STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	297115		10/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HOME HEALTH CARE, INC	501 SOUTH RANCHO DRIVE SUITE D-21 LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your facility on October 5, 2010 through October 15, 2010, in accordance with 42 CFR Part 484, Home Health Services. The census at the time of the survey was 329. Twenty Five home visits with record review were completed. Fifteen record reviews were completed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified:	G 000		
G 121	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. This STANDARD is not met as evidenced by: Based on observation, interview, record and document review, the agency failed to ensure care was provided according to professional standards for 8 of 40 patients (Patients #35, #14, #17, #24, #25, #27, #28 and #31). Findings include: Patient #35	G 121		12/15/10

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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G 121	Continued From page 1 Patient #35 was admitted to the agency on 9/29/10, with diagnoses including pleural effusion, congestive heart failure, hypertension and diabetes. Documentation in Patient #35's medical record indicated the initial assessment was completed on 9/29/10. The Plan of Care (POC) included orders for Skilled Nurse (SN) 2W4 (two times a week for 4 weeks). Patient #35's medical record included a physician's order to hold SN visits until authorization was received. A home visit was conducted on 10/12/10 with the Registered Nurse (RN). The SN home visit on 10/12/10 was the first visit since the original intake on 9/29/10. 1) Patient #35's POC included skilled instructions for O2 (Oxygen) use/precautions and care of equipment. The POC did not indicate the O2 volume flow and the timeframes to be worn. When the RN entered the patient's home, Patient #35 was sitting on a couch in a back room, slumped over and did not have O2 in place. The RN asked the patient and wife/caregiver why Patient #35 did not have O2 in place. The patient's wife indicated he only wore O2 at night. The RN proceeded to set up Patient #35 with the oxygen by pulling the O2 tubing from the concentrator in the front room through the house until it reached the patient, and placed the O2 on him. During the home visit, the RN stood on the O2 tubing for extended periods of time. An interview was conducted with the RN after the	G 121		

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G 121	Continued From page 2 home visit. The RN indicated she was not aware she was standing on the O2 tubing during the home visit. 2) When the RN checked Patient #35's blood pressure, she did not wipe down the blood pressure cuff with a disinfectant before or after she checked Patient #35's blood pressure. An interview was conducted with the RN after the home visit. The RN verbalized she never wiped off the blood pressure cuff between patients. Patient #14 On 9/3/10, Patient #14 was admitted with diagnoses including an open wound, cerebral palsy, and microcephalous. On 10/6/10 at 4:45 PM during a home visit with Patient #14, the registered nurse (RN) placed her nursing bag on the floor without a barrier underneath the bag. Then the RN obtained some newspaper and placed a couple of sheets of newspaper underneath the bag. The small family dog was eagerly sniffing and trying to push its nose the bag . After performing hand hygiene with soap and water, the RN donned gloves and cut the existing dressing, removed it and placed it into the garbage bag. With the same gloves still on, the RN used normal saline moistened gauze to clean around Patient #14's wound. Next, the RN removed the gloves and without performing hand hygiene, reached into her nursing bag for a measuring device and gloves.	G 121		

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G 121	Continued From page 3 The RN measured Patient #14's wound, donned the clean gloves and re-dressed the wound. With the gloves still on, the RN reached into the nursing bag and retrieved equipment with which to take Patient #14's vital signs. After the visit, the RN was interviewed regarding aseptic technique. The RN verbalized the need to wash hands or use a waterless sanitizer when gloves have been removed. The RN indicated she realized placing a barrier underneath the bag after having placed it on the floor without a barrier was not good practice. Patient #17 On 9/4/10, Patient #17 was admitted with diagnoses including osteomyelitis, abnormality of gait and hypertension. On 10/7/10 in the morning during a visit to Patient #17's home, the licensed practical nurse (LPN) failed to perform hand hygiene in 3 out of 12 opportunities to do so after removing gloves. The LPN failed to perform hand hygiene after removing gloves and prior to returning equipment to the nursing bag. Patient #24 On 12/6/08, Patient #24 was admitted with diagnoses including uncontrolled insulin dependent diabetes mellitus, visual disturbances, hypertension and abnormality of gait. On 10/7/10 in the morning during a home visit, the registered nurse (RN) placed her nursing bag on Patient #24's bed without a barrier underneath	G 121		

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G 121	Continued From page 4 it. After checking Patient #24's vital signs, the RN returned the automatic blood pressure cuff and pulse oximeter equipment into the case/nursing bag without first cleaning the equipment and performing hand hygiene. While waiting for the thermometer to register Patient #24's temperature, the RN reached into the nursing bag for alcohol swabs without first performing hand hygiene. Outside Patient #24's home, when interviewed regarding infection prevention, the RN replied, "I clean everything at the end of the day ... with Lysol which I carry in my car ... " When asked to view the spray can of Lysol, the nurse looked in a bag in her car and then explained, "I don't have it today ... it's usually in my bag - I must have run out ... I'll have to go and buy some." Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gait and hypertension. On 10/7/10 in the morning during a visit to Patient #25's home, the certified nursing assistant (CNA) placed her bag on a chair without a barrier underneath the bag. After the CNA obtained Patient #25's vital signs, the CNA failed to 1) remove the gloves; 2) clean the equipment, and; 3) perform hand hygiene	G 121		

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G 121	Continued From page 5 prior to returning the equipment to the bag. Patient #27 On 7/11/10, Patient #27 was admitted with diagnoses including multiple pressure sores, paraplegia, diabetes mellitus, hypertension and congestive heart failure. On 10/8/10 in the morning during a visit to Patient #27's home, the registered nurse (RN) failed to perform hand hygiene in 10 out of 24 opportunities to do so after removing gloves. The RN failed to perform hand hygiene prior to accessing the inside of the nursing bag three times. During Patient #27's visit, the RN discovered several new areas of non-intact skin. The RN provided wound care without first contacting the physician and obtaining an order for the wound care. Patient #28 On 9/29/10, Patient #28 was admitted with hypertension, status post cardiovascular accident. On 10/8/10 in the morning during a home visit, the physical therapist (PT) placed her bag on three different surfaces (twice on the floor) without a barrier underneath. On 10/8/10 after the visit to Patient #28's home, the PT was interviewed regarding bag technique. The PT responded by saying she had "never been told about a barrier underneath the bag but it makes sense."	G 121		

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G 121	Continued From page 6 Patient #31 On 9/30/10, Patient #31 was admitted with diagnoses including aftercare for a traumatic fracture of the foot, insulin dependent diabetes mellitus, hypertension and hemiplegia. On 10/13/10 in the morning during a home visit with Patient #31, the registered nurse (RN) entered the nursing bag with gloves on. After the RN finished taking Patient #31's vital signs and did a skin check of the patient's backside, the RN removed her gloves and, without performing hand hygiene, reached into the nursing bag for hand sanitizer. The RN donned a new pair of gloves and checked between Patient #31's toes. With the same gloves on, the RN cleaned the blood pressure cuff, pulse oximeter, thermometer and stethoscope and placed all the non-disposable equipment used on Patient #31 into the nursing bag. A few minutes later, the RN removed the gloves, and without performing hand hygiene, searched around in the nursing bag and came up with some gloves, which she put on. With the gloves on, the RN proceeded to re-enter the nursing bag to find a measuring device. After measuring Patient #31's incisions, the RN removed her gloves and then, checked the patient's right pedal pulse. The RN failed to perform hand hygiene after removing the gloves. The Standards of Home Care Nursing Practice:	G 121		

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G 121	Continued From page 7 Concepts and Applications by Robyn Rice, PhD, RN, indicated " ... Wash hands with liquid soap and water immediately after removing gloves. If soap and water are not available, antiseptic hand cleanser or towelettes may be used. Hands should then be washed with soap and water as soon as possible ... Do not reenter the (nursing) bag unless your hands are clean ..." The agency's undated policy C-110 Standards of Practice, indicated "Agency will provide services that are in compliance with acceptable professional standards for the Home Care industry as well as ... "	G 121		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review, interview and document review, the agency failed to ensure coordination of care for blood draws for 1 of 40 patients (Patient #33). Findings include: Patient #33 Patient #33 was admitted to the agency on 9/16/10 with diagnoses including acute posthemorrhagic anemia, hypertension and chronic kidney disease. Patient #33's plan of care included physician's	G 143		12/15/10

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G 143	Continued From page 8 orders for: - SN (Skilled Nurse) qow (every other week) for 9 weeks - SN to administer Aranesp QOW if HGB (hemoglobin) < 12 - Aranesp 40 mcg (micrograms)/0.4 ml (milliliters) sq (subcutaneous) QOW - Labs: HCG (Hemoglobin), HCT (hematocrit), QOW- Report to Dr. (Name) An additional physician order dated 9/27/10 documented "Renal Panel 9/28/10." Patient #33's skilled nursing notes dated 9/16/10 revealed Patient #36 was a very difficult blood draw blood. After several attempts, the patient refused to have blood drawn and went to Quest laboratory to have the blood drawn. The next scheduled blood draw for patient #33 was 9/30/10. The order dated 9/27/10 for a Renal Panel on 9/28/10, was received by the agency and a LPN (Licensed Practical Nurse) was sent to Patient #33's home. Documentation on the Skilled Nursing Visit Note dated 9/28/10 indicated the SN attempted to draw Patient #33's blood twice and was unable to obtain the specimen. Patient #33's spouse indicated she would take the patient to Quest Lab to have the blood drawn. Documentation on the Skilled Nursing Visit Note dated 9/30/10 revealed "Pt. (patient) refused venipuncture for labs ordered...." There was no documented evidence the physician was called to try to coordinate the blood draws from patient #33 to prevent multiple venipunctures of the patient.	G 143		

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G 143	Continued From page 9 On 10/14/10, the R.N. (Registered Nurse) Case Manager indicated she was not called regarding the extra lab draw scheduled for Patient #33 prior to the LPN going to the patient's house. The agency's policy #C-360, titled Coordination of Client Services, undated, documented: Purpose: "To ensure services are coordinated between members of the interdisciplinary team..." "To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care..." Special Instructions: "...2. Staff will notify the RN case manager and physician for changes in patient condition. Changes in the Plan of Care will be communicated to other appropriate agency disciplines, as appropriate. 3. The Director of Nursing will act as liaison related to clinical issues, to ensure communication occurs among disciplines and the patient/caregiver, and is on a continuing basis.."	G 143		
G 145	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. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure a written summary was sent to the attending physician at least every 60 days for 2 of 40 patients (Patients #24 and #25). Findings include:	G 145		12/15/10

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G 145	Continued From page 10 Patient #24 On 12/6/08, Patient #24 was admitted with diagnoses including uncontrolled insulin dependent diabetes mellitus, visual disturbances, hypertension and abnormality of gait. As of 10/13/10, Patient #24's clinical record lacked a 60 day summary for the certification period of 7/29/10 through 9/26/10, describing the patient's condition at the beginning of the certification period, treatment provided and how the patient tolerated/responded to the care. Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gait and hypertension. As of 10/13/10, Patient #25's clinical record lacked a 60 day summary describing the patient's condition at the beginning of the certification period, treatments provided and how the patient tolerated/responded to the care, for the two certification periods of 7/11/10 through 9/8/10 and 5/12/10 through 7/10/10.	G 145		
G 158	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. This STANDARD is not met as evidenced by: Based on interview, record and document review, the agency failed to ensure staff followed the	G 158		12/15/10

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G 158	Continued From page 11 written plan of care while providing services for 10 of 40 patients (Patients #14, #17, #24, #25, #29, #30, #11, #18, #22, and #33). Findings include: Patient #14 On 9/3/10, Patient #14 was admitted with diagnoses including an open wound, cerebral palsy, and microcephalous. Patient #14's plan of care for the certification period of 9/3/10 through 11/01/10 included orders for the nurse to see the patient two times a week for one week, and then; three times a week for eight weeks. Patient #14's clinical record lacked documented evidence the patient was seen by a nurse for one of three visits during the week of 9/19/10. There was no missed visit report for the week of 9/19/10. There was no documented evidence the physician was notified of the missed visit. There was no physician's order decreasing the frequency of nursing visits. Patient #17 On 9/4/10, Patient #17 was admitted with diagnoses including osteomyelitis, abnormality of gait and hypertension. Patient #17's clinical record included a physician's order dated 9/26/10 reading, "... CLEANSE RIGHT HEEL WITH WOUND CLEANSE ... " Documentation on skilled nursing visit notes dated 9/26/10, 9/27/10, 9/28/10, 9/29/10, 9/30/10	G 158		

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G 158	Continued From page 12 and 10/3/10, revealed the nurse cleansed Patient #17's wound with NS (normal saline). Patient #24 On 12/6/08, Patient #24 was admitted with diagnoses including uncontrolled insulin dependent mellitus, visual disturbances, hypertension and abnormality of gait. Patient #24's clinical record included a missed visit note (MVN) dated 9/5/10. The clinical record lacked a physician's order to change the frequency of nursing visits the week of 9/5/10. Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gait and hypertension. Patient #25's plan of care for the certification period of 7/11/10 through 9/8/10 included orders for skilled nursing (SN) to see the patient three times a week for one week; two times a week for two weeks, and then; one time a week for six weeks. Patient #25's clinical record lacked documented evidence of a second visit during the third week of the certification period. The clinical record lacked a physician's order to change the frequency of nursing visits the week of 7/25/10. Patient #29 On 9/17/10, Patient #29 was admitted with diagnoses including venous embolism, chronic	G 158		

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G 158	Continued From page 13 obstructive bronchitis, hypertension and peripheral vascular disease. Patient #29's plan of care for the certification period of 9/17/10 through 11/5/10 included orders for a certified nursing assistant (CNA) and physical therapy (PT). According to documentation in Patient #29's clinical record, the patient declined the services of a CNA for personal care assistance. The clinical record lacked a physician's order to cancel the CNA. The clinical record lacked documented evidence the physician was notified a PT evaluation did not occur within 72 hours of Patient #29's admission (and would not occur until the agency received insurance authorization). Patient #30 On 9/26/10, Patient #30 was admitted with diagnoses including a pressure sore of the buttock, abnormal gait and history of falls. Patient #30 was not seen by physical therapy (PT) until 10 days after the start of care. There was no documented evidence the physician was notified PT did not evaluate the patient within 72 hours of admission. The agency's undated policy C-140 Client Admission Process indicated, " ... 12. ...Ancillary services will be initiated within 72 hours after the initial nursing assessment, unless documentation supports alternate plan based on client needs and wishes and caregiver availability..."	G 158		

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G 158	Continued From page 14 On 10/12/10 at 8:53 AM, the Director of Nursing (DON) was interviewed regarding PT not evaluating Patient #30 until 10 days after the referral was received. At 9:30 AM, a Care Coordination form dated 9/30/10 which read, "Could not staff physical therapy till we received authorization from insurance company MD & RN case manager notified," was presented by the DON. Patient #11 Patient #11 was admitted to the agency on 8/31/10 with diagnoses including infected abdominal wound, diabetes hypertension and systemic lupus erythematosus. Patient #11's plan of care for certification period 8/31/10 - 10/29/10 included orders for: - SN (Skilled Nurse) QD (every day) for 14 days then re-evaluate. A verbal order dated 9/13/10 indicated: - SN QD for continued wound care The medical record contained Missed Visit Reports for Skilled Nursing which documented: - 9/15/10 - "Unable to contact patient." - 9/18/10 - "Pt (patient) went to urgent care to be seen due to c/o (complaints of) blisters in mouth." There was no documented evidence the physician was notified of these two missed visits Patient #18 Patient #18 was admitted to the agency on 6/26/10 with diagnoses including infection of	G 158		

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G 158	Continued From page 15 amputation of the foot, diabetes, end stage renal disease, dialysis, and hypertension. The Plan of Care for certification period 8/25/10 - 10/23/10 included: - SN (Skilled Nurse) 2W1 (two times a week for 1 week); 3W8 (three times a week for 8 weeks). A physician's order dated 9/4/10 indicated "SN every day except when patient goes to wound clinic." Patient #18's medical record did not contain a skilled nurse visit for 9/8/10. The Skilled Nursing Visit Note dated 9/7/10 indicated the approximate next visit date was 9/8/10, with the plan for the visit - wound care. There was no documentation the patient was scheduled for the wound clinic on 9/8/10. The Skilled Nursing Visit Note dated 9/9/10 had no documented evidence the patient was seen at the wound clinic on 9/8/10. Patient #18's medical record did not contain a skilled nurse visit for 9/15/10. The Skilled Nursing Visit Note dated 9/14/10 indicated the approximate next visit date was 9/15/10, with the plan for the visit - wound care and review of systems. There was no documentation the patient was scheduled for the wound clinic on 9/15/10. The Skilled Nursing Visit Note dated 9/16/10 had no documented evidence the patient was seen at the wound clinic on 9/15/10. Patient #18's medical record did not contain a skilled nurse visit for 9/22/10. The Skilled Nursing Visit Note dated 9/21/10 indicated the approximate next visit date was 9/22/10, with the plan for the visit - wound care and review of systems. There was no documentation the patient	G 158		

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G 158	Continued From page 16 was scheduled for the wound clinic on 9/22/10. The Skilled Nursing Visit Note dated 9/23/10 had no documented evidence the patient was seen at the wound clinic on 9/22/10. Patient #18's medical record did not contain missed visit reports for 9/8/10, 9/15/10, and 9/22/10. There was no documented evidence the physician was notified of the three missed visits. Patient #22 Patient #22 was admitted to the agency on 10/14/10 with diagnoses including late effects of cerebral vascular accident, muscle weakness and abnormality of gait. The Plan of Care for certification period 8/1/10 - 9/29/10 included orders for: - SN (Skilled Nursing) 3W1 (three times a week for 1 week); 2W2 (two times a week for 2 weeks); QOW4 (every other week for 4 weeks), 1W1 (Once a week for 1 week). Patient #22's medical record contained a Missed Visit Report for skilled nursing dated 8/16/10. There was no documented evidence the physician was notified of the missed visit. The agency's undated policy # C-680 titled "Clinical Documentation" revealed: - "Special Instructions: ... 6. Services not provided and the reason for the missed visit will be documented and reported to the physician via phone or fax..." Patient #33 Patient #33 was admitted to the agency on	G 158		

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G 158	Continued From page 17 9/16/10 with diagnoses including acute posthemorrhagic anemia, hypertension and chronic kidney disease. Patient #33's plan of care included physician's orders for: - SN (Skilled Nurse) qow (every other week) for 9 weeks - SN to administer Aranesp QOW if HGB (hemoglobin) < 12 - Aranesp 40 mcg (micrograms)/0.4 ml (milliliters) sq (subcutaneous) QOW - Labs: HCG (Hemoglobin), HCT (hematocrit), QOW- Report to Dr. (Name) Patient #33 medical record included laboratory results as follows: - 07/14/10 - Hgb - 10.6 L(Low), Hct - 31.0 L - 10/05/10 - Hgb - 10.3 L, Hct - 30.3 L Patient #33 medical record also contained a fax confirmation sheet from Quest Diagnostic Laboratories, dated 8/27/10 which indicated a physician's Standing order for a hemoglobin and hematocrit test qow x 6 months. The skilled nursing visit notes indicated Patient #33 was given Aranesp sq on 9/16/10 and 9/30/10. There was no documented evidence the Hgb and Hct was drawn every two weeks and the results available to the SN prior to the injections of the Aranesp. There was no documentation on the SN clinical notes that indicated the most current Hgb and Hct results. On 10/14/10, the SN indicated the first dose of Aranesp given on 9/16/10, was given based on	G 158		

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G 158	Continued From page 18 the results of the July Hgb and Hct results. She verbalized the subsequent laboratory values may have been in Patient #33's home, however, she could not recall. The agency's undated policy C-635 Physician Orders indicated, "Drugs and treatments are administered to patients by agency staff only as ordered by the physician. All medications, treatments and services administered by agency staff to patients must be ordered by a physician ... All medications and treatments that are part of the client's plan of care, must be ordered by the physician ... New orders are required when there is a change in the diagnosis, a change in physician, following hospitalization, or a change in treatment, medications or frequency ...5. If the client or caregiver initiates changes that have been communicated to them by the physician, the nurse or therapist will write and date the order the day he/she is informed of the change, but shall indicate on the order the actual day the change was made ... "	G 158		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to ensure staff provided care only as ordered by the physician for 5 of 40 patients (Patients #16, #17, #25, #27, and #33). Findings include: Patient #16	G 165		12/15/10

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G 165	Continued From page 19 On 7/13/10, Patient #16 was admitted with diagnoses including non-healing surgical wound, muscle weakness and abnormality of gait. According to documentation on a visit note dated 8/30/10, the nurse applied skin prep to the area surrounding Patient #16's abdominal wound. Patient #16's clinical record lacked a physician's order for the use of skin prep. Patient #17 On 9/4/10, Patient #17 was admitted with diagnoses including osteomyelitis, abnormality of gait and hypertension. Patient #17's clinical record included a physician's order dated 9/26/10 which read, " ... CLEANSE RIGHT HEEL WITH WOUND CLEANSE PAT DRY APPLY AQUACEL COVER WITH DSD (dry sterile dressing) WRAP WITH KERLEX AND SECURE WITH TAPE ... " Skilled nursing visit notes dated 9/26/10, 9/27/10, 9/28/10, 9/29/10, 9/30/10 and 10/3/10, revealed the nurse cleansed Patient #17's wound with NS (normal saline) and applied foam to the dressing of the patient's foot wound. Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gait and hypertension. Patient #25's clinical record included a nursing	G 165		

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G 165	Continued From page 20 note dated 7/24/10 in which the nurse documented using skin prep on the patient's skin. There was no physician's order to use skin prep. Patient #27 On 7/11/10, Patient #27 was admitted with diagnoses including multiple pressure sores, paraplegia, diabetes mellitus, hypertension and congestive heart failure. On 10/8/10 in the morning during a visit to Patient #27's home, the RN provided wound care to several new areas of non-intact skin without first contacting the physician for an order. Patient #33 Patient #33 was admitted to the agency on 9/16/10 with diagnoses including acute posthemorrhagic anemia, hypertension and chronic kidney disease. Patient #33's plan of care included physician's orders for: - SN (Skilled Nurse) qow (every other week) for 9 weeks - SN to administer Aranesp QOW if HGB (hemoglobin) < 12 - Aranesp 40 mcg (micrograms)/0.4 ml (milliliters) sq (subcutaneous) QOW - Labs: HCG (Hemoglobin), HCT (hematocrit), QOW- Report to Dr. (Name) Patient #33's medical record included laboratory results as follows: - 07/14/10 - Hgb - 10.6 L(Low), Hct - 31.0 L - 10/05/10 - Hgb - 10.3 L, Hct - 30.3 L	G 165		

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G 165	Continued From page 21 Patient #33 medical record also contained a fax confirmation sheet from Quest Diagnostic Laboratories, dated 8/27/10 which indicated a physician's Standing order for a hemoglobin and hematocrit test qow x 6 months. The skilled nursing visit notes indicated Patient #33 was given Aranesp sq on 9/16/10 and 9/30/10. There was no documented evidence that the Hgb and Hct was drawn every two weeks and the results available to the SN prior to the injections of the Aranesp. There was no documentation on the SN clinical notes that indicated the most current Hgb and Hct results. On 10/14/10, the SN indicated the first dose of Aranesp given on 9/16/10, was given based on the results of the July Hgb and Hct results. She verbalized the subsequent laboratory values may have been in Patient #33's home, however, she could not recall. The agency's undated policy C-635 Physician Orders indicated, "Drugs and treatments are administered to patients by agency staff only as ordered by the physician. All medications, treatments and services administered by agency staff to patients must be ordered by a physician ... All medications and treatments that are part of the client's plan of care, must be ordered by the physician ... New orders are required when there is a change in the diagnosis, a change in physician, following hospitalization, or a change in treatment, medications or frequency ...5. If the client or caregiver initiates changes that have been communicated to them by the physician, the	G 165		

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G 165	Continued From page 22 nurse or therapist will write and date the order the day he/she is informed of the change, but shall indicate on the order the actual day the change was made ... "	G 165		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS 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. This STANDARD is not met as evidenced by: Based on interview and record and document review, the agency failed to ensure verbal orders were signed in a timely manner by the physician for 2 of 40 patients (Patients #14 and #25). Findings include: Patient #14 On 9/3/10, Patient #14 was admitted with diagnoses including an open wound, cerebral palsy, and microcephalous. Patient #14's plan of care (POC) was dated 9/3/10 by the nurse who prepared it. As of 10/5/10, the POC was not signed by the physician. Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gain	G 166		12/15/10

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G 166	Continued From page 23 and hypertension. As of 10/13/10, Patient #25's plan of care for the certification period of 9/9/10 through 11/7/10 lacked a physician's signature and date. According to the Quality Improvement Director, physicians' orders were to be "signed and in the record within 20 days." The agency's undated policy C-635 Physician Orders, indicated "8. ... The Agency will implement a tracking system to assure orders are signed by the physician within 20 working days of receipt of the order ... "	G 166		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse regularly re-evaluated 1 of 40 patients (Patient #25). Findings include: Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gait and hypertension. A certified nursing assistant (CNA) note dated 7/27/10, revealed the CNA notified the registered nurse (RN) regarding Patient #25 having "skin	G 172		12/15/10

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G 172	Continued From page 24 tears on both buttock cheeks." Documentation in Patient #25's clinical record revealed the RN did not re-evaluate the patient's skin status until 7/31/10.	G 172		
G 176	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. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the nurse prepared and submitted complete, accurate documentation for 4 of 40 patients (Patients #14, #15, #17, and #27). Findings include: Patient #14 On 9/3/10, Patient #14 was admitted with diagnoses including an open wound, cerebral palsy, and microcephalous. Patient #14's clinical record included a Physician Verbal Order, dated 9/27/10. The form indicated: "Cleanse with normal saline, apply dry dsg. (dressing) and wrap with kerlix daily ... Change SN (skilled nurse) visit frequency to twice a week x (for) 3 weeks for wound assessment." The 9/27/10 order did not indicate who was to perform the wound care/dressing change for Patient #14 on the days the SN was not going see the patient. The order indicated the SN was to	G 176		12/15/10

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G 176	Continued From page 25 see the patient two times a week for three weeks (to "assess the wound"). There was no actual order for the nurse to perform wound care and dressing change. Patient #15 On 9/9/10, Patient #15 was admitted with diagnoses including cellulitis and abscess of the axilla, coronary artery disease, congestive heart failure, hypertension and abnormality of gait. Patient #15's clinical record included a Physician Verbal Order dated 9/23/10, which lacked documentation indicating: 1) who was to perform the care, 2) the frequency the wound care was to be done, and; 3) the frequency for the nursing visits. Patient #15's clinical record included several notes which lacked the title after the provider's signature. Patient #15's clinical record included a skilled nursing (SN) note dated 8/30/10, which indicated the lower abdominal wound had healed and no dressing was required. The clinical record lacked documented evidence revealing the SN: 1) notified the physician of the closed wound status and; 2) prepared a Physician Verbal Order to discontinue care for the healed wound. Patient #17 On 9/4/10, Patient #17 was admitted with	G 176		

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G 176	Continued From page 26 diagnoses including osteomyelitis, abnormality of gait and hypertension. A 9/14/10 physician's order in Patient #17's clinical record read, "SNV (skilled nurse visit) DAILY WITH THE EXCEPTION OF WOUND CLINIC DAY." The order lacked the duration of the daily visits. Patient #27 On 7/11/10, Patient #27 was admitted with diagnoses including multiple pressure sores, paraplegia, diabetes mellitus, hypertension and congestive heart failure. Patient #27's plan of care for the certification period of 9/4/10 through 11/2/10 included orders for skilled nursing (SN) 2W9 (two times a week for nine weeks), effective 9/5/10. As of 9/5/10, there were eight weeks left in the certification period. Patient #27's clinical record included several incomplete and inaccurate pages of an OASIS (Outcome and Assessment Information Set) recertification assessment. Page 9 of 14 of the OASIS indicated the patient had no injectable medications prescribed. Patient #27 was a diabetic and had insulin for use on a sliding scale basis. Page 11 of 14 included an area for the nurse to document the care provided and the patient/caregiver's response. This area included documentation which read, "Using aseptic technique" There was no other documentation on page 11 of 14 of Patient #27's recertification assessment.	G 176		

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G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record and document review, the agency failed to ensure the registered nurse performed a supervisory visit with the certified nursing assistant at least every 14 days for 1 of 40 patients (Patient #25). Findings include: Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gain and hypertension. During the certification period of 7/11/10 through 9/8/10, a certified nursing assistant (CNA) saw Patient #25 one time a week for one week and then, two times a week for eight weeks for personal care assistance. Patient #25's clinical record lacked documented evidence the registered nurse completed a CNA supervisory visit at least every 14 days during this certification period.	G 229		12/15/10
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every	G 236		12/15/10

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G 236	Continued From page 28 patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on interview, record and document review, the agency failed to ensure verbal orders were signed and in the clinical record in a timely manner by the physician for 2 of 40 patients (Patients #14 and #25). Findings include: Patient #14 On 9/3/10, Patient #14 was admitted with diagnoses including an open wound, cerebral palsy, and microcephalous. Patient #14's plan of care (POC) was dated 9/3/10 by the nurse who prepared it. The POC was not signed by the physician as of 10/5/10. Patient #25 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gait and hypertension. Patient #25's plan of care for the certification period of 9/9/10 through 11/7/10, which was prepared and dated by the registered nurse on	G 236		

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	297115		10/15/2010

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G 236	Continued From page 29 9/8/10, lacked a physician's signature and date as of 10/13/10. According to the Quality Improvement Director, physicians' orders were to be "signed and in the record within 20 days." The agency's undated policy C-635 Physician Orders, indicated " ... 8. ... The Agency will implement a tracking system to assure orders are signed by the physician within 20 working days of receipt of the order ... "	G 236		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the agency failed to ensure medication profiles were accurate and reviewed timely to ensure appropriate drug therapy for 8 of 40 patients. (Patients #35, #16, #17, #25, #27, #28, #29 and 32). Findings include: Patient #35 Patient #35 was admitted to the agency on 9/29/10, with diagnoses including pleural effusion, congestive heart failure, hypertension and diabetes.	G 337		12/15/10

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G 337	Continued From page 30 A home visit was conducted on 10/12/10, with the Registered Nurse (RN). Documentation in Patient #35's medical record indicated the initial assessment was completed on 9/29/10. The Plan of Care (POC) included orders for Skilled Nurse (SN) 2W4 (two times a week for 4 weeks). Patient #35's medical record included a physician's order to hold SN visits until authorization was received. The SN home visit on 10/12/10 was the first visit since the original intake on 9/29/10. 1) Patient # 35's POC included the following medications: - Torsemide (diuretic)10 mg (milligrams) Tab (s) Three times per day Oral (new) The medication profile located in Patient #35's home folder indicated: - Torsemide 20 mg three times a day. When the RN examined Patient #35's legs, she indicated he had pitting edema which had increased since the last visit. The RN asked Patient #35, and his caregiver/wife if the patient had been taking his diuretic. Patient #35's wife indicated she had been giving him Furosemide (diuretic) once a day. The RN did not identify the difference in the frequency and name of the medication, and continued her examination and teaching of Patient #35. The RN placed a call to the attending physician to notify him/her of the increased edema of Patient #35's extremities. As the RN was ending the visit, the surveyor asked Patient #35's caregiver/wife to bring out the	G 337		

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G 337	Continued From page 31 bottle of diuretic medications the patient was currently taking and give that to the RN to review. The medication bottle label indicated Furosemide 40 mg once a day. 2) Patient #35's POC included a skilled instruction for "O2 (Oxygen) use/precautions and care equipment." There was no documentation regarding the Oxygen flow rate or frequency for Patient #35's Oxygen. Patient #16 On 7/13/10, Patient #16 was admitted with diagnoses including a non-healing surgical wound, muscle weakness and abnormality of gait. On 10/7/10 in the afternoon during a home visit, Patient #16's medication profile (MP) obtained from the clinical record was compared with medications in the patient's home. According to Patient #16: -- the Lorazepam had been discontinued (date unknown) -- the dose of Paroxetine had been changed on 9/29/10 -- the dose of Xanax had been changed on 9/27/10 None of the above changes were noted on the MP in Patient #16's clinical record. The MP lacked the reasons for medications ordered to be taken PRN (as needed). Patient #16's medications in the home included Fentanyl patch and Opana ER. These two	G 337		

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G 337	Continued From page 32 medications were not listed on the original MP. They were not listed on any of the three MP Addendums in the clinical record. One of Patient #16's MP Addendums included two intravenous (IV) medications which were ordered in August, 2010. The MP lacked flushing solutions required to clear the line between medications and to keep the IV line open. Patient #17 On 9/4/10, Patient #17 was admitted with diagnoses including osteomyelitis, abnormality of gait and hypertension. On 10/7/10 in the morning during a home visit, Patient #17's medication profile (MP) was compared with the medications in the home. According to Patient #17, the warfarin was "... discontinued in the middle of August (2010) ..." The MP lacked documented evidence the warfarin was discontinued. The MP indicated Patient #17 was taking "HYDROCHLOROTHIAZIDE 1 TAB 25 MG (milligrams) BY MOUTH EVERY DAY." The label dated 7/8/10, read "1/2 tab by mouth every day." There was no documented evidence on the MP indicating the dose was increased and the date it was changed. Patient # 17 indicated he was taking Ginko Biloba 60 milligrams every day. The MP lacked an entry of Ginko Biloba. Patient #25	G 337		

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G 337	Continued From page 33 On 5/12/10, Patient #25 was admitted with diagnoses including a pressure sore on the buttock, multiple sclerosis, abnormality of gait and hypertension. On 10/7/10 in the morning during a home visit, Patient #25's medication profile (MP) was compared with the medications in the home. Patient #25 had several medications on hand (and indicated she was taking them) which were not on the MP prepared by the nurse. The medications present in the home (and not on the 5/12/10 MP prepared by the nurse) had labels which read: -- Diovan 40 mg (milligrams) 1 tablet every day (as of 7/13/10) -- Omeprazole 20 mg 1 tablet every day (as of 8/11/10) -- Loratadine 10 mg 1 tablet every day (start date unknown) -- Mestinon 160 mg 1 tablet every day (as of 7/9/10) -- Topramate 25 mg 2 tablets every day (as of 7/13/10) -- Baclofen 10 mg 1 tablet three times a day (as of 7/18/10) -- Simvastatin 40 mg 1 tablet every day (as of 9/24/10) -- Coumadin 1 mg 2.5 tablets as directed (as of 7/14/10) -- Hydrochlorothiazide 12.5 mg every day (as of 8/11/10) -- Detrol LA 4 mg 2 tablets per day as directed (as of 3/9/10) -- Vitamin A 8,000 international units every day -- Tylenol Arthritis 2 tablets at bed time	G 337		

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G 337	Continued From page 34 Patient #25 indicated she took the Baclofen twice a day. The physician wrote on the Simvastatin order, "STOP LIPITOR." Patient #25's clinical record included a MP, dated 5/12/10. There was no documented evidence of the updates above, including stopping the Lipitor, on the MP dated 5/12/10. The five areas on the MP to document subsequent dates of review and revision were all left blank except for the original start date of 5/12/10. The 5/12/10 MP was included with the paperwork requested for the certification period of 7/11/10 through 9/8/10. The MP for Patient #25's certification period of 9/9/10 through 11/7/10 lacked the purpose of each medication. Patient #27 On 7/11/10, Patient #27 was admitted with diagnoses including multiple pressure sores, paraplegia, diabetes mellitus, hypertension and congestive heart failure. On 10/8/10 in the morning during a home visit, Patient #27's medications in the home were compared with the medication profile (MP). Patient #27's MP listed the following medications: -- Furosemide 80 milligrams (mg) 2 tabs twice a day -- Lovaza 1 gram 1 tablet four times a day According to the medications in the home, Patient #27 was to take:	G 337		

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G 337	Continued From page 35 -- Furosemide 20 mg 2 tablets twice a day (as of 9/26/10) -- Lovaza 1 gram 4 caps every day (per the prescription label) -- Ferrous Sulfate 325 mg 1 tablet by mouth three times a day (as of 8/4/10) -- Metoprolol Tartrate 25 mg 1 tablet twice a day -- Oxycodone/APAP 5-325 mg 1 tablet every 4 hours as needed for pain -- Combivent 1 vial inhaled via small volume nebulizer every 6 hours These six medications were not documented as having been changed and/or added to Patient #27's MP. The column in which to document the purpose for all nine medications listed on the MP was blank. The area in which the nurse was to document the date of medication review, had one date entered (8/31/10). Patient #28 On 9/29/10, Patient #28 was admitted with hypertension, status post cardiovascular accident. On 10/8/10 in the morning during a home visit, the medications listed on the medication profile (MP) were compared with the medications Patient #28 had on hand in the home. Patient #28 presented the following medications and indicated he was taking: -- Simvastatin 20 mg (milligrams) one tablet at bedtime (since 9/27/10) -- Lisinopril 10 mg one tablet every day (since 9/27/10) -- Flomax 0.4 mg one tablet every day (since 7/28/09)	G 337		

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G 337	Continued From page 36 -- Enteric Coated Aspirin 325 mg one tablet every day (date unknown) Patient #28's MP lacked all four medications listed above. Patient #29 On 9/17/10, Patient #29 was admitted with diagnoses including venous embolism, chronic obstructive bronchitis, hypertension and peripheral vascular disease. On 10/8/10 in the morning during a home visit, Patient #29's medications in the home were compared with the medications listed on the medication profile (MP). Patient #29 indicated she was taking the following medications: -- Ferrous Sulfate 325 mg (milligrams) 1 tablet twice a day -- Dulcolax 1 tablet twice a day -- Fish Oil 1,000 mg 1 capsule three times a day -- Vitamin B-12 l,500 mg one capsule once a day -- Melatonin 3 mg 2 tablets at bedtime -- MSM (Methylsulfonylmethane) 1,000 mg 1 tablet three times a day Patient #29's MP lacked all six supplements listed above. Patient #29 indicated she had discontinued the oxygen and Atrovent on 10/1/10. The MP was not updated to reflect these changes. There was no documentation indicating the physician was notified of these changes. There was no physician's order for the patient to discontinue the	G 337		

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G 337	Continued From page 37 oxygen and Atrovent. Patient #29's MP lacked the purpose for seven of the nine medications/oxygen the patient was prescribed. Patient #32 On 9/25/10, Patient #32 was admitted with diagnoses including aftercare following surgery of the cervical spine, hypertension and abnormality of gait. On 10/13/10 during a home visit in the morning, Patient #32's medication profile (MP) was compared with medications in the home. The MP listed three medications: -- Carisoprodol 350 mg (milligrams) three times a day -- Oxycodone/APAP 325/10 mg four times per day -- Diazepam 10 mg three times per day The following medications were in Patient #32's home and were being taken per the patient and spouse: -- Percocet 10/325 mg one tablet between 2:00 PM and 4:00 PM -- Ambien 10 mg at bedtime -- Atenolol 25 mg every day -- Gabapentin 100 mg at bedtime for one week, then increase to 300 mg at bedtime -- Zocor 20 mg at bedtime -- Lisinopril 2.5 mg every day -- Omeprazole 20 mg every day -- Opana ER 20 mg twice a day	G 337		

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G 337	Continued From page 38 -- Premarin 0.625 mg every day -- Probiotic 10 Billion CFU (colony forming units) every day -- Stool softener one capsule every day The agency's undated policy C-700 Medication Profile indicated, "... The medication profile shall include all prescription and nonprescription including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the client is taking ... To provide documentation of changes in the medication regime as they happen, and support changes needed to the plan of care... 2. The Nurse/Therapist shall record on the Medication Profile all prescribed and over-the-counter (OTC) medications the client is currently taking... 5. If the physician changes the medication orders, the Nurse must add newly ordered drug or medication changes to the Medication Profile. Discontinued medication shall be identified on the profile as discontinued and the date the medication was discontinued will be listed... The Medication profile shall be reviewed by a Registered Nurse very 60 days and updated whenever there is a change or discontinuation in medication..."	G 337		