

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2012
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NAME OF PROVIDER OR SUPPLIER VISITING NURSE SERVICE	STREET ADDRESS, CITY, STATE, ZIP CODE 4701 N KEYSTONE AVE INDIANAPOLIS, IN 46205
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G0000	<p>This visit was a Home Health federal recertification survey. This was a fully extended survey.</p> <p>Survey Dates: September 17, 18, 19, 20, 21, and 24, 2012 Extended Survey Dates: September 21 and 24, 2012</p> <p>Facility Number: IN005250</p> <p>Medicaid Number: 100271960A</p> <p>Surveyors: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor, Team Leader Miriam Bennett, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 2214 Home Health Aide Only: 19 Personal Care Only: 0 Total: 2233</p> <p>Sample: RR w/HV: 10 RR w/o HV: 10 Total: 20</p>	G0000		

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>VNS at St. Francis, Inc is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning October 1, 2012, to October 1, 2014, due to being found out of compliance with the Condition of Participation 42 CFR 484.18: Acceptance of patients, plan of care and medical supervision and 484.30: Skilled Nursing Services.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 1, 2012</p>			

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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on policy review, document review, observation, and interview, the agency failed to ensure the home health agency's infection control policies were followed during 3 of 10 home visits with the potential to affect all the patients seen by employees J, Q, and A. (#1, 3, and 8)</p> <p>The findings include:</p> <p>1. Facility policy titled "Standards of Practice" policy number C-48 dated 1/11 states, "Visiting Nurse Service, Inc. will identify and define standards of care, service, and practice to guide the provision of patient care for home care services, in addition to the policies defined which support standards of care/service. Standards of Practice include State Practice Act Rules for each discipline ... Based on referral information and the initial assessment, the clinician / technician, in conjunction with other organization personnel, will select the most appropriate standards of</p>	G0121	The Clinical Managers will inservice the nursing, therapy and home health aide direct patient care staff on the agency's infection control policies and procedures and the Center for Disease Control "Standard Precautions". CPP13.15 PICC procedure was updated to include measurement of PICC line. All field staff will attend the October 2012 skillsfair and have discipline assigned competencies completed and documented on stations handwashing, infection control VAD, wounds, PICC and central lines. In addition, all field staff will be observed in the home by a Clinical Manger by January 31, 2013, then annually thereafter to ensure that the deficiencies are corrected and will not recur. Any noncompliance identified during observation will be addressed as a performance issue and competencies validated through one on one education and demonstration. Anyone identified with performance issues will have ongoing monitoring through home visit observation with progressive disciplinary action taken up to termination. The Director of Home Care Services will be responsible for monitoring these	10/31/2012

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	<p>care / service and practice guidelines for the patient's care / service ... Standards of care / service and practice guidelines will guide the interventions that are to be implemented. The following standards of care / service and practice are available for use in planning the care of the patient. A. Discipline Specific Practice Acts B. Professional Association member standards. Use of standards of care / service and practice will be evident in the documentation of visits and assessments, as well as in the care / service planning process."</p> <p>2. Facility policy titled "Application of Wound Dressing" policy number CPP5.03 dated 4/11 states, "Adhere to standard Precautions; review physician's orders; explain procedure to patient / caregiver; establish a clean field (sterile, if necessary) with all the supplies and equipment that will be necessary; Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves."</p> <p>3. Facility policy titled "BATH: BED (ADULT)," #CPP2.01, dated 4/11, states "27. Offer the client a soapy washcloth to wash her/his genital area, and then a</p>		corrective actions to ensure that the deficiencies are corrected and will not recur.		

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	<p>clean wet washcloth to rinse his/her self."</p> <p>4. Facility policy titled "PERINEAL CARE-FEMALE," #CPP2.07, dated 1/09, states "3. To prevent contamination, wipe from front to back or wipe toward the anus."</p> <p>5. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," #CPP13.15, dated 8/00, states "C. Dressing Change, Procedure: ... 10. Clean exit site with three alcohol applicators ... Allow to air dry."</p> <p>6. Document review from the Centers for Disease Control (CDC) titled "Guideline for Hand Hygiene in Health Care Settings" volume number 51, document number RR-16 dated 10/25/02 states, "Indications for handwashing and hand antisepsis: ... F. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. H. Decontaminate hands if moving from a contaminated-body site</p>			

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	<p>to a clean-body site during patient care.</p> <p>I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... 6. Other Aspects of Hand Hygiene ... C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur. D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients. E. Change gloves during patient care if moving from a contaminated body site to a clean body site. "</p> <p>7. Document review from the Centers for Disease Control (CDC) titled "Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011," states "Catheter Site Dressing Regimens ... 14. Monitor the catheter sites visually when changing the dressing or by palpation through an intact dressing on a regular basis."</p> <p>8. During a home visit on 9/19/12 at 1:10 PM, employee J, Licensed Practical Nurse (LPN), was performing a dressing change on patient #8. The LPN removed the old dressing, applied saline wash,</p>			

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	<p>measured wound, and proceeded to apply a new dressing to each wound. No glove change or hand sanitation was done throughout the entire dressing change.</p> <p>On 9/20/12 at 4:55 PM, employee R, Director, indicated she spoke with employee J regarding not changing her gloves and the LPN indicated she was nervous and realized that she had forgotten to do so.</p> <p>9. During home visit on 9/19/12 at 9:15 AM, employee Q, a Home Health Aide (HHA) was observed providing a bed bath for patient #1. The HHA failed to change gloves until the bath was complete, including helping the patient dress and comb hair. During the bath, the HHA failed to use clean washcloths for cleaning the perineal and rectal areas, and washed the rectal area prior to washing the perineal area. The HHA then proceeded to apply lotion to the patient's skin beginning with the legs and moving up to the the belly, arms and back, still wearing the same pair of gloves used for the bath. The HHA then applied Desitin cream to the folds of the patient's back and buttocks, arm pits, breast folds, and then to the groin folds. Clean clothes were gathered from the</p>			

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	<p>dresser while still wearing the same gloves used for the bath. The HHA then proceeded to brush the patient's hair with the same gloves.</p> <p>On 9/20/12 at 4:15 PM, employee S, Alternate Nursing Supervisor, indicated the HHA should have changed gloves prior to providing perineal and rectal washing and before putting clothes on the patient. Also the HHA should have washed the perineal area prior to the rectal area.</p> <p>10. During a home visit on 9/19/12 at 11:45 AM with patient #3, employee A, Registered Nurse (RN), was observed changing a PICC line dressing. The RN removed the old dressing and taped the line to the patient's arm. The tape came unfastened, leaving the line dangling. The RN touched the PICC insertion site with the same gloves used to remove the old dressing. Antiseptic skin prep was then applied and the RN fanned it with the gloved hand.</p>			

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G0143	<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> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure coordination of care occurred between all personnel furnishing services and the physician for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician." 2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated 	G0143	The Clinical Managers will inservice the clinical field staff on communicating significant information related to patient's needs and changes in condition to the physician and other disciplines to ensure optimal care for the patients as per P&Ps to ensure coordination of care as outlined in the plan of care. All field staff will be inserviced on required communication to the assigned case manager, information to be shared during case conferencing and the SBAR communication technique. Care coordination scenarios will be utilized for discipline specific competency evaluations. 10% of all clinical records will be audited quarterly for evidence that there is care coordination that support the objectives outlined in the plan of care and that the clinical staff have appropriately communicated with the physician and other disciplines involved in the patient's care. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	10/31/2012

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	10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs within 24 hours."			

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	<p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. Facility policy titled "Medical Social Service Assessment" policy number CD</p>			

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	<p>1.09 dated 4/11 states, "Social work services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's condition; maintains contact/communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p>			

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	<p>7. Clinical record #4, Start of Care (SOC) 5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee K, RN, documented a pressure ulcer on the "RLE</p>			

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	<p>[right lower extremity] upper." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There is no evidence this new wound was reported to the physician or that any orders were received for a dressing</p>			

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	<p>change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee D, LPN,</p>			

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	<p>documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm [centimeter] around. Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious disease doctor, patient states he has an appt on 9/20/12. Writer spoke with [employee F, RN] concerning visit and</p>			

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	<p>left shin blister."</p> <p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and to get orders to treat. The LPN gave the patient the fax number to VNS and told the patient to have the doctor's office fax any new orders to VNS. The LPN stated they have been aware of the wound on the left shin and have been</p>				

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	<p>monitoring it. The patient then took their blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer replacement would have been appropriate; however, there was no evidence that this was done.</p> <p>I. On 9/20/12 at 4:50 PM, employee R, Director indicated the new wound on the</p>			

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	<p>shin should have been reported to the physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p>			

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	<p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to</p>			

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	<p>the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/14/12 employee F, RN, documented "PRN [as needed] visit made after client's daughter called the office with concerns. When SN arrived</p>			

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	<p>client was lying in bed. Skin is pale, using accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address patient's depression. No new orders for skin repair cream were found and no follow up with physician was made.</p> <p>D. On 9/20/12 at 4:58 PM, employee R, Director, indicated the change in patient</p>			

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	<p>condition should have been reported to the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/6/12 employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or</p>						

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	<p>that any orders were received for a dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the</p>						

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	<p>front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the RN and PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented in the clinical notes.</p>			

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	<p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and there was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>15. Clinical record #16, start of care</p>			

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	<p>12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record blood sugar checks to determine trending and evaluate care. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/6/12, employee D, a LPN,</p>			

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	<p>documented the patient did not have batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to evidence follow up with orders.</p> <p>17. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patient's Vital</p>			

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	<p>Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>			

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G0156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on policy review, record review, job description review, and interview, it was determined the home health agency failed to ensure therapy visits were provided as ordered in 5 of 11 records reviewed of those receiving therapy services with the potential to affect all patient's of the agency who receive therapy services and treatments were provided as ordered in in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (See G 158); failed to ensure physician was notified regarding changes in the patient's condition for 11 of 20 patient records reviewed with the potential to affect all patients of the agency (See G 164); and failed to ensure treatments are provided only as ordered on the plan of care in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services (See G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.18:</p>	G0156	<p>The Clinical Managers will inservice the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and communicating significant information related to patient's needs and change in condition to the physicians and other disciplines to ensure optimal care for the patients. All filed staff will be inserviced on required communication to the assigned case manager. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will audited quarterly for evidence that the clinical staff have followed the plan of care and appropriately communicated with the physician and other disciplines involved in the patient's care. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>	10/31/2012	

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	Acceptance of patients, plan of care and medical supervision.				

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on policy review, record review, job description review, and interview, the home health agency failed to ensure therapy visits were provided as ordered in 5 of 11 records reviewed of those receiving therapy services with the potential to affect all patient's of the agency who receive therapy services (#5, 9, 10, 18 and 19) and treatments were provided as ordered in in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (#2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 17, and 18)</p> <p>Findings include:</p> <p>Related to therapy services:</p> <p>1. Facility policy titled "Missed Visit Report" policy number CD 5.8 dated 3/10 states, "A missed visit occurs, when a discipline makes less than the physician ordered frequency. This agency uses the Medicare week to base visit frequency (Sunday through Saturday) ... The missed</p>	G0158	The Clinical Managers will inservice the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and on communicating significant information related to patient's needs and change in condition to the physician and other disciplines to ensure optimal care for the patients. A field staff will be inserviced on required communication to the assigned case manager. Periodic review of patient's plan of care will occur at routinely scheduled case conferences. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will audited quarterly for evidence that the clinical staff have followed the plan of care and appropriatley communicated with the physician and other disciplines involved in the patient's care. The Director of Home Health Care Services will	10/31/2012	

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	<p>visit is documented in the EMR [Electronic Medical Record] clinical note with the reason. The visit is marked as unmade on the schedule. The visit is rescheduled, if at all possible with the Medicare. Visits not made in accordance with physician orders are communicated to the physician."</p> <p>2. Facility policy titled "Occupational Therapy Evaluation," policy number CD 1.23, dated 4/11, states "1. The OTR will be responsible for initial contact to the patient within 48 hours of receiving the referral. 2. The OTR must complete documentation within 48 hours after completing the evaluation."</p> <p>3. Clinical record #5, start of care 9/9/12, contained a plan of care for the certification period dated 9/9/12 - 11/7/12 with orders for Physical Therapy two times a week for one week. The record failed to evidence PT saw the patient two times the week of 9/9/12-9/15/12.</p> <p>4. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for Speech Therapy one time per week for one week beginning 9/2/12. Review of the record</p>		<p>be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>				

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	<p>failed to evidence any speech therapy visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>5. Clinical record #10, start of care 8/8/10, contained a plan of care for the certification period dated 8/8/12 - 10/6/12 with orders for Speech Therapy one time per week for six weeks beginning 8/26/12. Review of the record failed to evidence any speech therapy visits were made the week of 9/2/12. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>6. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Occupational Therapy (OT) evaluation. The record failed to evidence a OT evaluation had been completed.</p> <p>7. Clinical record #19, start of care 8/21/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for PT 2 times a week for 4 weeks (8/28/12). The record failed to evidence a second visit was made by PT during week 1.</p>			

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	<p>8. On 9/21/12 at 11:07 AM, employee T, Clinical Manager, indicated and verified the second PT visit was not done for patient #5 and #19.</p> <p>Related to treatments provided as ordered:</p> <p>1. Facility policy titled "Licensed Practical Nurse (LPN) Utilization," policy number CPP12.07 dated 4/11 states, "The LPN may make subsequent visits, report client status, follow Plan of Care, provide appropriate treatment, reinforce teaching, document on appropriate forms."</p> <p>2. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>3. Facility policy titled "Application of</p>			

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	<p>Wound Dressing," policy number CPP5.03, dated 4/11, states "After Care:</p> <p>1. Document in patient's record: ... c. Temperature and vital signs."</p> <p>4. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>5. The job description titled "Registered Nurse (RN)" last modified 9/24/12 states "Job Description Summary: Care for assigned patients by assessing needs, implementing nursing care plans, providing appropriate interventions, making appropriate revisions, and evaluating outcomes of care."</p> <p>6. The job description titled "Licensed Practical Nurse (LPN)" last modified 9/24/12 states "Implements plan of care initiated by the registered nurse."</p> <p>7. Clinical Record #2, start of care (SOC)</p>			

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	<p>8/30/12 contained a plan of care for the certification period dated 8/30/12-10/28/12 with orders to assess IV site in left upper arm Single Lumen (SL) Peripherally Inserted Central Catheter (PICC), change dressing to IV Access weekly and as needed (PRN) per agency protocol and record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12, employee K, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>B. On 9/1/12, employee Z, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>C. On 9/6/12, employee A, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>D. On 9/13/12, employee L, LPN, failed to measure the PICC line and record a blood sugar reading.</p> <p>E. On 9/1/12 employee Z documented the patient called to report the PICC site was bleeding and blood was running down the arm and may have been due to over manipulation of the line when</p>			

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	<p>antibiotics administered. Routine Visit note dated 9/1/12 by employee Z failed to indicate the line was measured after dressing change, and no physician contact was made.</p> <p>F. During home visit observation on 9/19/12 at 10:45 AM, employee I, a LPN, was observed drawing blood from a Peripherally Inserted Central Catheter (PICC) line and changing the PICC line dressing. The LPN failed to measure the PICC line catheter.</p> <p>8. Clinical record #3, start of care 8/18/12, contained a plan of care for the certification period dated 8/18/12 - 10/16/12 with orders to change dressing to IV access weekly and PRN per agency protocol. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/18/12, employee F, LPN, failed to measure the PICC line.</p> <p>B. On 8/21, 8/23, and 9/4, and 9/12/12, employee A, RN, failed to measure the PICC line.</p> <p>C. On 8/28/12, employee I, LPN, failed to measure the PICC line.</p> <p>D. During home visit observation with</p>			

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	<p>patient #3 on 9/19/12 at 11:45 AM, employee A, a RN, was observed changing a Peripherally Inserted Central Catheter (PICC) line dressing. The RN failed to measure the PICC line catheter.</p> <p>E. On 9/20/12 at 4:20 PM, employee R indicated the PICC lines do not ever have to be measured as it is not part of the agency's policy.</p> <p>9. Clinical record #4, start of care 5/16/11, contained a plan of care for the certification period 7/9/12 -,9/6/12 with orders for Skilled Nurse (SN) to assess vital signs and report any adverse results to physician, assess for signs and symptoms of infection and wound care to be performed by SN on visit days and by spouse on non-visit days. Review of the nursing assessment evidenced the following:</p> <p>A. On 7/13/12, employee T, RN, failed to record a temperature.</p> <p>B. On 7/25/12, employee V, LPN, failed to change dressing to right abdominal wound site.</p> <p>10. Clinical record #5, start of care 9/9/12, contained a plan of care for the certification period dated 9/9/12 -</p>			

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	<p>11/7/12 with orders for SN to assess vital signs and report any adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/9/12 employee T, RN, failed to record a temperature.</p> <p>B. On 9/14/12 employee Y, RN, failed to record a temperature.</p> <p>11. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity (RLE) and orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12, employee K, RN, documented a pressure ulcer on the "RLE upper." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>B. On 8/27/12, employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the</p>			

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	<p>dressings was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>C. On 8/29/12, employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>12. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 -9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary," and orders to</p>			

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	<p>"Assess/teach Diabetic care, diet, hyper / hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/12/12, employee G, RN, failed to record a blood sugar check.</p> <p>B. On 8/22/12, employee V, LPN, , failed to record a blood sugar check.</p> <p>D. On 8/29/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>E. On 9/7/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>F. On 9/10/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>G. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." The LPN failed to record the patient's blood sugar. The LPN's clinical note stated "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm around. Instructed patient to keep covered with dry 4x4 until seen by infectious disease doctor, patient states</p>			

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	<p>he has an appt [appointment] on 9/20/12." The plan of care failed to evidence any orders to instruct the patient to cover the wound and for a dressing to be applied.</p> <p>H. On 9/12/12, employee D, LPN, failed to record a blood sugar.</p> <p>I. On 9/17/12 employee F, RN, failed to record a blood sugar.</p> <p>J. On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken.</p> <p>13. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -,10/7/12 with orders to "Assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integument, endocrine, circulatory," orders to "assess vital signs and report any adverse results to the physician," and orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing</p>						

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	<p>assessment evidenced the following:</p> <p>A. On 8/10/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>B. On 8/13/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The</p>			

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	<p>assessment also fails to evidence that all vital signs were taken. Only respiration and blood pressure were documented.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>F. On 8/24/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care</p>			

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	<p>failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>G. On 8/27/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>H. On 8/29/12, employee H, RN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>I. On 8/31/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>J. On 9/3/12, employee M, RN, failed to document any vital signs.</p> <p>K. On 9/5/12, employee J, LPN, failed to</p>			

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	<p>document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>L. On 9/10/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>M. On 9/12/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>N. On 9/14/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>O. On 9/17/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>P. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>14. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders that state to assess</p>			

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	<p>vital signs and report and adverse results to physician. Review of the nursing clinical notes evidenced the following: On 8/2/12, employee F, RN, failed to document all vital signs. Only temperature was documented.</p> <p>15. Clinical record #10, start of care 8/8/12, contained a plan of care for the certification period dated 8/8/12 - 10/6/12 with orders to "assess vital signs and report and adverse results to the physician." Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee B, RN, failed to document all vital signs. Only pain was reported.</p> <p>B. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration, and temperature should be taken every visit.</p> <p>16. Clinical record #12, start of care 8/13/10, contained a plan of care for the certification period dated 8/2/12 - 10/11/12 with orders that state to assess vital signs and report and adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/23/12 employee W, RN, failed</p>			

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	<p>to document all vital signs. Only blood pressure was reported.</p> <p>B. On 8/30/12, employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>C. On 9/6/12, employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>D. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location. Also, the LPN failed to document all vital signs. Only pain, respiration, and blood pressure was reported.</p> <p>E. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and</p>			

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	<p>temperature should be taken every visit.</p> <p>17. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." The record failed to evidence any orders for a dressing to this location.</p> <p>18. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders for SN as needed for</p>			

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	<p>labs and also to record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 12/13/11, 1/23/12, 1/26/12, and 2/6/12, employee M, RN, failed to record the patient's blood sugar.</p> <p>B. On 2/3/12, employee J, LPN, failed to record the patient's blood sugar.</p> <p>19. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for SN to asses / teach Diabetic care, record blood sugar checks to determine trending and evaluate care, and wound care dressing changes each visit. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/17/12, employee T, RN, failed to record the patient's blood sugar.</p> <p>B. On 9/7/12, employee W, RN, failed to record the patient's blood sugar.</p> <p>C. On 7/25/12, employee V, LPN, failed to record the patient's blood sugar.</p> <p>D. On 8/6/12, employee D, LPN, failed to record the patient's blood sugar and</p>			

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	<p>measure the wound.</p> <p>E. On 8/24/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>F. On 9/14/12, employee L, LPN, failed to record the patient's blood sugar.</p> <p>20. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patients Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/4/12, employee L, LPN, failed to record a temperature reading.</p> <p>B. During interview on 9/21/12 at 2:45 PM, employee S, alternate nursing supervisor, indicated if the plan of care orders say SN to assess vital signs, the nurses should be taking blood pressure, pulse, respiration, and temperature.</p>			

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G0164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure physician was notified regarding changes in the patient's condition for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician." 2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated 10/11 states, "The physician is contact by 	G0164	The Clinical Managers will inservice the nursing and therapy field staff on the policies and procedures regarding the importance of communicating significant information related to patient needs and change in condition to the physician in order to review and update the plan of care as per P&Ps. All field staff will be inserviced on required communication to the assigned case manager. Periodic review of the patient's plan of care will occur at the routinely scheduled case conferences. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have communicated significant information related to the patients needs to the physician and that the plan of care has been reviewed and updated accordingly. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	10/31/2012

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	<p>professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs within 24 hours."</p>			

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	<p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. Facility policy titled "Medical Social Service Assessment" policy number CD 1.09 dated 4/11 states, "Social work</p>			

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	<p>services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's condition; maintains contact/communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p> <p>7. Clinical record #4, Start of Care (SOC)</p>			

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	<p>5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee K, RN, documented a pressure ulcer on the "RLE [right lower extremity] upper." The</p>			

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	<p>assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There is no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p>			

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	<p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee D, LPN, documented a "diabetic neuropathic</p>			

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	<p>ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm [centimeter] around. Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious disease doctor, patient states he has an appt on 9/20/12. Writer spoke with [employee F, RN] concerning visit and left shin blister."</p>			

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	<p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and to get orders to treat. The LPN gave the patient the fax number to VNS and told the patient to have the doctor's office fax any new orders to VNS. The LPN stated they have been aware of the wound on the left shin and have been monitoring it. The patient then took their</p>			

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	<p>blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer replacement would have been appropriate; however, there was no evidence that this was done.</p> <p>I. On 9/20/12 at 4:50 PM, employee R, Director indicated the new wound on the shin should have been reported to the</p>			

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	<p>physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -,10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p>			

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	<p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing."</p>			

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	<p>The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/14/12 employee F, RN, documented "PRN [as needed] visit made after client's daughter called the office with concerns. When SN arrived client was lying in bed. Skin is pale, using</p>			

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	<p>accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address patient's depression. No new orders for skin repair cream were found and no follow up with physician was made.</p> <p>D. On 9/20/12 at 4:58 PM, employee R, Director, indicated the change in patient condition should have been reported to</p>			

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	<p>the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/6/12 employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a</p>			

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	<p>13. dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the front porch. Pt is sitting in the living</p>			

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	<p>room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the RN and PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented in the clinical notes.</p>			

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	<p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and there was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>15. Clinical record #16, start of care 12/13/11, contained a plan of care for</p>			

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	<p>the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record blood sugar checks to determine trending and evaluate care. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/6/12, employee D, a LPN, documented the patient did not have</p>			

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	<p>batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to evidence follow up with orders.</p> <p>17. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood</p>			

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	<p>Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>			

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G0165	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure treatments are provided only as ordered on the plan of care in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (#2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 17, and 18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Licensed Practical Nurse (LPN) Utilization," policy number CPP12.07 dated 4/11 states, "The LPN may make subsequent visits, report client status, follow Plan of Care, provide appropriate treatment, reinforce teaching, document on appropriate forms." 2. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining 	G0165	<p>The Clinical Managers will inservice the nursing and therapy field staff on the policies and procedures regarding compliance to the ordered plan of care and ensuring the drugs and treatments are provided as ordered. All staff are to communicate significant information related to patient needs and change in condition to the physician in order to review and update the plan of care. All field staff will be inserviced on required communication to the assigned case manager, case conferencing and SBAR communication technique. 10% of all clinical records will be audited quarterly for evidence that all care is provided according to the physician orders with a specific indicator measuring that the drugs and treatments are administered by agency staff only as ordered by the physician. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>	10/31/2012

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	<p>outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ...</p> <p>AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>3. Facility policy titled "Application of Wound Dressing," policy number CPP5.03, dated 4/11, states "After Care: 1. Document in patient's record: ... c. Temperature and vital signs."</p> <p>4. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ...</p> <p>AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>5. The job description titled "Registered Nurse (RN)" last modified 9/24/12 states "Job Description Summary: Care for assigned patients by assessing needs, implementing nursing care plans, providing appropriate interventions, making appropriate revisions, and</p>			

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	<p>evaluating outcomes of care."</p> <p>6. The job description titled "Licensed Practical Nurse (LPN)" last modified 9/24/12 states "Implements plan of care initiated by the registered nurse."</p> <p>7. Clinical Record #2, start of care (SOC) 8/30/12 contained a plan of care for the certification period dated 8/30/12-10/28/12 with orders to assess IV site in left upper arm Single Lumen (SL) Peripherally Inserted Central Catheter (PICC), change dressing to IV Access weekly and as needed (PRN) per agency protocol and record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12, employee K, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>B. On 9/1/12, employee Z, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>C. On 9/6/12, employee A, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>D. On 9/13/12, employee L, LPN, failed</p>			

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	<p>to measure the PICC line and record a blood sugar reading.</p> <p>E. On 9/1/12 employee Z documented the patient called to report the PICC site was bleeding and blood was running down the arm and may have been due to over manipulation of the line when antibiotics administered. Routine Visit note dated 9/1/12 by employee Z failed to indicate the line was measured after dressing change, and no physician contact was made.</p> <p>F. During home visit observation on 9/19/12 at 10:45 AM, employee I, a LPN, was observed drawing blood from a Peripherally Inserted Central Catheter (PICC) line and changing the PICC line dressing. The LPN failed to measure the PICC line catheter.</p> <p>8. Clinical record #3, start of care 8/18/12, contained a plan of care for the certification period dated 8/18/12 - 10/16/12 with orders to change dressing to IV access weekly and PRN per agency protocol. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/18/12, employee F, LPN, failed to measure the PICC line.</p>			

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	<p>B. On 8/21, 8/23, and 9/4, and 9/12/12, employee A, RN, failed to measure the PICC line.</p> <p>C. On 8/28/12, employee I, LPN, failed to measure the PICC line.</p> <p>D. During home visit observation with patient #3 on 9/19/12 at 11:45 AM, employee A, a RN, was observed changing a Peripherally Inserted Central Catheter (PICC) line dressing. The RN failed to measure the PICC line catheter.</p> <p>E. On 9/20/12 at 4:20 PM, employee R indicated the PICC lines do not ever have to be measured as it is not part of the agency's policy.</p> <p>9. Clinical record #4, start of care 5/16/11, contained a plan of care for the certification period 7/9/12 - 9/6/12 with orders for Skilled Nurse (SN) to assess vital signs and report any adverse results to physician, assess for signs and symptoms of infection and wound care to be performed by SN on visit days and by spouse on non-visit days. Review of the nursing assessment evidenced the following:</p> <p>A. On 7/13/12, employee T, RN, failed to record a temperature.</p>			

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	<p>B. On 7/25/12, employee V, LPN, failed to change dressing to right abdominal wound site.</p> <p>10. Clinical record #5, start of care 9/9/12, contained a plan of care for the certification period dated 9/9/12 - 11/7/12 with orders for SN to assess vital signs and report any adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/9/12 employee T, RN, failed to record a temperature.</p> <p>B. On 9/14/12 employee Y, RN, failed to record a temperature.</p> <p>11. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity (RLE) and orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12, employee K, RN, documented a pressure ulcer on the "RLE</p>			

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	<p>upper." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>B. On 8/27/12, employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>C. On 8/29/12, employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>12. Clinical record #7, start of care</p>			

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	<p>8/2/12, contained a plan of care for the certification period dated 8/2/12 -9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper / hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/12/12, employee G, RN, failed to record a blood sugar check.</p> <p>B. On 8/22/12, employee V, LPN, , failed to record a blood sugar check.</p> <p>D. On 8/29/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>E. On 9/7/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>F. On 9/10/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>G. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." The LPN failed to record the patient's</p>			

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	<p>blood sugar. The LPN's clinical note stated "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm around. Instructed patient to keep covered with dry 4x4 until seen by infectious disease doctor, patient states he has an appt [appointment] on 9/20/12." The plan of care failed to evidence any orders to instruct the patient to cover the wound and for a dressing to be applied.</p> <p>H. On 9/12/12, employee D, LPN, failed to record a blood sugar.</p> <p>I. On 9/17/12 employee F, RN, failed to record a blood sugar.</p> <p>J. On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken.</p> <p>13. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -,10/7/12 with orders to "Assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integument, endocrine,</p>			

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	<p>circulatory," orders to "assess vital signs and report any adverse results to the physician," and orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>B. On 8/13/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p>			

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	<p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only respiration and blood pressure were documented.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse,</p>			

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	<p>respiration, and blood pressure were documented.</p> <p>F. On 8/24/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>G. On 8/27/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>H. On 8/29/12, employee H, RN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>I. On 8/31/12, employee J, LPN, failed to</p>			

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	<p>document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>J. On 9/3/12, employee M, RN, failed to document any vital signs.</p> <p>K. On 9/5/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>L. On 9/10/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>M. On 9/12/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>N. On 9/14/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>O. On 9/17/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>P. On 9/21/12 at 2:45 PM, employee S,</p>			

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	<p>Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>14. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders that state to assess vital signs and report and adverse results to physician. Review of the nursing clinical notes evidenced the following: On 8/2/12, employee F, RN, failed to document all vital signs. Only temperature was documented.</p> <p>15. Clinical record #10, start of care 8/8/12, contained a plan of care for the certification period dated 8/8/12 - 10/6/12 with orders to "assess vital signs and report and adverse results to the physician." Review of of the nursing assessment evidenced the following: A. On 8/24/12 employee B, RN, failed to document all vital signs. Only pain was reported. B. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration, and temperature should be taken every visit.</p> <p>16. Clinical record #12, start of care</p>			

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	<p>8/13/10, contained a plan of care for the certification period dated 8/2/12 - 10/11/12 with orders that state to assess vital signs and report and adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/23/12 employee W, RN, failed to document all vital signs. Only blood pressure was reported.</p> <p>B. On 8/30/12, employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>C. On 9/6/12, employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>D. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this</p>			

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	<p>location. Also, the LPN failed to document all vital signs. Only pain, respiration, and blood pressure was reported.</p> <p>E. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>17. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12 employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area</p>			

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	<p>moisturized instead of dry." The record failed to evidence any orders for a dressing to this location.</p> <p>18. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders for SN as needed for labs and also to record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 12/13/11, 1/23/12, 1/26/12, and 2/6/12, employee M, RN, failed to record the patient's blood sugar.</p> <p>B. On 2/3/12, employee J, LPN, failed to record the patient's blood sugar.</p> <p>19. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for SN to asses / teach Diabetic care, record blood sugar checks to determine trending and evaluate care, and wound care dressing changes each visit. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/17/12, employee T, RN, failed to record the patient's blood sugar.</p>			

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	<p>B. On 9/7/12, employee W, RN, failed to record the patient's blood sugar.</p> <p>C. On 7/25/12, employee V, LPN, failed to record the patient's blood sugar.</p> <p>D. On 8/6/12, employee D, LPN, failed to record the patient's blood sugar and measure the wound.</p> <p>E. On 8/24/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>F. On 9/14/12, employee L, LPN, failed to record the patient's blood sugar.</p> <p>20. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patients Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/4/12, employee L, LPN, failed to record a temperature reading.</p> <p>B. During interview on 9/21/12 at 2:45 PM, employee S, alternate nursing</p>			

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	supervisor, indicated if the plan of care orders say SN to assess vital signs, the nurses should be taking blood pressure, pulse, respiration, and temperature.			

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G0168	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on policy review, job description review, record review, and interview, it was determined the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services (See G 170); failed to ensure the registered nurse notified the physician of changes in the patient's condition for 11 of 20 patient records reviewed with the potential to affect all patients of the agency (See G 176); and failed to ensure the licensed practical nurse furnished services in accordance with agency policy in 9 of 20 records reviewed with the potential to affect all patients of the agency who receive services by a licensed practical nurse (See G 179).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.30: Skilled Nursing Services.</p>	G0168	<p>The Clinical Managers will inservice the nursing field staff on the policies and procedures regarding the importance of communicating significant information related to patient needs and change in condition to the physician in order to review and update the plan of care to ensure skilled nursing services are provided in accordance with the plan of care and within their discipline job description and agency policy. All field staff will be inserviced on required communication with the assigned case manager. In addition, the Clinical Managers will inservice the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and on appropriate communication with physicians and other disciplines to ensure optimal care for the patients. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have communicated significant information related to the patients</p>	10/31/2012	

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			needs to the physician, the plan of care has been reviewed and updated accordingly and that care is being provided as ordered. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.		

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G0170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on policy review, job description review, record review, and interview, the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (#2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 17, and 18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Licensed Practical Nurse (LPN) Utilization," policy number CPP12.07 dated 4/11 states, "The LPN may make subsequent visits, report client status, follow Plan of Care, provide appropriate treatment, reinforce teaching, document on appropriate forms." 2. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... 			G0170	<p>The Clinical Managers will inservice the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and on appropriate communication with physicians and other disciplines to ensure optimal care for the patients. All field staff will be inserviced on required communication with the assigned case manager. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have communicated significant information related to the patients needs to the physician, that the plan of care has been reviewed and updated accordingly and skilled nursing visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>		10/31/2012

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	<p>AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>3. Facility policy titled "Application of Wound Dressing," policy number CPP5.03, dated 4/11, states "After Care: 1. Document in patient's record: ... c. Temperature and vital signs."</p> <p>4. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>5. The job description titled "Registered Nurse (RN)" last modified 9/24/12 states "Job Description Summary: Care for assigned patients by assessing needs, implementing nursing care plans, providing appropriate interventions, making appropriate revisions, and evaluating outcomes of care."</p> <p>6. The job description titled "Licensed</p>			

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	<p>Practical Nurse (LPN)" last modified 9/24/12 states "Implements plan of care initiated by the registered nurse."</p> <p>7. Clinical Record #2, start of care (SOC) 8/30/12 contained a plan of care for the certification period dated 8/30/12-10/28/12 with orders to assess IV site in left upper arm Single Lumen (SL) Peripherally Inserted Central Catheter (PICC), change dressing to IV Access weekly and as needed (PRN) per agency protocol and record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12, employee K, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>B. On 9/1/12, employee Z, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>C. On 9/6/12, employee A, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>D. On 9/13/12, employee L, LPN, failed to measure the PICC line and record a blood sugar reading.</p>			

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	<p>E. On 9/1/12 employee Z documented the patient called to report the PICC site was bleeding and blood was running down the arm and may have been due to over manipulation of the line when antibiotics administered. Routine Visit note dated 9/1/12 by employee Z failed to indicate the line was measured after dressing change, and no physician contact was made.</p> <p>F. During home visit observation on 9/19/12 at 10:45 AM, employee I, a LPN, was observed drawing blood from a Peripherally Inserted Central Catheter (PICC) line and changing the PICC line dressing. The LPN failed to measure the PICC line catheter.</p> <p>8. Clinical record #3, start of care 8/18/12, contained a plan of care for the certification period dated 8/18/12 - 10/16/12 with orders to change dressing to IV access weekly and PRN per agency protocol. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/18/12, employee F, LPN, failed to measure the PICC line.</p> <p>B. On 8/21, 8/23, and 9/4, and 9/12/12, employee A, RN, failed to measure the PICC line.</p>						

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	<p>C. On 8/28/12, employee I, LPN, failed to measure the PICC line.</p> <p>D. During home visit observation with patient #3 on 9/19/12 at 11:45 AM, employee A, a RN, was observed changing a Peripherally Inserted Central Catheter (PICC) line dressing. The RN failed to measure the PICC line catheter.</p> <p>E. On 9/20/12 at 4:20 PM, employee R indicated the PICC lines do not ever have to be measured as it is not part of the agency's policy.</p> <p>9. Clinical record #4, start of care 5/16/11, contained a plan of care for the certification period 7/9/12 -,9/6/12 with orders for Skilled Nurse (SN) to assess vital signs and report any adverse results to physician, assess for signs and symptoms of infection and wound care to be performed by SN on visit days and by spouse on non-visit days. Review of the nursing assessment evidenced the following:</p> <p>A. On 7/13/12, employee T, RN, failed to record a temperature.</p> <p>B. On 7/25/12, employee V, LPN, failed to change dressing to right abdominal</p>			

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	<p>wound site.</p> <p>10. Clinical record #5, start of care 9/9/12, contained a plan of care for the certification period dated 9/9/12 - 11/7/12 with orders for SN to assess vital signs and report any adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/9/12 employee T, RN, failed to record a temperature.</p> <p>B. On 9/14/12 employee Y, RN, failed to record a temperature.</p> <p>11. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity (RLE) and orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12, employee K, RN, documented a pressure ulcer on the "RLE upper." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders</p>			

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	<p>for a dressing change to this location.</p> <p>B. On 8/27/12, employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>C. On 8/29/12, employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>12. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 -9/30/12 with orders for wound care to</p>			

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	<p>the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper / hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/12/12, employee G, RN, failed to record a blood sugar check.</p> <p>B. On 8/22/12, employee V, LPN, , failed to record a blood sugar check.</p> <p>D. On 8/29/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>E. On 9/7/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>F. On 9/10/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>G. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." The LPN failed to record the patient's blood sugar. The LPN's clinical note stated "Left shin has a new area, fluid filled blister added to skin assessment,</p>			

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	<p>fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm around. Instructed patient to keep covered with dry 4x4 until seen by infectious disease doctor, patient states he has an appt [appointment] on 9/20/12." The plan of care failed to evidence any orders to instruct the patient to cover the wound and for a dressing to be applied.</p> <p>H. On 9/12/12, employee D, LPN, failed to record a blood sugar.</p> <p>I. On 9/17/12 employee F, RN, failed to record a blood sugar.</p> <p>J. On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken.</p> <p>13. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -,10/7/12 with orders to "Assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integument, endocrine, circulatory," orders to "assess vital signs and report any adverse results to the physician," and orders for wound care to</p>						

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	<p>the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>B. On 8/13/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to</p>			

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	<p>the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only respiration and blood pressure were documented.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p>			

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	<p>F. On 8/24/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>G. On 8/27/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>H. On 8/29/12, employee H, RN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>I. On 8/31/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p>			

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	<p>J. On 9/3/12, employee M, RN, failed to document any vital signs.</p> <p>K. On 9/5/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>L. On 9/10/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>M. On 9/12/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>N. On 9/14/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>O. On 9/17/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>P. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p>			

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	<p>14. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders that state to assess vital signs and report and adverse results to physician. Review of the nursing clinical notes evidenced the following: On 8/2/12, employee F, RN, failed to document all vital signs. Only temperature was documented.</p> <p>15. Clinical record #10, start of care 8/8/12, contained a plan of care for the certification period dated 8/8/12 - 10/6/12 with orders to "assess vital signs and report and adverse results to the physician." Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee B, RN, failed to document all vital signs. Only pain was reported.</p> <p>B. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration, and temperature should be taken every visit.</p> <p>16. Clinical record #12, start of care 8/13/10, contained a plan of care for the certification period dated 8/2/12 - 10/11/12 with orders that state to assess</p>			

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	<p>vital signs and report and adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/23/12 employee W, RN, failed to document all vital signs. Only blood pressure was reported.</p> <p>B. On 8/30/12, employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>C. On 9/6/12, employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>D. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location. Also, the LPN failed to document all vital signs. Only pain, respiration, and blood pressure was</p>			

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	<p>reported.</p> <p>E. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>17. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." The record failed to evidence any orders for a dressing to this location.</p>				

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	<p>18. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders for SN as needed for labs and also to record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 12/13/11, 1/23/12, 1/26/12, and 2/6/12, employee M, RN, failed to record the patient's blood sugar.</p> <p>B. On 2/3/12, employee J, LPN, failed to record the patient's blood sugar.</p> <p>19. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for SN to asses / teach Diabetic care, record blood sugar checks to determine trending and evaluate care, and wound care dressing changes each visit. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/17/12, employee T, RN, failed to record the patient's blood sugar.</p> <p>B. On 9/7/12, employee W, RN, failed to record the patient's blood sugar.</p>			

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	<p>C. On 7/25/12, employee V, LPN, failed to record the patient's blood sugar.</p> <p>D. On 8/6/12, employee D, LPN, failed to record the patient's blood sugar and measure the wound.</p> <p>E. On 8/24/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>F. On 9/14/12, employee L, LPN, failed to record the patient's blood sugar.</p> <p>20. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patients Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/4/12, employee L, LPN, failed to record a temperature reading.</p> <p>B. During interview on 9/21/12 at 2:45 PM, employee S, alternate nursing supervisor, indicated if the plan of care orders say SN to assess vital signs, the nurses should be taking blood pressure,</p>			

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	pulse, respiration, and temperature.				

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G0176	<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 policy review, job description review, record review, and interview, the home health agency failed to ensure the registered nurse notified the physician of changes in the patient's condition for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician." 2. Facility policy titled "Physician Orders and Communication: Obtaining and 	G0176	The Clinical Managers will inservice all RNs on the duties of the registered nurse in coordinating the care as ordered by the physician and recorded in the plan of care in accordance to agency policies. All clinical field staff including PT, OT and ST will be inserviced that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff and PT, OT and ST as indicated will also be inserviced on communicating significant information related to patient's needs and change in condition to the physician and other disciplines to ensure optimal care for the patients. All field staff including PT, OT and ST will be inserviced on required communication with the assigned case manager. Periodic review of the patient's plan of care will occur at the routinely scheduled case conferences. 10% of all clinical records will be audited quarterly for evidence that the registered nurse has coordinated services, informed the physician and other personnel of changes in the patient's condition and	10/31/2012

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	Documenting" policy number C-11 dated 10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs		needs. In addition, evidence that the clinical staff including PT, OT and ST as indicated have communicated significant information related to the patients needs to the case manager/ physician, that the plan of care has been reviewed and updated accordingly and skilled nursing and therapy visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	

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	<p>within 24 hours."</p> <p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. Facility policy titled "Medical Social</p>						

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	<p>Service Assessment" policy number CD 1.09 dated 4/11 states, "Social work services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's condition; maintains contact/communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p>			

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	<p>7. Clinical record #4, Start of Care (SOC) 5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee K, RN,</p>			

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	<p>documented a pressure ulcer on the "RLE [right lower extremity] upper." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There is no evidence this new wound was reported to the physician or that any</p>			

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	<p>orders were received for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p>			

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	<p>A. On 8/10/12 employee D, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm [centimeter] around. Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious disease doctor, patient states he has an appt on 9/20/12. Writer spoke with</p>			

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	<p>[employee F, RN] concerning visit and left shin blister."</p> <p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and to get orders to treat. The LPN gave the patient the fax number to VNS and told the patient to have the doctor's office fax any new orders to VNS. The LPN stated they have been aware of the</p>						

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	<p>wound on the left shin and have been monitoring it. The patient then took their blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer replacement would have been appropriate; however, there was no evidence that this was done.</p> <p>I. On 9/20/12 at 4:50 PM, employee R,</p>			

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	<p>Director indicated the new wound on the shin should have been reported to the physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this</p>						

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	<p>location as of this date.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>F. On 8/24/12 employee J, LPN,</p>				

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	<p>documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/14/12 employee F, RN, documented "PRN [as needed] visit made after client's daughter called the</p>				

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	<p>office with concerns. When SN arrived client was lying in bed. Skin is pale, using accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address patient's depression. No new orders for skin repair cream were found and no follow up with physician was made.</p> <p>D. On 9/20/12 at 4:58 PM, employee R,</p>			

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	<p>Director, indicated the change in patient condition should have been reported to the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/6/12 employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new</p>			

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	<p>wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is</p>			

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	<p>present during the eval but staying in the front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the RN and PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented</p>			

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	<p>in the clinical notes.</p> <p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and there was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p>			

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	<p>15. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record blood sugar checks to determine trending and evaluate care. Review of the nursing clinical notes evidenced the following:</p>				

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	<p>A. On 8/6/12, employee D, a LPN, documented the patient did not have batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to evidence follow up with orders.</p> <p>17. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 -</p>			

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	<p>10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>				

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G0179	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy.</p> <p>Based on policy review, job description review, record review, observation, and interview, the home health agency failed to ensure the licensed practical nurse furnished services in accordance with agency policy in 9 of 20 records reviewed with the potential to affect all patients of the agency who receive services by a licensed practical nurse. (#2, 3, 6, 7, 8, 12, 16, 17, and 18)</p> <p>Findings include:</p> <p>1. Facility policy titled "Standards of Practice" policy number C-48 dated 1/11 states, "Visiting Nurse Service, Inc. will identify and define standards of care, service, and practice to guide the provision of patient care for home care services, in addition to the policies defined which support standards of care/service. Standards of Practice include State Practice Act Rules for each discipline ... Based on referral information and the initial assessment, the clinician / technician, in conjunction with other organization personnel, will select the most appropriate standards of</p>	G0179	The Clinical Managers will inservice all LPNs on the duties of the LPN in providing services to the patients in accordance to agency policies. All clinical field staff will be inserviced that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and communicating significant information related to patient's needs and change in condition to the physician and other disciplines to ensure optimal care for the patients. All field staff will be inserviced on required communication with the assigned case manager, case conferencing and SBAR communication technique. Care scenarios will be utilized for competency evaluation per discipline responsibilities. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will be audited quarterly for evidence that the LPN provided services in accordance with agency policy, the clinical staff have communicated significant	10/31/2012	

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	<p>care / service and practice guidelines for the patient's care / service ... Standards of care / service and practice guidelines will guide the interventions that are to be implemented. The following standards of care / service and practice are available for use in planning the care of the patient. A. Discipline Specific Practice Acts B. Professional Association member standards. Use of standards of care/service and practice will be evident in the documentation of visits and assessments, as well as in the care / service planning process."</p> <p>2. Facility policy titled "Application of Wound Dressing" policy number CPP5.03 dated 4/11 states, "Adhere to standard Precautions; review physician's orders; explain procedure to patient / caregiver; establish a clean field (sterile, if necessary) with all the supplies and equipment that will be necessary; Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves."</p> <p>3. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under</p>		<p>information related to the patients needs to the physician, that the plan of care has been reviewed and updated accordingly and skilled nursing visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>	

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	<p>section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>4. Facility policy titled "Licensed Practical Nurse (LPN) Utilization" policy number CPP12.07 dated 4/11 states, "The LPN may make subsequent visits, report client status, follow Plan of Care, provide appropriate treatment, reinforce teaching, document on appropriate forms."</p> <p>5. The job description titled "Licensed Practical Nurse (LPN)" last modified 9/24/12 states "Implements plan of care initiated by the registered nurse."</p> <p>6. Clinical Record #2, start of care 8/30/12, contained a plan of care for the certification period dated 8/30/12 - 10/28/12 with orders to assess IV site Left upper arm Single Lumen (SL) Peripherally Inserted Central Catheter (PICC), change dressing to IV Access weekly and as needed (PRN) per agency protocol and record blood sugar checks to determine trending and evaluate care.</p>			

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	<p>Review of the nursing assessment evidenced the following:</p> <p>A. On 9/13/12, employee L, LPN, failed to measure the PICC line and record a blood sugar reading.</p> <p>B. During home visit observation on 9/19/12 at 10:45 AM, employee I, a LPN, was observed drawing blood from a PICC line and changing the PICC line dressing. The LPN failed to measure the PICC line catheter.</p> <p>7. Clinical record #3, start of care 8/18/12, contained a plan of care for the certification period dated 8/18/12 - 10/16/12 with orders to change dressing to IV access weekly and PRN per agency protocol. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/28/12 employee I, LPN, failed to measure the PICC line.</p> <p>B. On 9/20/12 at 4:20 PM, employee R, Director, indicated the PICC lines do not ever have to be measured as it is not part of the agency's policy.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 -</p>				

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	<p>10/4/12 with orders for wound care to the right lower extremity (RLE) and orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary," and orders to "Assess /</p>			

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	<p>teach Diabetic care, diet, hyper / hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12, employee D, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/22/12, employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician. There was also no blood sugar check recorded. The LPN's clinical note stated "Patient is non-compliant with taking his blood sugar levels on a daily basis."</p> <p>C. On 8/29/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>D. On 9/12/12, employee D, LPN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician. There was also no blood sugar check recorded. The LPN's clinical note stated "Left shin</p>			

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	<p>has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm around. Instructed patient to keep covered with dry 4x4 until seen by infectious disease doctor, patient states he has an appt [appointment] on 9/20/12. Writer spoke with [employee F, RN] concerning visit and left shin blister."</p> <p>E. On 9/12/12, employee D, LPN, failed to document a blood sugar check.</p> <p>F. On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 - 10/7/12 with orders to "Assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integument, endocrine, circulatory," orders to "assess vital signs and report any adverse results to the physician," and orders for wound care to the lower calf on right leg. Orders dated 8/29/12 indicate for wound care to be completed on the right lateral heel, right calf distal, right anterior lower</p>				

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	<p>leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no</p>			

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	<p>evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only respiration and blood pressure were documented.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to</p>				

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	<p>the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>H. On 8/31/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>I. On 9/5/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>J. On 9/10/12 employee J, LPN, failed to</p>			

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	<p>document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>K. On 9/12/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>L. On 9/14/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>M. On 9/17/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>N. During a home visit on 9/19/12 at 1:10 PM, employee J, LPN, was performing a dressing change on patient #8. The LPN removed the old dressing, applied saline wash, measured wound, and proceeded to apply a new dressing to each wound. No glove change or hand sanitation was done throughout the entire dressing change.</p> <p>On 9/20/12 at 4:55 PM, employee R, Director, indicated she spoke with the LPN regarding not changing her gloves and the LPN indicated she was nervous</p>						

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	<p>and realized that she had forgotten to do so.</p> <p>O. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>11. Clinical record #12, start of care 8/113/10, contained a plan of care for the certification period dated 8/2/12-10/11/12 with orders to assess vital signs and report and adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/13/12, employee L, LPN, failed to document all vital signs. Only pain, respiration, and blood pressure was reported.</p> <p>B. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>12. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders for SN for labs and also to record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment</p>				

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	<p>evidenced the following: On 2/3/12 employee J, LPN, failed to record the patient's blood sugar.</p> <p>13. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12-9/22/12 with orders for SN to asses / teach Diabetic care, record blood sugar checks to determine trending and evaluate care, and wound care dressing changes each visit. Review of the nursing assessment evidenced the following:</p> <p>A. On 7/25/12 employee V, LPN, failed to record the patient's blood sugar.</p> <p>B. On 8/6/12 employee D, LPN, failed to record the patient's blood sugar and measure the wound.</p> <p>C. On 8/24/12 employee D, LPN, failed to record the patient's blood sugar.</p> <p>D. On 9/14/12 employee L, LPN failed to record the patient's blood sugar.</p> <p>14. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic</p>			

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	<p>less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/22/122 employee V, LPN, recorded a BP of 144/82, but failed to notify the physician of the systolic BP.</p> <p>B. On 9/4/12 employee L, LPN, failed to record a temperature reading.</p>			

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G0188	<p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel.</p> <p>Based on policy review, job description review, record review, and interview, the agency failed to ensure the therapist consulted with other agency personnel in 1 of 8 records reviewed of patients receiving Physical Therapy services with the potential to affect all patients of the agency who receive therapy services. (#13)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact / collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician." 2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated 10/11 states, "The physician is contact by professional staff for: .. Changes in 			G0188	<p>The Clinical Managers will inservice all therapy staff on the duties of the therapist in providing services to the patient and the importance of consulting with the family and other agency personnel in accordance to agency policies. All clinical field staff will be inserviced that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The therapy field staff will also be inserviced on communicating significant information realted to patient's needs and changes in condition to the physician and other disciplines to ensure optimal care for the patients. All therapy field staff will be inserviced on required communication to the assigned case manager, case conferencing and SBAR communication technique. Care coordination scenarios will be utilized for competency evaluation per discipline responsibilities. 10% of all clinical records will be audited quarterly for evidence that the field therapy staff have advised and consulted with the family and other agency personnel, have communicated significant information related to the patients needs to the case</p>		10/31/2012

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	<p>condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs within 24 hours."</p> <p>3. Facility policy titled "Urgent and</p>		<p>manager/physician, that the plan of care has been reviewed and updated accordingly and therapy visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>				

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	<p>Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the</p>			

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	<p>physician any changes in the patient's condition; maintains contact / communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p> <p>5. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12-11/9/12 with orders to "Assess / teach Diabetic care, diet, hyper / hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD [medical doctor] for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS [blood sugar] is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check</p>						

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	<p>her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented in the clinical notes.</p>				

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N0000	<p>This visit was a Home Health state relicensure survey.</p> <p>Survey Dates: September 17, 18, 19, 20, 21, and 24, 2012</p> <p>Facility Number: IN005250</p> <p>Surveyors: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor, Team Leader Miriam Bennett, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type:</p> <p>Skilled: 2214 Home Health Aide Only: 19 Personal Care Only: 0 Total: 2233</p> <p>Sample:</p> <p>RR w/HV: 10 RR w/o HV: 10 Total: 20</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 1, 2012</p>	N0000		

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N0458	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ol style="list-style-type: none"> (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. <p>Based on personnel file review and interview, the agency failed to ensure all employees had a limited criminal history for 1 of 17 personnel files reviewed with the potential to affect all patients of the agency. (employee I)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file I, a certified Licensed Practical Nurse, date of hire 1/24/11, failed to evidence a limited criminal history had been completed within 3 days of first patient contact. 2. On 9/24/11 at 11:30 AM, employee U, 	N0458	The Human Resource Manager will inservice the human resource department staff on Policy HR-30, Purpose of Criminal History Checks. A pre hire checklist will be completed on all new hires/rehires. All new hires, up to 10 per quarter, will be audited for compliance by the human resource staff. The Manager of Human Resources will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	10/10/2012			

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	the manager of Human Resources, indicated no criminal history was in the personnel file for employee I.				

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on policy review, document review, observation, and interview, the agency failed to ensure the home health agency's infection control policies were followed during 3 of 10 home visits with the potential to affect all the patients seen by employees J, Q, and A. (#1, 3, and 8)</p> <p>The findings include:</p> <p>1. Facility policy titled "Standards of Practice" policy number C-48 dated 1/11 states, "Visiting Nurse Service, Inc. will identify and define standards of care, service, and practice to guide the provision of patient care for home care services, in addition to the policies defined which support standards of care/service. Standards of Practice include State Practice Act Rules for each discipline ... Based on referral information and the initial assessment, the clinician / technician, in conjunction with other organization personnel, will select the most appropriate standards of care / service and practice guidelines for</p>	N0470	<p>The Clinical Managers will inservice the nursing, therapy and home health aide direct patient care staff on the agency's infection control policies and procedures and the Center for Disease Control "Standard Precautions". CPP13.15 PICC procedure was updated to include measurement of PICC line. All field staff will attend the October 2012 skillsfair and have discipline assigned competencies completed and documented on stations handwashing, infection control VAD, wounds, PICC and central lines. In addition, all field staff will be observed in the home by a Clinical Manger by January 31, 2013, then annually thereafter to ensure that the deficiencies are corrected and will not recur. Any noncompliance identified during observation will be addressed as a performance issue and competencies validated through one on one education and demonstration. Anyone identified with performance issues will have ongoing monitoring through home visit observation with progressive disciplinary action taken up to termination. The Director of Home Care Services will be</p>	10/31/2012			

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	<p>the patient's care / service ... Standards of care / service and practice guidelines will guide the interventions that are to be implemented. The following standards of care / service and practice are available for use in planning the care of the patient. A. Discipline Specific Practice Acts B. Professional Association member standards. Use of standards of care / service and practice will be evident in the documentation of visits and assessments, as well as in the care / service planning process."</p> <p>2. Facility policy titled "Application of Wound Dressing" policy number CPP5.03 dated 4/11 states, "Adhere to standard Precautions; review physician's orders; explain procedure to patient / caregiver; establish a clean field (sterile, if necessary) with all the supplies and equipment that will be necessary; Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves."</p> <p>3. Facility policy titled "BATH: BED (ADULT)," #CPP2.01, dated 4/11, states "27. Offer the client a soapy washcloth to wash her/his genital area, and then a clean wet washcloth to rinse his/her</p>		responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.		

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	<p>self."</p> <p>4. Facility policy titled "PERINEAL CARE-FEMALE," #CPP2.07, dated 1/09, states "3. To prevent contamination, wipe from front to back or wipe toward the anus."</p> <p>5. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," #CPP13.15, dated 8/00, states "C. Dressing Change, Procedure: ... 10. Clean exit site with three alcohol applicators ... Allow to air dry."</p> <p>6. During a home visit on 9/19/12 at 1:10 PM, employee J, Licensed Practical Nurse (LPN), was performing a dressing change on patient #8. The LPN removed the old dressing, applied saline wash, measured wound, and proceeded to apply a new dressing to each wound. No glove change or hand sanitation was done throughout the entire dressing change.</p> <p>On 9/20/12 at 4:55 PM, employee R, Director, indicated she spoke with employee J regarding not changing her gloves and the LPN indicated she was nervous and realized that she had forgotten to do so.</p>			

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	<p>7. During home visit on 9/19/12 at 9:15 AM, employee Q, a Home Health Aide (HHA) was observed providing a bed bath for patient #1. The HHA failed to change gloves until the bath was complete, including helping the patient dress and comb hair. During the bath, the HHA failed to use clean washcloths for cleaning the perineal and rectal areas, and washed the rectal area prior to washing the perineal area. The HHA then proceeded to apply lotion to the patient's skin beginning with the legs and moving up to the the belly, arms and back, still wearing the same pair of gloves used for the bath. The HHA then applied Desitin cream to the folds of the patient's back and buttocks, arm pits, breast folds, and then to the groin folds. Clean clothes were gathered from the dresser while still wearing the same gloves used for the bath. The HHA then proceeded to brush the patient's hair with the same gloves.</p> <p>On 9/20/12 at 4:15 PM, employee S, Alternate Nursing Supervisor, indicated the HHA should have changed gloves prior to providing perineal and rectal washing and before putting clothes on the patient. Also the HHA should have washed the perineal area prior to the</p>			

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	<p>rectal area.</p> <p>8. During a home visit on 9/19/12 at 11:45 AM with patient #3, employee A, Registered Nurse (RN), was observed changing a PICC line dressing. The RN removed the old dressing and taped the line to the patient's arm. The tape came unfastened, leaving the line dangling. The RN touched the PICC insertion site with the same gloves used to remove the old dressing. Antiseptic skin prep was then applied and the RN fanned it with the gloved hand.</p>			

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N0484	<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 policy review, job description review, record review, and interview, the home health agency failed to ensure coordination of care occurred between all personnel furnishing services and the physician for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <p>1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician."</p>	N0484	<p>The Clinical Managers will inservice the clinical field staff on communicating significant information related to patient's needs and changes in condition to the physician and other disciplines to ensure optimal care for the patients as per P&Ps to ensure coordination of care as outlined in the plan of care. All field staff will be inserviced on required communication to the assigned case manager, information to be shared during case conferencing and the SBAR communication technique. Care coordination scenarios will be utilized for discipline specific competency evaluations. 10% of all clinical records will be audited quarterly for evidence that there is care coordination that support the objectives outlined in the plan of care and that the clinical staff have appropriately communicated with the physician and other disciplines involved in the patient's care. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure</p>	10/31/2012			

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	2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated 10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there		that the deficiencies are corrected and will not recur.		

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	<p>was no change made in the plan of care ... all physician communication occurs within 24 hours."</p> <p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p>			

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	<p>4. Facility policy titled "Medical Social Service Assessment" policy number CD 1.09 dated 4/11 states, "Social work services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's condition; maintains contact/communication with other</p>			

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	<p>personnel involved in the patient's care to promote coordinated, efficient care."</p> <p>7. Clinical record #4, Start of Care (SOC) 5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity. Review of the nursing assessment evidenced the following:</p>			

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	<p>A. On 8/24/12 employee K, RN, documented a pressure ulcer on the "RLE [right lower extremity] upper." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders."</p>			

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	<p>There is no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing</p>			

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	<p>assessment evidenced the following:</p> <p>A. On 8/10/12 employee D, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm [centimeter] around. Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious</p>			

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	<p>disease doctor, patient states he has an appt on 9/20/12. Writer spoke with [employee F, RN] concerning visit and left shin blister."</p> <p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and to get orders to treat. The LPN gave the patient the fax number to VNS and told the patient to have the doctor's office</p>			

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	<p>fax any new orders to VNS. The LPN stated they have been aware of the wound on the left shin and have been monitoring it. The patient then took their blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer replacement would have been appropriate; however, there was no evidence that this was done.</p>			

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	<p>I. On 9/20/12 at 4:50 PM, employee R, Director indicated the new wound on the shin should have been reported to the physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -,10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported</p>			

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	<p>to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p>			

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	<p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/14/12 employee F, RN,</p>				

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	<p>documented "PRN [as needed] visit made after client's daughter called the office with concerns. When SN arrived client was lying in bed. Skin is pale, using accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address patient's depression. No new orders for skin repair cream were found and no follow up with physician was made.</p>			

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	<p>D. On 9/20/12 at 4:58 PM, employee R, Director, indicated the change in patient condition should have been reported to the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/6/12 employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment</p>			

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	<p>states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to</p>			

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	<p>pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the RN and PT should have reported the elevated blood sugar to the physician.</p>						

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	<p>She indicated all attempts to contact the physician should have been documented in the clinical notes.</p> <p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and there was no evidence this new wound was reported to the physician or that any orders were received for a dressing</p>			

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	<p>change to this location.</p> <p>15. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record blood sugar checks to determine trending and evaluate care. Review of the nursing clinical notes evidenced the</p>			

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	<p>following:</p> <p>A. On 8/6/12, employee D, a LPN, documented the patient did not have batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to evidence follow up with orders.</p> <p>17. Clinical record #18, start of care</p>				

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	<p>2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>			

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N0522	<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 policy review, record review, job description review, and interview, the home health agency failed to ensure therapy visits were provided as ordered in 5 of 11 records reviewed of those receiving therapy services with the potential to affect all patient's of the agency who receive therapy services (#5, 9, 10, 18 and 19) and treatments were provided as ordered in in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (#2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 17, and 18)</p> <p>Findings include:</p> <p>Related to therapy services:</p> <p>1. Facility policy titled "Missed Visit Report" policy number CD 5.8 dated 3/10 states, "A missed visit occurs, when a discipline makes less than the physician ordered frequency. This agency uses the Medicare week to base visit frequency (Sunday through Saturday) ... The missed</p>	N0522	The Clinical Managers will inservice the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and communicating significant information related to patient's needs and change in condition to the physicians and other disciplines to ensure optimal care for the patients. All field staff will be inserviced on required communication to the assigned case manager. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will audited quarterly for evidence that the clinical staff have followed the plan of care and appropriately communicated with the physician and other disciplines involved in the patient's care. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected	10/31/2012			

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	<p>visit is documented in the EMR [Electronic Medical Record] clinical note with the reason. The visit is marked as unmade on the schedule. The visit is rescheduled, if at all possible with the Medicare. Visits not made in accordance with physician orders are communicated to the physician."</p> <p>2. Facility policy titled "Occupational Therapy Evaluation," policy number CD 1.23, dated 4/11, states "1. The OTR will be responsible for initial contact to the patient within 48 hours of receiving the referral. 2. The OTR must complete documentation within 48 hours after completing the evaluation."</p> <p>3. Clinical record #5, start of care 9/9/12, contained a plan of care for the certification period dated 9/9/12 - 11/7/12 with orders for Physical Therapy two times a week for one week. The record failed to evidence PT saw the patient two times the week of 9/9/12-9/15/12.</p> <p>4. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for Speech Therapy one time per week for one week beginning 9/2/12. Review of the record</p>		and will not recur				

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	<p>failed to evidence any speech therapy visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>5. Clinical record #10, start of care 8/8/10, contained a plan of care for the certification period dated 8/8/12 - 10/6/12 with orders for Speech Therapy one time per week for six weeks beginning 8/26/12. Review of the record failed to evidence any speech therapy visits were made the week of 9/2/12. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>6. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Occupational Therapy (OT) evaluation. The record failed to evidence a OT evaluation had been completed.</p> <p>7. Clinical record #19, start of care 8/21/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for PT 2 times a week for 4 weeks (8/28/12). The record failed to evidence a second visit was made by PT during week 1.</p>			

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	<p>8. On 9/21/12 at 11:07 AM, employee T, Clinical Manager, indicated and verified the second PT visit was not done for patient #5 and #19.</p> <p>Related to treatments provided as ordered:</p> <p>1. Facility policy titled "Licensed Practical Nurse (LPN) Utilization," policy number CPP12.07 dated 4/11 states, "The LPN may make subsequent visits, report client status, follow Plan of Care, provide appropriate treatment, reinforce teaching, document on appropriate forms."</p> <p>2. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>3. Facility policy titled "Application of</p>			

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	<p>Wound Dressing," policy number CPP5.03, dated 4/11, states "After Care:</p> <p>1. Document in patient's record: ... c. Temperature and vital signs."</p> <p>4. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>5. The job description titled "Registered Nurse (RN)" last modified 9/24/12 states "Job Description Summary: Care for assigned patients by assessing needs, implementing nursing care plans, providing appropriate interventions, making appropriate revisions, and evaluating outcomes of care."</p> <p>6. The job description titled "Licensed Practical Nurse (LPN)" last modified 9/24/12 states "Implements plan of care initiated by the registered nurse."</p> <p>7. Clinical Record #2, start of care (SOC)</p>			

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	<p>8/30/12 contained a plan of care for the certification period dated 8/30/12-10/28/12 with orders to assess IV site in left upper arm Single Lumen (SL) Peripherally Inserted Central Catheter (PICC), change dressing to IV Access weekly and as needed (PRN) per agency protocol and record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12, employee K, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>B. On 9/1/12, employee Z, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>C. On 9/6/12, employee A, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>D. On 9/13/12, employee L, LPN, failed to measure the PICC line and record a blood sugar reading.</p> <p>E. On 9/1/12 employee Z documented the patient called to report the PICC site was bleeding and blood was running down the arm and may have been due to over manipulation of the line when</p>			

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	<p>antibiotics administered. Routine Visit note dated 9/1/12 by employee Z failed to indicate the line was measured after dressing change, and no physician contact was made.</p> <p>F. During home visit observation on 9/19/12 at 10:45 AM, employee I, a LPN, was observed drawing blood from a Peripherally Inserted Central Catheter (PICC) line and changing the PICC line dressing. The LPN failed to measure the PICC line catheter.</p> <p>8. Clinical record #3, start of care 8/18/12, contained a plan of care for the certification period dated 8/18/12 - 10/16/12 with orders to change dressing to IV access weekly and PRN per agency protocol. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/18/12, employee F, LPN, failed to measure the PICC line.</p> <p>B. On 8/21, 8/23, and 9/4, and 9/12/12, employee A, RN, failed to measure the PICC line.</p> <p>C. On 8/28/12, employee I, LPN, failed to measure the PICC line.</p> <p>D. During home visit observation with</p>				

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	<p>patient #3 on 9/19/12 at 11:45 AM, employee A, a RN, was observed changing a Peripherally Inserted Central Catheter (PICC) line dressing. The RN failed to measure the PICC line catheter.</p> <p>E. On 9/20/12 at 4:20 PM, employee R indicated the PICC lines do not ever have to be measured as it is not part of the agency's policy.</p> <p>9. Clinical record #4, start of care 5/16/11, contained a plan of care for the certification period 7/9/12 -,9/6/12 with orders for Skilled Nurse (SN) to assess vital signs and report any adverse results to physician, assess for signs and symptoms of infection and wound care to be performed by SN on visit days and by spouse on non-visit days. Review of the nursing assessment evidenced the following:</p> <p>A. On 7/13/12, employee T, RN, failed to record a temperature.</p> <p>B. On 7/25/12, employee V, LPN, failed to change dressing to right abdominal wound site.</p> <p>10. Clinical record #5, start of care 9/9/12, contained a plan of care for the certification period dated 9/9/12 -</p>			

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	<p>11/7/12 with orders for SN to assess vital signs and report any adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/9/12 employee T, RN, failed to record a temperature.</p> <p>B. On 9/14/12 employee Y, RN, failed to record a temperature.</p> <p>11. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity (RLE) and orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12, employee K, RN, documented a pressure ulcer on the "RLE upper." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>B. On 8/27/12, employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the</p>			

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	<p>dressings was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>C. On 8/29/12, employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>12. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 -9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary," and orders to</p>			

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	<p>"Assess/teach Diabetic care, diet, hyper / hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/12/12, employee G, RN, failed to record a blood sugar check.</p> <p>B. On 8/22/12, employee V, LPN, , failed to record a blood sugar check.</p> <p>D. On 8/29/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>E. On 9/7/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>F. On 9/10/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>G. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." The LPN failed to record the patient's blood sugar. The LPN's clinical note stated "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm around. Instructed patient to keep covered with dry 4x4 until seen by infectious disease doctor, patient states</p>			

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	<p>he has an appt [appointment] on 9/20/12." The plan of care failed to evidence any orders to instruct the patient to cover the wound and for a dressing to be applied.</p> <p>H. On 9/12/12, employee D, LPN, failed to record a blood sugar.</p> <p>I. On 9/17/12 employee F, RN, failed to record a blood sugar.</p> <p>J. On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken.</p> <p>13. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -,10/7/12 with orders to "Assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integument, endocrine, circulatory," orders to "assess vital signs and report any adverse results to the physician," and orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing</p>			

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	<p>assessment evidenced the following:</p> <p>A. On 8/10/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>B. On 8/13/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The</p>			

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	<p>assessment also fails to evidence that all vital signs were taken. Only respiration and blood pressure were documented.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>F. On 8/24/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care</p>			

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	<p>failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>G. On 8/27/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>H. On 8/29/12, employee H, RN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>I. On 8/31/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>J. On 9/3/12, employee M, RN, failed to document any vital signs.</p> <p>K. On 9/5/12, employee J, LPN, failed to</p>			

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	<p>document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>L. On 9/10/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>M. On 9/12/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>N. On 9/14/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>O. On 9/17/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>P. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>14. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders that state to assess</p>				

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	<p>vital signs and report and adverse results to physician. Review of the nursing clinical notes evidenced the following: On 8/2/12, employee F, RN, failed to document all vital signs. Only temperature was documented.</p> <p>15. Clinical record #10, start of care 8/8/12, contained a plan of care for the certification period dated 8/8/12 - 10/6/12 with orders to "assess vital signs and report and adverse results to the physician." Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee B, RN, failed to document all vital signs. Only pain was reported.</p> <p>B. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration, and temperature should be taken every visit.</p> <p>16. Clinical record #12, start of care 8/13/10, contained a plan of care for the certification period dated 8/2/12 - 10/11/12 with orders that state to assess vital signs and report and adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/23/12 employee W, RN, failed</p>			

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	<p>to document all vital signs. Only blood pressure was reported.</p> <p>B. On 8/30/12, employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>C. On 9/6/12, employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>D. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location. Also, the LPN failed to document all vital signs. Only pain, respiration, and blood pressure was reported.</p> <p>E. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and</p>			

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	<p>temperature should be taken every visit.</p> <p>17. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." The record failed to evidence any orders for a dressing to this location.</p> <p>18. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders for SN as needed for</p>			

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	<p>labs and also to record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 12/13/11, 1/23/12, 1/26/12, and 2/6/12, employee M, RN, failed to record the patient's blood sugar.</p> <p>B. On 2/3/12, employee J, LPN, failed to record the patient's blood sugar.</p> <p>19. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for SN to asses / teach Diabetic care, record blood sugar checks to determine trending and evaluate care, and wound care dressing changes each visit. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/17/12, employee T, RN, failed to record the patient's blood sugar.</p> <p>B. On 9/7/12, employee W, RN, failed to record the patient's blood sugar.</p> <p>C. On 7/25/12, employee V, LPN, failed to record the patient's blood sugar.</p> <p>D. On 8/6/12, employee D, LPN, failed to record the patient's blood sugar and</p>			

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	<p>measure the wound.</p> <p>E. On 8/24/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>F. On 9/14/12, employee L, LPN, failed to record the patient's blood sugar.</p> <p>20. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patients Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/4/12, employee L, LPN, failed to record a temperature reading.</p> <p>B. During interview on 9/21/12 at 2:45 PM, employee S, alternate nursing supervisor, indicated if the plan of care orders say SN to assess vital signs, the nurses should be taking blood pressure, pulse, respiration, and temperature.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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N0527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure physician was notified regarding changes in the patient's condition for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <p>1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician."</p> <p>2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated</p>	N0527	The Clinical Managers will inservice the nursing and therapy field staff on the policies and procedures regarding the importance of communicating significant information related to patient needs and change in condition to the physician in order to review and update the plan of care as per P&Ps. All field staff will be inserviced on required communication to the assigned case manager. Periodic review of the patient's plan of care will occur at the routinely scheduled case conferences. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have communicated significant information related to the patients needs to the physician and that the plan of care has been reviewed and updated accordingly. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	10/31/2012	

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	10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs within 24 hours."			

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	<p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. Facility policy titled "Medical Social Service Assessment" policy number CD</p>			

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	<p>1.09 dated 4/11 states, "Social work services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's condition; maintains contact/communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p>			

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	<p>7. Clinical record #4, Start of Care (SOC) 5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee K, RN, documented a pressure ulcer on the "RLE</p>			

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	<p>[right lower extremity] upper." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There is no evidence this new wound was reported to the physician or that any orders were received for a dressing</p>			

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	<p>change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee D, LPN,</p>			

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	<p>documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm [centimeter] around. Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious disease doctor, patient states he has an appt on 9/20/12. Writer spoke with [employee F, RN] concerning visit and</p>			

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	<p>left shin blister."</p> <p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and to get orders to treat. The LPN gave the patient the fax number to VNS and told the patient to have the doctor's office fax any new orders to VNS. The LPN stated they have been aware of the wound on the left shin and have been</p>				

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	<p>monitoring it. The patient then took their blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer replacement would have been appropriate; however, there was no evidence that this was done.</p> <p>I. On 9/20/12 at 4:50 PM, employee R, Director indicated the new wound on the</p>			

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	<p>shin should have been reported to the physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p>			

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	<p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to</p>			

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	<p>the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/14/12 employee F, RN, documented "PRN [as needed] visit made after client's daughter called the office with concerns. When SN arrived</p>			

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	<p>client was lying in bed. Skin is pale, using accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address patient's depression. No new orders for skin repair cream were found and no follow up with physician was made.</p> <p>D. On 9/20/12 at 4:58 PM, employee R, Director, indicated the change in patient</p>			

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	<p>condition should have been reported to the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/6/12 employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or</p>			

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	<p>that any orders were received for a dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the</p>						

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	<p>front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the RN and PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented in the clinical notes.</p>			

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	<p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and there was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>15. Clinical record #16, start of care</p>			

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	<p>12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record blood sugar checks to determine trending and evaluate care. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/6/12, employee D, a LPN,</p>			

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	<p>documented the patient did not have batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to evidence follow up with orders.</p> <p>17. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patient's Vital</p>				

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	<p>Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>			

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N0532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure physician was notified regarding changes in the patient's condition for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <p>1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise</p>	N0532	The Clinical Managers will inservice the nursing and therapy field staff on the policies and procedures regarding the importance of communicating significant information related to patient needs and change in condition to the physician in order to review and update the plan of care as per P&Ps. All field staff will be inserviced on required communication to the assigned case manager. Periodic review of the patient's plan of care will occur at the routinely scheduled case conferences. 10% of all clinical records will be audited quarterly for evidence that the clinical staff have communicated significant information related to the patients needs to the physician and that the plan of care has been reviewed and updated accordingly. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	10/31/2012	

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	<p>format to the patient's physician."</p> <p>2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated 10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that</p>			

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	<p>occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs within 24 hours."</p> <p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical</p>			

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	<p>Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. Facility policy titled "Medical Social Service Assessment" policy number CD 1.09 dated 4/11 states, "Social work services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's</p>			

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	<p>condition; maintains contact/communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p> <p>7. Clinical record #4, Start of Care (SOC) 5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity. Review of the</p>			

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	<p>nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee K, RN, documented a pressure ulcer on the "RLE [right lower extremity] upper." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE</p>			

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	<p>superior." The assessment states the dressing was changed "per orders." There is no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom management, and record blood sugar</p>				

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	<p>checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee D, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm [centimeter] around.</p>			

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	<p>Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious disease doctor, patient states he has an appt on 9/20/12. Writer spoke with [employee F, RN] concerning visit and left shin blister."</p> <p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and to get orders to treat. The LPN gave the</p>						

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	<p>patient the fax number to VNS and told the patient to have the doctor's office fax any new orders to VNS. The LPN stated they have been aware of the wound on the left shin and have been monitoring it. The patient then took their blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer replacement would have been</p>			

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	<p>appropriate; however, there was no evidence that this was done.</p> <p>I. On 9/20/12 at 4:50 PM, employee R, Director indicated the new wound on the shin should have been reported to the physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was</p>			

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	<p>changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were</p>			

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	<p>received for a dressing change to this location on this date.</p> <p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical notes evidenced the following:</p>				

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	<p>A. On 8/14/12 employee F, RN, documented "PRN [as needed] visit made after client's daughter called the office with concerns. When SN arrived client was lying in bed. Skin is pale, using accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address patient's depression. No new orders for</p>			

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	<p>skin repair cream were found and no follow up with physician was made.</p> <p>D. On 9/20/12 at 4:58 PM, employee R, Director, indicated the change in patient condition should have been reported to the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/6/12 employee I, LPN,</p>			

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	<p>documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p>			

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	<p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated</p>			

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	<p>the RN and PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented in the clinical notes.</p> <p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and there was no evidence this new wound</p>			

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	<p>was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>15. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record blood sugar checks to determine</p>			

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	<p>trending and evaluate care. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/6/12, employee D, a LPN, documented the patient did not have batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to evidence follow up with orders.</p>			

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	<p>17. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>			

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care in 14 of 20 records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (#2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 17, and 18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Licensed Practical Nurse (LPN) Utilization," policy number CPP12.07 dated 4/11 states, "The LPN may make subsequent visits, report client status, follow Plan of Care, provide appropriate treatment, reinforce teaching, document on appropriate forms." 2. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: 	N0537	<p>The Clinical Managers will inservice the clinical field staff that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and communicating significant information related to patient's needs and change in condition to the physicians and other disciplines to ensure optimal care for the patients. All field staff will be inserviced on required communication to the assigned case manager. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will audited quarterly for evidence that the clinical staff have followed the plan of care and appropriately communicated with the physician and other disciplines involved in the patient's care. The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected</p>	10/31/2012	

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	<p>... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>3. Facility policy titled "Application of Wound Dressing," policy number CPP5.03, dated 4/11, states "After Care: 1. Document in patient's record: ... c. Temperature and vital signs."</p> <p>4. Facility policy titled "Peripherally Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>5. The job description titled "Registered Nurse (RN)" last modified 9/24/12 states "Job Description Summary: Care for assigned patients by assessing needs, implementing nursing care plans, providing appropriate interventions,</p>		and will not recur.				

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	<p>making appropriate revisions, and evaluating outcomes of care."</p> <p>6. The job description titled "Licensed Practical Nurse (LPN)" last modified 9/24/12 states "Implements plan of care initiated by the registered nurse."</p> <p>7. Clinical Record #2, start of care (SOC) 8/30/12 contained a plan of care for the certification period dated 8/30/12-10/28/12 with orders to assess IV site in left upper arm Single Lumen (SL) Peripherally Inserted Central Catheter (PICC), change dressing to IV Access weekly and as needed (PRN) per agency protocol and record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12, employee K, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>B. On 9/1/12, employee Z, RN, failed to measure the PICC line and record a blood sugar reading.</p> <p>C. On 9/6/12, employee A, RN, failed to measure the PICC line and record a blood sugar reading.</p>			

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	<p>D. On 9/13/12, employee L, LPN, failed to measure the PICC line and record a blood sugar reading.</p> <p>E. On 9/1/12 employee Z documented the patient called to report the PICC site was bleeding and blood was running down the arm and may have been due to over manipulation of the line when antibiotics administered. Routine Visit note dated 9/1/12 by employee Z failed to indicate the line was measured after dressing change, and no physician contact was made.</p> <p>F. During home visit observation on 9/19/12 at 10:45 AM, employee I, a LPN, was observed drawing blood from a Peripherally Inserted Central Catheter (PICC) line and changing the PICC line dressing. The LPN failed to measure the PICC line catheter.</p> <p>8. Clinical record #3, start of care 8/18/12, contained a plan of care for the certification period dated 8/18/12 - 10/16/12 with orders to change dressing to IV access weekly and PRN per agency protocol. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/18/12, employee F, LPN, failed to measure the PICC line.</p>			

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	<p>B. On 8/21, 8/23, and 9/4, and 9/12/12, employee A, RN, failed to measure the PICC line.</p> <p>C. On 8/28/12, employee I, LPN, failed to measure the PICC line.</p> <p>D. During home visit observation with patient #3 on 9/19/12 at 11:45 AM, employee A, a RN, was observed changing a Peripherally Inserted Central Catheter (PICC) line dressing. The RN failed to measure the PICC line catheter.</p> <p>E. On 9/20/12 at 4:20 PM, employee R indicated the PICC lines do not ever have to be measured as it is not part of the agency's policy.</p> <p>9. Clinical record #4, start of care 5/16/11, contained a plan of care for the certification period 7/9/12 -,9/6/12 with orders for Skilled Nurse (SN) to assess vital signs and report any adverse results to physician, assess for signs and symptoms of infection and wound care to be performed by SN on visit days and by spouse on non-visit days. Review of the nursing assessment evidenced the following:</p> <p>A. On 7/13/12, employee T, RN, failed to</p>			

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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>record a temperature.</p> <p>B. On 7/25/12, employee V, LPN, failed to change dressing to right abdominal wound site.</p> <p>10. Clinical record #5, start of care 9/9/12, contained a plan of care for the certification period dated 9/9/12 - 11/7/12 with orders for SN to assess vital signs and report any adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/9/12 employee T, RN, failed to record a temperature.</p> <p>B. On 9/14/12 employee Y, RN, failed to record a temperature.</p> <p>11. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity (RLE) and orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12, employee K, RN,</p>				

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	<p>documented a pressure ulcer on the "RLE upper." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>B. On 8/27/12, employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>C. On 8/29/12, employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p>			

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	<p>12. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 -9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper / hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/12/12, employee G, RN, failed to record a blood sugar check.</p> <p>B. On 8/22/12, employee V, LPN, , failed to record a blood sugar check.</p> <p>D. On 8/29/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>E. On 9/7/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>F. On 9/10/12, employee F, RN, failed to record the patient's blood sugar.</p> <p>G. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin."</p>			

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	<p>The LPN failed to record the patient's blood sugar. The LPN's clinical note stated "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm around. Instructed patient to keep covered with dry 4x4 until seen by infectious disease doctor, patient states he has an appt [appointment] on 9/20/12." The plan of care failed to evidence any orders to instruct the patient to cover the wound and for a dressing to be applied.</p> <p>H. On 9/12/12, employee D, LPN, failed to record a blood sugar.</p> <p>I. On 9/17/12 employee F, RN, failed to record a blood sugar.</p> <p>J. On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken.</p> <p>13. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -,10/7/12 with orders to "Assess, observe, and do comprehensive management and care coordination related to the disease process / body</p>			

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	<p>system of integument, endocrine, circulatory," orders to "assess vital signs and report any adverse results to the physician," and orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>B. On 8/13/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were</p>			

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	<p>documented.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all vital signs were taken. Only respiration and blood pressure were documented.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also fails to evidence that all</p>				

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	<p>vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>F. On 8/24/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>G. On 8/27/12, employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." The plan of care failed to evidence any orders for a dressing change to this location. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>H. On 8/29/12, employee H, RN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p>			

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	<p>I. On 8/31/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>J. On 9/3/12, employee M, RN, failed to document any vital signs.</p> <p>K. On 9/5/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>L. On 9/10/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>M. On 9/12/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>N. On 9/14/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>O. On 9/17/12, employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p>			

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	<p>P. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>14. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders that state to assess vital signs and report and adverse results to physician. Review of the nursing clinical notes evidenced the following: On 8/2/12, employee F, RN, failed to document all vital signs. Only temperature was documented.</p> <p>15. Clinical record #10, start of care 8/8/12, contained a plan of care for the certification period dated 8/8/12 - 10/6/12 with orders to "assess vital signs and report and adverse results to the physician." Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee B, RN, failed to document all vital signs. Only pain was reported.</p> <p>B. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration, and temperature should be taken every visit.</p>			

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	<p>16. Clinical record #12, start of care 8/13/10, contained a plan of care for the certification period dated 8/2/12 - 10/11/12 with orders that state to assess vital signs and report and adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/23/12 employee W, RN, failed to document all vital signs. Only blood pressure was reported.</p> <p>B. On 8/30/12, employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>C. On 9/6/12, employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an order for a dressing change to this location.</p> <p>D. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." The record failed to evidence an</p>			

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	<p>order for a dressing change to this location. Also, the LPN failed to document all vital signs. Only pain, respiration, and blood pressure was reported.</p> <p>E. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>17. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife</p>			

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	<p>already had, to keep the area moisturized instead of dry." The record failed to evidence any orders for a dressing to this location.</p> <p>18. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders for SN as needed for labs and also to record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 12/13/11, 1/23/12, 1/26/12, and 2/6/12, employee M, RN, failed to record the patient's blood sugar.</p> <p>B. On 2/3/12, employee J, LPN, failed to record the patient's blood sugar.</p> <p>19. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for SN to asses / teach Diabetic care, record blood sugar checks to determine trending and evaluate care, and wound care dressing changes each visit. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/17/12, employee T, RN, failed to record the patient's blood sugar.</p>			

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	<p>B. On 9/7/12, employee W, RN, failed to record the patient's blood sugar.</p> <p>C. On 7/25/12, employee V, LPN, failed to record the patient's blood sugar.</p> <p>D. On 8/6/12, employee D, LPN, failed to record the patient's blood sugar and measure the wound.</p> <p>E. On 8/24/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>F. On 9/14/12, employee L, LPN, failed to record the patient's blood sugar.</p> <p>20. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patients Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/4/12, employee L, LPN, failed to record a temperature reading.</p> <p>B. During interview on 9/21/12 at 2:45</p>			

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	PM, employee S, alternate nursing supervisor, indicated if the plan of care orders say SN to assess vital signs, the nurses should be taking blood pressure, pulse, respiration, and temperature.			

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure the registered nurse coordinated care with all personnel furnishing services and the physician for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <p>1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician."</p> <p>2. Facility policy titled "Physician Orders and Communication: Obtaining and</p>	N0545	The Clinical Managers will inservice all RNs on the duties of the registered nurse in coordinating the care as ordered by the physician and recorded in the plan of care in accordance to agency policies. All clinical field staff including PT, OT and ST will be inserviced that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff and PT, OT and ST as indicated will also be inserviced on communicating significant information related to patient's needs and change in condition to the physician and other disciplines to ensure optimal care for the patients. All field staff including PT, OT and ST will be inserviced on required communication with the assigned case manager. Periodic review of the patient's plan of care will occur at the routinely scheduled case conferences. 10% of all clinical records will be audited quarterly for evidence that the registered nurse has coordinated services, informed the physician and other personel of changes in	10/31/2012	

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	Documenting" policy number C-11 dated 10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs		the patient's condition and needs. In addition, evidence that the clinical staff including PT, OT and ST as indicated have communicated significant information related to the patients needs to the case manager/ physician, that the plan of care has been reviewed and updated accordingly and skilled nursing and therapy visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.		

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	<p>within 24 hours."</p> <p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. Facility policy titled "Medical Social</p>				

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	<p>Service Assessment" policy number CD 1.09 dated 4/11 states, "Social work services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's condition; maintains contact/communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p>			

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	<p>7. Clinical record #4, Start of Care (SOC) 5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee K, RN,</p>			

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	<p>documented a pressure ulcer on the "RLE [right lower extremity] upper." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There is no evidence this new wound was reported to the physician or that any</p>			

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	<p>orders were received for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p>			

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	<p>A. On 8/10/12 employee D, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm [centimeter] around. Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious disease doctor, patient states he has an appt on 9/20/12. Writer spoke with</p>			

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	<p>[employee F, RN] concerning visit and left shin blister."</p> <p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and to get orders to treat. The LPN gave the patient the fax number to VNS and told the patient to have the doctor's office fax any new orders to VNS. The LPN stated they have been aware of the</p>			

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	<p>wound on the left shin and have been monitoring it. The patient then took their blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer replacement would have been appropriate; however, there was no evidence that this was done.</p> <p>I. On 9/20/12 at 4:50 PM, employee R,</p>			

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	<p>Director indicated the new wound on the shin should have been reported to the physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this</p>						

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	<p>location as of this date.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>F. On 8/24/12 employee J, LPN,</p>			

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	<p>documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/14/12 employee F, RN, documented "PRN [as needed] visit made after client's daughter called the</p>			

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	<p>office with concerns. When SN arrived client was lying in bed. Skin is pale, using accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address patient's depression. No new orders for skin repair cream were found and no follow up with physician was made.</p> <p>D. On 9/20/12 at 4:58 PM, employee R,</p>			

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	<p>Director, indicated the change in patient condition should have been reported to the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/6/12 employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new</p>			

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	<p>wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemc symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is</p>			

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	<p>present during the eval but staying in the front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the RN and PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented</p>			

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	<p>in the clinical notes.</p> <p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and there was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p>			

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	<p>15. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record blood sugar checks to determine trending and evaluate care. Review of the nursing clinical notes evidenced the following:</p>			

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	<p>A. On 8/6/12, employee D, a LPN, documented the patient did not have batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to evidence follow up with orders.</p> <p>17. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 -</p>				

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	<p>10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>			
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N0546	<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 policy review, job description review, record review, and interview, the home health agency failed to ensure the registered nurse notified the physician of changes in the patient's condition for 11 of 20 patient records reviewed with the potential to affect all patients of the agency. (#4, 6, 7, 8, 9, 12, 13, 14, 16, 17, and 18)</p> <p>Findings include:</p> <p>1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact/collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates</p>	N0546	The Clinical Managers will inservice all RNs on the duties of the registered nurse in coordinating the care as ordered by the physician and recorded in the plan of care in accordance to agency policies. All clinical field staff including PT, OT and ST will be inserviced that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff and PT, OT and ST as indicated will also be inserviced on communicating significant information related to patient's needs and change in condition to the physician and other disciplines to ensure optimal care for the patients. All field staff including PT, OT and ST will be inserviced on required communication with the assigned case manager. Periodic review of the patient's plan of care will occur at the routinely scheduled	10/31/2012			

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	<p>about the patient in a clear and concise format to the patient's physician."</p> <p>2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated 10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the</p>		<p>case conferences.10% of all clinical records will be audited quarterly for evidence that the registered nurse has coordinated services, informed the physician and other personel of changes in the patient's condition and needs. In addition, evidence that the clinical staff including PT, OT and ST as indicated have communicated significant information related to the patients needs to the case manager/ physician, that the plan of care has been reviewed and updated accordingly and skilled nursing and therapy visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>		

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	<p>call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs within 24 hours."</p> <p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate</p>			

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	<p>response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. Facility policy titled "Medical Social Service Assessment" policy number CD 1.09 dated 4/11 states, "Social work services are provided in accordance with the recognized standards of practice and patient's plan of care. Triggers for referral include but are not limited to: ... Inability to purchase essential products or services such as food, medications, heat, water or medical supplies."</p> <p>5. The job description titled "Registered Nurse (RN)" states the job duties include, "prepares clinical notes and updates the primary physician when necessary and in accordance with regulations and communicates with team members and community health related persons to coordinate the care plan; communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>6. The job description titled "Physical Therapist (PT)" states the job duties include, "Maintains appropriate clinical records, clinical notes, and reports to the</p>			

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	<p>physician any changes in the patient's condition; maintains contact/communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p> <p>7. Clinical record #4, Start of Care (SOC) 5/16/11, contained a plan of care for the certification period dated 7/9/12 - 9/6/12 with orders to assess for signs and symptoms of infection, wound care to be performed on SN (skilled nurse) visit days, and assess vital signs and report any adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 7/9/12, employee T, RN, documented the patient's hernia was protruding much more than usual, the patient was in more pain than usual, wound bed was more raw and bleeding and the skin was very thin and frail. Also the patient wondered about calling the doctor. The RN failed to notify the physician and, instead, told the patient to call the physician themselves and get an appointment.</p> <p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to</p>			

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	<p>the right lower extremity. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/24/12 employee K, RN, documented a pressure ulcer on the "RLE [right lower extremity] upper." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 8/27/12 employee F, RN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>D. On 8/27/12 employee F, RN,</p>			

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	<p>documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders."</p> <p>There is no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>E. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>F. During a home visit on 9/19/2012 at 2:00 PM, employee F, RN, indicated the patient never had a pressure ulcer, it was just a scratch. She indicated a new RN documented the scratch as a pressure ulcer and she continued to document it as the same because she didn't want to change the other RN's documentation.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and care coordination related to the disease process/body system of integumentary," and orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom</p>			

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	<p>management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee D, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/12/12 employee G, RN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>C. On 8/22/12 employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician.</p> <p>D. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician. The LPN's clinical note stated, "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister</p>			

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	<p>approx 0.4 cm [centimeter] around.</p> <p>Instructed patient to keep covered with dry 4x4 [dressing] until seen by infectious disease doctor, patient states he has an appt on 9/20/12. Writer spoke with [employee F, RN] concerning visit and left shin blister."</p> <p>E. On 9/12/12 employee D, LPN, documented a "blister" to the "left shin." There is no evidence this new wound was reported to the physician.</p> <p>F. On 9/14/12 employee D, LPN, documented in a clinical note "left shin blister area open, draing [draining] small amt [amount] purulent drainage, patient keeping covered with clean dry dressing." There was no evidence this was reported to the physician.</p> <p>G. On 9/17/12, employee F, RN, documented a "blister" to the "left shin." There was no evidence this new wound was reported to the physician.</p> <p>H. During a home visit on 9/19/12 at 11:35 AM, employee D, LPN completed an assessment on the patient. The patient had two wounds on the left shin. The LPN instructed the patient to tell the infectious disease doctor about them during the appointment on 9/20/12 and</p>			

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	<p>to get orders to treat. The LPN gave the patient the fax number to VNS and told the patient to have the doctor's office fax any new orders to VNS. The LPN stated they have been aware of the wound on the left shin and have been monitoring it. The patient then took their blood sugar which was 311. The patient indicated they have been increasing their insulin per self because their blood sugar had been running high. The LPN informed the patient this should be managed by the doctor and that the patient should not be increasing his insulin themselves. The LPN then recorded the patient's blood sugars with a 7 day average of 417. Employee R, Director, who was present for the home visit looked at the patient's meter and noted that several days of the patient's blood sugar was missing. The patient indicated their glucometer was broken for a few weeks so they were unable to take their blood sugar. There was no evidence the broken glucometer had been addressed.</p> <p>On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken. Employee R did indicate a referral to a Social Worker for a glucometer</p>			

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	<p>replacement would have been appropriate; however, there was no evidence that this was done.</p> <p>I. On 9/20/12 at 4:50 PM, employee R, Director indicated the new wound on the shin should have been reported to the physician.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 -10/7/12 with orders for wound care to the lower calf on right leg. Orders dated 8/29/12 state for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing."</p>						

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	<p>The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location as of this date.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported</p>				

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	<p>to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location on this date.</p> <p>H. On 9/20/12 at 4:53 PM, employee R, Director, indicated the wound of the right heel should have been reported to the physician.</p> <p>11. Clinical record #9, start of care 8/2/10, contained a plan of care for the certification period dated 8/2/12 - 9/30/12. Review of the nursing clinical</p>				

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	<p>notes evidenced the following:</p> <p>A. On 8/14/12 employee F, RN, documented "PRN [as needed] visit made after client's daughter called the office with concerns. When SN arrived client was lying in bed. Skin is pale, using accessory muscles for breathing with a respiratory rate of 28. Coughing up thick yellow/white sputum. Fine crackles noted in the lung bases with ex/wheeze on the right. HR [heart rate] 104. Client reportedly had a HR in the 130's earlier in the day with activity. SN discussed with client and daughter the option of going to the ER [Emergency Room] for treatment and discussed hospice as an option. Client is not ready to accept to hospice at this time. Family called the paramedics and client was transported to St. V's ER per ambulance." There was no evidence in the medical record that the RN reported this change in condition to the physician.</p> <p>B. On 8/22/12 employee G, RN, documented "Phone call: ... Requesting a skin protectant cream for patient to peri [perineal] - area for prevention of skin breakdown."</p> <p>C. On 8/31/12, a new order for Paroxetine HCl was received to address</p>				

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	<p>patient's depression. No new orders for skin repair cream were found and no follow up with physician was made.</p> <p>D. On 9/20/12 at 4:58 PM, employee R, Director, indicated the change in patient condition should have been reported to the physician.</p> <p>E. On 9/20/12 at 4:59 PM, employee R indicated follow up with the physician regarding an order for skin repair cream should have occurred through triage and this should have been documented in the clinical notes if this had occurred.</p> <p>12. Clinical record #12, start of care 8/13/12, contained a plan of care for the certification period dated 8/13/12 - 10/11/12 with orders for wound care to the right heel and left plantar wound. Review of of the nursing assessment evidenced the following:</p> <p>A. On 8/30/12 employee A, RN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p>			

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	<p>B. On 9/6/12 employee I, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>C. On 9/13/12 employee L, LPN, documented a pressure ulcer on the "right plantar foot." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>13. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12 - 11/9/12 with orders to "Assess/teach Diabetic care, diet, hyper/hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p>			

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	<p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS is high at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S,</p>			
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	<p>alternate nursing supervisor, indicated the RN and PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented in the clinical notes.</p> <p>14. Clinical record #14, start of care 8/16/12, contained a plan of care for the certification period dated 8/16/12 - 10/14/12 with orders for wound care to the bilateral buttocks. Review of the nursing clinical notes evidenced the following:</p> <p>On 9/13/12, employee A, RN, documented "Pressure Ulcer: patient stated pain was a 7 in the buttocks area ... SN assessed buttocks area and found 2 skin tears on [the patient's] right buttocks near [the patient's] scrotum and 1 skin tear on [the patient's] left buttock near [the patient's] upper thigh. Patient states when getting on and off the toilet [the patient] has to drag [themselves] over the toilet seat, causing the tears. SN advised patient and wife to wrap a towel around toilet seat. SN also advised using Calazime cream, that wife already had, to keep the area moisturized instead of dry." There was no documentation of the new skin tears found in the nursing assessment and</p>			

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	<p>there was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>15. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders to record blood sugar checks to determine trending and evaluate care, and assess vital signs and report adverse results to physician. Review of the nursing clinical notes evidenced the following:</p> <p>On 12/15/11, employee X, LPN, documented the patient was admitted to the hospital with hyperglycemia. Resumption of Care (ROC) was on 1/23/12. Employee M, a RN, documented the patient became lethargic, unable to communicate, cool to touch, spouse gave patient orange juice and peanut butter, patient aroused and said they had a hypoglycemic episode. Record failed to indicate physician was notified of episode.</p> <p>16. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12 - 9/22/12 with orders for skilled nursing to asses/teach Diabetic care, and record</p>			

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	<p>blood sugar checks to determine trending and evaluate care. Review of the nursing clinical notes evidenced the following:</p> <p>A. On 8/6/12, employee D, a LPN, documented the patient did not have batteries for the glucometer to check blood sugars. The record failed to evidence coordination of care to remedy the situation. On 8/17/12 employee T, a RN, documented the patient said they were going to get batteries that day for the glucometer.</p> <p>B. On 9/14/12 employee L, a LPN, documented they heard fine crackles in the lungs, observed 2+ edema to bilateral lower extremities and was unable to palpate a pedal pulse due to edema. The clinical notes indicated the LPN would contact the CM and PCP for wound care orders and compression stockings. The record failed to evidence any follow up with the CM or PCP regarding the crackles in the lungs and the edema.</p> <p>C. On 9/21/12 at 1:40 PM, employee T, Clinical Manager, was asked if orders were received concerning the edema and the crackles in record #17. As of 2:00 PM, there was no documentation provided to</p>			

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	<p>evidence follow up with orders.</p> <p>17. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 - 10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>On 9/18/12 employee Y, RN, recorded a BP of 162/90, the patient had wheezes to the right lower lobes of the lungs, with diminished lung sounds to the left lung and the right upper lobes, productive cough with moderate thick white sputum, and right and left lower extremity edema. The record failed to evidence the physician was notified of the BP findings, the diminished and wheezy lung sounds, and the edema.</p>			

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N0553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies.</p> <p>Based on policy review, job description review, record review, observation, and interview, the home health agency failed to ensure the licensed practical nurse furnished services in accordance with agency policy in 9 of 20 records reviewed with the potential to affect all patients of the agency who receive services by a licensed practical nurse. (#2, 3, 6, 7, 8, 12, 16, 17, and 18)</p> <p>Findings include:</p> <p>1. Facility policy titled "Standards of Practice" policy number C-48 dated 1/11 states, "Visiting Nurse Service, Inc. will identify and define standards of care, service, and practice to guide the provision of patient care for home care services, in addition to the policies defined which support standards of care/service. Standards of Practice include State Practice Act Rules for each discipline ... Based on referral information and the initial assessment,</p>	N0553	The Clinical Managers will inservice all LPNs on the duties of the LPN in providing services to the patients in accordance to agency policies. All clinical field staff will be inserviced that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The nursing field staff will also be inserviced on wound treatments/documentation and communicating significant information related to patient's needs and change in condition to the physician and other disciplines to ensure optimal care for the patients. All field staff will be inserviced on required communication with the assigned case manager, case conferencing and SBAR communication technique. Care coordination scenarios will be utilized for competency evaluation per discipline responsibilities. Weekly the regular visit frequency exception report will be monitored prior to the end of the Medicare week for exceptions. 10% of all clinical records will be audited quarterly for evidence that the	10/31/2012	

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	<p>the clinician / technician, in conjunction with other organization personnel, will select the most appropriate standards of care / service and practice guidelines for the patient's care / service ... Standards of care / service and practice guidelines will guide the interventions that are to be implemented. The following standards of care / service and practice are available for use in planning the care of the patient. A. Discipline Specific Practice Acts B. Professional Association member standards. Use of standards of care/service and practice will be evident in the documentation of visits and assessments, as well as in the care / service planning process."</p> <p>2. Facility policy titled "Application of Wound Dressing" policy number CPP5.03 dated 4/11 states, "Adhere to standard Precautions; review physician's orders; explain procedure to patient / caregiver; establish a clean field (sterile, if necessary) with all the supplies and equipment that will be necessary; Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves."</p> <p>3. Facility policy titled "Peripherally</p>		<p>LPN provided services in accordance with agency policy, the clinical staff have communicated significant information related to the patients needs to the physician, that the plan of care has been reviewed and updated accordingly and skilled nursing visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.</p>		

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	<p>Inserted Central Catheter (PICC) Insertion Care and Maintenance," policy number CPP13.15, dated 8/00, states under section "C. Dressing Change, Procedure: ... 12. Verify catheter length remaining outside corresponds to initial placement measurement. If it does not, notify physician before continuing use. ... AFTER CARE: 1. Document in client's record: ... c. Length of catheter exposed under dressing."</p> <p>4. Facility policy titled "Licensed Practical Nurse (LPN) Utilization" policy number CPP12.07 dated 4/11 states, "The LPN may make subsequent visits, report client status, follow Plan of Care, provide appropriate treatment, reinforce teaching, document on appropriate forms."</p> <p>5. The job description titled "Licensed Practical Nurse (LPN)" last modified 9/24/12 states "Implements plan of care initiated by the registered nurse."</p> <p>6. Clinical Record #2, start of care 8/30/12, contained a plan of care for the certification period dated 8/30/12 - 10/28/12 with orders to assess IV site Left upper arm Single Lumen (SL) Peripherally Inserted Central Catheter (PICC), change dressing to IV Access</p>			

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	<p>weekly and as needed (PRN) per agency protocol and record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/13/12, employee L, LPN, failed to measure the PICC line and record a blood sugar reading.</p> <p>B. During home visit observation on 9/19/12 at 10:45 AM, employee I, a LPN, was observed drawing blood from a PICC line and changing the PICC line dressing. The LPN failed to measure the PICC line catheter.</p> <p>7. Clinical record #3, start of care 8/18/12, contained a plan of care for the certification period dated 8/18/12 - 10/16/12 with orders to change dressing to IV access weekly and PRN per agency protocol. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/28/12 employee I, LPN, failed to measure the PICC line.</p> <p>B. On 9/20/12 at 4:20 PM, employee R, Director, indicated the PICC lines do not ever have to be measured as it is not part of the agency's policy.</p>			

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	<p>8. Clinical record #6, start of care 6/7/12, contained a plan of care for the certification period dated 8/6/12 - 10/4/12 with orders for wound care to the right lower extremity (RLE) and orders to "assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integumentary." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/29/12 employee D, LPN, documented a pressure ulcer on the "RLE superior." The assessment states the dressing was changed "per orders." There was no evidence this new wound was reported to the physician or that any orders were received for a dressing change to this location.</p> <p>B. On 9/18/2012 at 2:30 PM, Employee T, Clinical Manager, and employee R, Director, indicated there were no orders for a dressing change for the pressure ulcer.</p> <p>9. Clinical record #7, start of care 8/2/12, contained a plan of care for the certification period dated 8/2/12 - 9/30/12 with orders for wound care to the left foot, orders to "assess, observe, and do comprehensive management and</p>			

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	<p>care coordination related to the disease process / body system of integumentary," and orders to "Assess / teach Diabetic care, diet, hyper / hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12, employee D, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe" that was "not healing." There was no evidence this new wound was reported to the physician.</p> <p>B. On 8/22/12, employee V, LPN, documented a "diabetic neuropathic ulcer" to the "bottom of right great toe." There was no evidence this new wound was reported to the physician. There was also no blood sugar check recorded. The LPN's clinical note stated "Patient is non-compliant with taking his blood sugar levels on a daily basis."</p> <p>C. On 8/29/12, employee D, LPN, failed to record the patient's blood sugar.</p> <p>D. On 9/12/12, employee D, LPN, documented a "blister" to the "left shin." There was no evidence this new wound</p>			

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	<p>was reported to the physician. There was also no blood sugar check recorded. The LPN's clinical note stated "Left shin has a new area, fluid filled blister added to skin assessment, fluid looks thick yellow, blister intact, redness surrounding blister approx 0.4 cm around. Instructed patient to keep covered with dry 4x4 until seen by infectious disease doctor, patient states he has an appt [appointment] on 9/20/12. Writer spoke with [employee F, RN] concerning visit and left shin blister."</p> <p>E. On 9/12/12, employee D, LPN, failed to document a blood sugar check.</p> <p>F. On 9/20/12 at 4:48 PM, employee R, Director, indicated the blood sugar was not monitored at each visit because the patient's glucometer was broken.</p> <p>10. Clinical record #8, start of care 10/19/10, contained a plan of care for the certification period dated 8/9/12 - 10/7/12 with orders to "Assess, observe, and do comprehensive management and care coordination related to the disease process / body system of integument, endocrine, circulatory," orders to "assess vital signs and report any adverse results to the physician," and orders for wound care to the lower calf on right leg.</p>			

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	<p>Orders dated 8/29/12 indicate for wound care to be completed on the right lateral heel, right calf distal, right anterior lower leg, and middle right toe. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/10/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>B. On 8/13/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also fails to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>C. On 8/17/12 employee J, LPN, documented a "venous stasis ulcer" to</p>			

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	<p>the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only respiration and blood pressure were documented.</p> <p>D. On 8/20/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>E. On 8/22/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p>				

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	<p>F. On 8/24/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>G. On 8/27/12 employee J, LPN, documented a "venous stasis ulcer" to the "right heel" that was "not healing." The assessment states the dressing was changed "per orders." There was no evidence that any orders were received for a dressing change to this location as of this date. The assessment also failed to evidence that all vital signs were taken. Only pulse, respiration, and blood pressure were documented.</p> <p>H. On 8/31/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>I. On 9/5/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were</p>			

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	<p>documented.</p> <p>J. On 9/10/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>K. On 9/12/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>L. On 9/14/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>M. On 9/17/12 employee J, LPN, failed to document all vital signs. Only pulse, respiration, and blood pressure were documented.</p> <p>N. During a home visit on 9/19/12 at 1:10 PM, employee J, LPN, was performing a dressing change on patient #8. The LPN removed the old dressing, applied saline wash, measured wound, and proceeded to apply a new dressing to each wound. No glove change or hand sanitation was done throughout the entire dressing change.</p> <p>On 9/20/12 at 4:55 PM, employee R,</p>			

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	<p>Director, indicated she spoke with the LPN regarding not changing her gloves and the LPN indicated she was nervous and realized that she had forgotten to do so.</p> <p>O. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>11. Clinical record #12, start of care 8/113/10, contained a plan of care for the certification period dated 8/2/12-10/11/12 with orders to assess vital signs and report and adverse results to physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 9/13/12, employee L, LPN, failed to document all vital signs. Only pain, respiration, and blood pressure was reported.</p> <p>B. On 9/21/12 at 2:45 PM, employee S, Alternate nursing supervisor, indicated blood pressure, pulse, respiration and temperature should be taken every visit.</p> <p>12. Clinical record #16, start of care 12/13/11, contained a plan of care for the certification period dated 12/13/11 - 2/10/12 with orders for SN for labs and</p>				

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	<p>also to record blood sugar checks to determine trending and evaluate care. Review of the nursing assessment evidenced the following: On 2/3/12 employee J, LPN, failed to record the patient's blood sugar.</p> <p>13. Clinical record #17, start of care 5/26/12, contained a plan of care for the certification period dated 7/25/12-9/22/12 with orders for SN to asses / teach Diabetic care, record blood sugar checks to determine trending and evaluate care, and wound care dressing changes each visit. Review of the nursing assessment evidenced the following:</p> <p>A. On 7/25/12 employee V, LPN, failed to record the patient's blood sugar.</p> <p>B. On 8/6/12 employee D, LPN, failed to record the patient's blood sugar and measure the wound.</p> <p>C. On 8/24/12 employee D, LPN, failed to record the patient's blood sugar.</p> <p>D. On 9/14/12 employee L, LPN failed to record the patient's blood sugar.</p> <p>14. Clinical record #18, start of care 2/23/12, contained a plan of care for the certification period dated 8/21/12 -</p>			

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	<p>10/19/12 with orders for Patient's Vital Signs within therapeutic ranges: Blood Pressure (BP) Systolic 80-140, Diastolic less than 90, Respirations 12-20, Pulse 62-100, Temp between 97.0 Fahrenheit (F)- 99.5 F. Unless otherwise indicated by the physician. Review of the nursing assessment evidenced the following:</p> <p>A. On 8/22/122 employee V, LPN, recorded a BP of 144/82, but failed to notify the physician of the systolic BP.</p> <p>B. On 9/4/12 employee L, LPN, failed to record a temperature reading.</p>			

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N0567	<p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel;</p> <p>Based on policy review, job description review, record review, and interview, the agency failed to ensure the therapist consulted with other agency personnel in 1 of 8 records reviewed of patients receiving Physical Therapy services with the potential to affect all patients of the agency who receive therapy services. (#13)</p> <p>Findings include:</p> <p>1. Facility policy titled "Responsibilities of the Patient, Physicians, and VNS in Providing Care to VNS Patients" policy number C-14 dated 9/04 states, "Purpose: To assure continual verbal and written contact / collaboration between the patient's physician and the patient's nurse ... VNS is responsible for providing complete and accurate clinical updates about the patient in a clear and concise format to the patient's physician."</p> <p>2. Facility policy titled "Physician Orders and Communication: Obtaining and Documenting" policy number C-11 dated</p>	N0567	The Clinical Managers will inservice all therapy staff on the duties of the therapist in providing services to the patient and the importance of consulting with the family and other agency personnel in accordance to agency policies. All clinical field staff will be inserviced that prior to seeing a patient, the clinician will review and follow the written plan of care and/or interim orders and provide visits, procedures and treatments accordingly as per P&Ps. The therapy field staff will also be inserviced on communicating significant information related to patient's needs and changes in condition to the physician and other disciplines to ensure optimal care for the patients. All therapy field staff will be inserviced on required communication to the assigned case manager, case conferencing and SBAR communication technique. Care coordination scenarios will be utilized for competency evaluation per discipline responsibilities. 10% of all clinical records will be audited quarterly for evidence that the field therapy staff have advised and consulted with the family and other agency personnel, have communicated	10/31/2012	

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	10/11 states, "The physician is contact by professional staff for: .. Changes in condition. Professional staffs of the home health programs of Visiting Nurse Service, Inc. are to promptly contact the physician or other appropriate parties using any of the methods listed: initial physician orders, changes in orders, to discuss the care of the client, to discuss changes in the client's condition, to coordinate any changes in the plan of care for the client ... Written physician orders are necessary to provide clinical services to a client ... The professional staff is to contact the client's physician when there is a change in the client's condition which suggests a need to alter the plan of care. This could include, but is not limited to, a change in the client's physical or psychological condition ... any changes in visit frequency, treatment protocol recommendations ... All attempts to reach the physician should be documented. The contact of all communication that does not involve the receiving of orders will be documented. This should include the purpose of the call to the physician; the discussion that occurred; and any recommendation that the doctor made including that there was no change made in the plan of care ... all physician communication occurs within 24 hours."		significant information related to the patients needs to the case manager/physician, that the plan of care has been reviewed and updated accordingly and therapy visits were made in accordance with the plan of care. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	

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	<p>3. Facility policy titled "Urgent and Critical Issue Follow Up" policy number CD8.0 dated 10/11 states, "Purpose: To document failure to reach a physician or physician designee to address an urgent or critical patient issue that clinical judgement warrants a return call for intervention. Three follow up attempts are to be made at 24 hour intervals until information has been directly communicated to the physician or physician designee. All attempts to reach the physician and the final outcome are to be documented in the clinical record ... If physician or physician designee is not reached on the third attempt or the critical nature of follow up needed warrants a more timely response: 1. Clinical manager will evaluate and pursue physician response; 2. If still unable to obtain guidance from the physician of record, Clinical Manager will discuss with Director of Nursing and gain direction from the Medical Director if needed. Any patient need or change in condition that warrants an immediate response will be directed to a Clinical Manager or Director of Nursing if no response received within 30 minutes."</p> <p>4. The job description titled "Physical Therapist (PT)" states the job duties</p>			

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	<p>include, "Maintains appropriate clinical records, clinical notes, and reports to the physician any changes in the patient's condition; maintains contact / communication with other personnel involved in the patient's care to promote coordinated, efficient care."</p> <p>5. Clinical record #13, start of care 9/11/12, contained a plan of care for the certification period dated 9/11/12-11/9/12 with orders to "Assess / teach Diabetic care, diet, hyper / hypo glycemic symptom management, and record blood sugar checks to determine trending and evaluate care." The plan of care states, "Patient was recently discharged from agency and now referred from MD [medical doctor] for increased weakness, uncontrolled DM II [Diabetes type 2], and med management." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 9/13/12 employee C, Physical Therapist (PT), documented "PT came to pt [patient] home per scheduled visit for initial eval. [evaluation]. Pt spouse is present during the eval but staying in the front porch. Pt is sitting in the living room with bowel movement smell. Pt gave a note from her dau [daughter] this morning stating BS [blood sugar] is high</p>			

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	<p>at 455 to 500 and she gave [patient] insulin. Pt asked pt whether she check her BS this afternoon yet and [the patient] said no. Pt checked [their] BS and was able to do it [themselves] with assistance just to hold the glucometer and [it] said HI. PT called pt [daughter] phone number she left in the note and she called me back. PT spoke to dau and told her the reading of glucometer and she said she is working late today. PT suggested to her to call her mother or father and they talk to each other. Pt is alert and coherent and able to clean herself up standing up with walker. Pt is able to walk short distance with walker and able to answer all question appropriately." There was no evidence the patient was instructed to take any insulin or that this was reported to the RN case manager or attending physician.</p> <p>B. On 9/21/12 at 2:50 PM, employee S, alternate nursing supervisor, indicated the PT should have reported the elevated blood sugar to the physician. She indicated all attempts to contact the physician should have been documented in the clinical notes.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2012
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NAME OF PROVIDER OR SUPPLIER VISITING NURSE SERVICE	STREET ADDRESS, CITY, STATE, ZIP CODE 4701 N KEYSTONE AVE INDIANAPOLIS, IN 46205
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