

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K065	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/04/2014
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NAME OF PROVIDER OR SUPPLIER  HELP AT HOME SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3347 N GREEN RIVER RD EVANSVILLE, IN 47715
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G000000	<p>This was a home health Federal Medicaid recertification survey.</p> <p>Survey Dates: 2-27-14, 2-28-14, 3-3-14, 3-4-14, and 3-5-14 Partial extended: 2-28-14 Extended 3-4-14</p> <p>Facility #: 012482</p> <p>Medicaid Vendor #: 201010780</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Help At Home Skilled Care is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 3-10-14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision, 484.30 Skilled Nursing Services, and 484.55 Comprehensive Assessment of Patients.</p> <p>The Administrator and the Supervising Nurse were informed of the above-stated preclusion at the exit conference held on 3-5-14 at 121:15 AM.</p> <p>Quality Review: Joyce Elder, MSN,</p>	G000000		
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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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G000121	<p>BSN, RN March 10, 2014</p> <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. Based on observation, agency policy review, and interview, the agency failed to ensure staff had provided services in accordance with its own infection control policies and procedures in 4 (patients #s 1, 7, 8, &amp; 9) of 5 home visit observations completed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Infection Control - Standard Precautions &amp; Handling of Infectious Waste &amp; Biohazardous Materials" policy number B-403 states, "Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC) . . . Use of Standard Precautions Policy. Standard Precautions will be used on ALL patients."</p>	G000121	<p>1. Help At Home, Inc. will conduct an in-service training on the company Polices and Procedures for Infection Control and Universal Precautions – Policy B 403.</p> <p>2. The deficiency will be prevented by implementing an infection control compliance program which will be reviewed quarterly and the findings will be reviewed and evaluated in the QA program meeting.</p> <p>3. The Nursing Supervisor will ensure all staff has been in-serviced on Agency policies and procedures B403. The internal monitoring will be conducted by the Nursing Supervisor quarterly to ensure infection control processes have been followed according to company policy.</p> <p>4. The deficiency will be corrected by 4-09-14</p>	04/09/2014
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	<p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective</p>			

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	<p>equipment (PPE) . . . IV.B.2. Gloves.</p> <p>IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>3. A home visit was made to patient number 1 with employee B, a home health aide, on 2-28-14 at 9:00 AM. The aide was observed to provide a total bed bath to the patient. After completing the bath to the patient's upper body, the aide rolled the patient to the left side. Observation noted a soiled Chux (plastic backed pad) under the patient's buttocks and lower back. The aide rolled and tucked the soiled Chux under the patient and washed, rinsed, and dried the patient's back. The aide then rolled the patient to the right side and removed the soiled Chux from under the patient. Without changing her gloves or cleansing her hands, the aide continued to wash the patient's back. The aide then applied deodorant to the patient's underarms and applied the patient's shirt.</p> <p>With the same gloves on, the aide then removed the patient's socks, washed, rinsed, and dried the patient's feet, and applied lotion to the feet and</p>			

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	<p>lower legs. Without changing her gloves or cleansing her hands, the aide then washed, rinsed, and dried the patient's peri-anal area. Observation noted a small amount of dried feces in the area. The aide applied an adult diaper, and, without changing her gloves or cleansing her hands, the aide applied the patient's socks, shoes, and shorts and assisted the patient out of bed into a wheelchair.</p> <p>4. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The RN was observed to perform an assessment of the patient. The RN cleansed her hands and retrieved a blood pressure cuff, a thermometer, and a stethoscope from her nursing bag. The RN took the patient's vital signs and assessed the patient's chest and abdomen. The RN charted her findings on the skilled nurse visit note. The RN then donned clean gloves without cleansing her hands and assessed the patient's ankles. The RN removed her gloves and without cleansing her hands, reached into her bag to retrieve hand cleanser. The RN then cleansed her hands. The RN then retrieved a bottle of Betadine and some gauze from her bag and donned clean gloves without cleansing her hands. The RN prepared</p>			

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	<p>to administer an intramuscular injection but was unable to complete the task due to a problem with the dosage of the medication.</p> <p>5. A home visit was made to patient number 8 with employee C, a home health aide, on 3-4-14 at 9:45 AM. The aide was observed to retrieve several gloves from her bag and place them in her pocket. The aide dropped two gloves on the floor in the process and was observed to pick the gloves up off the floor and place them in her pocket.</p> <p>6. A home visit was made to patient number 9 with employee E, a RN, on 3-4-14 at 2:05 PM. The RN was observed to perform an assessment and fill the patient's medication planner. The RN was observed to place a thermometer with a plastic sheath in the patient's mouth. Without donning gloves, the RN removed the thermometer from the patient's mouth and removed the plastic sheath and disposed of it creating the potential for the transfer of disease causing organisms from the patient's mouth to the RN's hands.</p> <p>7. The above-stated observations were discussed with the Administrator, the Nursing Supervisor, and the Regional</p>			
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G000145	<p>Manager on 3-5-14 at 10:15 AM. The participants indicated the agency staff had not provided care in accordance with agency infection control policies and procedures.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. Based on clinical record and agency policy review and interview, the agency failed to ensure written summary reports that included a compilation of pertinent factors had been sent to the physician at least every 60 days in 2 (#s 8 and 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 8 included a skilled nurse (SN) visit note dated 1-21-14 that states, "Seen [name of physician] last wk [week] new script for Keflex given states has infected (Rt [right]) thumb." The written summary report, sent to the physician on 2-28-14, failed to mention the new medication or the condition of the patient's right thumb.</p>	G000145	<p>1. The nurse will be in serviced on completing the written summary report that included a compilation of pertinent factors that have been sent to the Physician every 60 days.</p> <p>2. The deficiency shall be prevented in the future by reviewing the summary prior to submitting to the physician to ensure it includes a compilation of pertinent factors. 100% of the summaries will be reviewed by 4-09-14.</p> <p>3. The Nursing Supervisor shall be responsible for auditing the summaries.</p> <p>4. The deficiency will be corrected by 4-09-14</p>	04/09/2014
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	<p>The plan of care for the certification period 12-27-13 to 2-26-14 evidenced the physician had ordered the skilled nurse to fill the medication planner every week and monitor the patient's compliance with the medications. The written summary report failed to include any mention of the patient's compliance with the medication regimen.</p> <p>2. Clinical record number 10 included a SN visit note dated 1-13-14 that states, "Pt [patient] states lower back has been bothering [the patient], has interrupted sleep at night. Pt is not currently doing anything about back pain. Pt was instructed to contact MD if pain continues, becomes worse or other s/s [signs or symptoms]."</p> <p>A. The record included a SN visit note dated 1-20-14 that states, "Pt states [the patient] has hx [history] of back/disc issues. pt states isn't using any medication for back pain, plans on talking [with] MD when visits on Friday. SN encouraged pt to call MD if pain gets worse or has other s/s [signs and symptoms]."</p> <p>B. A SN visit note dated 1-27-14 states, "Pt states Nurse Practitioner was there to visit on Friday 1-24-14. Has ordered medication for back pain."</p>			

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	<p>C. The written summary report, sent to the physician on 2-18-14 states, "No major changes in pt's condition." The report failed to include any mention of the patient's back pain and the effectiveness of the new pain medication.</p> <p>3. The Administrator and the Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>4. The agency's undated "Medical Supervision" policy number C - 645 states, "Written reports on the patient's condition are provided to the physician at least every sixth [sic] 60 days."</p> <p>5. The agency's undated "Coordination of Patient Services and Clinical Summary" policy number C - 360 states, "Care conferences will be documented on the Care Conference/Clinical Summary form or in the progress notes. A written summary report of services provided and response to care for each patient shall be sent to the physician at least every sixty (60) days."</p>				

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G000156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure ensure treatments and services had been provided in accordance with physician orders in 5 of 10 records reviewed creating the potential to affect all of the agency's 119 current patients (See G 158); by failing to ensure the plan of care included all medications in 1 of 10 records reviewed creating the potential to affect all of the agency's 119 current patients (See G 159); by failing to ensure the physician had been alerted to changes in the patient's condition in 1 of 10 records reviewed creating the potential to affect all of the agency's 119 current patients (See G 164); and by failing to ensure medications had been administered as ordered in 1 of 10 records reviewed creating the potential to affect all of the agency's 119 current patients (See G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.18 Acceptance</p>	G000156	<p>G156</p> <ol style="list-style-type: none"> <li>The Nurses will be in-serviced on following physician orders to ensure the physician has been alerted to changes and all medications have been administrated.</li> <li>The deficiency shall be prevented in the future by having a supervisory nurse audit the charts and in-servicing the nursing staff. 100% of the patient records will be audited by 4-09-14 for compliance to ensure the physician has been alerted to changes and all medications have been administrated</li> <li>The Nursing Supervisor shall be responsible for auditing the patient charts.</li> <li>The deficiency will be corrected by 4-09-14</li> </ol>	04/09/2014
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G000158	<p>of Patients, Plan of Care, and Medical Supervision.</p> <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. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure treatments and services had been provided in accordance with physician orders in 5 (#s 2, 3, 5, 7, and 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 12-22-13 to 2-19-14 that states, "SN (skilled nurse) 2 wks 9 [two times a week for 9 weeks]. SN for med set up and check compliance of medication administration . . . Monitor Glucometer readings for variations and compliance. Client is responsible for doing own Accuchecks 3x daily." The plan of care identified</p>	G000158	<p>1. The Nurses will be in-serviced on following physician orders to ensure treatment and services had been provided in accordance with the physician orders.</p> <p>2. The deficiency shall be prevented in the future by having a supervising nurse audit the charts and in-servicing the nursing staff. 100% of the patient records will be audited by 4-09-14.</p> <p>3. The Nursing Supervisor shall be responsible for auditing the patient charts.</p> <p>4. the deficiency will be corrected by 4-09-14</p>	04/09/2014
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	<p>the physician had ordered the administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings (sliding scale).</p> <p>A. SN visit notes, dated 12-18-13, 12-30-13, 1-13-14, 1-27-14, 2-7-14, and 2-10-14, failed to evidence the SN had monitored the patient's compliance with performing the blood sugar testing 3 times per day and if the patient had self-administered the sliding scale insulin based on the readings per the physician's orders.</p> <p>1.) A SN visit note dated 1-27-14 evidenced the patient's most recent blood sugar reading was 299. The plan of care evidenced 6 units of Novolog insulin per the sliding scale for readings 251 to 300. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>2.) A SN visit note dated 2-7-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced the 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the</p>			

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	<p>administration of the sliding scale insulin.</p> <p>3.) A SN visit note dated 2-10-14 evidenced the most recent blood sugar reading was 203. The plan of care evidenced 4 units of Novolog insulin per the sliding scale for readings 201-250. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>4.) A SN visit note dated 2-17-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>B. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>C. The plan of care identified home</p>						

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	<p>health aide services were to be provided 3 to 5 times per week for 9 weeks during the certification period. The record evidenced only 2 home health aide visits had been provided the week of 2-3-14.</p> <p>2. Clinical record number 3 included a plan of care established by the physician for the certification period 1-21-14 to 3-21-14 that states, "SN 1w9 for med set up and check compliance with medication administration, monitor glucometer readings for variation and compliance . . . Patient checks blood sugars TID [three times per day] daily." The plan of care identified the physician had ordered the administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings.</p> <p>A. A SN visit note dated 1-16-14 failed to evidence the SN had monitored the patient's compliance with performing the blood sugar checks three times per day. The note evidenced the blood sugar reading was "206 today." The plan of care identified 4 units of Novolog insulin per sliding scale was ordered for readings 181-240. The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p>			

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	<p>B. A SN visit note dated 1-21-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "today 226 but ranging 155-226." The plan of care evidenced 4 units of Novolog insulin per sliding scale was ordered for readings 181-240. The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>C. A SN visit note dated 1-28-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS [blood sugar] ranging 178-265." The plan of care evidenced 4 units of insulin had been ordered for readings 181 to 240 and 6 units for readings 241 to 300 per the sliding scale. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>D. A SN visit note dated 2-4-15 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "blood sugar range 90-188." The plan of care evidenced 4</p>			

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	<p>units of Novolog insulin had been ordered per the sliding scale for readings of 181-240. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>E. A SN visit note dated 2-11-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS 211. BS ranging in 200s." The plan of care evidenced 4 units for readings 181-240 and 6 units for readings 241-300 of Novolog insulin per sliding scale had been ordered. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>F. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 6-14-13 to</p>			

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	<p>8-12-13 that states, "SN 1w9 for med set up and check compliance of medication administration . . . patient does accuchecks qid [4 times per day] per self." The plan of care included orders for the administration of insulin with the dosage based on blood sugar readings per a sliding scale.</p> <p>A. SN visit notes, dated 6-21-13 and 6-23-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>B. The record included a transfer to inpatient facility note dated 7-2-13 that identified the patient had been admitted to the hospital. The note states, "pt [patient] blood sugar was over 400 and [patient's] blood pressure systolic was over 180."</p> <p>C. The record included resumption of care orders dated 7-8-14 for SN to be resumed 1 time per week for medication set-up and "check compliance with medication administration." The orders included sliding scale insulin orders.</p> <p>D. SN visit notes dated 7-15-13 and 7-22-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times</p>						

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	<p>per day.</p> <p>E. A SN visit note dated 7-29-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 173." The plan of care identified 2 units of Novolog insulin was to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with self-administration of the sliding scale insulin.</p> <p>F. A SN visit note dated 8-6-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 152." The plan of care identified 2 units of Novolog insulin was to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with self-administration of the sliding scale insulin.</p> <p>G. A SN visit note dated 8-12-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>H. The administrator indicated, on</p>						

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	<p>3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>4. Clinical record number 7 included a plan of care established by the physician for the certification period 12-22-13 to 2-19-14 and 2-20-14 to 4-20-14 that states, "SN 1x/w [one time per week] to administer Testosterone 400 mg [milligrams] IM [intramuscular] 1 time per week." The record failed to evidence the ordered Testosterone had been administered the week of 2-24-14.</p> <p>A. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The RN prepared to administer the Testosterone injection when the patient stated, "I only get 1 cc [cubic centimeter] every week now which is 200 milligrams." The nurse was observed to check the prescription on the box with the vial of Testosterone and the prescription indicated the dosage was 400 mg (2 cc). The patient stated it had been 1 cc "for about a month." The patient stated he had been telling employee G [the patient's regular</p>						

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	<p>licensed practical nurse] about the dose change "for a long time."</p> <p>B. The RN, employee D, placed a telephone call to the ordering physician to clarify the dosage from the patient's home. The physician did not return the call and at 3:35 PM, the nurse instructed the patient she would attempt to call the physician again from the agency's office and would come back later that evening to administer the medication when the dosage had been clarified.</p> <p>C. Employee D, the RN, indicated, on 3-5-14 at 9:45 AM, she had received an order that date to clarify the dosage of the Testosterone and it was 200 milligrams every week instead of 400. The nurse indicated the dosage had been changed at the 2-18-14 doctor appointment and that employee G had been unaware of the dose change.</p> <p>D. A SN visit note, signed and dated by employee G on 2-21-14 evidenced the nurse had administered testosterone 400 mg IM, instead of 200 mg per the dose change on 2-18-14.</p> <p>E. The record included a "Physician Order Form", signed and dated by employee D on 3-4-14, that states, "Please sign and immediately return the</p>			

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	<p>following clarification order: Order clarification Change Testosterone 400 mg IM 1 time per week, to Testosterone 200 mg 1 time week."</p> <p>F. The plan of care for the certification period 12-22-13 to 2-19-14 states, "SN 1xwx9 . . . Client will monitor own blood sugars QID. SN will monitor glucometer readings for variations and compliance."</p> <p>1.) SN visit notes, dated 12-27-13, 1-3-14, 1-10-14, 1-17-14, 1-24-14, 1-31-14, 2-7-14, 2-14-14, and 2-19-14, failed to evidence the SN had assessed the patient's compliance with performing the blood sugar checks 4 times per day.</p> <p>2.) During a home visit to the patient, on 2-28-14 at 2:55 PM, with employee D, an RN, the patient stated, "I take my blood sugar at least twice a day. Sometimes I forget to test before breakfast. I will test before I take my insulin."</p> <p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 12-21-13 to 2-18-14. The plan of care states, "SN 1w9 to assess medication compliance . . . Pt is responsible to check blood sugars</p>			
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	<p>BID [2 times per day] and drawing up own insulin. SN to monitor glucometer recordings for variations and compliance."</p> <p>A. SN visit notes, dated 1-2-14 and 1-9-14, failed to evidence the SN had assessed the patient's compliance with performing the blood sugar checks 2 times per day and failed to evidence the SN had monitored the blood sugar readings.</p> <p>B. A SN visit note dated 1-20-14 states, "Pt states checking blood sugar BID." The note failed to evidence the SN had assessed the blood sugar readings.</p> <p>C. SN visit notes, dated 1-27-14, 2-3-14, and 2-10-14, failed to evidence the SN had assessed the patient's compliance with checking the blood sugar 2 times per day or had assessed the glucometer readings.</p> <p>6. The Administrator and Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>7. The agency's undated "Medical Supervision" policy number C - 645</p>			

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G000159	<p>states, "Agency responsibilities include: ... To follow the Physician Plan of Care."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the plan of care included all medications in 1 (# 8) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 8 included a skilled nurse (SN) visit note dated 1-21-14 that states, "Seen [name of physician] last wk [week] new script for Keflex given states has infected (Rt) thumb."</p> <p>The record failed to evidence the plan of care had been updated to include the</p>	G000159	<p>1. The Nursing Supervisor will in-service the RN's on the development of the patient plan of care with all medications.</p> <p>2. The deficiency shall be prevented in the future by the reviewing all plans of care before submitting to the physician.</p> <p>3. The supervising nurse will be responsible for reviewing all plans of cares before sent to the physician and providing care.</p> <p>4. The in-service will be conducted by the Nursing Supervisor by 4-09-14</p>	04/09/2014			

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G000164	<p>new medication, Keflex.</p> <p>2. The Administrator stated, on 3-5-14 at 9:40 AM, "The plan of care is updated by adding any new medications to the Medication Profile. The Keflex had not been added."</p> <p>3. The agency's undated "Plan of Care" policy number C-580 states, "The Plan of Care shall be completed in full to include: . . . Medications, treatment, and procedures . . . Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <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. Based on clinical record and agency policy review and interview, the agency failed to ensure the physician had been alerted to changes in the patient's condition in 1 (# 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 10 failed to evidence the registered nurse (RN) had notified the physician of the patient's</p>	G000164	<p>1. The Nursing Supervisor will in-service all nursing staff on promptly alerting the physician to any changes that suggest a need to alter the plan of care and document in the patient clinical record.</p> <p>2. The deficiency shall be prevented in the future by auditing 100% of the charts for physician notification by 4-09-14 and continuing education for staff on alerting the physician of any changes.</p> <p>3. The Nursing Supervisors will be responsible for auditing the patient files and the education.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>	04/09/2014

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	<p>onset of back pain.</p> <p>A. The record included a skilled nurse (SN) visit note dated 1-13-14 that states, "Pt [patient] states lower back has been bothering [the patient], has interrupted sleep at night. Pt is not currently doing anything about back pain. Pt was instructed to contact MD if pain continues, becomes worse or other s/s [signs or symptoms]."</p> <p>B. The record included a SN visit note dated 1-20-14 that states, "Pt states [the patient] has hx [history] of back/disc issues. pt states isn't using any medication for back pain, plans on talking [with] MD when visits on Friday. SN encouraged pt to call MD if pain gets worse or has other s/s."</p> <p>C. A SN visit note dated 1-27-14 states, "Pt states Nurse Practitioner was there to visit on Friday 1-24-14. Has ordered medication for back pain."</p> <p>2. The Administrator indicated, on 3-5-14 at 10:00 AM, the record did not evidence the agency's nurse had notified the physician of the patient's onset of back pain. The Administrator indicated she was not sure how the Nurse Practitioner knew to go see the patient unless the patient called the physician."</p>						

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G000165	<p>3. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "The registered nurse: . . . Informs the physician and other personnel of changes in the patient condition and needs."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and agency policy review and interview, the agency failed to ensure medications had been administered as ordered in 1 (# 7) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 12-22-13 to 2-19-14 and 2-20-14 to 4-20-14 that states, "SN 1x/w to administer Testosterone 400 mg [milligrams] IM [intramuscular] 1 time per week." The record failed to evidence the ordered Testosterone had been administered the week of 2-24-14.</p>	G000165	<p>1. The Nursing Supervisor will in-service all nursing staff on following the Plan of Care and ensuring medication and treatment is followed as prescribed by the physician.</p> <p>2. The deficiency shall be prevented in the future by monitoring the nursing visit records and comparing to the plan of care. 100% of the charts will be audited by 4-9-14 and continuing education for staff to ensure the plan of care has been followed.</p> <p>3. The Nursing Supervisors will be responsible for auditing the nursing notes and comparing to the plan of care.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>	04/09/2014

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	<p>A. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The RN prepared to administer the Testosterone injection when the patient stated, "I only get 1 cc [cubic centimeter] every week now which is 200 milligrams." The nurse was observed to check the prescription on the box with the vial of Testosterone and the prescription indicated the dosage was 400 mg (2 cc). The patient stated it had been 1 cc "for about a month." The patient stated he had been telling employee G [the patient's regular licensed practical nurse] about the dose change "for a long time."</p> <p>B. The RN, employee D, placed a telephone call to the ordering physician to clarify the dosage from the patient's home. The physician did not return the call and at 3:35 PM, the nurse instructed the patient she would attempt to call the physician again from the agency's office and would come back later that evening to administer the medication when the dosage had been clarified.</p> <p>C. Employee D, the RN, indicated, on 3-5-14 at 9:45 AM, she had received an order that date to clarify the dosage of the Testosterone and it was 200 milligrams every week instead of 400.</p>			

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G000168	<p>The nurse indicated the dosage had been changed at the 2-18-14 doctor appointment and that employee G had been unaware of the dose change.</p> <p>D. A SN visit note, signed and dated by employee G on 2-21-14 evidenced the nurse had administered testosterone 400 mg IM, instead of 200 mg per the dose change on 2-18-14.</p> <p>E. The record included a "Physician Order Form", signed and dated by employee D on 3-4-14, that states, "Please sign and immediately return the following clarification order: Order clarification Change Testosterone 400 mg IM 1 time per week, to Testosterone 200 mg 1 time week."</p> <p>2. The agency's undated "Medical Supervision" policy number C - 645 states, "Agency responsibilities include: . . . To follow the Physician Plan of Care."</p> <p>484.30 SKILLED NURSING SERVICES Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to maintain compliance with this</p>	G000168	<p>1. The Nursing Supervisor will in-service all nursing staff on following the Plan of Care as prescribed by the physician.</p> <p>2. The deficiency shall be prevented in the future by monitoring the nursing visit</p>	04/09/2014			

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	<p>condition by failing to ensure skilled nursing services had been provided in accordance with physician orders in 5 of 10 records reviewed creating the potential to affect all of the agency's 119 current patients (See G 170); by failing to ensure the registered nurse accurately and completely completed the start of care comprehensive assessments to accurately reflect the patients' status in 3 of 10 records reviewed creating the potential to affect all of the agency's new patients (See G 171); by failing to ensure the registered nurse reevaluated the patient's need by a complete update of the comprehensive assessment that accurately reflected the patients' status in 3 of 10 records reviewed creating the potential to affect all of the agency's patients receiving services more than 60 days (See G 172); by failing to ensure a revision to the plan of care had been initiated and implemented in 1 of 10 records reviewed creating the potential to affect all of the agency's 119 current patients (See G 173); and by failing to ensure the physician had been alerted to changes in the patient's condition in 1 of 10 records reviewed creating the potential to affect all of the agency's 119 current patients (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being</p>		<p>records and comparing to the plan of care. 100% of the charts will be audited by 4-09-14 and continuing education for staff to ensure the plan of care has been followed.</p> <p>3. The Nursing Supervisors will be responsible for auditing the nursing notes and comparing to the plan of care.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>		

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G000170	<p>found out of compliance with this condition, 42 CFR 484.30 Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 5 (#s 2, 3, 5, 7, and 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 12-22-13 to 2-19-14 that states, "SN (skilled nurse) 2 wks 9 [two times a week for 9 weeks]. SN for med set up and check compliance of medication administration . . . Monitor Glucometer readings for variations and compliance. Client is responsible for doing own Accuchecks 3x daily." The plan of care identified the physician had ordered the</p>	G000170	<p>1. The Nursing Supervisor will in-service all nursing staff on following the Plan of Care as prescribed by the physician.</p> <p>2. The deficiency shall be prevented in the future by monitoring the nursing visit records and comparing to the plan of care. 100% of the charts will be audited by 4-09-14 and continuing education for staff to ensure the plan of care has been followed.</p> <p>3. The Nursing Supervisors will be responsible for auditing the nursing notes and comparing to the plan of care.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>	04/09/2014

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	<p>administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings (sliding scale).</p> <p>A. SN visit notes, dated 12-18-13, 12-30-13, 1-13-14, 1-27-14, 2-7-14, and 2-10-14, failed to evidence the SN had monitored the patient's compliance with performing the blood sugar testing 3 times per day and if the patient had self-administered the sliding scale insulin based on the readings per the physician's orders.</p> <p>1.) A SN visit note dated 1-27-14 evidenced the patient's most recent blood sugar reading was 299. The plan of care evidenced 6 units of Novolog insulin per the sliding scale for readings 251 to 300. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>2.) A SN visit note dated 2-7-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced the 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale</p>			

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	<p>insulin.</p> <p>3.) A SN visit note dated 2-10-14 evidenced the most recent blood sugar reading was 203. The plan of care evidenced 4 units of Novolog insulin per the sliding scale for readings 201-250. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>4.) A SN visit note dated 2-17-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>B. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>2. Clinical record number 3 included a plan of care established by the physician</p>				

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	<p>for the certification period 1-21-14 to 3-21-14 that states, "SN 1w9 for med set up and check compliance with medication administration, monitor glucometer readings for variation and compliance . . . Patient checks blood sugars TID [three times per day] daily." The plan of care identified the physician had ordered the administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings.</p> <p>A. A SN visit note dated 1-16-14 failed to evidence the SN had monitored the patient's compliance with performing the blood sugar checks three times per day. The note evidenced the blood sugar reading was "206 today." The plan of care identified 4 units of Novolog insulin per sliding scale was ordered for readings 181-240. The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>B. A SN visit note dated 1-21-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "today 226 but ranging 155-226." The plan of care evidenced 4 units of Novolog insulin per sliding scale was ordered for readings 181-240.</p>			

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	<p>The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>C. A SN visit note dated 1-28-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS [blood sugar] ranging 178-265." The plan of care evidenced 4 units of insulin had been ordered for readings 181 to 240 and 6 units for readings 241 to 300 per the sliding scale. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>D. A SN visit note dated 2-4-15 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "blood sugar range 90-188." The plan of care evidenced 4 units of Novolog insulin had been ordered per the sliding scale for readings of 181-240. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p>			

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	<p>E. A SN visit note dated 2-11-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS 211. BS ranging in 200s." The plan of care evidenced 4 units for readings 181-240 and 6 units for readings 241-300 of Novolog insulin per sliding scale had been ordered. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>F. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 6-14-13 to 8-12-13 that states, "SN 1w9 for med set up and check compliance of medication administration . . . patient does accuchecks qid [4 times per day] per self." The plan of care included orders for the administration of insulin with the dosage based on blood sugar readings per a sliding scale.</p>						

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	<p>A. SN visit notes, dated 6-21-13 and 6-23-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>B. The record included a transfer to inpatient facility note dated 7-2-13 that identified the patient had been admitted to the hospital. The note states, "pt [patient] blood sugar was over 400 and [patient's] blood pressure systolic was over 180."</p> <p>C. The record included resumption of care orders dated 7-8-14 for SN to be resumed 1 time per week for medication set-up and "check compliance with medication administration." The orders included sliding scale insulin orders.</p> <p>D. SN visit notes dated 7-15-13 and 7-22-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>E. A SN visit note dated 7-29-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 173." The plan of care identified 2 units of Novolog insulin was</p>			

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	<p>to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with self-administration of the sliding scale insulin.</p> <p>F. A SN visit note dated 8-6-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 152." The plan of care identified 2 units of Novolog insulin was to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with self-administration of the sliding scale insulin.</p> <p>G. A SN visit note dated 8-12-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>H. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p>			

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	<p>4. Clinical record number 7 included a plan of care established by the physician for the certification period 12-22-13 to 2-19-14 and 2-20-14 to 4-20-14 that states, "SN 1x/w [one time per week] to administer Testosterone 400 mg [milligrams] IM [intramuscular] 1 time per week." The record failed to evidence the ordered Testosterone had been administered the week of 2-24-14.</p> <p>A. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The RN prepared to administer the Testosterone injection when the patient stated, "I only get 1 cc [cubic centimeter] every week now which is 200 milligrams." The nurse was observed to check the prescription on the box with the vial of Testosterone and the prescription indicated the dosage was 400 mg (2 cc). The patient stated it had been 1 cc "for about a month." The patient stated he had been telling employee G [the patient's regular licensed practical nurse] about the dose change "for a long time."</p> <p>B. The RN, employee D, placed a telephone call to the ordering physician to clarify the dosage from the patient's home. The physician did not return the call and at 3:35 PM, the nurse instructed</p>			

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	<p>the patient she would attempt to call the physician again from the agency's office and would come back later that evening to administer the medication when the dosage had been clarified.</p> <p>C. Employee D, the RN, indicated, on 3-5-14 at 9:45 AM, she had received an order that date to clarify the dosage of the Testosterone and it was 200 milligrams every week instead of 400. The nurse indicated the dosage had been changed at the 2-18-14 doctor appointment and that employee G had been unaware of the dose change.</p> <p>D. A SN visit note, signed and dated by employee G on 2-21-14 evidenced the nurse had administered testosterone 400 mg IM, instead of 200 mg per the dose change on 2-18-14.</p> <p>E. The record included a "Physician Order Form", signed and dated by employee D on 3-4-14, that states, "Please sign and immediately return the following clarification order: Order clarification Change Testosterone 400 mg IM 1 time per week, to Testosterone 200 mg 1 time week."</p> <p>F. The plan of care for the certification period 12-22-13 to 2-19-14 states, "SN 1xwx9 . . . Client will</p>			

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	<p>monitor own blood sugars QID. SN will monitor glucometer readings for variations and compliance."</p> <p>1.) SN visit notes, dated 12-27-13, 1-3-14, 1-10-14, 1-17-14, 1-24-14, 1-31-14, 2-7-14, 2-14-14, and 2-19-14, failed to evidence the SN had assessed the patient's compliance with performing the blood sugar checks 4 times per day.</p> <p>2.) During a home visit to the patient, on 2-28-14 at 2:55 PM, with employee D, an RN, the patient stated, "I take my blood sugar at least twice a day. Sometimes I forget to test before breakfast. I will test before I take my insulin."</p> <p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 12-21-13 to 2-18-14. The plan of care states, "SN 1w9 to assess medication compliance . . . Pt is responsible to check blood sugars BID [2 times per day] and drawing up own insulin. SN to monitor glucometer recordings for variations and compliance."</p> <p>A. SN visit notes, dated 1-2-14 and 1-9-14, failed to evidence the SN had assessed the patient's compliance with</p>			
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	<p>performing the blood sugar checks 2 times per day and failed to evidence the SN had monitored the blood sugar readings.</p> <p>B. A SN visit note dated 1-20-14 states, "Pt states checking blood sugar BID." The note failed to evidence the SN had assessed the blood sugar readings.</p> <p>C. SN visit notes, dated 1-27-14, 2-3-14, and 2-10-14, failed to evidence the SN had assessed the patient's compliance with checking the blood sugar 2 times per day or had assessed the glucometer readings.</p> <p>6. The Administrator and Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>7. The agency's undated "Medical Supervision" policy number C - 645 states, "Agency responsibilities include: . . . To follow the Physician Plan of Care."</p> <p>7. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "Skilled nursing services will be provided by a Registered Nurse or a</p>			

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G000171	<p>Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders)."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse accurately and completely completed the start of care comprehensive assessments to accurately reflect the patients' status in 3 (#s 4, 5, and 8) of 10 records reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included a start of care comprehensive assessment dated 11-15-13. The assessment identified the patient experienced "generalized" pain in the "legs, neck" that was chronic. The assessment failed to identify the intensity of the pain, a description of the pain, the frequency of pain interfering with activities, or factors that influenced the pain.</p>	G000171	<p>1. The Nursing Supervisor will in-service the registered nurses to ensure the nurses accurately and completely complete the start of care comprehensive assessments to accurately reflect the patients status.</p> <p>2. The deficiency shall be prevented in the future by reviewing the start of care comprehensive assessment to ensure the patient status is reflected. 100% of the charts will be reviewed going forward to ensure the start of care comprehensive assessment has been accurately completed and staff will be re-educated.</p> <p>3. The Nursing Supervisors will be responsible for reviewing the comprehensive assessment.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>	04/09/2014

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	<p>A. The assessment identified the patient was incontinent of urine. The assessment failed to identify frequency, volume, normal patterns, fluid intake, and other factors related to incontinence.</p> <p>B. The assessment included a "mental status" portion that identified the patient was oriented, forgetful, and "confused at times." The assessment failed to identify when the patient was confused, the patient's appearance, thought processes, affect, mood, and other factors related to mental status.</p> <p>2. Clinical record number 5 included a start of care comprehensive assessment dated 6-14-13 that identified the patient performed self-catheterization 4 times per day. The assessment failed to identify the amount, odor, or if the patient had experienced any problems associated with the catheterizations.</p> <p>3. Clinical record number 8 included a start of care comprehensive assessment dated 10-30-13 that identified the patient's urinary status was "WNL [within normal limits]." The assessment also identified the patient was incontinent of urine. The assessment failed to identify frequency, volume, normal patterns, fluid intake, and other</p>			

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G000172	<p>factors related to incontinence.</p> <p>4. The Administrator and Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>5. The agency's undated "Comprehensive Patient Assessment" policy number C - 145 states, "A thorough, well-organized, comprehensive assessment and accurate assessment, consistent with the patients immediate needs will be completed for all patients in a timely manner."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's need by a complete update of the comprehensive assessment that accurately reflected the patients' status in 3 (#s 1, 2, &amp; 4) of 10 records reviewed creating the potential to affect all of the agency's patients receiving services more than 60 days.</p> <p>The findings include:</p>	G000172	<p>1. The Nursing Supervisor will in-service the registered nurses to ensure the nurses update the comprehensive assessments to accurately reflect the patient's status.</p> <p>2. The deficiency shall be prevented in the future by reviewing the update comprehensive assessment to ensure the patient status is reflected. 100% of the charts will be reviewed going forward to ensure the update comprehensive assessment has been accurately completed and staff will be re-educated.</p> <p>3. The Nursing Supervisor will be responsible for reviewing the comprehensive assessment to ensure the assessment is accurately completed and completely completed the update of the comprehensive</p>	04/09/2014
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	<p>1. Clinical record number 1 included an updated comprehensive assessment dated 1-3-14 that identified the patient's appetite was "fair." The assessment failed to identify if the patient had any weight loss, who prepared the patient's meals, the patient's PO (by mouth) intake in 24 hours, the number of meals or snacks the patient might consume, or any other factors that might affect appetite.</p> <p>2. Clinical record number 2 included an updated comprehensive assessment dated 12-18-13 that identified "glucometer testing to be performed by client tid [three times per day]." The assessment failed to evidence an assessment of the patient's compliance with the three time per day testing, compliance with insulin administration based on the readings (sliding scale), or if the patient had experienced any signs and/or symptoms of hypo or hyperglycemia.</p> <p>3. Clinical record number 4 included an updated comprehensive assessment dated 1-9-14. The assessment included a "mental status" portion that identified the patient was oriented, forgetful, and "confused at times." The assessment failed to identify when the patient was confused, the patient's appearance,</p>		<p>assessment. 4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>				

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G000173	<p>thought processes, affect, mood, and other factors related to mental status.</p> <p>4. The Administrator and the Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and agency policy review and interview, the registered nurse (RN) failed to ensure a revision to the plan of care had been initiated and implemented in 1 (# 7) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification periods 12-22-13 to 2-19-14 and 2-20-14 to 4-20-14 that states, "SN [skilled nurse] 1x/w [one time per week] to administer Testosterone 400 mg [milligrams] IM [intramuscular] 1 time per week." The record failed to evidence the ordered Testosterone had been administered the week of 2-24-14.</p>	G000173	<p>1. The Nursing Supervisor will in-service all nursing staff to ensure the revision to the plan of care had been initiated and implemented as prescribed by the physician.</p> <p>2. The deficiency shall be prevented in the future by ensuring the revision to the plan of care had been initiated and implemented as prescribed by the physician monitoring the nursing visit records and comparing to the plan of care. 100% of the charts will be audited by 4-9-14 to ensure the revision has been initiated and implemented as prescribed by the physician and staff re-educated.</p> <p>3. The Nursing Supervisors will be responsible for auditing the nursing notes and comparing to the plan of care to ensure the update has been initiated and implemented as prescribed by the physician.</p> <p>4. The in-service will take place by 4-9-14 with the Nursing Staff.</p>	04/09/2014

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	<p>A. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The registered nurse (RN) prepared to administer the Testosterone injection when the patient stated, "I only get 1 cc [cubic centimeter] every week now which is 200 milligrams." The nurse was observed to check the prescription on the box with the vial of Testosterone and the prescription indicated the dosage was 400 mg (2 cc). The patient stated it had been 1 cc "for about a month." The patient stated he had been telling employee G [the patient's regular licensed practical nurse] about the dose change "for a long time."</p> <p>B. The RN, employee D, placed a telephone call to the ordering physician to clarify the dosage from the patient's home. The physician did not return the call and at 3:35 PM, the nurse instructed the patient she would attempt to call the physician again from the agency's office and would come back later that evening to administer the medication when the dosage had been clarified.</p> <p>C. Employee D, the RN, indicated, on 3-5-14 at 9:45 AM, she had received an order that date to clarify the dosage of the Testosterone and it was 200</p>						

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G000176	<p>milligrams every week instead of 400. The nurse indicated the dosage had been changed at the 2-18-14 doctor appointment and that employee G had been unaware of the dose change.</p> <p>D. A SN visit note, signed and dated by employee G on 2-21-14, evidenced the nurse had administered testosterone 400 mg IM, instead of 200 mg per the dose change on 2-18-14.</p> <p>E. The record included a "Physician Order Form", signed and dated by employee D on 3-4-14, that states, "Please sign and immediately return the following clarification order: Order clarification Change Testosterone 400 mg IM 1 time per week, to Testosterone 200 mg 1 time week."</p> <p>2. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "The registered nurse: . . . Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p>				

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	<p>Based on clinical record and agency policy review and interview, the registered nurse failed to ensure the physician had been alerted to changes in the patient's condition in 1 (# 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 10 failed to evidence the registered nurse (RN) had notified the physician of the patient's onset of back pain.</p> <p>A. The record included a skilled nurse (SN) visit note dated 1-13-14 that states, "Pt [patient] states lower back has been bothering [the patient], has interrupted sleep at night. Pt is not currently doing anything about back pain. Pt was instructed to contact MD if pain continues, becomes worse or other s/s [signs or symptoms]."</p> <p>B. The record included a SN visit note dated 1-20-14 that states, "Pt states [the patient] has hx [history] of back/disc issues. pt states isn't using any medication for back pain, plans on talking [with] MD when visits on Friday. SN encouraged pt to call MD if pain gets worse or has other s/s."</p>	G000176	<p>1. The Nursing Supervisor will in-service all nursing staff on promptly alerting the physician to any changes that suggest a need to alter the plan of care and document in the patient clinical record.</p> <p>2. The deficiency shall be prevented in the future by auditing 100% of the charts for physician notification by 4-9-14 and continuing education for staff on alerting the physician of any changes.</p> <p>3. The Nursing Supervisors will be responsible for auditing the patient files.</p> <p>4. The in-service will take place by 4-9-14 with the Nursing Staff.</p>	04/09/2014
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	<p>C. A SN visit note dated 1-27-14 states, "Pt states Nurse Practitioner was there to visit on Friday 1-24-14. Has ordered medication for back pain."</p> <p>2. The Administrator indicated, on 3-5-14 at 10:00 AM, the record did not evidence the agency's nurse had notified the physician of the patient's onset of back pain. The Administrator indicated she was not sure how the Nurse Practitioner knew to go see the patient unless the patient called the physician."</p> <p>3. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "The registered nurse: . . . Informs the physician and other personnel of changes in the patient condition and needs."</p>			

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G000330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure start of care comprehensive assessments were complete and accurately reflected the patients' status in 3 of 10 records reviewed creating the potential to affect all of the agency's new patients (See G 335); by failing to ensure updated comprehensive assessments were complete and accurately reflected the</p>	G000330	<p>1. The Nurses will be in-serviced on the completion of the Comprehensive Assessment according to the Federal Guidelines. 2. The deficiency shall be prevented in the future by reviewing 100% of the patient records by 4-9-14 and re-educating staff on the completion of the comprehensive assessment. 3. The Supervising Nurse will be responsible for ensuring compliance with the Federal Guidelines. 4. The in-service will be conducted by the Nursing</p>	04/09/2014
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G000335	<p>patients' status in 3 of 10 records reviewed creating the potential to affect all of the agency's patients that received services longer than 60 days (See G 339); and by failing to ensure the comprehensive assessment had been updated at the time of a transfer to an inpatient facility in 1 of 2 records reviewed of patients transferred to inpatient facilities creating the potential to affect all of the agency's patients who were transferred (See G 341).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and agency policy review and interview, the agency failed to ensure start of care comprehensive assessments were</p>	G000335	<p>Supervisor by 4-9-14.</p> <p>1. The Nursing Supervisor will in-service the registered nurses to ensure the nurses accurately and completely complete the start of care comprehensive assessments to accurately reflect the patients status.</p>	04/09/2014	

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	<p>complete and accurately reflected the patients' status in 3 (#s 4, 5, and 8) of 10 records reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included a start of care comprehensive assessment dated 11-15-13. The assessment identified the patient experienced "generalized" pain in the "legs, neck" that was chronic. The assessment failed to identify the intensity of the pain, a description of the pain, the frequency of pain interfering with activities, or factors that influenced the pain.</p> <p>A. The assessment identified the patient was incontinent of urine. The assessment failed to identify frequency, volume, normal patterns, fluid intake, and other factors related to incontinence.</p> <p>B. The assessment included a "mental status" portion that identified the patient was oriented, forgetful, and "confused at times." The assessment failed to identify when the patient was confused, the patient's appearance, thought processes, affect, mood, and other factors related to mental status.</p> <p>2. Clinical record number 5 included a</p>		<p>2. The deficiency shall be prevented in the future by reviewing the start of care comprehensive assessment to ensure the patient status is reflected. 100% of the charts will be reviewed going forward to ensure the start care comprehensive assessment has been accurately completed and re-educating staff on the completion of the comprehensive assessment.</p> <p>3. The Nursing Supervisors will be responsible for reviewing the comprehensive assessment.</p> <p>4. The in-service will take place by 4-9-14 with the Nursing Staff.</p>				

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	<p>start of care comprehensive assessment dated 6-14-13 that identified the patient performed self-catheterization 4 times per day. The assessment failed to identify the amount, odor, or if the patient had experienced any problems associated with the catheterizations.</p> <p>3. Clinical record number 8 included a start of care comprehensive assessment dated 10-30-13 that identified the patient's urinary status was "WNL [within normal limits]." The assessment also identified the patient was incontinent of urine. The assessment failed to identify frequency, volume, normal patterns, fluid intake, and other factors related to incontinence.</p> <p>4. The Administrator and Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>5. The agency's undated "Comprehensive Patient Assessment" policy number C - 145 states, "A thorough, well-organized, comprehensive assessment and accurate assessment, consistent with the patients immediate needs will be completed for all patients in a timely manner."</p>			

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G000339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record review and interview, the agency failed to ensure updated comprehensive assessments were complete and accurately reflected the patients' status in 3 (#s 1, 2, &amp; 4) of 10 records reviewed creating the potential to affect all of the agency's patients receiving services more than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included an updated comprehensive assessment dated 1-3-14 that identified the patient's appetite was "fair." The assessment failed to identify if the patient had any weight loss, who prepared the patient's meals, the patient's PO (by mouth) intake in 24 hours, the number of meals or snacks the patient might consume, or any other factors that might affect appetite.</p>	G000339	<p>1. The Nursing Supervisor will in-service the registered nurses to ensure the nurses update the comprehensive assessments to accurately reflect the patient's status. 2. The deficiency shall be prevented in the future by reviewing the update comprehensive assessment to ensure the patient status is reflected. 100% of the charts will be reviewed going forward to ensure the update comprehensive assessment has been accurately completed and staff will be re-educated. 3. The Nursing Supervisor will be responsible for reviewing the comprehensive assessment to ensure the assessment is accurately completed and completely completed the update of the comprehensive assessment. 4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>	04/09/2014
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	<p>2. Clinical record number 2 included an updated comprehensive assessment dated 12-18-13 that identified "glucometer testing to be performed by client tid [three times per day]." The assessment failed to evidence an assessment of the patient's compliance with the three time per day testing, compliance with insulin administration based on the readings (sliding scale), or if the patient had experienced any signs and/or symptoms of hypo or hyperglycemia.</p> <p>3. Clinical record number 4 included an updated comprehensive assessment dated 1-9-14. The assessment included a "mental status" portion that identified the patient was oriented, forgetful, and "confused at times." The assessment failed to identify when the patient was confused, the patient's appearance, thought processes, affect, mood, and other factors related to mental status.</p> <p>4. The Administrator and the Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p>			

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G000341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record and agency policy review and interview, the agency failed to ensure the comprehensive assessment had been updated at the time of a transfer to an inpatient facility in 1 (# 1) of 2 records reviewed of patients transferred to inpatient facilities creating the potential to affect all of the agency's patients that are transferred.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 1, start of care 5-20-11, included a verbal order dated 11-25-13 that states, "Effective 11-22-13, Place Home Health Services on HOLD due to admission to ICU [name of hospital]."</li> </ol> <p>The record failed to evidence the comprehensive assessment had been updated and revised at the time of the transfer of the patient to the hospital.</p> <ol style="list-style-type: none"> <li>The Nursing Supervisor stated, on 3-5-14 at 9:05 AM, "We don't do an</li> </ol>	G000341	<ol style="list-style-type: none"> <li>Help At Home, Inc. will create and implement a transfer comprehensive assessment form which will be utilized for all non-skilled patients. All patient comprehensive assessments will be updated and revised at time of transfer or knowledge of transfer within 48 hours.</li> <li>The deficiency shall be prevented in the future by reviewing 100% of the patient files by 4-09-14 then within 3 months re-audit the files to ensure the transfer form has been utilized.</li> <li>The Supervising Nurse is responsible for implementing the transfer comprehensive assessment form for all non-skilled patient transfers.</li> <li>The in-service will be conducted by the Administrator by 4-09-14.</li> </ol>	04/09/2014
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N000000	<p>update to the comprehensive assessment on home health aide only records when the patient is transferred to the hospital. We just do a clinical note that says the patient is in the hospital."</p> <p>3. The agency's undated "Comprehensive Patient Reassessments/Updates, Resumption of Care, SCIC, and Transfer/Discharge OASIS for Skilled Patients" policy number C - 155 states, "Patients who are not receiving skilled services under the Medicare or Medicaid program will be assessed using the OASIS tool or an alternative form identified by the agency. Reassessments for patients must be done as follows: . . . Transfer/Discharge OASIS assessments must be done within 48 hours of (or knowledge of) discharge or transfer."</p> <p>This was a home health State re-licensure survey.</p> <p>Survey Dates: 2-27-14, 2-28-14, 3-3-14, 3-4-14, and 3-5-14</p> <p>Facility #: 012482</p> <p>Medicaid Vendor #: 201010780</p>	N000000		

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N000456	<p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 10, 2014</p> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on quality assessment performance improvement (QAPI) document review and interview, the administrator failed to ensure the agency's QAPI program included monitoring and evaluation of agency staff infection control practices in 4 (1st, 2nd, 3rd, and 4th quarters for fiscal year 2013) of 4 quarters reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. The agency's QAPI summary document for the fiscal year 2013 failed to evidence the agency's program tracked, monitored, and evaluated staff</p>	N000456	<p>1. Help At Home, Inc. will include infection control monitoring and evaluation in the agency quarterly QAPI Plan meeting.</p> <p>2. The deficiency will be prevented by monitoring the all staff during the supervisory visit and review the findings in the company QA program meeting.</p> <p>3. The Administrator will monitor and evaluation the agency staff for infection control quarterly and document any findings.</p> <p>4. The administrator will be responsible for complete the monitoring and evaluation for the QAPI plan. This will be completed by 4-9-14</p>	04/09/2014

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N000470	<p>infection control practices during the 1st, 2nd, 3rd, and 4th quarters of the agency's fiscal year 2013.</p> <p>2. Observations completed during 4 of 5 home visits noted non-compliance with Standard Precautions. (See N 460).</p> <p>3. The Regional Manager indicated, on 3-5-14 at 10:45 AM, that staff infection control practices were observed during supervisory visits and were "dealt with on an individual" basis. The manager indicated the results of the audits were not tracked and monitored in the QAPI program.</p> <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. Based on observation, agency policy review, and interview, the agency failed to ensure staff had provided services in accordance with its own infection control policies and procedures in 4 (patients #s 1, 7, 8, &amp; 9) of 5 home visit observations completed creating the potential to affect all of the agency's 119 current patients.</p>	N000470	<p>1. Help At Home, Inc. will conduct an in-service training on the company Policies and Procedures for Infection Control and Universal Precautions – Policy B 403.</p> <p>2. The deficiency will be prevented by implementing an infection control compliance program which will be reviewed quarterly and the findings will be reviewed and evaluated in the QA program meeting.</p> <p>3. The Nursing Supervisor will ensure all staff has been in-serviced on Agency policies</p>	04/09/2014

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	<p>The findings include:</p> <ol style="list-style-type: none"> <li>The agency's undated "Infection Control - Standard Precautions &amp; Handling of Infectious Waste &amp; Biohazardous Materials" policy number B-403 states, "Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC) . . . Use of Standard Precautions Policy. Standard Precautions will be used on ALL patients."</li> <li>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body</li> </ol>		<p>and procedures B403. The internal monitoring will be conducted by the Nursing Supervisor quarterly to ensure infection control processes have been followed according to company policy.</p> <p>4. The deficiency will be corrected by 4-09-14</p>	

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	<p>site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>3. A home visit was made to patient number 1 with employee B, a home health aide, on 2-28-14 at 9:00 AM. The aide was observed to provide a total bed bath to the patient. After completing the bath to the patient's upper body, the aide rolled the patient to the left side. Observation noted a soiled Chux (plastic backed pad) under the patient's buttocks and lower back. The aide rolled and tucked the soiled Chux under the patient and washed, rinsed,</p>						



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	<p>RN took the patient's vital signs and assessed the patient's chest and abdomen. The RN charted her findings on the skilled nurse visit note. The RN then donned clean gloves without cleansing her hands and assessed the patient's ankles. The RN removed her gloves and without cleansing her hands, reached into her bag to retrieve hand cleanser. The RN then cleansed her hands. The RN then retrieved a bottle of Betadine and some gauze from her bag and donned clean gloves without cleansing her hands. The RN prepared to administer an intramuscular injection but was unable to complete the task due to a problem with the dosage of the medication.</p> <p>5. A home visit was made to patient number 8 with employee C, a home health aide, on 3-4-14 at 9:45 AM. The aide was observed to retrieve several gloves from her bag and place them in her pocket. The aide dropped two gloves on the floor in the process and was observed to pick the gloves up off the floor and place them in her pocket.</p> <p>6. A home visit was made to patient number 9 with employee E, a RN, on 3-4-14 at 2:05 PM. The RN was observed to perform an assessment and fill the patient's medication planner.</p>			

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	<p>The RN was observed to place a thermometer with a plastic sheath in the patient's mouth. Without donning gloves, the RN removed the thermometer from the patient's mouth and removed the plastic sheath and disposed of it creating the potential for the transfer of disease causing organisms from the patient's mouth to the RN's hands.</p> <p>7. The above-stated observations were discussed with the Administrator, the Nursing Supervisor, and the Regional Manager on 3-5-14 at 10:15 AM. The participants indicated the agency staff had not provided care in accordance with agency infection control policies and procedures.</p>			

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N000472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on quality assessment performance improvement (QAPI) document review and interview, the administrator failed to ensure the agency's QAPI program included monitoring and evaluation of agency staff infection control practices in 4 (1st, 2nd, 3rd, and 4th quarters for fiscal year 2013) of 4 quarters reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. The agency's QAPI summary document for the fiscal year 2013 failed to evidence the agency's program tracked, monitored, and evaluated staff infection control practices during the 1st, 2nd, 3rd, and 4th quarters of the agency's fiscal year 2013.</p>	N000472	<p>1. Help At Home, Inc. will include infection control monitoring and evaluation in the agency quarterly QAPI Plan meeting.</p> <p>2. The deficiency will be prevented by implementing an infection control compliance program which will be reviewed quarterly and the findings will be reviewed and evaluated in the QA program meeting.</p> <p>3. The Administrator will monitor and evaluation the agency staff for infection control quarterly and document any findings.</p> <p>4. The administrator will be responsible for complete the monitoring and evaluation for the QAPI plan. This will be completed by 4-9-14</p>	04/09/2014

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N000522	<p>2. Observations completed during 4 of 5 home visits noted non-compliance with Standard Precautions. (See N 460).</p> <p>3. The Regional Manager indicated, on 3-5-14 at 10:45 AM, that staff infection control practices were observed during supervisory visits and were "dealt with on an individual" basis. The manager indicated the results of the audits were not tracked and monitored in the QAPI program.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure treatments and services had been provided in accordance with physician orders in 5 (#s 2, 3, 5, 7, and 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician</p>	N000522	<p>1. The Nurses will be in-serviced on following physician orders to ensure treatment and services had been provided in accordance with the physician orders.</p> <p>2. The deficiency shall be prevented in the future by having a supervising nurse audit the charts and in-servicing the nursing staff. 100% of the patient records will be audited by 4-09-14.</p> <p>3. The Nursing Supervisor shall be responsible for auditing the patient charts.</p> <p>4. The deficiency will be corrected by 4-09-14</p>	04/09/2014

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	<p>for the certification period 12-22-13 to 2-19-14 that states, "SN (skilled nurse) 2 wks 9 [two times a week for 9 weeks]. SN for med set up and check compliance of medication administration . . . Monitor Glucometer readings for variations and compliance. Client is responsible for doing own Accuchecks 3x daily." The plan of care identified the physician had ordered the administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings (sliding scale).</p> <p>A. SN visit notes, dated 12-18-13, 12-30-13, 1-13-14, 1-27-14, 2-7-14, and 2-10-14, failed to evidence the SN had monitored the patient's compliance with performing the blood sugar testing 3 times per day and if the patient had self-administered the sliding scale insulin based on the readings per the physician's orders.</p> <p>1.) A SN visit note dated 1-27-14 evidenced the patient's most recent blood sugar reading was 299. The plan of care evidenced 6 units of Novolog insulin per the sliding scale for readings 251 to 300. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p>			

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	<p>2.) A SN visit note dated 2-7-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced the 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>3.) A SN visit note dated 2-10-14 evidenced the most recent blood sugar reading was 203. The plan of care evidenced 4 units of Novolog insulin per the sliding scale for readings 201-250. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>4.) A SN visit note dated 2-17-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>B. The administrator indicated, on</p>						

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	<p>3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>C. The plan of care identified home health aide services were to be provided 3 to 5 times per week for 9 weeks during the certification period. The record evidenced only 2 home health aide visits had been provided the week of 2-3-14.</p> <p>2. Clinical record number 3 included a plan of care established by the physician for the certification period 1-21-14 to 3-21-14 that states, "SN 1w9 for med set up and check compliance with medication administration, monitor glucometer readings for variation and compliance . . . Patient checks blood sugars TID [three times per day] daily." The plan of care identified the physician had ordered the administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings.</p> <p>A. A SN visit note dated 1-16-14 failed to evidence the SN had monitored the patient's compliance with performing the blood sugar checks three times per day. The note evidenced the blood sugar</p>			

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	<p>reading was "206 today." The plan of care identified 4 units of Novolog insulin per sliding scale was ordered for readings 181-240. The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>B. A SN visit note dated 1-21-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "today 226 but ranging 155-226." The plan of care evidenced 4 units of Novolog insulin per sliding scale was ordered for readings 181-240. The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>C. A SN visit note dated 1-28-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS [blood sugar] ranging 178-265." The plan of care evidenced 4 units of insulin had been ordered for readings 181 to 240 and 6 units for readings 241 to 300 per the sliding scale. The visit note failed to evidence the SN had assessed the patient's compliance with</p>			

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	<p>self-administering the sliding scale insulin.</p> <p>D. A SN visit note dated 2-4-15 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "blood sugar range 90-188." The plan of care evidenced 4 units of Novolog insulin had been ordered per the sliding scale for readings of 181-240. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>E. A SN visit note dated 2-11-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS 211. BS ranging in 200s." The plan of care evidenced 4 units for readings 181-240 and 6 units for readings 241-300 of Novolog insulin per sliding scale had been ordered. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>F. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored</p>			

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	<p>the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>3. Clinical record number 5 included a plan of care established by the physician for the certification period 6-14-13 to 8-12-13 that states, "SN 1w9 for med set up and check compliance of medication administration . . . patient does accuchecks qid [4 times per day] per self." The plan of care included orders for the administration of insulin with the dosage based on blood sugar readings per a sliding scale.</p> <p>A. SN visit notes, dated 6-21-13 and 6-23-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>B. The record included a transfer to inpatient facility note dated 7-2-13 that identified the patient had been admitted to the hospital. The note states, "pt [patient] blood sugar was over 400 and [patient's] blood pressure systolic was over 180."</p> <p>C. The record included resumption of care orders dated 7-8-14 for SN to be</p>				

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	<p>resumed 1 time per week for medication set-up and "check compliance with medication administration." The orders included sliding scale insulin orders.</p> <p>D. SN visit notes dated 7-15-13 and 7-22-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>E. A SN visit note dated 7-29-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 173." The plan of care identified 2 units of Novolog insulin was to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with self-administration of the sliding scale insulin.</p> <p>F. A SN visit note dated 8-6-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 152." The plan of care identified 2 units of Novolog insulin was to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with</p>				

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	<p>self-administration of the sliding scale insulin.</p> <p>G. A SN visit note dated 8-12-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>H. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>4. Clinical record number 7 included a plan of care established by the physician for the certification period 12-22-13 to 2-19-14 and 2-20-14 to 4-20-14 that states, "SN 1x/w [one time per week] to administer Testosterone 400 mg [milligrams] IM [intramuscular] 1 time per week." The record failed to evidence the ordered Testosterone had been administered the week of 2-24-14.</p> <p>A. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The RN prepared to administer the Testosterone injection when the patient stated, "I only get 1 cc [cubic</p>			

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	<p>centimeter] every week now which is 200 milligrams." The nurse was observed to check the prescription on the box with the vial of Testosterone and the prescription indicated the dosage was 400 mg (2 cc). The patient stated it had been 1 cc "for about a month." The patient stated he had been telling employee G [the patient's regular licensed practical nurse] about the dose change "for a long time."</p> <p>B. The RN, employee D, placed a telephone call to the ordering physician to clarify the dosage from the patient's home. The physician did not return the call and at 3:35 PM, the nurse instructed the patient she would attempt to call the physician again from the agency's office and would come back later that evening to administer the medication when the dosage had been clarified.</p> <p>C. Employee D, the RN, indicated, on 3-5-14 at 9:45 AM, she had received an order that date to clarify the dosage of the Testosterone and it was 200 milligrams every week instead of 400. The nurse indicated the dosage had been changed at the 2-18-14 doctor appointment and that employee G had been unaware of the dose change.</p> <p>D. A SN visit note, signed and dated</p>			

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	<p>by employee G on 2-21-14 evidenced the nurse had administered testosterone 400 mg IM, instead of 200 mg per the dose change on 2-18-14.</p> <p>E. The record included a "Physician Order Form", signed and dated by employee D on 3-4-14, that states, "Please sign and immediately return the following clarification order: Order clarification Change Testosterone 400 mg IM 1 time per week, to Testosterone 200 mg 1 time week."</p> <p>F. The plan of care for the certification period 12-22-13 to 2-19-14 states, "SN 1xwx9 . . . Client will monitor own blood sugars QID. SN will monitor glucometer readings for variations and compliance."</p> <p>1.) SN visit notes, dated 12-27-13, 1-3-14, 1-10-14, 1-17-14, 1-24-14, 1-31-14, 2-7-14, 2-14-14, and 2-19-14, failed to evidence the SN had assessed the patient's compliance with performing the blood sugar checks 4 times per day.</p> <p>2.) During a home visit to the patient, on 2-28-14 at 2:55 PM, with employee D, an RN, the patient stated, "I take my blood sugar at least twice a day. Sometimes I forget to test before</p>						

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	<p>breakfast. I will test before I take my insulin."</p> <p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 12-21-13 to 2-18-14. The plan of care states, "SN 1w9 to assess medication compliance . . . Pt is responsible to check blood sugars BID [2 times per day] and drawing up own insulin. SN to monitor glucometer recordings for variations and compliance."</p> <p>A. SN visit notes, dated 1-2-14 and 1-9-14, failed to evidence the SN had assessed the patient's compliance with performing the blood sugar checks 2 times per day and failed to evidence the SN had monitored the blood sugar readings.</p> <p>B. A SN visit note dated 1-20-14 states, "Pt states checking blood sugar BID." The note failed to evidence the SN had assessed the blood sugar readings.</p> <p>C. SN visit notes, dated 1-27-14, 2-3-14, and 2-10-14, failed to evidence the SN had assessed the patient's compliance with checking the blood sugar 2 times per day or had assessed the glucometer readings.</p>				

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	<p>6. The Administrator and Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>7. The agency's undated "Medical Supervision" policy number C - 645 states, "Agency responsibilities include: . . . To follow the Physician Plan of Care."</p>			

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the plan of care included all medications in 1 (# 8) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 8 included a skilled nurse (SN) visit note dated 1-21-14 that states, "Seen [name of</p>	N000524	<p>1. The Nursing Supervisor will in-service the RN's on the development of the patient plan of care with all medications.</p> <p>2. The deficiency shall be prevented in the future by the reviewing all plans of care before submitting to the physician.</p> <p>3. The supervising nurse will be responsible for reviewing all plans of cares before sent to the physician and providing care.</p> <p>4. The in-service will be conducted by the Nursing Supervisor by 4-09-14</p>	04/09/2014
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N000527	<p>physician] last wk [week] new script for Keflex given states has infected (Rt) thumb."</p> <p>The record failed to evidence the plan of care had been updated to include the new medication, Keflex.</p> <p>2. The Administrator stated, on 3-5-14 at 9:40 AM, "The plan of care is updated by adding any new medications to the Medication Profile. The Keflex had not been added."</p> <p>3. The agency's undated "Plan of Care" policy number C-580 states, "The Plan of Care shall be completed in full to include: . . . Medications, treatment, and procedures . . . Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <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. Based on clinical record and agency policy review and interview, the agency failed to ensure the physician had been alerted to changes in the patient's condition in 1 (# 10) of 10 records</p>	N000527	<p>1. The Nursing Supervisor will in-service all nursing staff on promptly alerting the physician to any changes that suggest a need to alter the plan of care and document in the patient clinical record.</p>	04/09/2014			

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	<p>reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. 1. Clinical record number 10 failed to evidence the registered nurse (RN) had notified the physician of the patient's onset of back pain.</p> <p>A. The record included a skilled nurse (SN) visit note dated 1-13-14 that states, "Pt [patient] states lower back has been bothering [the patient], has interrupted sleep at night. Pt is not currently doing anything about back pain. Pt was instructed to contact MD if pain continues, becomes worse or other s/s [signs or symptoms]."</p> <p>B. The record included a SN visit note dated 1-20-14 that states, "Pt states [the patient] has hx [history] of back/disc issues. pt states isn't using any medication for back pain, plans on talking [with] MD when visits on Friday. SN encouraged pt to call MD if pain gets worse or has other s/s."</p> <p>C. A SN visit note dated 1-27-14 states, "Pt states Nurse Practitioner was there to visit on Friday 1-24-14. Has ordered medication for back pain."</p>		<p>2. The deficiency shall be prevented in the future by auditing 100% of the charts for physician notification by 4-09-14 and continuing education for staff on alerting the physician of any changes.</p> <p>3. The Nursing Supervisors will be responsible for auditing the patient files and the education.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>	

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N000529	<p>2. The Administrator indicated, on 3-5-14 at 10:00 AM, the record did not evidence the agency's nurse had notified the physician of the patient's onset of back pain. The Administrator indicated she was not sure how the Nurse Practitioner knew to go see the patient unless the patient called the physician."</p> <p>3. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "The registered nurse: . . . Informs the physician and other personnel of changes in the patient condition and needs."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on clinical record and agency policy review and interview, the agency failed to ensure written summary reports that included a compilation of pertinent factors had been sent to the physician at least every 2 months in 2 (#s 8 and 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p>	N000529	<p>1. The nurse will be in serviced on completing the written summary report that included a compilation of pertinent factors that have been sent to the Physician every 60 days.</p> <p>2. The deficiency shall be prevented in the future by reviewing the summary prior to submitting to the physician to ensure it includes a compilation of pertinent factors. 100% of the summaries will be reviewed by 4-09-14.</p>	04/09/2014

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	<p>The findings include:</p> <p>1. Clinical record number 8 included a skilled nurse (SN) visit note dated 1-21-14 that states, "Seen [name of physician] last wk [week] new script for Keflex given states has infected (Rt [right]) thumb." The written summary report, sent to the physician on 2-28-14, failed to mention the new medication or the condition of the patient's right thumb.</p> <p>The plan of care for the certification period 12-27-13 to 2-26-14 evidenced the physician had ordered the skilled nurse to fill the medication planner every week and monitor the patient's compliance with the medications. The written summary report failed to include any mention of the patient's compliance with the medication regimen.</p> <p>2. Clinical record number 10 included a SN visit note dated 1-13-14 that states, "Pt [patient] states lower back has been bothering [the patient], has interrupted sleep at night. Pt is not currently doing anything about back pain. Pt was instructed to contact MD if pain continues, becomes worse or other s/s [signs or symptoms]."</p>		<p>3. The Nursing Supervisor shall be responsible for auditing the summaries.</p> <p>4. The deficiency will be corrected by 4-09-14</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K065	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/04/2014
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	<p>A. The record included a SN visit note dated 1-20-14 that states, "Pt states [the patient] has hx [history] of back/disc issues. pt states isn't using any medication for back pain, plans on talking [with] MD when visits on Friday. SN encouraged pt to call MD if pain gets worse or has other s/s [signs and symptoms]."</p> <p>B. A SN visit note dated 1-27-14 states, "Pt states Nurse Practitioner was there to visit on Friday 1-24-14. Has ordered medication for back pain."</p> <p>C. The written summary report, sent to the physician on 2-18-14 states, "No major changes in pt's condition." The report failed to include any mention of the patient's back pain and the effectiveness of the new pain medication.</p> <p>3. The Administrator and the Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>4. The agency's undated "Medical Supervision" policy number C - 645 states, "Written reports on the patient's condition are provided to the physician at least every sixth [sic] 60 days."</p>			

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N000537	<p>5. The agency's undated "Coordination of Patient Services and Clinical Summary" policy number C - 360 states, "Care conferences will be documented on the Care Conference/Clinical Summary form or in the progress notes. A written summary report of services provided and response to care for each patient shall be sent to the physician at least every sixty (60) days."</p> <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: Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 5 (#s 2, 3, 5, 7, and 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician</p>	N000537	<p>1. The Nursing Supervisor will in-service all nursing staff on following the Plan of Care as prescribed by the physician.</p> <p>2. The deficiency shall be prevented in the future by monitoring the nursing visit records and comparing to the plan of care. 100% of the charts will be audited by 4-09-14 and continuing education for staff to ensure the plan of care has been followed.</p> <p>3. The Nursing Supervisors will be responsible for auditing the nursing notes and comparing to the plan of care.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>	04/09/2014

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	<p>for the certification period 12-22-13 to 2-19-14 that states, "SN (skilled nurse) 2 wks 9 [two times a week for 9 weeks]. SN for med set up and check compliance of medication administration . . . Monitor Glucometer readings for variations and compliance. Client is responsible for doing own Accuchecks 3x daily." The plan of care identified the physician had ordered the administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings (sliding scale).</p> <p>A. SN visit notes, dated 12-18-13, 12-30-13, 1-13-14, 1-27-14, 2-7-14, and 2-10-14, failed to evidence the SN had monitored the patient's compliance with performing the blood sugar testing 3 times per day and if the patient had self-administered the sliding scale insulin based on the readings per the physician's orders.</p> <p>1.) A SN visit note dated 1-27-14 evidenced the patient's most recent blood sugar reading was 299. The plan of care evidenced 6 units of Novolog insulin per the sliding scale for readings 251 to 300. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p>			

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	<p>2.) A SN visit note dated 2-7-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced the 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>3.) A SN visit note dated 2-10-14 evidenced the most recent blood sugar reading was 203. The plan of care evidenced 4 units of Novolog insulin per the sliding scale for readings 201-250. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>4.) A SN visit note dated 2-17-14 evidenced the most recent blood sugar reading was 157. The plan of care evidenced 2 units of Novolog insulin per the sliding scale for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with the administration of the sliding scale insulin.</p> <p>B. The administrator indicated, on</p>						

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	<p>3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>2. Clinical record number 3 included a plan of care established by the physician for the certification period 1-21-14 to 3-21-14 that states, "SN 1w9 for med set up and check compliance with medication administration, monitor glucometer readings for variation and compliance . . . Patient checks blood sugars TID [three times per day] daily." The plan of care identified the physician had ordered the administration of insulin on a daily basis with the dosage based on the patient's blood sugar readings.</p> <p>A. A SN visit note dated 1-16-14 failed to evidence the SN had monitored the patient's compliance with performing the blood sugar checks three times per day. The note evidenced the blood sugar reading was "206 today." The plan of care identified 4 units of Novolog insulin per sliding scale was ordered for readings 181-240. The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale</p>				

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	<p>insulin.</p> <p>B. A SN visit note dated 1-21-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "today 226 but ranging 155-226." The plan of care evidenced 4 units of Novolog insulin per sliding scale was ordered for readings 181-240. The note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>C. A SN visit note dated 1-28-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS [blood sugar] ranging 178-265." The plan of care evidenced 4 units of insulin had been ordered for readings 181 to 240 and 6 units for readings 241 to 300 per the sliding scale. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>D. A SN visit note dated 2-4-15 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day.</p>			

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	<p>The note states, "blood sugar range 90-188." The plan of care evidenced 4 units of Novolog insulin had been ordered per the sliding scale for readings of 181-240. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>E. A SN visit note dated 2-11-14 failed to evidence the SN had monitored the patient's compliance with performing blood sugar checks three times per day. The note states, "BS 211. BS ranging in 200s." The plan of care evidenced 4 units for readings 181-240 and 6 units for readings 241-300 of Novolog insulin per sliding scale had been ordered. The visit note failed to evidence the SN had assessed the patient's compliance with self-administering the sliding scale insulin.</p> <p>F. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>3. Clinical record number 5 included a</p>						

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	<p>plan of care established by the physician for the certification period 6-14-13 to 8-12-13 that states, "SN 1w9 for med set up and check compliance of medication administration . . . patient does accuchecks qid [4 times per day] per self." The plan of care included orders for the administration of insulin with the dosage based on blood sugar readings per a sliding scale.</p> <p>A. SN visit notes, dated 6-21-13 and 6-23-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>B. The record included a transfer to inpatient facility note dated 7-2-13 that identified the patient had been admitted to the hospital. The note states, "pt [patient] blood sugar was over 400 and [patient's] blood pressure systolic was over 180."</p> <p>C. The record included resumption of care orders dated 7-8-14 for SN to be resumed 1 time per week for medication set-up and "check compliance with medication administration." The orders included sliding scale insulin orders.</p> <p>D. SN visit notes dated 7-15-13 and 7-22-13 failed to evidence the SN had</p>						

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	<p>assessed the patient's compliance with performing blood sugar checks 4 times per day.</p> <p>E. A SN visit note dated 7-29-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 173." The plan of care identified 2 units of Novolog insulin was to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with self-administration of the sliding scale insulin.</p> <p>F. A SN visit note dated 8-6-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day. The note states, "BS 152." The plan of care identified 2 units of Novolog insulin was to be self-administered for readings 151-200. The visit note failed to evidence the SN had assessed the patient's compliance with self-administration of the sliding scale insulin.</p> <p>G. A SN visit note dated 8-12-13 failed to evidence the SN had assessed the patient's compliance with performing blood sugar checks 4 times per day.</p>			

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	<p>H. The administrator indicated, on 3-5-14 at 9:10 AM, the SN visit notes did not evidence the SN had monitored the patient's compliance with performing the blood sugar tests three times per day or if the patient had self-administered insulin per the sliding scale ordered by the physician.</p> <p>4. Clinical record number 7 included a plan of care established by the physician for the certification period 12-22-13 to 2-19-14 and 2-20-14 to 4-20-14 that states, "SN 1x/w [one time per week] to administer Testosterone 400 mg [milligrams] IM [intramuscular] 1 time per week." The record failed to evidence the ordered Testosterone had been administered the week of 2-24-14.</p> <p>A. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The RN prepared to administer the Testosterone injection when the patient stated, "I only get 1 cc [cubic centimeter] every week now which is 200 milligrams." The nurse was observed to check the prescription on the box with the vial of Testosterone and the prescription indicated the dosage was 400 mg (2 cc). The patient stated it had been 1 cc "for about a month." The</p>						

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	<p>patient stated he had been telling employee G [the patient's regular licensed practical nurse] about the dose change "for a long time."</p> <p>B. The RN, employee D, placed a telephone call to the ordering physician to clarify the dosage from the patient's home. The physician did not return the call and at 3:35 PM, the nurse instructed the patient she would attempt to call the physician again from the agency's office and would come back later that evening to administer the medication when the dosage had been clarified.</p> <p>C. Employee D, the RN, indicated, on 3-5-14 at 9:45 AM, she had received an order that date to clarify the dosage of the Testosterone and it was 200 milligrams every week instead of 400. The nurse indicated the dosage had been changed at the 2-18-14 doctor appointment and that employee G had been unaware of the dose change.</p> <p>D. A SN visit note, signed and dated by employee G on 2-21-14 evidenced the nurse had administered testosterone 400 mg IM, instead of 200 mg per the dose change on 2-18-14.</p> <p>E. The record included a "Physician Order Form", signed and dated by</p>			

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	<p>employee D on 3-4-14, that states, "Please sign and immediately return the following clarification order: Order clarification Change Testosterone 400 mg IM 1 time per week, to Testosterone 200 mg 1 time week."</p> <p>F. The plan of care for the certification period 12-22-13 to 2-19-14 states, "SN 1xwx9 . . . Client will monitor own blood sugars QID. SN will monitor glucometer readings for variations and compliance."</p> <p>1.) SN visit notes, dated 12-27-13, 1-3-14, 1-10-14, 1-17-14, 1-24-14, 1-31-14, 2-7-14, 2-14-14, and 2-19-14, failed to evidence the SN had assessed the patient's compliance with performing the blood sugar checks 4 times per day.</p> <p>2.) During a home visit to the patient, on 2-28-14 at 2:55 PM, with employee D, an RN, the patient stated, "I take my blood sugar at least twice a day. Sometimes I forget to test before breakfast. I will test before I take my insulin."</p> <p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 12-21-13 to 2-18-14. The plan of care states, "SN</p>			

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	<p>1w9 to assess medication compliance . . . Pt is responsible to check blood sugars BID [2 times per day] and drawing up own insulin. SN to monitor glucometer recordings for variations and compliance."</p> <p>A. SN visit notes, dated 1-2-14 and 1-9-14, failed to evidence the SN had assessed the patient's compliance with performing the blood sugar checks 2 times per day and failed to evidence the SN had monitored the blood sugar readings.</p> <p>B. A SN visit note dated 1-20-14 states, "Pt states checking blood sugar BID." The note failed to evidence the SN had assessed the blood sugar readings.</p> <p>C. SN visit notes, dated 1-27-14, 2-3-14, and 2-10-14, failed to evidence the SN had assessed the patient's compliance with checking the blood sugar 2 times per day or had assessed the glucometer readings.</p> <p>6. The Administrator and Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p>			

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N000540	<p>7. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders)."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse accurately and completely completed the start of care comprehensive assessments to accurately reflect the patients' status in 3 (#s 4, 5, and 8) of 10 records reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included a</p>	N000540	<p>1. The Nursing Supervisor will in-service the registered nurses to ensure the nurses accurately and completely complete the start of care comprehensive assessments to accurately reflect the patients status.</p> <p>2. The deficiency shall be prevented in the future by reviewing the start of care comprehensive assessment to ensure the patient status is reflected. 100% of the charts will be reviewed going forward to ensure the start of care comprehensive assessment has been accurately completed and staff will be re-educated.</p> <p>3. The Nursing Supervisors will be responsible for reviewing the comprehensive assessment.</p> <p>4. The in-service will take place</p>	04/09/2014

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	<p>start of care comprehensive assessment dated 11-15-13. The assessment identified the patient experienced "generalized" pain in the "legs, neck" that was chronic. The assessment failed to identify the intensity of the pain, a description of the pain, the frequency of pain interfering with activities, or factors that influenced the pain.</p> <p>A. The assessment identified the patient was incontinent of urine. The assessment failed to identify frequency, volume, normal patterns, fluid intake, and other factors related to incontinence.</p> <p>B. The assessment included a "mental status" portion that identified the patient was oriented, forgetful, and "confused at times." The assessment failed to identify when the patient was confused, the patient's appearance, thought processes, affect, mood, and other factors related to mental status.</p> <p>2. Clinical record number 5 included a start of care comprehensive assessment dated 6-14-13 that identified the patient performed self-catheterization 4 times per day. The assessment failed to identify the amount, odor, or if the patient had experienced any problems associated with the catheterizations.</p>		by 4-09-14 with the Nursing Staff.				

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N000541	<p>3. Clinical record number 8 included a start of care comprehensive assessment dated 10-30-13 that identified the patient's urinary status was "WNL [within normal limits]." The assessment also identified the patient was incontinent of urine. The assessment failed to identify frequency, volume, normal patterns, fluid intake, and other factors related to incontinence.</p> <p>4. The Administrator and Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM.</p> <p>5. The agency's undated "Comprehensive Patient Assessment" policy number C - 145 states, "A thorough, well-organized, comprehensive assessment and accurate assessment, consistent with the patients immediate needs will be completed for all patients in a 410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record review and</p>	N000541	1. The Nursing Supervisor will in-service	04/09/2014			

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	<p>interview, the agency failed to ensure the registered nurse reevaluated the patient's need by a complete update of the comprehensive assessment that accurately reflected the patients' status in 3 (#s 1, 2, &amp; 4) of 10 records reviewed creating the potential to affect all of the agency's patients receiving services more than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included an updated comprehensive assessment dated 1-3-14 that identified the patient's appetite was "fair." The assessment failed to identify if the patient had any weight loss, who prepared the patient's meals, the patient's PO (by mouth) intake in 24 hours, the number of meals or snacks the patient might consume, or any other factors that might affect appetite.</p> <p>2. Clinical record number 2 included an updated comprehensive assessment dated 12-18-13 that identified "glucometer testing to be performed by client tid [three times per day]." The assessment failed to evidence an assessment of the patient's compliance with the three time per day testing, compliance with insulin administration based on the readings (sliding scale), or</p>		<p>the registered nurses to ensure the nurses update the comprehensive assessments to accurately reflect the patient's status.</p> <p>2. The deficiency shall be prevented in the future by reviewing the update comprehensive assessment to ensure the patient status is reflected. 100% of the charts will be reviewed going forward to ensure the update comprehensive assessment has been accurately completed and staff will be re-educated.</p> <p>3. The Nursing Supervisor will be responsible for reviewing the comprehensive assessment to ensure the assessment is accurately completed and completely completed the update of the comprehensive assessment.</p> <p>4. The in-service will take place by 4-09-14 with the Nursing Staff.</p>		

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N000542	<p>if the patient had experienced any signs and/or symptoms of hypo or hyperglycemia.</p> <p>3. Clinical record number 4 included an updated comprehensive assessment dated 1-9-14. The assessment included a "mental status" portion that identified the patient was oriented, forgetful, and "confused at times." The assessment failed to identify when the patient was confused, the patient's appearance, thought processes, affect, mood, and other factors related to mental status.</p> <p>4. The Administrator and the Nursing Supervisor were unable to provide any additional documentation and/or information when asked on 3-4-14 at 12:10 PM and on 3-5-14 at 10:15 AM. 410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record and agency policy review and interview, the registered nurse (RN) failed to ensure a revision to the plan of care had been initiated and implemented in 1 (# 7) of 10 records reviewed creating the potential to affect all of the agency's 119</p>	N000542	<p>1. The Nursing Supervisor will in-service all nursing staff to ensure the revision to the plan of care had been initiated and implemented as prescribed by the physician.</p> <p>2. The deficiency shall be prevented in the future by ensuring the revision to the plan of care had been initiated and implemented as prescribed by the physician monitoring the</p>	04/09/2014

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	<p>current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification periods 12-22-13 to 2-19-14 and 2-20-14 to 4-20-14 that states, "SN [skilled nurse] 1x/w [one time per week] to administer Testosterone 400 mg [milligrams] IM [intramuscular] 1 time per week." The record failed to evidence the ordered Testosterone had been administered the week of 2-24-14.</p> <p>A. A home visit was made to patient number 7 with employee D, a registered nurse (RN), on 2-28-14 at 2:55 PM. The registered nurse (RN) prepared to administer the Testosterone injection when the patient stated, "I only get 1 cc [cubic centimeter] every week now which is 200 milligrams." The nurse was observed to check the prescription on the box with the vial of Testosterone and the prescription indicated the dosage was 400 mg (2 cc). The patient stated it had been 1 cc "for about a month." The patient stated he had been telling employee G [the patient's regular licensed practical nurse] about the dose change "for a long time."</p>		<p>nursing visit records and comparing to the plan of care. 100% of the charts will be audited by 4-9-14 to ensure the revision has been initiated and implemented as prescribed by the physician and staff re-educated.</p> <p>3. The Nursing Supervisors will be responsible for auditing the nursing notes and comparing to the plan of care to ensure the update has been initiated and implemented as prescribed by the physician.</p> <p>4. The in-service will take place by 4-9-14 with the Nursing Staff.</p>	

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	<p>B. The RN, employee D, placed a telephone call to the ordering physician to clarify the dosage from the patient's home. The physician did not return the call and at 3:35 PM, the nurse instructed the patient she would attempt to call the physician again from the agency's office and would come back later that evening to administer the medication when the dosage had been clarified.</p> <p>C. Employee D, the RN, indicated, on 3-5-14 at 9:45 AM, she had received an order that date to clarify the dosage of the Testosterone and it was 200 milligrams every week instead of 400. The nurse indicated the dosage had been changed at the 2-18-14 doctor appointment and that employee G had been unaware of the dose change.</p> <p>D. A SN visit note, signed and dated by employee G on 2-21-14, evidenced the nurse had administered testosterone 400 mg IM, instead of 200 mg per the dose change on 2-18-14.</p> <p>E. The record included a "Physician Order Form", signed and dated by employee D on 3-4-14, that states, "Please sign and immediately return the following clarification order: Order clarification Change Testosterone 400 mg IM 1 time per week, to Testosterone</p>						

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N000546	<p>200 mg 1 time week."</p> <p>2. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "The registered nurse: . . . Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan."</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on clinical record and agency policy review and interview, the registered nurse failed to ensure the physician had been alerted to changes in the patient's condition in 1 (# 10) of 10 records reviewed creating the potential to affect all of the agency's 119 current patients.  The findings include:</p>	N000546	<p>1. The Nursing Supervisor will in-service all nursing staff on promptly alerting the physician to any changes that suggest a need to alter the plan of care and document in the patient clinical record. 2. The deficiency shall be prevented in the future by auditing 100% of the charts for physician notification by 4-9-14 and continuing education for staff on alerting the physician of any changes. 3. The Nursing</p>	04/09/2014			

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	<p>1. Clinical record number 10 failed to evidence the registered nurse (RN) had notified the physician of the patient's onset of back pain.</p> <p>A. The record included a skilled nurse (SN) visit note dated 1-13-14 that states, "Pt [patient] states lower back has been bothering [the patient], has interrupted sleep at night. Pt is not currently doing anything about back pain. Pt was instructed to contact MD if pain continues, becomes worse or other s/s [signs or symptoms]."</p> <p>B. The record included a SN visit note dated 1-20-14 that states, "Pt states [the patient] has hx [history] of back/disc issues. pt states isn't using any medication for back pain, plans on talking [with] MD when visits on Friday. SN encouraged pt to call MD if pain gets worse or has other s/s."</p> <p>C. A SN visit note dated 1-27-14 states, "Pt states Nurse Practitioner was there to visit on Friday 1-24-14. Has ordered medication for back pain."</p> <p>2. The Administrator indicated, on 3-5-14 at 10:00 AM, the record did not evidence the agency's nurse had notified the physician of the patient's onset of</p>		Supervisors will be responsible for auditing the patient files. 4. The in-service will take place by 4-9-14 with the Nursing Staff. with the Nursing Staff. The in-service will be conducted by the Nursing Supervisor by 4-9-14		

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	<p>back pain. The Administrator indicated she was not sure how the Nurse Practitioner knew to go see the patient unless the patient called the physician."</p> <p>3. The agency's undated "Skilled Nursing Services" policy number C - 200 states, "The registered nurse: . . . Informs the physician and other personnel of changes in the patient condition and needs."</p>			