol>	N000462	Administrator has retrained staffing coordinator that employee must have a physical examination by physician or nurse practitioner no more than 180 days before the date that the employee has direct patient contact. Ten percent of employee records will be reviewed by the HR director quarterly to ensure that the standard is in compliance. The Staffing Coordinator will be responsible for monitoring this correction and ensuring it does not recur.	02/23/2015

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N000484	<p>Suedkamp Enterprise, states "All employees providing patient care are required to submit evidence of a physical examination by a physician or nurse practitioner no more than one hundred eighty days before the date that the employee has direct patient contact."</p> <p>3. The Alternate Nursing Supervisor indicated the employee roster provided listed a hire date of a previous term of employment. The most recent rehire date was 11-17-10 and Employee A's the physical exam was made after the employee had direct patient contact and was not as per agency policy.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record review and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care for</p>	N000484	Administrator has retrained clinicians that all personnel providing services shall maintain effective communications to ensure that their efforts appropriately complement one another and support the objective of patient care. The means of communication of the result shall	02/23/2015

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	<p>1 of 10 records reviewed of patients receiving more than one agency service (10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 10, start of care 12-20-14, evidenced a plan of care for the certification period of 12-20-14 to 2-17-15 with orders for Skilled Nursing (SN), Physical Therapy (PT), and Occupational Therapy (OT) The record failed to evidence communication between the disciplines.</li> <li>Agency policy "Coordination of Care", copyright 2014 by Suedkamp Enterprises, Inc., states "Staff should coordinate care with the patient/family and other team members providing care, including any personnel providing care under agreement. The RN or qualified therapist case manager oversees the process. Coordination efforts also include the physician and other agencies involved."</li> <li>The Alternate Administrator indicated on 1-23-15 at 9:30 AM the clinicians use informal means of communication such as phone calls or emails, but that these were not part of the clinical record. The clinical record failed to evidence the personnel effectively supported the</li> </ol>		<p>be documented in the clinical record or minutes of case conferences. Ten percent of clinical records will be reviewed quarterly for evidence of this documnetation. The Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>				

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N000486	<p>patient's care plan objectives through intercommunication. The agency expectation is these communications will be incorporated into the clinical record.</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on policy review, review of clinical records, and interview, the agency failed to ensure the agency personnel maintained timely liaison to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care with another agency providing services for 1 of 3 wound care patients records reviewed (1).</p> <p>Findings include:</p> <p>1. Agency policy "Coordination of Care", copyright 2014 by Suedkamp Enterprise, states, "Coordination of care is an ongoing process among personnel providing care and other team members.</p>	N000486	<p>Administrator retrained nursing staff that the home health agency's personnel shall coordinate its services with other health or social services providers serving the patient to ensure that clinicians maintain timely liaison to efficiently coordinate their efforts and support the objectives in the patient's Plan of Care. Coordination efforts and interventions will be documented in the patient's record.</p> <p>Ten percent of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard N486 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring</p>	02/23/2015

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	<p>Coordination efforts should be effectively coordinated and support the outcomes and goals identified in the plan of care and then recorded in the clinical record ... The clinical record should contain documentation of effective interchange, reporting, and coordination of patient care ... Coordination efforts also include the physician and other agencies involved."</p> <p>2. Clinical Record (CR) 1, start of care (SOC) 3-4-14, diagnoses included pneumonia, methicillin resistant staph aureus, varicose ulcer of lower extremity, diabetes mellitus type 2, dysphagia, mild mental retardation, anemia, osteoporosis, and gastrostomy as identified in the plan of care (POC) for certification period 8-31 to 10-29-14. The skilled nursing (SN) goal for the certification period was "Wounds will heal without Complications within cert. period." Patient lived in a residential home with 2 other developmentally delayed patients.</p> <p>A. Patient 1 received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers.</p> <p>B. Patient 1 was also receiving 24 hour a day attendant care services from another agency.</p>		these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	<p>C. The clinical record failed to evidence the agency maintained liaison with the agency providing 24 hour a day attendant care services which effectively coordinated their efforts to support the objectives in the patient's plan of care.</p> <p>3. During home visit of patient 10, on 1-23-15 at 10:45 AM, start of care 12-20-14, whose clinical record included a plan of care for the certification period of 12-20-14 to 2-17-15 with orders for services from skilled nursing, physical therapy, and occupational therapy, the patient indicated she received attendant care services from another agency. The clinical record failed to evidence documentation of coordination of care between this agency and the agency providing attendant care services.</p> <p>4. On 1-26-15 at 3:30 PM, Employee E indicated there were no case conference minutes for the patients 1 and 10 to show coordination of care between the 2 agencies.</p> <p>5. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the clinical record failed to evidence communication and interventions were effectively coordinated and implemented.</p>			

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N000502	<p>410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency.</p> <p>Based on observation and interview, the agency failed to provide the correct phone number of the Home Health Hotline to 3 of 8 patients who received home visits (11, 13, and 16).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During home visit on 1-22-15 at 8:30 AM for patient 16, a document was observed in the patient's home packet titled "Home Care Patients / Clients Right and Responsibilities", undated, which included a phone number for the Indiana Home Health Complaint Hotline 1-800-246-8913. This reached a fast busy signal when called.</li> <li>2. During a home visit on 1-23-15 at 10:00 AM for patient 11, a document was observed in the patient's home packet titled "Home Care Patients / Clients</li> </ol>	N000502	<p>Administrator reeducated clinicians and a clerical personnel to ensure that correct phone number of home health hotline is included in all patients home records. All home records have been updated to reflect the correct hotline number.</p> <p>Ten percent of home records will be selected by clinicians each quarter to ensure that the number in the home is correct. Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	01/26/2015
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N000524	<p>Right and Responsibilities", undated, which included a phone number for the Indiana Home Health Complaint Hotline 800-277-6634. This was a disconnected phone number when called.</p> <p>3. During a home visit on 1-22-15 at 1:45 PM for patient 13, a document was observed in the patient's home packet titled "Home Care Patients / Clients Right and Responsibilities", undated, which included a phone number for the Indiana Home Health Complaint Hotline 800-277-6634, which was a disconnected phone number when called.</p> <p>4. The Alternate Administrator and Alternate Director of Nursing indicated on 1-23-15 at 9:30 AM the patient packets had been recently assembled and a mistake must have been made in the hotline phone number, the correct phone number on the ISDH website is 800-246-8909, but the agency has used 800-227-6334 in the past and this reaches the complaint hotline.</p> <p>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</p>			

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	<p>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> <p>Based on clinical record, policy review, and interview the agency failed to ensure all durable medical equipment in the home was on the plan of care for 2 of 8 home visits whose clinical records were reviewed (11,12) and 1 of 8 patients with clinical records review only (2), failed to include all indicated safety measures for 1 of 16 clinical records reviewed (10), failed to include all the medications the patient was taking for 1 of 8 home visits whose clinical records were reviewed (9), failed to include oxygen orders for a patient using oxygen for 1 of 16 clinical</p>	N000524	<p>Administrator has retrained clinicians that 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</p>	02/23/2015

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	<p>records reviewed (7), and failed to ensure the plan of care accurately reflected the activities permitted for 1 of 16 clinical records reviewed (1).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During home visit on 1-22-15 at 3:00 PM of patient 12, start of care (SOC), a rolling walker and cane were observed in the home, which the patient said he/she uses, but were not listed on the plan of care (POC) for the certification period 12-29-14 to 2-26-15.</li> <li>2. During home visit on 1-23-15 at 10:00 AM of patient 11, SOC 1-2-04, a rolling walker was observed in the home, which the patient said he/she uses, but was not listed on the POC for the certification period 1-5-15 to 3-5-15.</li> <li>3. Clinical record 10, SOC 12-20-14, contained a plan of care for the certification period 12-20-14 to 2-17-15 with orders for skilled nursing, physical therapy, and occupational therapy. The patient's medication orders included aspirin 325 mg by mouth every day. The safety precaution on the plan of care failed to include bleeding precautions.</li> <li>4. On 1-23-15 at 12:30 PM, during home visit of patient 9, the patient indicated</li> </ol>		<p>timely discharge or referral Ten percent of clinical records will be reviewed quarterly for evidence of this documnetation. Director of clinical services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>he/she had started a new medication just before start of care. The medication he/she presented was not on the POC or the patient's medication profile. Both failed to include Chlordiazepoxide [milligrams ?] 1 tablet twice a day for 7 days, then 1 tablet daily for 7 days, then stop.</p> <p>5. Clinical record 7, start of care (SOC) 4-20-14, contained a plan of care for the certification period 4-20-14 to 6-18-14 with orders for skilled nursing, physical therapy, occupational therapy, and medical social worker services. Skilled nursing notes indicated the patient was using 3 liters of oxygen per nasal cannula. Oxygen precautions were implemented and instruction given. The POC failed to include an order for the oxygen use.</p> <p>6. Clinical record 2, start of care (SOC) 1-9-01, contained a plan of care for the certification period 12-27-14 to 2-24-15 with orders for skilled nursing services for skilled "observation and assessment of cardiopulmonary status, nutrition / hydration. Prepare insulin syringes, teach signs and symptoms of Wound Infection." The POC listed "chem strips" under equipment and supplies but failed to include the patient's glucometer as durable medical equipment.</p>			

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	<p>7. Clinical Record 1, SOC 3-4-14, contained a POC for certification period 8-31 to 10-29-14 which listed Complete Bedrest on the Activities Permitted section of the POC.</p> <p>On 1-26-15 at 3:30 PM, Employee E indicated patient 1 was able to transfer with the assist of 1 person and could be up in wheelchair. The POC was not correct and did not accurately reflect the patient's activities permitted.</p> <p>8. Agency policy, "Plan of Care", copyright 2014 Suedkamp Enterprise, states, "Each patient has an individualized plan of care (POC) based on assessments and/or physician orders. The Plan of Care is not a static document. It includes but is not limited to ... discipline specific interventions ... The written plan of care (POC) is developed following a comprehensive assessment and collaboration with the physician for orders at admission ... This minimally includes: ... i. activities permitted ... j. safety measures ... l. drugs and treatments ... n. supplies and equipment."</p> <p>10. The Alternate Administrator indicated on 1-23-15 at 9:30 AM, for clinical records 11 and 12, the POC's did</p>			

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N000529	<p>not include all equipment and supplies; clinical record 10 should have included bleeding precautions as a safety measure; and clinical record 7 should have had an order authorizing the use of oxygen per nasal cannula at a physician determined flow rate. On 1-16-15 at 3:30 PM, Alternate Administrator indicated clinical record 2 should have included glucometer as durable medical equipment.</p> <p>11. The Nursing Supervisor indicated on 1-23-15 at 1:30 PM, the medication profile failed to include all the medications patient 9 was taking.</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on clinical record review and interview, the agency failed to ensure the 60 day clinical summary sent to the physician included information about the patient's condition as per agency policy for 1 of 9 clinical records reviewed containing 60 day summaries (2).</p>	N000529	Administrator retrained clinicians that a written summary report will be sent to the physician at every 60 days and include information about the patient's condition and services provided. Ten percent of clinical records will be reviewed quarterly for evidence of this documentation. Director of clinical services will be responsible for monitoring these corrective actions to ensure that	02/23/2015

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	<p>Findings include:</p> <p>1. Clinical record 2, start of care 1-9-01, contained a plan of care (POC) for the certification period 12-27-14 to 2-24-15 with orders for skilled nursing services (SN). The 60 day clinical summary in this POC regarding the previous certification period of 10-28-14 to 12-26-14 stated, " Skilled nursing sees patient one time a week to prefill insulin syringes and med set up to assist the patient in medication compliance." During the certification period, SN had assessed cardiopulmonary status, performed diabetic foot examinations, monitored patient's compliance with medications, monitored blood sugar testing log for results and compliance, and reinforced education regarding signs and symptoms of infections to report.</p> <p>2. Agency policy "Coordination of Patient Care", copyright 2000 MED-PASS, states "A written report summarizing the patient's condition and services provided will be sent to the patient's physician at least every 60 days."</p> <p>3. The Alternate Administrator indicated on 1-26-15 at 3:30 PM, indicated the nurse had performed the assessments and interventions above (finding 1). The 60</p>		this deficiency is corrected and does not recur.		

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N000542	<p>day summary described some of the services provided by SN, but failed to contain pertinent information about the patient's condition during the certification period as required by agency policy.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse initiated a necessary revision to the plan of care to accurately reflect the patient's activities permitted for 1 of 16 clinical records reviewed (1), and failed to ensure the registered nurse initiated a necessary revision to the plan of care to specify the duties of the nurse in 1 of 9 active clinical records with skilled nursing services reviewed (16).</p> <p>Findings include:</p> <p>1. Clinical Record 1, start of care 3-4-14, contained a plan of care (POC) for certification period 8-31 to 10-29-14 which listed Complete Bedrest on the Activities Permitted section of the POC.</p>	N000542	Administrator has reinserviced registered nurses that they must initiate necessary revisions to the plan of care to accurately reflect the patients activities. Ten percent of clinical records will be reviewed quarterly for evidence of this documentation. Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	02/23/2015

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	<p>On 1-26-15 at 3:30 PM, Employee E indicated the patient was able to transfer with the assist of 1 person and could be up in wheelchair. The POC was not correct and did not accurately reflect the patient's activities permitted, the registered nurse should have had the POC amended with the correct activity level.</p> <p>2. Clinical record 16, start of care 12-19-14, contained a POC for the certification period 12-19-14 to 2-16-15 with orders for skilled nursing services (SN). The order for SN states "Once every da[y] X [for] 59 das[days]". The order failed to specify the duties of the SN during the once daily visits.</p> <p>The Alternate Administrator indicated on 1-23-15 at 9:30 AM, for clinical record 16, the SN was in the patient's home for daily Lovenox injections and for supervisory visits of the home health aide. The order for SN services in the POC should have included specific interventions.</p>			

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N000543	<p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse addressed the accumulation of flies in the patient's home for 1 of 3 patients who were receiving wound care. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 1 identified the patient was sent to the emergency room by the skilled nurse, employee D on 9-7-14 for treatment of larvae in the right leg dressing. The patient had venous stasis ulcers for which the agency was providing wound care. Flies had been observed in the patient's room by Employee D on 9-5-14, and flies had landed on the removed dressing and on the legs during the dressing change.</li> <li>Flies were also observed in the</li> </ol>	N000543	<p>Administrator retrained the nurses that the registered nurse (except where services are limited to Therapy-only) shall: initiate appropriate preventive and rehabilitative nursing procedures. If a situation occurs that could affect the care of the patient the registered nurse shall immediately address the situation and coordinate efforts with other agency to insure the situation is rectified immediately. The documentation in the patient record should show evidence of nurse's efforts. 10% of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard N543 and the HSU policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/23/2015

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N000546	<p>patient's room on 9-24-14 by Employee D but did not contaminate the wound.</p> <p>3. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the patient's home environment issue was resolved 10-8-14 when the attendant care agency made a comprehensive review of the home, implemented additional interventions, and educated attendant caregiver staff regarding the maintaining a safe and healthy home environment for patients.</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the skilled nurse (SN), Employee D, notified the physician of a change in patient's condition for 1 of 3 wound care patients whose clinical records were reviewed (1).</p> <p>Finding include:</p>	N000546	Administrator retrained nurses that the registered nurse must inform physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family, meeting the nursing related needs, participate in in-service programs and supervise and teach other nursing personnel, with the exception	02/23/2015

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	<p>1. Clinical Record 1, start of care 3-4-14, contained a plan of care for certification period 8-31 to 10-29-14. The patient received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers.</p> <p>A. Patient 1 was sent to the emergency room by SN Employee D, on 9-7-14 for treatment of larvae in the right leg dressing.</p> <p>B. The clinical record failed to evidence the agency notified the attending physician of this change in patient's condition.</p> <p>2. On 1-26-15 at 3:45 PM, Employee B indicated the agency expectation is that the physician will be notified when a change in the patient's condition necessitates an Emergency Room visit and this did not occur.</p>		<p>where services are limited to therapy only. 10% of all clinical records will be audited quarterly for evidence of documentation that nurses are notifying physicians of changes in patients' condition. The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				