

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2012
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NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 14TH STREET BEDFORD, IN 47421
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G0000	<p>This was a federal home health complaint investigation survey.</p> <p>Complaint #: IN0011727 - Unsubstantiated: lack of sufficient evidence. Unrelated deficiencies are cited.</p> <p>Facility #: 012617</p> <p>Survey Date: 11-7-12</p> <p>Medicaid Vendor #: 201044850</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 9, 2012</p>	G0000		

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

TITLE

(X6) DATE

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

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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had followed the agency's own policy regarding physician orders in 4 (#s 1, 2, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's 140 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included telephone/verbal orders signed and dated by the LPN, employee D, on 8-21-12, 8-23-12, 8-24-12, 9-7-12, 9-10-12, 9-18-12, 9-20-12, 9-23-12, and 9-24-12, that evidenced the LPN had requested an order for an evaluation for home care services, had reported blood sugar ranges, changes in insulin dosages, and transportation issues. The record failed to evidence the RN had checked the orders received for accuracy and appropriateness.</p> <p>2. Clinical record number 2 included telephone/verbal orders signed and dated by the LPN, employee C, on 5-21-12 and</p>	G0121	<p>1. All LPN's will be in-serviced on the fact that they are not allowed to submit orders without them first being checked and signed off on by an RN. The company form has been changed to reflect this requirement. 2. All LPN's are going to in-serviced and will have consequences if they submit any orders without them first being checked and signed off on by an RN. All nursing staff will also have regular in-services to ensure that they are following proper protocol and following company policy. 3. The Director of Nursing will be responsible for ensuring that every LPN hired is trained on this requirement and knows that their orders must be checked and signed off on by an RN. 4. The plan of correction will be completed by 12/10/12.</p>	12/10/2012

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	<p>5-28-12, that evidenced the LPN had informed the physician of the need for the nurse to accompany the patient to therapy sessions and a change in medications. The record failed to evidence the RN had checked the orders received for accuracy and appropriateness.</p> <p>3. Clinical record number 4 included telephone/verbal orders signed and dated by the LPN, employee A, on 10-19-12, 10-20-12, 10-23-12, 10-26-12, and 10-30-12, informing the physician of medication changes. The record failed to evidence the RN had checked the orders received for accuracy and appropriateness.</p> <p>4. Clinical record number 5 included telephone/verbal orders signed and dated by the LPN, employee D, on 7-17-12 informing the physician of the potential need for home care services and requesting to evaluate the patient. The record failed to evidence the RN had checked the orders received for accuracy and appropriateness.</p> <p>5. The Director of Nursing (DON) indicated, on 11-7-12, at 2:45 PM, she was unaware of the agency's policy regarding verbal orders.</p> <p>6. The agency's 6-17-11 "Confirmation of</p>			

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	Physician Telephone/Verbal Orders" policy number 2027 states, "All orders for medical care, treatment and/or services are reviewed/evaluated for appropriateness and accuracy by an appropriately licensed individual (i.e., Registered Nurse, Licensed Therapist, Pharmacist) prior to providing care, treatment, and/or services."			

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G0166	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had received, signed, and dated verbal orders from the physician in 4 (#s 1, 2, 4, and 5) of 5 records reviewed and the agency's policy is congruent with federal regulations creating the potential to affect all of the agency's 140 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included telephone/verbal orders signed and dated by the LPN, employee D, on 8-21-12, 8-23-12, 8-24-12, 9-7-12, 9-10-12, 9-18-12, 9-20-12, 9-23-12, and 9-24-12, that evidenced the LPN had requested an order for an evaluation for home care services, had reported blood sugar ranges, changes in insulin dosages, and transportation issues.</p> <p>2. Clinical record number 2 included telephone/verbal orders signed and dated by the LPN, employee C, on 5-21-12 and 5-28-12, that evidenced the LPN had</p>	G0166	<p>1. All LPN's will be in-serviced on the fact that they are not allowed to submit orders without them first being checked and signed off on by an RN. The company form has been changed to reflect this requirement. 2. All LPN's are going to in-serviced and will have consequences if they submit any orders without them first being checked and signed off on by an RN. All nursing staff will also have regular in-services to ensure that they are following proper protocol and following company policy. 3. The Director of Nursing will be responsible for ensuring that every LPN hired is trained on this requirement and knows that their orders must be checked and signed off on by an RN. 4. The plan of correction will be completed by 12/10/12.</p>	12/10/2012	

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	<p>informed the physician of the need for the nurse to accompany the patient to therapy sessions and a change in medications.</p> <p>3. Clinical record number 4 included telephone/verbal orders signed and dated by the LPN, employee A, on 10-19-12, 10-20-12, 10-23-12, 10-26-12, and 10-30-12, informing the physician of medication changes.</p> <p>4. Clinical record number 5 included telephone/verbal orders signed and dated by the LPN, employee D, on 7-17-12 informing the physician of the potential need for home care services and requesting to evaluate the patient.</p> <p>5. The Director of Nursing (DON) indicated, on 11-7-12, at 2:45 PM, she was unaware LPNs could not take verbal orders in home health.</p> <p>6. The agency's 6-17-11 "Confirmation of Physician Telephone/Verbal Orders" policy number 2027 states, "All orders for medical care, treatment and/or services are reviewed/evaluated for appropriateness and accuracy by an appropriately licensed individual (i.e., Registered Nurse, Licensed Therapist, Pharmacist) prior to providing care, treatment, and/or services."</p>						

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G0178	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had supervised the licensed practical nurses' (LPN) reporting changes to the physician and had ensured the accuracy and appropriateness of physician orders in 4 (#s 1, 2, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's 140 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included telephone/verbal orders signed and dated by the LPN, employee D, on 8-21-12, 8-23-12, 8-24-12, 9-7-12, 9-10-12, 9-18-12, 9-20-12, 9-23-12, and 9-24-12, that evidenced the LPN had requested an order for an evaluation for home care services, had reported blood sugar ranges, changes in insulin dosages, and transportation issues. The record failed to evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>2. Clinical record number 2 included</p>	G0178	<p>1. All LPN's will be in-serviced on the fact that they are not allowed to submit orders without them first being checked and signed off on by an RN. The company form has been changed to reflect this requirement. 2. All LPN's are going to in-serviced and will have consequences if they submit any orders without them first being checked and signed off on by an RN. All nursing staff will also have regular in-services to ensure that they are following proper protocol and following company policy. 3. The Director of Nursing will be responsible for ensuring that every LPN hired is trained on this requirement and knows that their orders must be checked and signed off on by an RN. 4. The plan of correction will be completed by 12/10/12.</p>	12/10/2012

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	<p>telephone/verbal orders signed and dated by the LPN, employee C, on 5-21-12 and 5-28-12, that evidenced the LPN had informed the physician of the need for the nurse to accompany the patient to therapy sessions and a change in medications. The record failed to evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>3. Clinical record number 4 included telephone/verbal orders signed and dated by the LPN, employee A, on 10-19-12, 10-20-12, 10-23-12, 10-26-12, and 10-30-12, informing the physician of medication changes. The record failed to evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>4. Clinical record number 5 included telephone/verbal orders signed and dated by the LPN, employee D, on 7-17-12 informing the physician of the potential need for home care services and requesting to evaluate the patient. The record failed to evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received</p>				

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	<p>for accuracy and appropriateness.</p> <p>5. The Director of Nursing (DON) indicated, on 11-7-12, at 2:45 PM, she was unaware LPNs were to consult with the supervising RN prior to reporting to the physician. The DON stated, "I talk to the LPNs all the time. I just do not document it."</p> <p>6. The agency's 6-17-11 "Confirmation of Physician Telephone/Verbal Orders" policy number 2027 states, "All orders for medical care, treatment and/or services are reviewed/evaluated for appropriateness and accuracy by an appropriately licensed individual (i.e., Registered Nurse, Licensed Therapist, Pharmacist) prior to providing care, treatment, and/or services."</p>				

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G0334	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments that included age appropriate data had been completed in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's future pediatric patient admissions and all of the agency's pediatric patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 identified the patient was a pediatric patient less than 18 years of age. The record included a start of care comprehensive assessment completed by employee E, a registered nurse (RN), on 8-23-12. The assessment failed to evidence age appropriate data such as birth history, identification of any major illnesses, familial or hereditary diseases, daily living patterns, growth and developmental data or age specific psychosocial data had been collected.</p> <p>2. Clinical record number 2 identified the patient was a pediatric patient less than 18</p>	G0334	<p>1. This deficiency has been corrected. The company was in the process of using a new computer program, Allscripts, which includes a pediatric assessment for any patients under the age of 18. This assessment is now being used.</p> <p>2. The comprehensive assessments are all completed via Allscripts now, which tailors the assessment based upon the patient's age, which fixes this deficiency.</p> <p>3. The Director of Nursing is responsible for ensuring that the correct comprehensive assessment is completed on all patients. This is completed by random audits of patient charts.</p> <p>4. This deficiency was corrected on 11/16/12.</p>	11/16/2012	

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	<p>years of age. The record included a follow-up comprehensive assessment completed by employee B, the Director of Nursing (DON), on 10-8-12. The assessment failed to evidence age appropriate data such as birth history, identification of any major illnesses, familial or hereditary diseases, daily living patterns, growth and developmental data or age specific psychosocial data had been collected.</p> <p>3. Clinical record number 3 identified the patient was a pediatric patient less than 18 years of age. The record included a follow-up comprehensive assessment completed by employee B, the DON, on 10-11-12. The assessment failed to evidence age appropriate data such as birth history, identification of any major illnesses, familial or hereditary diseases, daily living patterns, growth and developmental data or age specific psychosocial data had been collected.</p> <p>4. Clinical record number 4 identified the patient was a pediatric patient less than 18 years of age. The record included a start of care comprehensive assessment completed by employee F, an RN, on 8-12-12 and a follow-up comprehensive assessment completed by employee G, an RN, on 10-8-12. The assessments failed to evidence age appropriate data such as</p>			

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	<p>birth history, identification of any major illnesses, familial or hereditary diseases, daily living patterns, growth and developmental data or age specific psychosocial data had been collected.</p> <p>5. Clinical record number 5 identified the patient was a pediatric patient less than 18 years of age. The record included a start of care comprehensive assessment completed by employee F, an RN, on 7-31-12 and a follow-up comprehensive assessment completed by B, the DON, on 9-29-12. The assessments failed to evidence age appropriate data such as birth history, identification of any major illnesses, familial or hereditary diseases, daily living patterns, growth and developmental data or age specific psychosocial data had been collected.</p> <p>6. The DON indicated, on 11-7-12 at 2:45 PM Central Time, records numbered 1 through 5 did not include pediatric nursing assessments.</p> <p>7. The agency's 6-17-11 "Assessment" policy number 2008 states, "A Registered Nurse completes a comprehensive initial assessment of the patient's needs for care, treatment and/or services within the time frames specified in above policy . . . The Comprehensive Assessment: Conforms to clinical practice guidelines."</p>				

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N0000	<p>This was a State home health complaint investigation survey.</p> <p>Complaint #: IN0011727 - Unsubstantiated: lack of sufficient evidence. Unrelated deficiencies are cited.</p> <p>Facility #: 012617</p> <p>Survey Date: 11-7-12</p> <p>Medicaid Vendor #: 201044850</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">November 9, 2012</p>	N0000			

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N0546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had supervised the licensed practical nurses' (LPN) reporting changes to the physician and had ensured the accuracy and appropriateness of physician orders in 4 (#s 1, 2, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's 140 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included telephone/verbal orders signed and dated by the LPN, employee D, on 8-21-12, 8-23-12, 8-24-12, 9-7-12, 9-10-12, 9-18-12, 9-20-12, 9-23-12, and 9-24-12, that evidenced the LPN had requested an order for an evaluation for home care services, had reported blood sugar ranges, changes in insulin dosages, and transportation issues. The record failed to</p>	N0546	<p>1. All LPN's will be in-serviced on the fact that they are not allowed to submit orders without them first being checked and signed off on by an RN. The company form has been changed to reflect this requirement. 2. All LPN's are going to in-serviced and will have consequences if they submit any orders without them first being checked and signed off on by an RN. All nursing staff will also have regular in-services to ensure that they are following proper protocol and following company policy. 3. The Director of Nursing will be responsible for ensuring that every LPN hired is trained on this requirement and knows that their orders must be checked and signed off on by an RN. 4. The plan of correction will be completed by 12/10/12.</p>	12/10/2012			

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NAME OF PROVIDER OR SUPPLIER SAFE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 14TH STREET BEDFORD, IN 47421		
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	<p>evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>2. Clinical record number 2 included telephone/verbal orders signed and dated by the LPN, employee C, on 5-21-12 and 5-28-12, that evidenced the LPN had informed the physician of the need for the nurse to accompany the patient to therapy sessions and a change in medications. The record failed to evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>3. Clinical record number 4 included telephone/verbal orders signed and dated by the LPN, employee A, on 10-19-12, 10-20-12, 10-23-12, 10-26-12, and 10-30-12, informing the physician of medication changes. The record failed to evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>4. Clinical record number 5 included telephone/verbal orders signed and dated by the LPN, employee D, on 7-17-12</p>				

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	<p>informing the physician of the potential need for home care services and requesting to evaluate the patient. The record failed to evidence the RN had supervised the LPN's reporting of information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>5. The Director of Nursing (DON) indicated, on 11-7-12, at 2:45 PM, she was unaware LPNs were to consult with the supervising RN prior to reporting to the physician. The DON stated, "I talk to the LPNs all the time. I just do not document it."</p> <p>6. The agency's 6-17-11 "Confirmation of Physician Telephone/Verbal Orders" policy number 2027 states, "All orders for medical care, treatment and/or services are reviewed/evaluated for appropriateness and accuracy by an appropriately licensed individual (i.e., Registered Nurse, Licensed Therapist, Pharmacist) prior to providing care, treatment, and/or services."</p>				

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N0549	<p>410 IAC 17-14-1(a)(1)(J) Scope of Services Rule 14 Sec. 1(a) (1)(J) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (J) Direct the activities of the licensed practical nurse. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had directed the licensed practical nurse (LPN) to report changes to the physician and had ensured the accuracy and appropriateness of physician orders in 4 (#s 1, 2, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's 140 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included telephone/verbal orders signed and dated by the LPN, employee D, on 8-21-12, 8-23-12, 8-24-12, 9-7-12, 9-10-12, 9-18-12, 9-20-12, 9-23-12, and 9-24-12, that evidenced the LPN had requested an order for an evaluation for home care services, had reported blood sugar ranges, changes in insulin dosages, and transportation issues. The record failed to evidence the RN had directed the LPN to report the information to the physician and had checked the subsequent orders received for accuracy and</p>	N0549	<p>1. All LPN's will be in-serviced on the fact that they are not allowed to submit orders without them first being checked and signed off on by an RN. The company form has been changed to reflect this requirement. 2. All LPN's are going to in-serviced and will have consequences if they submit any orders without them first being checked and signed off on by an RN. All nursing staff will also have regular in-services to ensure that they are following proper protocol and following company policy. 3. The Director of Nursing will be responsible for ensuring that every LPN hired is trained on this requirement and knows that their orders must be checked and signed off on by an RN. 4. The plan of correction will be completed by 12/10/12.</p>	12/10/2012			

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	<p>appropriateness.</p> <p>2. Clinical record number 2 included telephone/verbal orders signed and dated by the LPN, employee C, on 5-21-12 and 5-28-12, that evidenced the LPN had informed the physician of the need for the nurse to accompany the patient to therapy sessions and a change in medications. The record failed to evidence the RN had directed the LPN to report the information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>3. Clinical record number 4 included telephone/verbal orders signed and dated by the LPN, employee A, on 10-19-12, 10-20-12, 10-23-12, 10-26-12, and 10-30-12, informing the physician of medication changes. The record failed to evidence the RN had directed the LPN to report the information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>4. Clinical record number 5 included telephone/verbal orders signed and dated by the LPN, employee D, on 7-17-12 informing the physician of the potential need for home care services and requesting to evaluate the patient. The record failed to evidence the RN had</p>				

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	<p>directed the LPN to report the information to the physician and had checked the subsequent orders received for accuracy and appropriateness.</p> <p>5. The Director of Nursing (DON) indicated, on 11-7-12, at 2:45 PM, she was unaware LPNs were to consult with the supervising RN prior to reporting to the physician. The DON stated, "I talk to the LPNs all the time. I just do not document it."</p> <p>6. The agency's 6-17-11 "Confirmation of Physician Telephone/Verbal Orders" policy number 2027 states, "All orders for medical care, treatment and/or services are reviewed/evaluated for appropriateness and accuracy by an appropriately licensed individual (i.e., Registered Nurse, Licensed Therapist, Pharmacist) prior to providing care, treatment, and/or services."</p>			

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N0559	<p>410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse. Based on clinical record review and interview, the agency failed to ensure the licensed practical nurse (LPN) had consulted with the registered nurse (RN) prior to reporting changes to the physician that resulted in order modifications in 4 (#s 1, 2, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's 140 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included telephone/verbal orders signed and dated by the LPN, employee D, on 8-21-12, 8-23-12, 8-24-12, 9-7-12, 9-10-12, 9-18-12, 9-20-12, 9-23-12, and 9-24-12, that evidenced the LPN had requested an order for an evaluation for home care services, had reported blood sugar ranges, changes in insulin dosages, and transportation issues. The record failed to evidence the LPN had consulted with the supervising RN prior to reporting to the physician.</p>	N0559	<p>1. All LPN's will be in-serviced on the fact that they are not allowed to submit orders without them first being checked and signed off on by an RN. The company form has been changed to reflect this requirement. 2. All LPN's are going to in-serviced and will have consequences if they submit any orders without them first being checked and signed off on by an RN. All nursing staff will also have regular in-services to ensure that they are following proper protocol and following company policy. 3. The Director of Nursing will be responsible for ensuring that every LPN hired is trained on this requirement and knows that their orders must be checked and signed off on by an RN. 4. The plan of correction will be completed by 12/10/12.</p>	12/10/2012			

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	<p>2. Clinical record number 2 included telephone/verbal orders signed and dated by the LPN, employee C, on 5-21-12 and 5-28-12, that evidenced the LPN had informed the physician of the need for the nurse to accompany the patient to therapy sessions and a change in medications. The record failed to evidence the LPN had consulted with the supervising RN prior to reporting to the physician.</p> <p>3. Clinical record number 4 included telephone/verbal orders signed and dated by the LPN, employee A, on 10-19-12, 10-20-12, 10-23-12, 10-26-12, and 10-30-12, informing the physician of medication changes. The record failed to evidence the LPN had consulted with the supervising RN prior to reporting to the physician.</p> <p>4. Clinical record number 5 included telephone/verbal orders signed and dated by the LPN, employee D, on 7-17-12 informing the physician of the potential need for home care services and requesting to evaluate the patient. The record failed to evidence the LPN had consulted with the supervising RN prior to reporting to the physician.</p> <p>5. The Director of Nursing (DON) indicated, on 11-7-12, at 2:45 PM, she</p>			

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	was unaware LPNs were to consult with the supervising RN prior to reporting to the physician. The DON stated, "I talk to the LPNs all the time. I just do not document it."				