

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157582	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2016
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NAME OF PROVIDER OR SUPPLIER BROOKDALE HOME HEALTH INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST INDIANAPOLIS, IN 46268
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G 0000 Bldg. 00	<p>This survey was a Federal recertification survey. The survey was extended.</p> <p>Survey dates: February 17, 18, 19, 23, and 24, 2016</p> <p>Facility ID#: 011129</p> <p>Provider #: 157582</p> <p>Census: 80</p> <p>Brookdale Home Health, Indianapolis is precluded from providing its own training and competency evaluation program for a period of 2 years beginning February 24, 2106 to February 25, 2016, for being found out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care and Medical Supervision; 484.30 Skilled Nursing Services; 484.32 Therapy Services; 484. 48 Clinical Records; and Condition of Participation 484.55 Comprehensive Assessment.</p>	G 0000	<p>Thefollowing is the Plan of Correction for Brookdale Home Health Indianapolis inregards to the Statement of Deficiencies (SOD) received April 7, 2016 for a re-certificationsurvey visit conducted February 17 - 24, 2016 and SOD dated April 5, 2016. This Plan of Correction is not to beconstrued as an admission of or agreement with the findings and conclusions inthe Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation ofour ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specificactions in response to identified issues. We have not provided a detailed response to each individual allegationor finding, nor have we identified individual mitigating factors. We remain committed to the delivery ofquality health care services and will continue to make changes and improvementto satisfy that objective.</p>	
G 0108	484.10(c)(1) RIGHT TO BE INFORMED AND			

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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Bldg. 00	<p>PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on record review and interview, the agency failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 6 of 12 records reviewed (# 1, 3, 6, 7, 11, and 12)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1, SOC (start of care) 05/15/15, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" section failed to evidence a frequency for skilled nursing. 2. Clinical record number 3, SOC 01/18/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" 	G 0108	<p>Regional Director of Survey Readiness (RDSR) re-trained clinicians on March 8-9, 2016, to review the requirements of a patient's right to be informed and participate in planning. The Admission Consent Service Agreement with special emphasis on the Consent for Treatment section was included in the re-training. To assist with compliance, the Document Tracking Specialist will give consent agreements to the Director of Clinical Services (DCS) for accuracy review prior to scanning the document into the patient's medical record. If the consent is found to be inaccurate, the clinician who obtained the consent will be contacted to have the document corrected with the patient/legal representative signature indicating the corrected agreement has been received. The clinician will then return the correct consent agreement to the office for the review process. To assist with</p>	03/23/2016

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	<p>section indicated skilled nursing, home health aide, physical therapy and occupational therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse and home health aide.</p> <p>3. Clinical record number 6, SOC 02/17/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 02/17/16. The "Consent For Treatment" section indicated skilled nursing, physical therapy and occupational therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse.</p> <p>4. Clinical record number 7, SOC 01/27/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/27/16. The "Consent For Treatment" section indicated skilled nursing two times a week for six weeks, physical therapy and occupational therapy two times a week for six weeks.</p>		<p>compliance the DCS or designee will audit 100% of consent agreements for new admissions beginning February 25, 2016, to verify completion. This audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter, 50% of admissions per month will be reviewed until 100% compliance has been maintained for three(3) consecutive months. Finally, a random sampling of 10% of admissions per month will be reviewed until 100%compliance has been maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. On March 9,2016, Regional Director of Survey Readiness (RDSR) re-trained clinicians on the therapy evaluation process which included frequency and duration documentation as approved by the physician and by the patient/representative. An additional verification process was added to the electronic documentation system for therapy evaluations, which requires acknowledgment of patient/representation approval of the therapy services frequency and duration. To assist with compliance the DCS or designee will audit initial therapy evaluations to verify completion on a weekly basis. Any</p>	

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	<p>a. The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the home health aide.</p> <p>b. Review of the OASIS comprehensive admission assessment dated 01/27/16, the narrative note indicated the patient refused skilled nursing services. The admitting clinician also failed to change the frequency proposed to a one time visit on the Admission Consent Service Agreement.</p> <p>c. Review of the physical therapy initial evaluation visit note dated 01/27/16, the physical therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>d. Review of the occupational therapy initial evaluation visit note dated 02/03/16, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>5. Clinical record number 11, SOC 10/18/15, had an established plan of care by a physician for the certifying period</p>		<p>discrepancies will be brought to the attention of the therapist who will notify the physician and/or patient/representative of frequency and duration with documentation in coordination notes to validate compliance within 48 hours of notification. This audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter, 50% of initial therapy evaluations per month will be reviewed until 100% compliance has been maintained for three (3) consecutive months. Finally, a random sampling of 10% of initial therapy evaluations per month will be reviewed until 100% compliance has been maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>10/18/15 to 12/16/15, with orders for skilled nursing, physical and occupational therapy services. The "Consent for Treatment" section failed to include physical an occupational therapy services. The admitting clinician failed to inform the patient / representative in advance about the proposed physical and occupational therapy services.</p> <p>6. Clinical record number 12, SOC 11/10/15, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 11/10/15. The "Consent For Treatment" section indicated skilled nursing, physical therapy, occupational therapy, and speech therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse.</p> <p>a. Review of the occupational therapy initial evaluation visit note dated 11/13/15, the occupational therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p>			

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G 0121 Bldg. 00	<p>b. Review of the speech therapy initial evaluation visit note dated 11/13/15, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>7. The Administrator was unable to provide any additional documentation and/or information when asked on 2/19/16 at 2:50 PM.</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, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 1 of 6 home visit observations. (# 3)</p> <p>Findings include:</p> <p>1. A policy titled "Hand Hygiene" revised 12/2012, indicated " ... 3. Hand decontamination using an alcohol - based hand gel should e performed: A. Before</p>	G 0121	<p>On March8-10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements to comply with professional standards and principles requirements, and agency polices for Hand Hygiene (#C:2-048.1), ContaminatedMaterials Disposal (#C:051-.1) and Bag Technique (C:2-055.1) for infection control requirements. All aforementioned policies will be provided to each clinician retrained. The nurse cited during a home visit was retrained by the Director of Clinical Services and</p>	03/23/2016

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	<p>having direct contact with patients. B. Before accessing the clean area of the visit bag. C. Before donning sterile gloves when performing sterile procedures; before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices. D. After contact with a patient's intact skin (when taking a pulse, blood pressure or lifting a patient. E. After contact with body fluids or excretions, mucous membranes, non - intact skin, and wound dressings, if hands are not visibly contaminated. F. When moving from a contaminated body site to a clean body site during patient care. G. After contact with inanimate objects, including medical equipment, in the immediate vicinity of the patient. H. After removing gloves. I. After completing care, prior to leaving the patient's home "</p> <p>2. A policy titled "Contaminated Materials Disposition" revised 12/2012, indicated " ... 3. Equipment: A. Cleaning reusable equipment that may come in contact with mucous membranes or body fluids: [This refers to equipment that personnel transports from patient to patient in the performance of their duties, i.e., BP [blood pressure] cuffs, stethoscope, thermometers, scales]"</p> <p>1. wipe exposed portions of equipment with alcohol or other appropriate</p>		<p>the Home Health Director on infection control procedures. To assist with compliance, random home supervisory visits by the Director of Clinical Services, Home Health Director or designee have been conducted for all categories of clinicians. Ongoing random home visits by the Director of Clinical Services or designee will be conducted monthly for four (4) clinicians. This audit will continue until 100% compliance has been achieved and maintained for four(4) consecutive months. Thereafter, monthly home visit observation by the Director of Clinical Services or designee will be continued for all new staff clinicians and current clinicians (at least 2 per month) until 100% compliance has been maintained for 3 consecutive months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>cleaning solution "</p> <p>3. A policy titled "Contaminated Waste Disposition" revised 12/2012, indicated " ... 3. COntaminated paper wastes [disposable flovess, gowns, masks, paper towels, tubings dressings, etc.], should be placed in a plastic puncture resistant bag and secured. It should be double bagged and, in possible, placed in a plastic trash container with tight lid and labeled as appropriate "</p> <p>4. The Centers for Disease Control Standard Precautions indicated, "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</p>			

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	<p>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>5. A home visit was made to patient number 3, with Employee C, a registered nurse, on 02/18/16 at 10:30 AM. Employee B, was observed providing wound care to the patient's left heel. The patient's primary diagnosis was necrotizing fasciitis [flesh eating disorder]. Employee B was observed to clean hands and applied gloves, remove the patient's sock and stocking, cut the patient's kerlix wrap and removed a soiled dressing. Without changing gloves, the employee B continued to clean the patient's wound, applied</p>			

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G 0143 Bldg. 00	<p>solosite wound gel around the patient's wound. Continuing to not change his / her gloves, Employee B removed and cut a piece of medicated dressing with the same scissors that was used to to remove the kerlix without cleaning to prior use. Employee B proceeded to apply the medicated dressing, 4 x 4, foam dressing, then wrapped the foot with kerlix. At this time, Employee B removed his / her gloves and cleaned hands with hand gel. Employee B cleaned the patient area of soiled dressings with his / her bare hands and carried it to the patient's kitchen and placed the soiled items in the trash can. Employee B cleaned her hands and applied gloves, obtained a blood sample from the patient's finger, removed the strip that contained the patient's blood, put the hand held machine in his / her traveling bag without cleaning.</p> <p>6. Employee C, Registered Nurse, was interviewed after the home visit on 02/18/16. Employee C was unable to identify his / her error with infection control.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on interview and record review,</p>	G 0143	On March 3,9, 10, 2016, the	03/23/2016

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	<p>the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that were furnishing services for 2 of 2 records reviewed (# 2 and 11) of patients receiving outside services, and failed to ensure all disciplines providing service to patients coordinated effectively for 3 of 9 patients receiving therapy services in a sample of 12. (# 7, 8, and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had a plan of care established by a physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. <ul style="list-style-type: none"> A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. Review of the care coordination notes, the agency failed to evidence coordination of care between 		<p>Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for coordination of Patient Services, agency's policy on Continuity of Care(#HH:2-013.1), and coordination with outside services (dialysis centers and wound care centers) and within the agency disciplines. A review of all current patients receiving outside services was conducted to verify coordination hasbeen completed and documented in the medical record. To assist with compliance, the intake process will include notification to the Directorof Clinical Services (DCS) or designee that the referred patient has outside services being provided. If the initial Outcome and Assessment InformationSet (OASIS) assessment indicates outside services are provided and this was not known or previously documented in the medical record, the DCS or designee will be notified. To assist with compliance, the DCS or designee will audit 100% of medical records with known outside services provided on amonthly basis to verify coordination of care. If it is missing, clinicians will be required to perform coordination and document the interaction. This audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter,</p>	

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	<p>the agency and the dialysis center.</p> <p>2. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy</p>		<p>50% of medical records withoutside services per month will be reviewed until 100% compliance has been maintained for three (3) consecutive months. Finally, a random sampling of 10% of medical records with outside services per month will be reviewed until 100% compliance has been maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Clinicians are now documenting their interactions with each other in visit notes under coordination of care or in coordination note section of the medical record. To assist with compliance, each patient discussed at weekly case conferences will have a quality review done by the team focusing on documented interaction with other disciplines. The Director of Clinical Services (DCS) or designee will audit a random selection of ten (10) multiple discipline medical records on a monthly basis. This audit will continue until 100% compliance has been achieved and maintained for three (3) consecutive months. Thereafter, random selection of seven (7) multiple discipline medical records per month will be reviewed until 100% compliancehas been maintained for two (2) consecutive months. Finally, a random sampling of</p>	

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	<p>initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>b. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of</p>		<p>10% of multiple discipline medical records per month will be reviewed until 100% compliance has been maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly QualityImprovement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>5. Clinical record number 11, SOC 10/18/15, included a plan of care established by the physician for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p> <p>6. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic."</p> <p>7. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.</p> <p>8. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members</p>			

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G 0144 Bldg. 00	<p>concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes ... F. Coummunicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided "</p> <p>9. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences "</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that were furnishing services for 2 of 2 records reviewed of patients receiving outside services (# 2 and 11), and failed to ensure all disciplines providing service to patients coordinated effectively and documented for 3 of 9 patients receiving therapy services in a sample of 12. (# 7,</p>	G 0144	<p>On March 3,8-10, 2016, the Regional Director of Survey Readiness (RDSR) retrained staff onthe Medicare requirements for Coordination of Patient Services and instruction was provided to clinicians using agency Policy Case Conference/Progress Summary(H:2-014.1) . Copies of the policy were provided to each clinician. Case conferences have been established weekly to include clinicians providing direct care and those in a support role. The documentation from the case</p>	03/23/2016

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	<p>8, and 9)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks.</p> <p style="padding-left: 40px;">a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday.</p> <p>2. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p style="padding-left: 40px;">a. Review of the physical therapy initial evaluation visit dated 01/27/16,</p>		<p>conferences will be placed in the coordination of care section of the medical record. Patients currently on service as of March 21,2016, will have their medical record audited for the presence of case conference documentation. As applicable,a case conference will be conducted and documented for any patients that are missing the case conference documentation. To assistwith compliance, the Director of Clinical Services (DCS) or designee will audit a random selection of ten (10) multiple discipline medical records on a monthly basis for the presence of case conference notes. This audit will continue until 100% compliance has been achieved and maintained for three (3) consecutive months. Thereafter, random selection of seven(7) multiple discipline medical records per month will be reviewed until 100% compliance has been maintained for two (2) consecutive months. Finally, a random sampling of 10% of multiple discipline medical records per month will be reviewed until 100% compliance hasbeen maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly QualityImprovement committee meeting. ResponsiblePerson: Director of Clinical Services</p>	

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	<p>indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational</p>			

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	<p>therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.</p> <p>a. A skilled nursing visit note dated 01/29/16, indicated that the RN obtained a verbal order from the physician office to repeat an INR on 2/2/16.</p> <p>b. A skilled nursing visit note dated 02/04/16, indicated that the LPN obtained a PT/INR from the patient. The clinical record failed to evidence written documentation of the coordination of services related to correct date of the lab specimen to be obtained.</p> <p>c. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical</p>			

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	<p>therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>d. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The agency failed to ensure efforts were coordinated effectively. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p> <p>6. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic."</p>			

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G 0156 Bldg. 00	<p>7. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.</p> <p>8. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes ... F. Coummunicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided "</p> <p>9. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences "</p>			
	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER			

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	Based on record review and interview, the agency failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed; failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed; skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed; occupational and physical therapy follow the therapy frequency in the plan of care for 2 of 9 records reviewed; failed to obtain PT/INR as ordered in the plan of care for 1 of 2 records reviewed of patients with PT/INR orders; and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds (See G 158); failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed (See G 159); failed to ensure primary care physicians are notified within a timely manner of missed visits in 2 of 12 records reviewed and failed to notify the physician of a patient's significant weight loss in 1 of 12 record reviewed (See G 164); failed to ensure that treatment provided to patients were ordered by a physician for 3 of 5 records reviewed	G 0156	This condition is explained in detail with each standard listed under it individually (G158, G159, G164, G165, G166)	03/23/2016

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G 0158	<p>(See G 165); and failed to ensure orders provided by outside facilities were clarified and had all pertinent and specific information including route, rate, and strength within the order for 1 of 1 patient record reviewed with Intravenous fluids; failed to include include if a PT/INR was to be obtained peripherally or by finger stick for 1 of 2 patient records reviewed getting PT/INRs; failed to include all locations of wounds in a physician's order for 1 of 5 records reviewed of patient's with wounds, and failed to write an order for speech therapy for 1 of 2 patient's receiving speech therapy in a sample of 12 patient records (See G 166).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p>			

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Bldg. 00	<p>ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on record review and interview, the agency failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed (# 3); failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed (# 3); skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed (# 8, 9, 10); occupational and physical therapy follow the therapy frequency in the plan of care for 2 of 9 records reviewed (# 9, 11); failed to obtain PT/INR as ordered in the plan of care for 1 of 2 records reviewed of patients with PT/INR orders (# 9); and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds. (#10)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p>	G 0158	<p>On March 3,8-10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for written plan/reviewed by physician. Components of the training included</p> <ol style="list-style-type: none"> 1.the necessity of having complete wound care orders along with the appropriate intervention and goals on the Plan of Care 2.the POC must list specific physician names inthe statement "may accept orders from..." 3.the necessity of following frequency andduration orders for each discipline (no extra visits without orders and no lessvisits without missed visit notification to the physician) 4.interventions must be performed as ordered onthe date ordered when specified or in the frequency ordered otherwise <p>A quality review will be conducted for each new admission to verify specific physician names are listed for order acceptance and that all wounds have appropriate interventions with goals. A qualityreview will be conducted on all wound care orders to verify completeness of the order prior to being approved and sent to the</p>	03/23/2016			

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	<p>a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.</p> <p>b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency.</p> <p>c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians:</p>		<p>physician for signature. A patient with ordered dates for specific interventions will be plotted on a calendar by the clinician who took the order or the nurse that approved the order and reviewed by the scheduler daily Monday through Friday to assign clinicians on that date. The same process will be followed for discipline ordered frequency. To assist with compliance, the Director of Clinical Services (DCS) or designee will randomly audit ten (10) current records each month to verify the Plan Of Care is accurate and orders have been followed for frequency and specificity. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two(2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record number 9, SOC</p>			

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	<p>01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks and occupational therapy two times a week for four weeks starting week starting 01/17/16.</p> <p>a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The occupational therapist failed to follow the plan of care.</p> <p>c. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled</p>			

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	<p>nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p> <p>5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of</p>			

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G 0159 Bldg. 00	<p>10/18/15 to 12/16/15, with orders for physical therapy one time a week for one week and occupational therapy one time a week for one week. Physical and Occupation therapy failed to follow the plan of care.</p> <p>6. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>7. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</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</p>			

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	<p>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 record review and interview, the agency failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. <ol style="list-style-type: none"> A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she 	G 0159	<p>On March 3, 8, 9, 10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians in the Medicare requirements for the Plan of Care (POC) coverage of all pertinent diagnoses. Components of the training included</p> <ol style="list-style-type: none"> POC must include documentation that the patient is receiving outside services (dialysis) POC must include an accurate diet for the patient <ol style="list-style-type: none"> POC must list specific physician names in the statement "may accept orders from..." <ol style="list-style-type: none"> DME listed on POC must be accurate (updated/revise) for current conditions listed Medication profile will be kept updated with changed/added/discontinued meds (ALF and HH records should agree) Allergy section of POC is accurate at SOC and updated if new information is obtained while patient is on service Best practice interventions for CHF are included in the POC High risk medications are identified and appropriate interventions are included in POC POC included measures to 	03/23/2016

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	<p>received dialysis on Monday, Wednesday, and Friday. The OASIS dated 02/13/16, states in a narrative, "Patient has renal failure and has dialysis on Monday Wednesday and Friday." The Plan of Care (POC) failed to indicate that the patient was receiving dialysis treatments.</p> <p>b. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient stated that she was on a 1500 calorie diet with fluid restrictions. The plan of care (POC) indicated that the patient was on a regular diet.</p> <p>c. A physician order dated 1/26, 2/2, and 2/16/16 from the wound clinic and a physician order from a coagulation clinic dated 2/5/16 were reviewed. The plan of care failed to be updated to include acceptance of physician orders from the outside clinics / facilities.</p>		<p>prevent pressure ulcers when Braden Scale result is 16 or less</p> <p>7.Skin lesions will be correctly identified with interventions/goals ordered on the POC</p> <p>8.Patients meeting criteria for depression will have interventions/goals ordered on the POC</p> <p>9.Wound Vac orders must be complete including type of foam dressing used, draping and suction settings</p> <p>10.Medications are listed correctly with accurate dosage on the POC</p> <p>11.POC is updated as changes in patient condition occur or additional information is obtained that affects patient care</p> <p>A quality review function will be run on each new admission looking at the components of the POC to verify all active diagnoses are included along with appropriate interventions and goals, that all sections have accurate information, that the OASIS answers match what is included on the POC, that medications are listed correctly including high risk identification and that specific physician names are listed for order acceptance. The case management function will review the file for changes in condition or new information obtained that affects patient care and will update the POC appropriately. To assist with compliance the Director of Clinical Services</p>	

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G 0164 Bldg. 00	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on record review and interview, the agency failed to ensure primary care physicians are notified within a timely manner of missed visits in 2 of 12 records reviewed (# 9 and 11) and failed to notify the physician of a patient's significant weight loss in 1 of 12 record reviewed. (# 9)</p> <p>Findings include:</p>	G 0164	<p>(DCS) or designee will randomly audit 10 current records each month to verify that the POC is accurate with all components and that orders have been followed for frequency and specificity. The audit will continue until 100% compliance has been achieved and maintained for 2 consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, 5 current records each month will be randomly audited until 100% compliance has been maintained for (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p> <p>On March 3, 8, 9, 10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for alerting the patient's physician of changes in condition. Components of the training included 1. Physicians will be notified of missed visits in a timely manner 2. Significant weight loss will be reported to the physician</p>	03/23/2016

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	<p>1. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.</p> <p>a. The plan of care indicated the frequency for occupational therapy was two times a week for four weeks starting week starting 01/17/16. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits.</p> <p>b. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss.</p> <p>2. Clinical record number 11, SOC (start of care) 10/18/15, with an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing two times a week for five weeks, physical therapy one time a week for one week, and occupational therapy one time a week for one week.</p>		<p>3. Nutritional consultation will be provided as appropriate with physician orders The scheduler or designee will audit patient calendars weekly for compliance with frequency ordered. Any missed visits will be noted by clinicians as to date and reason why with a coordination note so that physicians are notified via automated fax in a timely manner. The scheduler will review the fax log daily Monday-Friday to verify the fax reports were successfully sent and re-send failed reports.. The patients with clinical records number 9 and 11 will be discussed when the patient is scheduled for the weekly case conference. The Director of Clinical Services (DCS) or designee will randomly audit ten (10) current records each month to determine that the physician has been notified of any missed visits and changes in condition with appropriate follow-up. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be</p>	

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	<p>a. Review of the "Visits to Orders Comparison Report", the skilled nurse had attempted to schedule visits on 10/20 (patient hospitalized), 10/24 (patient / caregiver refused), 10/28 (patient / caregiver refused), 10/30 (scheduling error), and 11/03/15 (patient declined skilled nursing service). The only visit made was the admission assessment on 10/18/15.</p> <p>b. A "Client Coordination Note Report" dated 10/28/15, indicated care was projected to continue, but the patient had been refusing visits. The note indicated the case manager was to follow up with primary care physician.</p> <p>c. A "Client Coordination Note Report" dated 11/05,15, indicated that the primary care physician was notified of the patient's refusal and was being discharged from services. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>4. A policy titled "Nutritional</p>		<p>tracked,trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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G 0165 Bldg. 00	<p>Assessment" dated 12/2012, indicated " ... When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment ... 3. Documentation in the clinical record will reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult "</p> <p>5. A policy titled "Assessing Patient's Response / Reporting To Physician" dated 12/2012, indicated " ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient "</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 record review and interview, the agency failed to ensure that treatment provided to patients were ordered by a physician for 3 of 5 records reviewed (# 3, 9, and 10)</p> <p>Findings include:</p>	G 0165	<p>On March 8, 10,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on theMedicare requirements for the Administration of drugs and treatments ordered bythe patient's physician. Components of the training included</p> <p>1.Wound care is provided only with a physician order that is</p>	03/23/2016

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	<p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16. The plan of care did not include any wound treatments.</p> <p>a. An admission skilled nursing visit note dated 01/18/16, provided a wound assessment indicating the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The skilled nurse provided treatment to the left heel wound without a physician's order.</p> <p>b. A skilled nursing visit note dated 01/22/16, indicated had a "closed pressure ulcer wound on lt [left] heel." The wound assessment indicated the skilled nurse "removed old dressing, cleanse with plain water, cleanse with peri ulcer area moisturize heel and legs, use 4 x 4 gauze, foam feel [sic], kerlix and paper tape as secondary dressing. Sterile technique provided." The skilled nurse provided treatment to the left heel</p>		<p>complete and specific in description</p> <p>2.Lab draws are only done with a specific physician order</p> <p>3.PT/INR testing order must include how obtained (peripheral stick or finger stick)</p> <p>4.Wound care section of visit notes (IntegumentaryControl Center-ICC) only includes approved orders for wound care to be performed and documentation that the nurse followed the orders</p> <p>A quality review will be conducted before order approval to verify inclusion of method ofobtaining PT/INR (peripheral stick or finger stick) and inclusion of specific date order is to be carried out. Once order is approved and plotted on patient calendar, scheduler will assign visit on ordered day. A quality review will be conducted before wound care orders are approved to include complete and specific description of treatments to be carried out. Once orders are approved,visits will be plotted and scheduled on specific dates as indicated. Clinicians will document specific wound care orders carried out during the visit in the Integumentary Control Center-ICC area of the visit note. To assist with compliance, the Director of Clinical Services (DCS) or designee will auditfive (5) current records each month to verify wound care was provided and documented following</p>	

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	<p>wound without a physician's order.</p> <p>c. A skilled nursing visit note dated 01/29/16, indicated that the LPN obtained a PT/INR (lab test that checks the viscosity of blood for patients taking blood thinners). The clinical record failed to evidence an order for the lab draw.</p> <p>d. A skilled nursing visit note dated 02/02/16, indicated that the LPN obtained a PT/INR from the patient. The clinical record failed to evidence an order for the lab draw.</p> <p>e. A physician order dated 02/05/16, indicated to repeat the INR (lab test to test the viscosity of blood with patients on blood thinners) in 2 weeks. The order failed to indicate if the sample of blood was to be obtained by peripheral stick or by finger stick.</p> <p>2. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.</p> <p>a. Review of a skilled nursing visit note dated 01/22/16, the narrative note indicated a PT/INR had been obtained. The clinical record failed to evidence a physician order for the blood draw.</p>		<p>approved complete physician orders. Additionally, three (3) current records with orders for lab draws including PT/INR will be audited each month by the DCS for compliance. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter six (6) current records each month will be audited as indicated previously until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be audited as indicated previously until 100% compliance has been maintained for 3 additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>b. Review of a skilled nursing visit note dated 01/25/16, the narrative note indicated a PT/INR had been obtained. The clinical record failed to evidence a physician order for the blood draw.</p> <p>c. Review of the skilled nursing visit note dated 01/29/16, the narrative note indicated a PT/INR had been obtained. The clinical record failed to evidence a physician order for the blood draw.</p> <p>d. Review of the skilled nursing visit note dated 02/02/16, the narrative note indicated a PT/INR had been obtained. The clinical record failed to evidence a physician order for the blood draw.</p> <p>e. Review of the skilled nursing visit note dated 02/18/16, the narrative note indicated a PT/INR had been obtained. The clinical record failed to evidence a physician order for the blood draw.</p> <p>3. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing.</p> <p>a. Review of skilled nursing visit notes dated 02/09, 02/12, 02/16, and 02/19/16, the wound care section</p>			

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	<p>indicated, "wound care provided" skilled nursing five times a week for one week, two times a week for four weeks, then one time a week for two weeks, "This order has not yet been approved. Skilled nurse to provide instruction / reinforcement related to complications of integumentary status including pressure ulcer prevention ... Skilled nurse to perform / teach decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. Change 2 x week [two times a week] using clean / aseptic technique ... Skilled nurse to perform / teach wound care to LLE [left lower extremity] wounds cleanse with normal saline, pat dry, apply calcium alginate, cover with foam dressing and secure with rolled gauze. Using clean / aseptic technique change 2x wk [two times a week] " The skilled nurse failed to obtain orders prior to providing treatment.</p> <p>4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>5. A policy titled "Assessing Patient's Response / Reporting To Physician" dated 12/2012, indicated " ... Clinicians</p>			

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G 0166 Bldg. 00	<p>will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient "</p> <p>6. A policy titled "Verification of Physician Orders" dated 12/2012, indicated "All telephone orders will be received and processed in accordance with state and federal laws and regulations "</p> <p>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. Based on record review and interview, the agency failed to ensure orders provided by outside facilities were clarified and had all pertinent and specific information including route, rate, and strength within the order for 1 of 1 patient record reviewed with Intravenous fluids (#12); failed to include include if a PT/INR was to be obtained peripherally or by finger stick for 1 of 2 patient records reviewed getting PT/INRs (#9); failed to include all locations of wounds in a physician's order for 1 of 5 records</p>	G 0166	<p>On March 8, 9,10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians addressing the Medicare requirements for verbal orders to be put in writing, signed, and dated. Components of the training include</p> <ol style="list-style-type: none"> 1.Wound orders are complete including site of wound 2.Verbal orders are written down, not just mentioned in visit or coordination notes 3.PT/INR testing order must include how obtained (peripheral stick or finger stick) 	03/23/2016

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	<p>reviewed (# 9) of patient's with wounds, and failed to write an order for speech therapy for 1 of 2 patient's receiving speech therapy (# 9) in a sample of 12 patient records.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 9, SOC (start of care) 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. <ol style="list-style-type: none"> a. A physician's order dated 01/20/16, indicated for the skilled nurse to "remove old dressing, cleanse wound with normal saline, pat dry, cover with foam dressings." The physicians order failed to include location of the wound. b. A skilled nursing visit note dated 01/29/16, indicated in the narrative note "Repeat INR next Tuesday 2/2/16." The verbal order failed to be put into writing, signed, and dated by the skilled nurse. c. A physician order dated 02/09/16, indicated for a skilled nurse to obtain a PT/INR on 02/23/16. The order failed to include if the PT/INR was to be obtained by peripheral stick or by finger stick. d. Review of the therapy visit notes, the clinical record evidence speech 		<p>4.Orders are obtained for all disciplines providing services to a patient</p> <p>5.IV orders for fluid administration must be complete to include fluid name and strength, rate of infusion, and if a peripheral site needed to be established or if a current port/central line is to be used A qualityreview function will be completed each time a new wound order is received and includes verification of the location of each wound with the specific step-by-step instructions of the wound care and the appropriate frequency,which then will be plotted to the patient calendar. Clinicians will document specific wound care orders carried out during the visit in the Integumentary Control Center (ICC) area of the visit note. All verbal orders will be written down under "Order" section (in combination with the appropriate Coordination notation). The PT/INR testing order will include the way blood sample will be obtained (finger stick or peripheral) and include specific date order is to be carried out. Once order is approved and plotted on patient calendar, scheduler will assign visit on ordered day. All disciplines will provide services only asordered by the patient's physician. The visits to orders report will be run prior to or at the time of the case conference for each patient. IV</p>	

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	<p>therapy visits dated 01/25, 01/27, 02/03, and 02/08/16. The clinical record failed to evidence an order for speech therapy.</p> <p>2. Clinical record number 12, SOC 11/10/15, included an established plan of care for the certification periods of 11/10/15 to 01/08/16.</p> <p>a. A physician order dated 11/19/15, indicated "HH [home health] nurse to administer 500 ml [milliliters] NS [normal saline] now, then repeat tomorrow." The order was taken by the residential living nurse. The agency failed to have the order clarified to include the strength of the normal saline, rate of infusion, and if the patient needed a peripheral IV started for infusion or if the patient already had an implanted port / central line for route.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>4. A policy titled "Intravenous Administration of Medications / Solutions" dated 12/2012, indicated " ... All orders for IV medications and solutions will specify medication name and dosage, diluent type and amount,</p>		<p>orders for fluid administration will include fluid name and strength, rate of infusion, and if a peripheral site needed to be established or if a current port/central line is to be used. To assist with compliance, the Director of Clinical Services (DCS) or designee will randomly audit ten (10) current records each month to determine all disciplines have orders for service, wound orders are complete, PT/INR orders include the method to obtain a sample and that IV orders contain all the required components. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for 2 consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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G 0168 Bldg. 00	<p>route, frequency of administration, and rate of infusion ... IV medications and solutions will only be administered through a peripheral or central venous line "</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on record review and interview, the Registered Nurse failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed; failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed; skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed; failed to obtain PT/INR as ordered in the plan of care for 1 of 2 records reviewed of patients with PT/INR orders; and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds (See G 170); failed to assess patient wounds within a timely manner and per agency policy for 4 of 5 records reviewed of patients with wounds in a sample of 12 (See G 172); failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being</p>	G 0168	This condition is explained in detail with each standard listed under it individually (G170, G172, G173, G174, G175, G176, G179, G181)	03/23/2016

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	provided for 7 of 12 records reviewed (See G 173); failed to ensure that wound documentation was consistent and accurate in relation to wound locations, assessment, and treatments for 1 of 5 records reviewed of patients with wounds (See G 174); failed to address / consult with a dietician in regards to a patient's significant weight loss for 1 of 1 record reviewed of a patient with weight loss in a sample of 12 (See G 175); failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services for 2 of 2 records reviewed of patients receiving outside services in a sample of 12 (See G 176); failed to ensure the LPN [Licensed Practical Nurse] followed the agency administrative policy / job description in regards to communicating with the RN [registered nurse] and / or Director of Professional Services and the physician in relation to a patient developing integumentary changes to his / her lower extremity for 1 of 5 records reviewed with a patient receiving services from a LPN (See G 179); and the LPN (Licensed Practical Nurse) failed to include a description of wounds being observed and failed to document treatments that were being provided in accordance to physician orders in 3 of 5 records reviewed of patients with wounds (See G			

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G 0170 Bldg. 00	181). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.30 Skilled Nursing Services. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment. 484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview, the Registered Nurse failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed (# 3); failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed (# 3); skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed (# 8, 9, 10); failed to obtain PT/INR as ordered in the plan of care for 1 of 2 records	G 0170	On March 8,10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements Standard: In accordance with a POC. Components of the training included 1.POC includes initial and ongoing treatment with interventions and goals 2.POC must list specific physician names in the statement "may accept orders from..." 3.Nursing visits are made per physician ordered frequency or	03/23/2016

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	<p>reviewed of patients with PT/INR orders (# 9); and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds. (#10)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.</p> <p>b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of</p>		<p>exact dates as ordered</p> <p>4.Wound care is provided exactly as ordered</p> <p>5.Best practice interventions for CHF are included in the POC</p> <p>6.High risk medications are identified and appropriate interventions are included in POC</p> <p>7.POC included measures to prevent pressure ulcers when Braden Scale result is 16 or less</p> <p>A quality review function will be conducted on each new admission for components of the 485 Plan of Care (POC) to ensure all active diagnoses are included along with appropriate interventions and goals, all sections have accurate information,the OASIS answers match what is included on the POC, medications are listed correctly including high risk identification, and specific physician names are listed for order acceptance. The case management function will review the file for changes in condition or new information obtained which affects patient care and will update the POC appropriately. To assist with compliance, the Director of Clinical Services (DCS) or designee will randomly audit ten (10) current records each month to verify the POC is accurate with all components and orders have been followed for frequency and specificity. The audit will continue until 100% compliance has been achieved and maintained for two (2)</p>	

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	<p>care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency.</p> <p>c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care.</p>		<p>consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting.</p> <p>Responsible Person: Director of Clinical Services</p>	

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	<p>b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks.</p> <p>a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care.</p>			

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	<p>b. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p>			

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G 0172 Bldg. 00	<p>5. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>6. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on record review and interview, the Registered Nurse failed to assess patient wounds within a timely manner and per agency policy for 4 of 5 records reviewed of patients with wounds in a sample of 12. (# 3, 8, 9 and 10)</p> <p>Findings include:</p>	G 0172	<p>On March 8, 10,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians ionthe Medicare requirements for Registered Nurses to regularly re-evaluate the patient's nursing needs. Components ofthe training included</p> <p>1.RN needs to assess wound healing weekly per agency policy</p>	03/23/2016

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	<p>1. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16.</p> <p>a. A physician order from the wound clinic dated 02/02/16, indicated for skilled nursing to provide wound treatment to the bilateral lower extremities daily for 2 weeks.</p> <p>b. Review of the skilled nursing visit notes, the clinical record evidenced a LPN (Licensed Practical Nurse) made daily visits to the patient between 02/04/16 to 02/15/16. The last assessment by registered nurse was made on 1/27/16. The registered nurse failed to reassess the patient's wounds between 01/27/16 to 02/15/16.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing wound to the left lower</p>		<p>2. Request for assessment by wound certified RN must be met within reasonable time frame</p> <p>3. RN visit notes must indicate if wounds were measured that visit</p> <p>1. Wound orders are complete including site of wound</p> <p>A quality review of wound patients will include: development of wound tracking tool for weekly review for all current wound patients. Review will include adherence to agency policy for weekly wound measurements by a RN. Requests for an assessment by wound certified RN will be entered by agency scheduler notification. The scheduler will plot visit, following frequency order, to appropriate RN for the next visit. Wound measurements will be entered into wound care section of visit notes (Integumentary Control Center-ICC). Wound care orders will be reviewed for approval and include site of wound. To assist with compliance, the Director of Clinical Services (DCS) or designee will randomly audit eight (8) current wound care records each month to verify wound orders are complete and documentation includes weekly measurements as well as RN assessment. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter six (6) current records each month will be randomly audited</p>	

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	<p>leg. A skilled nursing visit note dated 12/14/15, indicated the patient requested Employee L, a Registered Nurse / Wound Nurse, assess her wound. Employee L did not see the patient until 12/21/15. Between 12/10/15 to 12/21/15, the patient developed three areas, two partial thickness wounds to the mid - pretibial lower leg and one to the left lateral ankle. The registered nurse failed to follow up and assess the patient's left lower leg wounds within a timely manner.</p> <p>b. A skilled nursing visit note dated 12/28/16, indicated the patient's had two left partial thickness wound to the mid - pretibial lower leg and a trauma wound to the left lateral ankle. The wounds were measured during this time.</p> <p>c. A skilled nursing visit note dated 01/04/16, indicated the registered nurse provided treatment to the three wounds, but failed to evidence that the wounds had not been measured.</p> <p>d. A skilled nursing visit note dated 01/07/16, indicated skilled nursing was going to continue with visits and was not discharging at the present time due to a wound that was not completely healed. The visit note failed to evidence that the wounds had not been measured.</p>		<p>until 100% compliance has been maintained for two (2) consecutive months. Finally, four (4) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>e. Review of the skilled nursing visit notes, the clinical record failed to evidence a visit by the registered nurse for reassessment of the wounds between 01/10/16 to 01/16/16.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16, with orders for skilled nursing.</p> <p>a. A physician order dated 01/20/16, indicated the skilled nurse was to perform wound treatments to an unknown area.</p> <p>b. Review of skilled nursing visit notes dated 02/08/16 and 02/11/16, indicated the registered nurse performed treatment to the right anterior mid pretibial area. The visits notes failed to evidence measurements of the wound for both nursing visit. The clinical record failed to evidenced wound measurements between 02/07/16 to 02/15/16.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period of 02/09/16 to 04/04/16, with orders for skilled nursing to perform / teach decubitus care to the left upper buttock.</p>			

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G 0173 Bldg. 00	<p>a. Review of the skilled nursing visits, the clinical record evidenced a LPN made visits twice a week between 02/09/16 and 2/19/16. The registered nurse failed to reassess the patient's wound between 02/09/16 to 02/19/16.</p> <p>5. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on record review and interview, the Registered Nurse failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of</p>	G 0173	<p>On March 8,10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for RN Initiation of the patient's POC and the necessary revisions. Components of the training included</p> <ol style="list-style-type: none"> 1.The POC includes information that patient is receiving outside services (dialysis) 2.The POC includes accurate dietary information 3.The POC is updated to include acceptance of orders from another specific physician or entity 4.The POC is updated to reflect DME for current medical needs 	03/23/2016

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	<p>02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks.</p> <p>a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. The OASIS dated 02/13/16, states in a narrative, "Patient has renal failure and has dialysis on Monday Wednesday and Friday." The Plan of Care (POC) failed to indicate that the patient was receiving dialysis treatments.</p> <p>b. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient stated that she was on a 1500 calorie diet with fluid restrictions. The plan of care (POC) indicated that the patient was on a regular diet.</p> <p>c. A physician order dated 1/26, 2/2, and 2/16/16 from the wound clinic and a physician order from a coagulation clinic dated 2/5/16 were reviewed. The plan of care failed to be updated to include</p>		<p>5.The POC is updated with current medications(changes/additions/di scontinuations) including dosage and frequency</p> <p>6.The POC includes accurate allergy information</p> <p>7.Skin lesions will be correctly identified with interventions/goals ordered on the POC</p> <p>8.Patients meeting criteria for depression willhave interventions/goals ordered on the POC</p> <p>9.Wound Vac orders must be complete including type of foam dressing used, draping and suction settings</p> <p>A quality review function will be run on each new admission looking at the components of the 485 Plan of Care (POC) to verify all outside services such as dialysis, adult day care or/and wound clinic are listed. The POC will include acceptance of the orders from other physicians (listed by name) or entities (listed byname). The POC will include all current medications, including prescription,remedies, and Over-The-Counter drugs. The medication list will be reviewed and revised every visit if changes occur. The allergy information will be gathered during initial comprehensive assessment, medical records and patient/family interview; any additional allergy-related information obtained during services will be updated to the</p>	

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	<p>acceptance of physician orders from the outside clinics / facilities.</p> <p>2. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16.</p> <p>a. Section 14 of the DME (durable medical equipment) and supplies portion of the plan of care, indicated the patient was being supplied foam dressings. The clinical record failed to evidence a wound or skin condition warranting the need for foam dressings. The agency failed to update and revise the plan of care.</p> <p>b. After a home visit with the patient on 02/18/16, the patient's clinical record with the Assisted Living Facility was reviewed. An order dated 08/07/16, indicated the patient's Atorvastatin had been discontinued. Section 10 of the medication section continued to indicate the patient was taking Atorvastatin 10 milligrams daily. The plan of care failed to be revised and updated to reflect the patient's current medication list.</p> <p>3. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to</p>		<p>POC on a timely manner. The POC will include accurate dietary information. The durable medical equipment will be updated on a timely manner to reflect current medical needs. All patients screened positively for depression will have interventions/goals addressed on the POC. The POC for a patient receiving NPWT will include type and amount of the foam dressing used, draping and suction settings. To assist with compliance the Director of Clinical Services (DCS) or designee will randomly audit ten (10) current records each month to determine that all disciplines have orders for service, wound orders are complete, PT/INR orders include the method to obtain a sample and that IV orders contain all therequired components. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting.</p>	

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	<p>03/17/16.</p> <p>1. Section 10 of the medication portion of the plan of care indicated the patient was taking Creon [medication for pancreatitis] 24,000 - 76,000 - 120,000 units, 2 tabs 3 times a day, Saccharomyces Boulardii oral, 250 mg [milligrams] 1 tab daily, acetaminophen 325 mg every 6 hours as needed for pain. Section 17 of the allergy portion indicated the patient was allergic to neomycin sulfate and niaspan.</p> <p>2. A hospital discharge summary dated 12/29/15, indicated the patient discharged home with Creon 24,000 3 tabs 3 times a day, no saccharomyces was listed on the discharged list of medications, and acetaminophen 2 - 500 mg tabs every 6 hours three times a day. The summary also indicated the patient was allergic to not only neomycin sulfate and niaspan, but also to neomycin otic and neosporin.</p> <p>3. During a home visit with the patient on 02/18/16 at 10:30 a.m., the patient stated he / she was not familiar nor did he / she know what saccharomyces medication was. The plan of care failed to be updated and revised to include all allergies and correct medications with accurate dosages and</p>		Responsible Person: Director of Clinical Services	

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	<p>frequency.</p> <p>4. Clinical record number 5, SOC 02/01/16, included an established plan of care by a physician for the certification period of 02/01/16 to 03/31/16.</p> <p>a. Review of the discharge paperwork from a skilled nursing facility dated 01/14/16, indicated the patient was allergic to Albuterol, Lexapro, and Duricef.</p> <p>b. Section 17 of the Allergy section of the plan of care indicated the patient was only allergic to Duricef. The plan of care failed to include allergies to Albuterol and Lexapro.</p> <p>5. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 02/08/16, the Registered Nurse indicated the main focus of the patient's care, was to assess / evaluate cardiovascular and respiratory status, monitor daily weights, edema, and shortness of breath due to the patient has</p>			

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	<p>a history of congestive heart failure and atrial fibrillation.</p> <p>a. The cardiovascular assessment indicated the patient's had a trace of edema to the bilateral lower extremities. In reviewing the plan of care, the Registered failed to include interventions such as obtaining / assessing the patient's weight at each visit, when to notify the physician for increase in weight due to fluid retention, and educate the patient on sodium restrictions / diet and measurable goals.</p> <p>b. The Registered Nurse also had indicated the patient was not taking an anticoagulant. In reviewing of the plan of care and medication profile, the patient was taking Xarelto (anticoagulant medication) 15 mg (milligrams) daily. The plan of care failed to include interventions such as education, assessment, and safety measures and measurable goals.</p> <p>c. M1302 asked if the patient was at risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates</p>			

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	<p>patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16, which indicated the patient is at a low risk of developing pressure ulcers. The plan of care failed to include interventions to prevent skin breakdown and measurable goals.</p> <p>d. M1350 asked if the patient had a skin lesion or open wound that was receiving interventions by the agency. The OASIS assessment was reviewed by quality assurance nurse within the office and the question was changed from "no" to "yes". The admitting nurse agreed to the change of answers. The plan of care failed to include the cite of the skin lesion being treated, failed to include the interventions for the skin lesion and measurable goals.</p> <p>6. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/27/16, line M1730 asked if the patient had been screened for depression, using a standardized validated depression screening tool. The answer provided</p>			

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	<p>indicated "yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression." The plan of care failed to be revised and updated to include interventions and goals for depression.</p> <p>7. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing 2 times a week for 5 weeks to " ... perform / teach wound care to the patient and caregiver, wound vac to RLE diabetic " The plan of care failed to include the type of foam dressing to be used, draping, and the suction settings for the wound vac to be used upon admission.</p> <p>a. Review of the patient's most recent Podiatry visit note dated 10/13/15, included, but not limited to the following medications: Combigan 0.2 - 0.5 % 45 grams APP AA solution twice a day; Glucosamine - Chondroitin 500 400 mg two tablets twice a day; Nitro Bid 2% apply 1" twice a day, Imdur ER 60 mg daily, and a Multivitamin daily. Section 10 of the plan of care failed to evidence the prescribed medications listed.</p> <p>b. The podiatry visit note dated</p>			

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	<p>10/13/15, also indicated the patient was taking Lopressor 50 mg, 1/2 tab twice a day, Vitamin D3 daily, and Vitamin E 200 U, 2 capsules daily. Section 10 of the plan of care indicated the patient was taking 50 mg of Lopressor twice a day, Vitamin D2 & K - Berberine - Hops orally 500 units - 500 mcg (micrograms) - 90 mg - 370 mg daily, and Vitamin E - Vitamin C - Magnesium - Zinc oral 100 Units - 100 mg - 10 mg - 18 mg. The medications on the plan of care failed to provide accurate medications and their dosage.</p> <p>8. The agency policy and procedure for contents of clinical record (Policy No. HH:2-055.1; revised December, 2012) states as follows: "A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel." The procedure related to said policy indicates that "[r]elevant diet or dietary restrictions, in any" be included in the clinical record for skilled patients.</p> <p>9. The Administrator and Director of Clinical Services was unable to provide</p>			

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G 0174	<p>any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>10. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>11. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p>			

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Bldg. 00	<p>The registered nurse furnishes those services requiring substantial and specialized nursing skill.</p> <p>Based on record review and interview, the Registered Nurse failed to ensure that wound documentation was consistent and accurate in relation to wound locations, assessment, and treatments for 1 of 5 records reviewed of patients with wounds. (#3)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16, with orders for skilled nursing 2 times a week for 6 weeks.</p> <p>a. A physician order from the wound clinic dated 01/26/16, indicated an ulcer to the right anterior leg measuring 3.5 cm x 1 cm x 0.1 cm. The treatment included to cleanse the per i- ulcer area with sterile water and moisturize the dry skin 3 times a week for 1 week. The order also indicated an ulcer to the left heel measuring 1.8 cm x 1.3 cm x 0.1 cm. The treatment included to cleanse the peri - ulcer area with plain water and moisturize the heels and legs. Apply a nickel thick layer of Santyl [debrding agent] to the wound, followed by 4 x 4</p>	G 0174	<p>On March 8,10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for services requiring specialized nursing skill. Components of the training included</p> <ol style="list-style-type: none"> 1.Documentation of wound care will follow orders exactly and include all wound sites 2.Wound care will be performed using accepted infection control methods as addressed in agency policy #C:040.1-C:2-0405 3.Re-useable equipment will be cleaned before returning to the nursing bag as addressed in agency policy #C:2-0551-C:055.2 4.Patient education provided will be accurate 5.Correct techniques for obtaining PT/INR bloodsample from finger stick will be utilized when orders are present for the test to be done <p>A quality review function will be run on each new admission to verify the wound care order is complete for each wound and treatment is carried out using accepted infection control methods as addressed by the Agency policy # C: 2-040.1-C:2-040.5, all reusable equipment is cleaned before returning to the nursing bagas addressed in Agency policy # C</p>	03/23/2016

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	<p>gauze, foam heel, hydrogel, kerlix, and paper tape daily for 1 week. A third wound / ulcer to the right 2nd toe measuring 1.7 cm x 0.8 cm x 0.1 cm. The treatment included to cleanse the wound with plain water. Use vicks vapor rub as the primary dressing, place a pad between left 3rd and 4th toes, daily for 1 week.</p> <p>1. A skilled nursing visit note dated 01/27/16, indicated the skilled nurse provided wound to the bilateral lower extremities. The clinical record failed to evidence the exact location, assessment, and treatment provided to the bilateral lower extremity wounds.</p> <p>b. A physician order from the wound clinic dated 02/16/16, did not indicate treatment to the right anterior leg nor to the right 2nd digit toe. The order included a measurement to the left heel of 1.1 cm x 0.8 cm x 0.1 cm. The treatment included cleanse the peri ulcer area with sterile water and moisturize the heel and legs, apply PRISMA (tear to fit wound size), followed by 4 x 4 gauze, foam heel, kerlix and tape, every other day for two weeks.</p> <p>1. A home visit was made to patient number 3, with Employee C, a registered nurse, on 02/18/16 at 10:30</p>		<p>2-055.1-C 2-055.2, the education provided to patients is accurate and reflects best practices, and PT/INR is performed asordered by physician via specified method obtaining the blood sample and on the day specified by the physician order. To assist with compliance, the Director of Clinical Services (DCS) or designee will auditten (10) current wound patient and PT/INR test records each month to verify wound orders are complete and carried out for each wound. Compliance with the infection control, use of re-usable equipment, and proper PT/INR technique will be determined during on-site supervision by the Director of Clinical Services (DCS) or designee. The audit and on-site supervision will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>AM. Employee B, was observed providing wound care to the patient's left heel. The patient's primary diagnosis was necrotizing fasciitis [flesh eating disorder]. Employee B was observed to clean hands and applied gloves, remove the patient's sock and stocking, cut the patient's kerlix wrap and removed a soiled dressing. Without changing gloves, the employee B continued to clean the patient's wound, applied solosite wound gel to the patient's heel and leg. Continuing to not change his / her gloves, Employee B removed and cut a piece of medicated dressing with the same scissors that was used to to remove the kerlix without cleaning to prior use. Employee B proceeded to apply the medicated dressing, 4 x 4, foam dressing, then wrapped the foot with kerlix. At this time, Employee B removed his / her gloves and cleaned hands with hand gel. Employee B cleaned the patient area of soiled dressings with his / her bare hands and carried it to the patient's kitchen and placed the soiled items in the trash can. Employee B cleaned her hands and applied gloves, obtained a blood sample from the patient's finger, removed the strip that contained the patient's blood, put the hand held machine in his / her traveling bag without cleaning. The Registered Nurse indicated it was house stock moisturizer. After looking at the</p>			

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	<p>tube again, the Registered Nurse indicated he / she thought that wound gel was skin moisturizer and that he / she should have contacted the wound clinic for verification of orders. The Registered Nurse placed the solosite wound gel back in her travel bag. The Registered Nurse failed to follow infection control protocol and failed to follow the physician order for wound treatment.</p> <p>2. Also during the home visit, the Registered Nurse was observed trying to obtain a blood sample via finger stick to apply to the INR Ratio machine (machine that looks like a blood sugar machine but used to test blood viscosity for patient on blood thinners). The Registered Nurse was observed 3 times trying to obtain the blood sample. During the attempts, the patient had indicated that he had spinach for the past 3 days. The Registered Nurse indicated the spinach should had helped thin the blood to obtain the specimen. The Registered Nurse expressed different times the difficulty he / she had with obtaining blood and utilizing the machine. The Registered Nurse failed to provide accurate education to the patient in regards to blood thinners and green leafy vegetables (green leafy vegetables causes the blood to thicken) and failed to demonstrate other techniques to obtain blood from the patient (ie. dangle hands,</p>			

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G 0175	<p>warm the fingers, notify physician and obtain a peripheral stick).</p> <p>2. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visit on 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p>			

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Bldg. 00	<p>The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>Based on record review and interview, the Registered Nurse failed to address / consult with a dietician in regards to a patient's significant weight loss for 1 of 1 record reviewed of a patient with weight loss in a sample of 12. (# 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. Patient diagnoses include but not limited to, heart failure, atrial fibrillation, diabetes mellitus II, and chronic kidney disease stage five. <ol style="list-style-type: none"> A skilled nursing visit note dated 01/22/16, indicated the patient had a weight of 197 pounds.. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss. The Administrator was unable to provide any additional documentation 	G 0175	<p>On March 8,10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for preventive and rehabilitative nursing procedures. Components of the training included</p> <ol style="list-style-type: none"> Physician notification of significant weight loss Obtaining physician orders for nutritional consult for weight loss <p>A quality review of the patient's nutritional assessment as stated in Policy, HH:2-025-1, will be conducted on initial assessment and on-going to identify any significant weight loss will be reported to physician and an order for a Registered Dietitian will be obtained. Clinical record will reflect recommended interventions and goals. Updates to patient's response and condition will be reviewed and discussed in Case Conference by all disciplines. The physician will be contacted with significant nutritional changes and for orders. To assist with compliance, the Director of Clinical Services (DCS) or designee will audit 100% of current records each month, which include significant weight loss to verify the nutritional assessment was completed with orders for Registered Dietitian obtained as appropriate, and</p>	03/23/2016

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G 0176 Bldg. 00	<p>and/or information when asked on 2/19/16 at 2:50 PM.</p> <p>3. A policy titled "Nutritional Assessment" dated 12/2012, indicated " ... When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment ... 3. Documentation in the clinical record will reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult "</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. Based on interview and record review, the Registered Nurse failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services for 2 of 2 records reviewed of patients receiving outside services in a sample of 12. (# 2 and 11)</p> <p>Findings include:</p>	G 0176	<p>documentation of recommendations with additional orders and interventions and goals added if needed . This audit will continue until 100% has been achieved and maintained for seven (7) months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p> <p>On March 8,10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for Preparing clinical and progress notes, coordinating services, and informing physician of changes. Components of the training included 1. Care coordination will be evident in the medical record between the agency and outside</p>	03/23/2016

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	<p>1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had a plan of care established by a physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks.</p> <p>a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p> <p>2. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p>		<p>services provided (dialysis center) The intake process will include notification to the Director of Clinical Services (DCS) or designee that the referred patient has outside services being provided, if known. If the initial OASIS assessment finds outside services provided that were not known previously, the DCS or designee will be notified. To assist with compliance, the DCS or designee will audit 100% of medical records with known outside services provided on a monthly basis to find evidence of care coordination. If it is missing, clinicians will be required to perform coordination and document the interaction. This audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter, 50% of medical records with outside service providers will be reviewed per month until 100% compliance has been maintained for three (3) consecutive months. Finally, a random sampling of 10% of medical records with outside services will be reviewed per month until 100% compliance has been maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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G 0179 Bldg. 00	<p>3. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic."</p> <p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy. Based on record review and interview, the agency failed to ensure the LPN [Licensed Practical Nurse] followed the agency administrative policy / job description in regards to communicating with the RN [registered nurse] and / or Director of Professional Services and the physician in relation to a patient developing integumentary changes to his / her lower extremity for 1 of 5 records reviewed with a patient receiving services from a LPN. (# 8)</p> <p>Finding include:</p> <p>1. A job description for an LPN dated 12/2012, indicated " ... Essential functions ... 3. Performs an ongoing assessment during each visit and documents data inpatient medical records. Communicates significant findings, problems, or changes in the patient's condition to the supervising RN</p>	G 0179	<p>On March 10,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for LPN furnishing services in accordance with policies. Components of the training included</p> <p>1. Review of the LPN job description that includes reporting significant findings, problems or change in condition to the RN/Director of Clinical Services and physician with documentation of such in the medical record</p> <p>2. Review of the LPN portion of the policy Scope of service (#HH:1-1001.1) Agency LPNs were instructed to contact the RN working with the patient after each visit for an update. Confirmation of the communication will be found in the care coordination or narrative sections of the visit note or in a separate communication note. To assist with compliance, the Director of Clinical Services (DCS) or designee will randomly</p>	03/23/2016

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	<p>and / or Director of Professional Services and the physician and documents all findings, communications and appropriate interventions. Documents nursing interventions including patient response "</p> <p>2. Clinical record number 8, SOC (start of care) 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16.</p> <p>a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing area on LLE [left lower extremity] anterior lower half was noted. SN [skilled nurse] offered to interfere and help in taking care of that wound but the pt [patient] refused completely and stated that his / her dermatologist said that this is contact dermatitis and it will heal by self." The clinical record failed to evidence that the LPN notified the RN / Director of Professional Services.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>4. A policy titled "Scope of Service" dated 12/2012, indicated " ... 2. Licensed practical / vacation nurses supplement the</p>		<p>audit ten (10) current records each month to determine LPNS have coordinated care with RNs. The audit will continue until 100% compliance hasbeen achieved and maintained for two (2) consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5)current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked,trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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G 0181 Bldg. 00	<p>nursing care needs of the patient as provided by the registered nurse. These include ... Providing services in accordance with organization policies ... Preparing clinical and progress notes ... Assisting the registered nurse or physician in performing specialized procedures and duties ... Assisting the registered nurse in carrying out the plan of care "</p> <p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the physician and registered nurse in performing specialized procedures. Based on record review and interview, the LPN (Licensed Practical Nurse) failed to include a description of wounds being observed and failed to document treatments that were being provided in accordance to physician orders in 3 of 5 records reviewed of patients with wounds. (# 3, 8, and 10)</p> <p>Finding include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16, with orders for skilled nursing 2 times a week for 6 weeks.</p>	G 0181	<p>On March 10,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for LPN assistance of physician/RN with specialized procedures. Components of the training included</p> <p>1.Wound care is provided exactly as ordered anddocumented as such including wound location, assessment and treatment provided</p> <p>2.Narrative note of visit matches the ICC information documented (same number of wounds, assessment of each, and care provided) To prevent are-occurrence, wound documentation will be reviewed at case conferences for</p>	03/23/2016

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	<p>a. A physician order from the wound clinic dated 01/26/16, indicated three ulcer areas to be treated. 1. An ulcer to the right anterior leg measuring 3.5 cm x 1 cm x 0.1 cm. The treatment included to cleanse the per i- ulcer area with sterile water and moisturize the dry skin 3 times a week for 1 week. 2. An ulcer to the left heel measuring 1.8 cm x 1.3 cm x 0.1 cm. The treatment included to cleanse the peri - ulcer area with plain water and moisturize the heels and legs, apply a nickel thick layer of Santyl [debrding agent] to the wound, followed by 4 x 4 gauze, foam heel, hydrogel, kerlix, and paper tape daily for 1 week. 3. An ulcer to the right 2nd toe measuring 1.7 cm x 0.8 cm x 0.1 cm. The treatment included to cleanse the wound with plain water. Use vicks vapor rub as the primary dressing, place a pad between left 3rd and 4th toes, daily for 1 week.</p> <p>1. A skilled nursing visit note dated 01/28/16, indicated the LPN provided wound care to the bilateral lower extremity wounds under aseptic technique per orders. The skilled nursing assessment failed to evidence the specific location (left heels, right anterior leg, and right 2nd digit toe), assessment, and treatment provided to the bilateral extremity wounds.</p>		<p>completeness in the ICC section and agreement in the narrative. To assist with compliance, the Director of Clinical Services (DCS) or designee will randomly audit ten (10) current records each month to determine the LPNS have documented wound care correctly. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter, seven (7) current records with LPN wound care will be randomly audited each month until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records with LPN wound care will be randomly audited each month until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>2. A skilled nursing visit note dated 01/30/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>3.. A skilled nursing visit note dated 01/31/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>4. A skilled nursing visit note dated 02/01/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>b. A physician order from the wound clinic dated 02/02/16, indicated the right anterior leg ulcer measured 3 cm x 1 cm x 0.1 cm. The treatment included to cleanse the per i- ulcer area with sterile water and moisturize the dry skin 3 times</p>			

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	<p>a week for 1 week. The order also indicated an ulcer to the left heel measuring 1.5 cm x 0.8 cm x 0.1 cm. The treatment included to cleanse the peri - ulcer area with sterile water and moisturize the heels and legs, apply PRISMA [medicated dressing], followed by 4 x 4 gauze, foam heel, kerlix and tape daily for two weeks. The right 2nd digit toe ulcer measured 0.8 cm x 0.6 cm x 0.1 cm. The treatment included to cleanse the wound with plain water. Use vicks vapor rub as the primary dressing, place a pad between left 3rd and 4th toes, daily for 2 weeks.</p> <p>1. A skilled nursing visit note dated 02/04/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>2. A skilled nursing visit note dated 02/05/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p>			

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	<p>3. A skilled nursing visit note dated 02/06/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>4. A skilled nursing visit note dated 02/07/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>5. A skilled nursing visit note dated 02/08/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>6. A skilled nursing visit note dated 02/09/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an</p>			

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	<p>assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>7. A skilled nursing visit note dated 02/10/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>8. A skilled nursing visit note dated 02/11/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>9. A skilled nursing visit note dated 02/12/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p>			

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	<p>10. A skilled nursing visit note dated 02/13/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>11. A skilled nursing visit note dated 02/14/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>12. A skilled nursing visit note dated 02/15/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16,</p>			

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	<p>with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing area on LLE [left lower extremity] anterior lower half was noted. A skilled nursing visit note dated 12/14/15, indicated the patient had a wound, but failed to evidence an assessment of the wound.</p> <p>3. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19/16, the wound care section indicated, "wound</p>			

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G 0184 Bldg. 00	<p>care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p> <p>4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.32 THERAPY SERVICES</p> <p>Based on record review and interview, the agency failed to ensure the occupational and physical therapy follow the therapy frequency in the plan of care for 5 of 9 records reviewed in a sample of 12 (See 185); failed to include frequency of proposed visits with speech, physical, and occupational therapy and if the patient / representative was in agreement with the plan of care in 3 of 9 records reviewed of patients receiving therapy in a sample of 12 (See G 186); Occupational and Speech therapy failed to ensure that a discharge summary had been completed at the end of services that were provide for 1 of 4 records reviewed</p>	G 0184	This condition is explained in detail with each standard listed under it individually (G185, G186, G187,G188,G190)	03/23/2016

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G 0185 Bldg. 00	<p>of patient with discharged therapy services in a sample of 12 (See G 187); Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12 (See G 188); and Physical Therapist and Occupational Therapist failed to provide supervision of the physical therapy assistance according to Article 6 and certified occupational therapy assistant according to Article 10 for 1 of 1 patient who had therapy assistants in a sample of 12 (See G 190).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.32: Therapy Services.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p> <p>484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of</p>			

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	<p>care.</p> <p>Based on record review and interview, the agency failed to ensure the occupational and physical therapy follow the therapy frequency in the plan of care for 5 of 9 records reviewed in a sample of 12. (# 3, 8, 9, 10, and 11)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.</p> <p>b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied</p>	G 0185	<p>On March 3, 9,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for services performed by a qualified therapist. Components of the training included</p> <p>1. Following physician ordered frequency</p> <p>A quality review function will be completed on each new admission verifying therapy treatment visit frequencies are plotted on the calendar per orders. At patient case conferences the frequency will be assessed again for compliance. Any deviation will be addressed by reviewing the missed visit documentation with the physician. To assist with compliance, the Director of Clinical Services (DCS) or designee will audit ten (10) current therapy patient records each month to verify ordered frequency is carried out as ordered by the physician. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter, seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked,</p>	03/23/2016

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	<p>moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency.</p> <p>c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit</p>		<p>trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks and occupational therapy two times a week for four weeks starting week starting 01/17/16.</p> <p>a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the</p>			

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	<p>week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The occupational therapist failed to follow the plan of care.</p> <p>c. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and</p>			

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G 0186 Bldg. 00	<p>2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p> <p>5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for physical therapy one time a week for one week and occupational therapy one time a week for one week. Physical and Occupation therapy failed to follow the plan of care.</p> <p>6. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function,</p>			

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	<p>and helps develop the plan of care (revising it as necessary.)</p> <p>Based on record review and interview, the therapist failed to include frequency of proposed visits with speech, physical, and occupational therapy and if the patient / representative was in agreement with the plan of care in 3 of 9 records reviewed of patients receiving therapy in a sample of 12. (# 8, 9, and 12)</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC (start of care) 11/18/15, included a plan of care established by a physician for the certification period of 11/18/15 to 01/16/16, with orders for physical and occupational therapy services.</p> <p>a. Review of the physical therapy initial evaluation visit dated 11/18/15, the physical therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, the occupational assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in</p>	G 0186	<p>On March 9,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for Assisting physicians in evaluating and developing POCs. Components of the training included</p> <p>1. The therapy evaluation process that must include the frequency and duration documented as approved by the physician</p> <p>A quality review function will be run on each new admission to verify therapy evaluation include the frequency and duration documented as approved by the physician. The Director of Clinical Services (DCS) or designee will audit ten (10) current therapy patient records each month to verify therapy evaluation include the frequency and duration documented as approved by the physician. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up</p>	03/23/2016

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	<p>agreement with the plan of care.</p> <p>2. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for physical and occupational therapy services.</p> <p>a. Review of the occupational therapy initial evaluation visit dated 01/18/16, failed to include the frequency of the proposed visits.</p> <p>b. Review of the physical therapy initial evaluation visit dated 01/19/16, failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>3. Clinical record number 12, SOC 11/10/15, included a plan of care established by a physician for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services.</p> <p>a. Review of the occupational therapy initial evaluation visit note dated 11/13/15, the occupational therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient /</p>		<p>through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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G 0187 Bldg. 00	<p>representative was in agreement with the plan of care.</p> <p>b. Review of the speech therapy initial evaluation visit note dated 11/13/15, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.32 THERAPY SERVICES The qualified therapist prepares clinical and progress notes. Based on record review and interview, Occupational and Speech therapy failed to ensure that a discharge summary had been completed at the end of services that were provide for 1 of 4 records reviewed of patient with discharged therapy services in a sample of 12. (# 12)</p> <p>Findings include:</p> <p>1. Clinical record number 12, SOC (start of care) 11/10/15, included an established plan of care for the certification period of</p>	G 0187	<p>On March 3, 9, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for Preparing clinical and progress notes. Components of the training included</p> <p>1. Review of agency policy Discharge Summary (#HH:2-012.1) requiring that a discharge summary be written by each discipline when services are completed A quality review function will be run on each time a patient is discharged by a discipline</p>	03/23/2016

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G 0188 Bldg. 00	<p>11/10/15 to 01/08/16, with orders for occupational and speech therapy services.</p> <p>a. Review of the occupational therapy visit notes, the occupational therapist last visit was made on 12/03/15. The occupational therapist failed to complete a discharge summary.</p> <p>b. Review of the speech therapy visit notes the speech therapist last visit was made on 12/01/15. The speech therapist failed to complete a discharge summary.</p> <p>2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel. Based on record review and interview, the Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12. (# 7, 8, and 9)</p>			G 0188	<p>ensuring a discharge summary is written by each discipline when services are completed. To assist with compliance, the Director of Clinical Services (DCS) or designee will audit ten (10) current patient records each month to verify a discharge summary is written by each discipline when services are completed. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter, seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p> <p>An in-service was conducted by the Regional Director of Survey Readiness (RDSR) on March 3, 9, 2016, which addressed the Medicare Standard: Advises/consults with family/personnel. Components of the training</p>		03/23/2016

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	<p>Findings include:</p> <p>Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to</p>		<p>included</p> <p>1. The therapy evaluation process must include the frequency and duration documented as approved by the patient/representative</p> <p>2. The medical record will have evidence of coordination between disciplines following agency policy for Coordination of care (#C:2-008.1)</p> <p>To ensure this deficiency does not re-occur, a quality review function will be run on each new admission ensuring therapy evaluation includes the frequency and duration documented as approved by the patient/representative. At least one case conference will be held to coordinate care between disciplines. Additional documentation of coordination can be found in visit notes when the coordination occurs. The Director of Clinical Services (DCS) or designee will audit 10 current patient records each month to determine therapy evaluation includes the frequency and duration documented as approved by the patient/representative and the medical record has evidence of coordination between disciplines. The audit will continue until 100% compliance has been achieved and maintained for 2 consecutive months. Thereafter 7 current records each month will be randomly audited until 100% compliance has been maintained</p>	

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	<p>01/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the occupational therapy initial evaluation visit dated</p>		<p>for 2 consecutive months. Finally, 5 current records each month will be randomly audited until 100% compliance has been maintained for 3 additional months. Results will be tracked, trended and reported up through the quarterly QI committee meeting. Responsible Person: Director of Clinical Services</p>		

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G 0190 Bldg. 00	<p>01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>5. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.</p> <p>484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and</p>			

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	<p>supervised by the therapist.</p> <p>Based on record review and interview, the Physical Therapist and Occupational Therapist failed to provide supervision of the physical therapy assistance according to Article 6 and certified occupational therapy assistant according to Article 10 for 1 of 1 patient who had therapy assistants in a sample of 12. (# 7)</p> <p>Findings include:</p> <p>1. Article 6. Physical Therapists and Physical Therapists' Assistants, 844 IAC (Indiana Administrative Code) 6 - 1 - 2 Definitions indicated " ... [g] ... With respect to the supervision of physical therapist's assistants under IC [Indiana Code] 25 - 27 - 1 - 2 [c], unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments ... [3] A consultation between a supervising physical therapist or a physician and the physical therapist's assistant may be in person, by telephone, or by a telecommunications device for the deaf [TDD], so long as there is interactive communication concerning patient care "</p>	G 0190	<p>On March 3,9, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for Supervision by a qualified PT/OT. Components of the training included</p> <ol style="list-style-type: none"> 1. Review of Article 6 of Indiana Physical Therapy Code requiring PT oversight of PTA each visit 2. Review of Article 10 of Indiana Occupational Therapy Code requiring OT counter sign of COTA notes within 7 days 3. Plans to add buddy codes in the electronic documentation system for the PT to co-sign each PTA note and for the OT to co-sign COTA notes every 7 days (later changed to each note to ensure not missing a 7 day date) <p>A quality review function at SOC will have buddy codes plotted on a patient calendar for PT to co-sign every PTA note and for OT to co-sign every COTA note. Collaboration between PT/PTA and OT/COTA will be reviewed at case conferences to verify documentation in visit notes. To assist with compliance, the Director of Clinical Services (DCS) or designee will audit 100% current patient records with PTA or COTA services each month to determine oversight was provided as required by the Indiana Practice Act. The audit will continue until 100% compliance has been achieved</p>	03/23/2016

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	<p>2. Article 10. Occupational Therapists and Occupational Therapy Assistants, 844 IAC 10 - 5 - 6 Documentation Sec. 6 indicated "Thee occupational therapist shall countersign within seven [7] calendar days all documentation written by the occupational therapy assistant, which will become part of the patient's permanent record."</p> <p>3. Clinical record number 7, SOC 01/27/16 (start of care), included a plan of care established by the physician for the certification period of 01/27/16 to 03/26/16, with orders for physical therapy one time a week for one week then two times a week for six weeks, and occupational therapy one time a week for one week then two times a week for five weeks.</p> <p>a. Review of supervisory visit report completed by a registered nurse on 02/09 and 02/23/16, asked for the name of therapist being evaluated. The registered nurse indicated Employee A, PT [physical therapist] Employee F, OT [occupational therapist], Employee G, COTA [certified occupational therapy assistant], Employee K, PT, and Employee H, PTA [physical therapy assistant].</p>		<p>and maintained for two (2) consecutive months. Thereafter, 50% current records with PTA or COTA services each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, 25% current records with PTA or COTA services each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>b. Review of the physical therapy assistant notes dated 02/05, 02/17, and 02/19/16, the visit note and the clinical record failed to evidence that the physical therapist and the physical therapy assistant communicated with each other after the visit was.</p> <p>c. Review of the certified occupational therapy assistant note dated 02/12/16, the visit note and clinical record failed to evidence co-signature / communication between the occupational therapist and the certified occupational therapy assistant.</p> <p>4. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated physical / occupational therapist and physical therapy assistants / certified occupational therapy assistants would email and / or text each other if there was a need but was not aware of the of the daily communication to be documented between PT and PTA, as well as weekly signatures between OT and COTA.</p> <p>5. The Administrator and Director of Clinical Services was interviewed on 2/24/16 at 2:00 PM. The Administrator and Director of Clinical Services stated PT / OT only supervises the PTA / COTA.</p>			

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G 0224 Bldg. 00	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on record review and interview, the agency failed to ensure that the home health aide written instructions were accurate in relation to the patient's performance abilities. (#3)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with personal care and activities of daily living.</p> <p>a. A home health aide written plan of instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks.</p> <p>b. During a home visit on 02/16/16 at 10:30 AM, the patient verbalized that he / she had his / her first bath in 6 months</p>	G 0224	<p>On March 8,10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for written instructions by the RN or Therapist to the Home Health (HH) aide. Clinical record number 3 was reviewed. Questions from RNs were posed and answered. Therapists in the agency do not initiate HH aide care plans at this time. The HH aide and LPNs acting in a HH aide role were instructed to notify the RN if the patient could not or would not allow the HH aide to perform all tasks on the plan during/after each visit. They were also instructed hat they could not deviate from the plan by changing the task type or adding tasks not included in the plan. The RNs were instructed to update the plan after re-assessing patient needs and abilities. To assist with compliance, the Director of Clinical Services (DCS) or designee reviewed 100% of current records as of March, 9, 2016 with current HH aide services ordered to verify the plan correctly reflected the patient's</p>	03/23/2016

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G 0235 Bldg. 00	<p>recently. The patient verbalized he / she had been afraid to get into the shower due to his illness, weakness, and unsteady gait. The patient indicated he / she had been getting sponge bathes at the sink. The home health aide written care instructions failed to be specific to the patient needs.</p> <p>2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on record review and interview, the agency failed to ensure that clinical visit notes were truthful and accurate for 2 of 12 records reviewed and failed to ensure the clinical record include discharge summaries from speech and occupational therapy for 1 of 9 record reviewed of patients receiving therapy.</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48: Clinical Records.</p>	G 0235	<p>ability. Ongoing, the Director of Clinical Services(DCS) or designee will audit 100% of current HH aide cases each month until 100% compliance is achieved and maintained for two (2) months. Thereafter, audits will be made on 50% of HH aide cases each month until 100% compliance is maintained for three (3) months. Finally random audits of three (3) cases each month will be made until 100% compliance is maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly QualityImprovement committee meeting. Responsible Person: Director of Clinical Services</p> <p>This condition is explained in detail with each standard listed under it individually</p>	03/23/2016

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G 0236 Bldg. 00	<p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p> <p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every 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.</p> <p>Based on record review and interview, the agency failed to ensure that clinical visit notes were truthful and accurate for 2 of 12 records reviewed (# 1 and 3), failed to ensure the clinical record include discharge summaries from speech and occupational therapy for 1 of 9 record reviewed of patients receiving therapy. (# 12)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to</p>	G 0236	<p>On March 8, 9, 10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for maintenance of clinical records in accordance with professional standards. Components of the training included</p> <p>1.HH aide care plan must be followed exactly-RN to be notified if the patient could not or would not allow the tasks to be performed as ordered during/after each visit. Further, the HH aide visit could not deviate from the plan by changing the task type or adding tasks notincluded in the plan.</p> <p>2.Skin assessments must</p>	03/23/2016

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	<p>03/09/16. The patient has a known history of a sacral debubitous ulcer that was treated by the agency in September, 2015.</p> <p>a. A home visit was made with the LPN (licensed practical nurse) on 02/18/16 at 8:15 a.m. The LPN was observed to calibrate the patient's glucometer, obtain blood sugar, inject insulin, obtained vital signs, and ask generalized assessments. The LPN did not assess the patient's skin in the coccyx area. The skilled nursing visit note indicated the LPN had performed a skin assessment. The LPN inaccurately documented an assessment that was not performed.</p> <p>2. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with personal care and activities of daily living.</p> <p>a. A home health aide written plan of instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks.</p>		<p>include all areas of the body to be complete and accurate in documenting skin assessment was performed</p> <p>3. Therapy disciplines are required to complete a discharge summary each time a patient has completed services for that discipline</p> <p>The Director of Clinical Services (DCS) or designee reviewed 100% of current records as of March, 9, 2016 with current HH aide services ordered to verify the plan correctly reflected the patient ability. Ongoing, the Director of Clinical Services (DCS) or designee will audit 100% of current HH aide cases each month until 100% compliance is achieved and maintained for two (2) months. Thereafter, audits will be made on 50% of HH aide cases each month until 100% compliance is maintained for three (3) months. Finally random audits of three (3) cases each month will be made until 100% compliance is maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. To assist with compliance, the Director of Clinical Services (DCS) or designee reviewed 100% of discharged records between March 10, 2016, and March 20, 2016, for evidence of discharge summaries from each therapy discipline to establish a baseline.</p>	

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	<p>b. Review of the home health aide visit notes, that are being performed by a licensed practical nurse, indicated the patient had received a shower on 01/28, 02/02, 02/09, 02/16/16.</p> <p>c. During a home visit on 02/16/16 at 10:30 AM, the patient verbalized that he / she had his / her first bath in 6 months recently. The patient verbalized he / she had been afraid to get into the shower due to his illness, weakness, and unsteady gait. The patient indicated he / she had been getting sponge bathes at the sink. The LPN acting as a home health aide inaccurately documented the bathing task that was not performed.</p> <p>3. Clinical record number 12, SOC (start of care) 11/10/15, included an established plan of care for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services.</p> <p>a. Review of the occupational therapy visit notes, the occupational therapist last visit was made on 12/03/15. The occupational therapist failed to complete a discharge summary.</p> <p>b. Review of the speech therapy visit notes the speech therapist last visit was made on 12/01/15. The speech therapist</p>		<p>Thereafter, the Director of Clinical Services (DCS) or designee will review 100% of current records with therapy services on a monthly basis to determine if discharge summaries were completed as required when each therapy service was discontinued. This audit will continue until 100% compliance is achieved and maintained for two (2) months. Thereafter, audits will be made on 50% of therapy case record each month until 100% compliance is maintained for two (2) additional months. Finally random audits of five (5) therapy case records each month will be made until 100% compliance is maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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G 0322 Bldg. 00	<p>failed to complete a discharge summary.</p> <p>4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the agency failed to ensure encoded OASIS data accurately reflected the patient's status at the time of the assessment for 2 of 12 records reviewed. (# 3 and 6)</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis.</p> <p>1. Question M1306 asked if the patient had at least one unhealed pressure</p>	G 0322	<p>On March 8,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for accuracy of encoded OASIS data. Components of the training included</p> <ol style="list-style-type: none"> 1. Correct identification of all wounds as to type and location is crucial to be accurate in answering the OASIS questions 2. Including any lesion that have treatment in the OASIS question (M1350) 3. Including measures to prevent pressure ulcers when Braden Scale result is 16 or less on M2250 <p>The Director of Clinical Services (DCS) or designee will review of five (5) current records with wounds at SOC and 2 re-cert records with wounds on a monthly basis to verify if the OASIS accurately reflects wound status as determined by review of</p>	03/23/2016

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	<p>ulcer at stage 2 or higher or designated as an unstageable. The answer indicated "1 - yes."</p> <p>2. Question 1308 asked for the current number of unhealed pressure ulcers at stage II, partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open / ruptured serum filled blister. The answer indicated "1".</p> <p>3. Question 1320 asked for the status of the most problematic pressure ulcer that is observable. The answer indicated "3 - Not healing."</p> <p>4. Question 1324 asked for the stage of the most problematic unhealed pressure ulcer that is stageable. The answer indicated "2 - Stage II."</p> <p>5. Question 1340 asked if the patient had a surgical wound. The answer indicated "0 - no."</p> <p>6. Question 1350 asked if the patient had a skin lesion or open wound, excluding bowel ostomy, other than those described above that is receiving interventions by the home health agency. The answer indicated "0 - no."</p>		<p>theclinical record. This audit will continue until 100% compliance is achieved and maintained for two (2)months. Thereafter, audits will be made on three (3) current records with wounds at SOC and 2 re-cert records with wounds on a monthly basis to determine if the OASIS accurately reflects wound status as determined by review of the clinical record until 100% compliance is maintained for three (3) additional months. Finally random audits of five (5) OASIS records each month with wounds willbe made until 100% compliance is maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. To assistwith compliance, the Director of Clinical Services (DCS) or designee will review of five (5) SOC and two (2) re-cert records on a monthly basis to determine if the OASIS accurately reflects Braden score of 16 or below with M2250 answered YES as determined by review of the clinical record. This audit will continue until 100%compliance is achieved and maintained for three (3) months. Thereafter, audits will be made on three (3)current SOC records and two (2) re-cert records on a monthly basis to determine if the OASIS accurately reflects Braden score of 16 or below with M2250 answered YES as determined by</p>	

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	<p>7. M2250G asked if the plan of care synopsis included a physician ordered plan of care to include pressure ulcer treatment based on principles of moist wound healing or order for treatment based on moist wound healing had been requested from the physician. The answer indicated "NA [not applicable] - Patient has no pressure ulcers or has no pressure ulcers for which moist wound healing is indicated."</p> <p>8. The narrative nursing assessment indicated " ... Pt [patient] had multiple surgeries to bilat [bilateral] LE [lower extremities] due to necrotizing fascitis and sepsis. wounds have healed, Pt to see wound clinic this week to be discharged "</p> <p>9. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape.</p> <p>10. A physician order from the</p>		<p>review of the clinical record until 100% compliance is maintained for two (2) additional months. Finally random audits of a combination of five (5) SOC and re-cert OASIS records each month will be made until 100% compliance is maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>wound clinic described the patient wounds as "Non - pressure chronic ulcer of left heel and midfoot with unspecified severity" and "Non - pressure chronic ulcer of unspecified part of right lower leg with unspecified severity." The agency failed to ensure that the diagnoses were accurate. The admitting clinician failed to answer the OASIS assessment questions appropriately, failed to indicate the location of the necrotizing faciitis, and failed to include the ulcer to the right anterior leg.</p> <p>2. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 02/08/16, M1302 asked if the patient was at risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16, which indicated the patient is at a low</p>			

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G 0330 Bldg. 00	<p>risk of developing pressure ulcers. The registered nurse failed to be consistent on his / her assessment.</p> <p>b. M1350 asked if the patient had a skin lesion or open wound that was receiving interventions by the agency. The OASIS assessment was reviewed by quality assurance nurse within the office and the question was changed from "no" to "yes". The admitting nurse agreed to the change of answers. The comprehensive assessment failed to include an assessment and location of the skin lesion that was to receive interventions by the agency.</p> <p>3. The Administrator was interviewed on 2/24/16 at 2:40 PM. The Administrator stated Employee N was new to OASIS and corporate would be providing training soon.</p> <p>4. Employee N, RN Manager, was interviewed on 2/24/16 at 3:00 PM. Employee N stated he / she was responsible for proofreading the OASIS questions and reaching out to the case managers on corrections.</p> <p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA</p>			

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	<p>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 record review and interview, the agency failed to ensure comprehensive assessments were complete, accurate, and consistent with the patient's immediate needs within 5 days of the start of care for 2 of 12 patient record reviewed (See G 334); failed to ensure the Medication profiles were reconciled with a physician and listed the medications accurately upon admission and with each update for 7 of 12 records reviewed (See G 337); failed to ensure that the registered nurse performed a comprehensive assessment for recertification in the last 5 days of the 60 day certification period for 1 of 2</p>	G 0330	This condition is explained in detail with each standard listed under it individually (G334, G335, G,337, G339, G341)	03/23/2016

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G 0334 Bldg. 00	<p>patient record reviewed who was recertified for an additional 60 days (See G 339); and failed to ensure that the OASIS discharge assessment had been completed upon discharge for 1 of 3 closed records reviewed (See G 341).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.55: Comprehensive Assessments.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p> <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 record review and interview, the agency failed to ensure comprehensive assessments were complete, accurate, and consistent with the patient's immediate needs within 5 days of the start of care for 2 of 12</p>	G 0334	<p>On March 8,2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the following components: 1.Comprehensive assessment that is complete and accurate must be completed within 5 days of admission. This includes</p>	03/23/2016

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	<p>patient record reviewed. (# 3 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.</p> <p>1. Question M1306 asked if the patient had at least one unhealed pressure ulcer at stage 2 or higher or designated as an unstageable. The answer indicated "1 - yes."</p> <p>2. Question 1308 asked for the current number of unhealed pressure ulcers at stage II, partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bd, without slough. May also present as an intact or open / ruptured serum filled blister. The answer indicated "1".</p>		<p>weights on any patient with CHF, COPD, or has edema present</p> <p>2. Comprehensive assessment that is complete and accurate must be completed within the last 5 days of a cert period for re-certification</p> <p>3. Comprehensive assessment that is complete and accurate must be completed within 2 days of discharge</p> <p>A quality review of the comprehensive assessment is done at the SOC, ROC, RE-CERT, and D/C. The RNs performing the comprehensive assessment have had individual training to enhance their understanding of how to determine what type of wound exists and using best practices for CHF and COPD. The DCS or designee will audit 100% of medical records with CHF or COPD diagnoses on a monthly basis to find evidence of appropriate assessment and interventions. This audit will continue until 100% compliance has been achieved and maintained for three (3) consecutive months. Thereafter, 50% of medical records with CHF or COPD will be reviewed until 100% compliance has been maintained for three (3) consecutive months. Finally, a random sampling of 10% of medical records with CHF or COPD per month will be reviewed until 100% compliance has been maintained for (2) additional</p>	

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	<p>3. Question 1320 asked for the status of the most problematic pressure ulcer that is observale. The answer indicated "3 - Not healing."</p> <p>4. Question 1324 asked for the stage of the most problematic unhealed pressure ulcer that is stageable. The answer indicated "2 - Stage II."</p> <p>5. Question 1340 asked if the patient had a surgical wound. The answer indicated "0 - no."</p> <p>6. Question 1350 asked if the patient had a skin leasion or open wound, excluding bowel ostomy, other than those described above that is receiving interventions by the home health agency. The answer indicated "0 - no."</p> <p>7. M2250G asked if the plan of care synopsis included a physician ordered plan of care to include pressure ulcer treatment based on principles of moist wound healing or order for treatment based on moist wound healing had been requested from the physician. The answer indicated "NA [not applicable] - Patiet has no pressure ulcers or has no pressure ulcers for which moist wound healing is indicated."</p>		<p>months. Results will be tracked, trended and reportedup through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p>	

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	<p>8. The narrative nursing assessment indicated " ... Pt [patient] had multiple surgeries to bilat [bilateral] LE [lower extremities] due to necrotizing fascitis and sepsis. wounds have healed, Pt to see wound clinic this week to be discharged "</p> <p>9. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape.</p> <p>10. A physician order from the wound clinic described the patient wounds as "Non - pressure chronic ulcer of left heel and midfoot with unspecified severity" and "Non - pressure chronic ulcer of unspecified part of right lower leg with unspecified severity." The agency failed to ensure that the diagnoses were accurate. The admitting clinician failed to answer the OASIS assessment questions appropriately, failed to indicate the location of the necrotizing faciitis, and failed to include the ulcer to the right</p>			

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	<p>anterior leg.</p> <p>2. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 02/08/16, the Registered Nurse indicated the main focus of the patient's care, was to assess / evaluate cardiovascular and respiratory status, monitor daily weights, edema, and shortness of breath due to the patient has a history of congestive heart failure and atrial fibrillation.</p> <p>a. The cardiovascular assessment indicated the patient's had a trace of edema to the bilateral lower extremities. In reviewing the comprehensive assessment, the Registered failed to obtain a weight upon admission.</p> <p>b. The Registered Nurse also had indicated the patient was not taking an anticoagulant. In reviewing of the plan of care and medication profile, the patient was taking Xarelto (anticoagulant medication) 15 mg (milligrams) daily.</p> <p>c. M1302 asked if the patient was at</p>			

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	<p>risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16, which indicated the patient is at a low risk of developing pressure ulcers. The registered nurse failed to be consistent on his / her assessment.</p> <p>d. M1350 asked if the patient had a skin lesion or open wound that was receiving interventions by the agency. The OASIS assessment was reviewed by quality assurance nurse within the office and the question was changed from "no" to "yes". The admitting nurse agreed to the change of answers. The comprehensive assessment failed to include an assessment and location of the skin lesion that was to receive interventions by the agency.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p>			

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G 0337 Bldg. 00	<p>4. A policy titled "Initial and Comprehensive Assessment" dated 12/2012, indicated "A comprehensive patient assessment will be completed within five (5) calendar days of the patient's start of care ... The assessment will be patient - specific and comprehensive ... "</p> <p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on record review and interview, the agency failed to ensure the Medication profiles were reconciled with a physician and listed the medications accurately upon admission and with each update for 7 of 12 records reviewed. (# 1, 2, 3, 5, 9, 10, and 11)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one</p>	G 0337	<p>On March 8,9, 10, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the Medicare requirements for drug regimen review. Components of the training were:</p> <p>1.Comprehensive assessment that is complete and accurate must be completed within 5 days of admission. This includes an all-inclusive list of medications that the patient is taking is reconciled with medications the physician has ordered including from specialists</p> <p>2.Medications should be checked for any additions,changes or discontinuations on visits by all disciplines</p>	03/23/2016

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	<p>week, two days a week for 3 weeks, and 1 day a week for two weeks.</p> <p>a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient reported that she was diabetic and used insulin.</p> <p>b. The agency plan of care (POC) dated 02/13/16, failed to indicate that the patient was ordered to use insulin. The OASIS dated 02/13/16, indicated that the "[p]atient is not diabetic" and has "no injectable medications prescribed." The history and physical (H&P) dated 02/02/16, indicated that the patient uses "Lantus 50 units every [bedtime] and Novolog 8 units with meals." The patient's Clinical Physician Orders dated 02/10/16, indicated Accuchecks four times daily and call [physician] if BS (blood sugar) is less than 60 or greater than 300.</p> <p>c. The agency POC dated 02/13/16, indicated that the patient's medications included: B complex oral, 1 daily; Centurm silver 400/250, 1 tab daily; Eliquis oral 5MG, 1, 2 times daily; Fluoxetine oral 40 MG, 1 cap daily; Gabapentin oral 300MG, 3 times daily; Krill oil oral 500MG, 1 daily; Metoprolol tartrate 25MG, 1 tab daily; Midodrine oral 5MG, 1 tab Tuesday, Thursday,</p>		<p>3. Medication profile is verified as accurate at ROC and re-cert as well</p> <p>A quality review will be conducted to review the reconciliation of all medication profiles from ordering physician(s) coordinating care at SOC, ROC, and re-cert. During the intake process most current medication profiles will be obtained from physician(s) coordinating care prior to admission. Profiles will be scanned into patient records prior to SOC for clinician access. The Director of Clinical Services (DCS) or designee will audit ten (10) current patient records each month to determine accuracy of medication profile. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter, seven (7) current records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, five (5) current records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting.</p> <p>Responsible Person: Director of Clinical Services</p>	

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	<p>Saturday, Sunday; Midodrine 5MG, 2 tabs Monday, Wednesday, Friday; Percocet oral 5/325, 1 tab 4 times daily; Probiotic 5 billion cell, 1 tab daily; Renal caps oral 1 MG, 1 daily.</p> <p>1. The OASIS comprehensive assessment dated 02/13/16, indicated that the patient's medications included: B complex oral; Centurm silver 400/250; Eliquis oral 5MG; Fluoxetine oral 40 MG; Gabapentin oral 300MG; Krill oil oral 500MG; Metoprolol tartrate 25MG; Midodrine oral 5MG; Midodrine 5MG; Percocet oral 5/325; Probiotic 5 billion cell; Renal caps oral 1 MG; Renvela oral 800MG; Simvastatin oral 40MG; Vitamin D2 oral 400 unit; Vitamin E oral 400 unit; Zantac oral 150MG.</p> <p>2. A physician's order dated 02/10/16, indicated that the patient's medications include: Florastor Capsule 250 MG with stop date 02/17/16; Metoprolol Succinate ER tablet extended release 24 hour 50MG; Nystop powder 100000 unit/GM (Nystatin) with stop date of 02/18/16; Ranitidine HCL tablet 150MG; Keflex capsule 500MG with stop date 02/10/16; Percocet tablet 5/325MG; Dialysis binder; O2: oxygen at 1 liter per nasal canula; Atorvastatin calcium tablet 40MG; Sevelmar carbonate tablet 800MG; Renal capsule</p>			

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	<p>1MG (B Complex-C-Folic acid); Midodrine HCL tablet 5MG; Gabapentin capsule 300MG; Eliquis Tablet 5 MG; Acetaminophen tablet 325MG; Accuchecks four times daily and call [physician] if BS (blood sugar) is less than 60 or greater than 300. The medication profile failed to evidence documentation that the medications for this patient were reconciled and/or clarified for accurate usage.</p> <p>2. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16.</p> <p>a. After a home visit with the patient on 02/18/16, the patient's clinical record with the Assisted Living Facility was reviewed. An order dated 08/07/16, indicated the patient's Atrovastatin had been discontinued. Section 10 of the medication section continued to indicate the patient was taking Atorvastatin 10 milligrams daily. The medication profile failed to be updated to reflect the patient's current medication list.</p> <p>3. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the</p>			

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	<p>certification periods of 01/18/16 to 03/17/16.</p> <p>a. A hospital discharge summary dated 12/29/15, indicated the patient discharged home with Creon 24,000 3 tabs 3 times a day, no saccharomyces was listed on the discharged list of medications, and acetaminophen 2 - 500 mg tabs every 6 hours three times a day. The summary also indicated the patient was allergic to not only neomycin sulfate and niaspan, but also to neomycin otic and neosporin.</p> <p>b. The narrative note in the OASIS comprehensive admission assessment dated 01/18/16, indicated the patient did not have a prescription for Creon but did have a supply of the medication from prior to hospitalization.</p> <p>c. During a home visit with the patient on 02/18/16 at 10:30 a.m., the patient stated he / she was not familiar nor did he / she know what saccharomyces medication was. The admitting clinician failed to transcribe and / or failed to evidence that the discrepancy in the specific medications had been reconciled the physician and failed to list all allergies to medications on the medication profile.</p>			

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	<p>4. Clinical record number 5, SOC 02/01/16, included an established plan of care by a physician for the certification period of 02/01/16 to 03/31/16.</p> <p>a. Review of the discharge paperwork from a skilled nursing facility dated 01/14/16, indicated the patient was allergic to Albuterol, Lexapro, and Duricef.</p> <p>b. Review of the medication profile dated 02/01/16, indicated the patient was only allergic to Duricef. The medication profile failed to include allergies to Albuterol and Lexapro.</p> <p>5. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.</p> <p>a. A physician order dated 02/09/16, indicated the patient was to take 7.5 mg of coumadin on Tuesday's and 5 mg of coumadin "all other days."</p> <p>b. Review of the medication profile indicated the coumadin dosage was changed on 02/18/16. The medication profile failed to be updated in a timely manner.</p> <p>6. Clinical record number 10, SOC</p>			

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	<p>12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16.</p> <p>a. A skilled nursing visit note dated 02/09/16, indicated the patient was started on Levaquin on 02/08/16. Review of the medication profile failed to evidence that the Levaquin had been added.</p> <p>7. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15.</p> <p>a. Review of the patient's most recent Podiatry visit note dated 10/13/15, included, but not limited to the following medications: Combigan 0.2 - 0.5 % 45 gramsAPP AA solution twice a day; Glucosamine - Chondroitin 500 400 mg two tablets twice a day; Nitro Bid 2% apply 1" twice a day, Imdur ER 60 mg daily, and a Multivitamin daily. The admitting clincial failed to include the list of medications to the medication profile.</p> <p>b. The podiatry visit note dated 10/13/15, also indicated the patient was taking Lopressor 50 mg, 1/2 tab twice a day, Vitamin D3 daily, and Vitamin E 200 U, 2 capsules daily. Section 10 of the plan of care indicated the patient was</p>			

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G 0339 Bldg. 00	<p>taking 50 mg of Lopressor twice a day, Vitamin D2 & K - Berberine - Hops orally 500 units - 500 mcg (micrograms) - 90 mg - 370 mg daily, and Vitamine E - Vitamin C - Magnesium - Zinc oral 100 Units - 100 mg - 10 mg - 18 mg. The admitting clinician failed to transcribe and / or failed to evidence that the discrepancy in the specific medications had been reconciled the physician</p> <p>8. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>9. A policy titled "Medication Profile" dated 12/2012, indicated " ... A drug regimen review will be performed at the time of admission, when updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of a new medication. The review will identify drug / food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy "</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p>			

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	<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 record review and interview, the agency failed to ensure that the registered nurse performed a comprehensive assessment for recertification in the last 5 days of the 60 day certification period for 1 of 2 patient record reviewed who was recertified for an additional 60 days. (# 8)</p> <p>Finding include:</p> <ol style="list-style-type: none"> 1. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16. <ol style="list-style-type: none"> a. The clinical record evidenced a comprehensive reassessment dated 01/21/16. The skilled nurse failed to complete the comprehensive assessment for recertification between the dates of 01/12/16 to 01/16/16. 2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 	G 0339	<p>On March 8, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the requirements to update the ComprehensiveAssessment. Components of the training include:</p> <ol style="list-style-type: none"> 1. Comprehensive assessment that is complete and accurate must be completed within five (5) days of admission. 2. Comprehensive assessment that is complete and accurate must be completed within the last five (5) days of a cert period for re-certification 3. Comprehensive assessment that is complete and accurate must be completed within two (2) days of discharge <p>Dates for comprehensive assessments will be plotted on the patient calendar by the nurse that originally performed the initial assessment and reviewed during case conference to verify the dates planned are appropriate. Quality review will check for correct date planning to complete the re-cert and discharge comprehensive assessments. To assist with compliance, the Director of Clinical Services</p>	03/23/2016

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G 0341 Bldg. 00	<p>2:20 PM.</p> <p>3. A policy titled "Initial and Comprehensive Assessment" dated 12/2012, indicated "A comprehensive patient assessment will be completed ... The last five (5) days of every 60 - day episode beginning with the start of care date (recertification) "</p> <p>4. A policy titled "Reassessments / Recertification" dated 12/2012, indicated " ... The comprehensive assessment must be updated and revised every 60 days from the start of care ... OASIS assessments within the mandated time frames: A. recertification day 56 - 60 of the current certification period ... 2. For each new episode of care, a comprehensive assessment will be completed no earlier than five (5) days before and no later than one (1) day before the calendar day on which the new episode of care will begin "</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on record review and interview, the agency failed to ensure that the OASIS discharge assessment had been</p>			G 0341	<p>(DCS) or designee will audit a combination of ten (10) re-cert and discharge patient records each month to determine accuracy of the assessment date. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter a combination of seven (7) re-cert and discharge records each month will be randomly audited until 100% compliance has been maintained for two (2) consecutive months. Finally, a combination of five (5) re-cert and discharge records each month will be randomly audited until 100% compliance has been maintained for three (3) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p> <p>On March 8, 2016, the Regional Director of Survey Readiness (RDSR) retrained clinicians on the requirements to update the</p>		03/23/2016

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	<p>completed upon discharge for 1 of 3 closed records reviewed. (# 11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing 2 times a week for 5 weeks, physical and occupation therapy 1 time 1 week for an evaluation. A client coordination note dated 11/05/15, indicated the registered nurse notified the physician of the patient refusing visits and obtained verbal orders to discharge the patient from services. The clinical record failed to evidence an OASIS discharge assessment. 2. The Administrator was interviewed on 2/24/16 at 10:50 AM. The Administrator stated corporate advisors indicated that an OASIS discharge did not need to be completed. 3. A policy titled "Initial and Comprehensive Assessment" dated 12/2012, indicated "A comprehensive patient assessment will be completed ... at discharge " 4. A policy titled "Reassessment / Recertification" dated 12/2012, indicated 		<p>comprehensive assessment at discharge. Components of the training include:</p> <ol style="list-style-type: none"> 1. Comprehensive assessment that is complete and accurate must be completed within five (5) days of admission. 2. Comprehensive assessment that is complete and accurate must be completed within the last five (5) days of a cert period for re-certification 3. Comprehensive assessment that is complete and accurate must be completed within two (2) days of discharge <p>The comprehensive assessment is placed on the patient calendar for the date of last billable service. If the last billable service turns out to request extension orders, then the RN will be notified by the scheduler to delay until the last billable service has been provided. The calendar will be updated to reflect the change. To assist with compliance the Director of Clinical Services (DCS) or designee will audit four(4) discharge patient records each month to verify accuracy of the assessment date. The audit will continue until 100% compliance has been achieved and maintained for two (2) consecutive months. Thereafter a combination of three(3) discharge records each month will be randomly audited until 100% compliance has been maintained for three (3) consecutive months. Finally, a</p>	

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N 0000 Bldg. 00	<p>" ... D. Discharge: at the time of the discharge assessment, discharge OASIS must be completed within 48 hours of the discharge assessment visit "</p> <p>This survey was a State relicensure survey. The survey was extended.</p> <p>Survey dates: February 17, 18, 19, 23, and 24, 2016</p> <p>Facility ID#: 011129</p> <p>Provider #: 157582</p> <p>Census: 80</p>	N 0000	<p>combination of two (2) discharge records each month will be randomly audited until 100% compliance has been maintained for two (2) additional months. Results will be tracked, trended and reported up through the quarterly Quality Improvement committee meeting. Responsible Person: Director of Clinical Services</p> <p>The following is the Plan of Correction for Brookdale Home Health Indianapolis in regards to the Statement of Deficiencies (SOD) received April 7, 2016 for a re-certification survey visit conducted February 17 - 24, 2016 and SOD dated April 5, 2016. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each individual allegation or finding, nor have we identified individual mitigating factors. We remain committed to the delivery of quality health care services and will</p>	

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N 0470 Bldg. 00	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 1 of 6 home visit observations. (# 3)</p> <p>Findings include:</p> <p>1. A policy titled "Hand Hygiene" revised 12/2012, indicated " ... 3. Hand decontamination using an alcohol - based hand gel should e performed: A. Before having direct contact with patients. B. Before accessing theclean area of the visit bag. C. Before donning sterile gloves when performing sterile procedures; before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices. D. After contact with a patient's intact skin (when taking a pulse, blood pressure or lifting a patient. E. After contact with</p>	N 0470	<p>continue to make changes and improvementto satisfy that objective.</p> <p>No report</p>	03/23/2016

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	<p>body fluids or excretions, mucous membranes, non - intact skin, and wound dressings, if hands are not visibly contaminated. F. When moving from a contaminated body site to a clean body site during patient care. G. After contact with inanimate objects, including medical equipment, in the immediate vicinity of the patient. H. After removing gloves. I. After completing care, prior to leaving the patient's home "</p> <p>2. A policy titled "Contaminated Materials Disposition" revised 12/2012, indicated " ... 3. Equipment: A. Cleaning reusable equipment that may come in contact with mucous membranes or body fluids: [This refers to equipment that personnel transports from patient to patient in the performance of their duties, i.e., BP [blood pressure] cuffs, stethoscope, thermometers, scales]"</p> <p>1. wipe exposed portions of equipment with alcohol or other appropriate cleaning solution "</p> <p>3. A policy titled "Contaminated Waste Disposition" revised 12/2012, indicated " ... 3. COntaminated paper wastes [disposable flovess, gowns, masks, paper towels, tubings dressings, etc.], should be placed in a plastic puncture resistant bag and secured. It should be double bagged and, in possible, placed in a plastic trash</p>			

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	<p>container with tight lid and labeled as appropriate "</p> <p>4. The Centers for Disease Control Standard Precautions indicated, "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</p>			

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	<p>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>5. A home visit was made to patient number 3, with Employee C, a registered nurse, on 02/18/16 at 10:30 AM. Employee B, was observed providing wound care to the patient's left heel. The patient's primary diagnosis was necrotizing fasciitis [flesh eating disorder]. Employee B was observed to clean hands and applied gloves, remove the patient's sock and stocking, cut the patient's kerlix wrap and removed a soiled dressing. Without changing gloves, the employee B continued to clean the patient's wound, applied solosite wound gel around the patient's wound. Continuing to not change his / her gloves, Employee B removed and cut a piece of medicated dressing with the same scissors that was used to to remove the kerlix without cleaning to prior use. Employee B proceeded to apply the medicated dressing, 4 x 4, foam dressing, then wrapped the foot with kerlix. At this time, Employee B removed his / her</p>			

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N 0484 Bldg. 00	<p>gloves and cleaned hands with hand gel. Employee B cleaned the patient area of soiled dressings with his / her bare hands and carried it to the patient's kitchen and placed the soiled items in the trash can. Employee B cleaned her hands and applied gloves, obtained a blood sample from the patient's finger, removed the strip that contained the patient's blood, put the hand held machine in his / her traveling bag without cleaning.</p> <p>6. Employee C, Registered Nurse, was interviewed after the home visit on 02/18/16. Employee C was unable to identify his / her error with infection control.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with all disciplines providing service to patients coordinated effectively and documented for 3 of 9 patients receiving therapy services in a</p>	N 0484	No Report	03/23/2016

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	<p>sample of 12. (# 7, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>2. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy, and occupational</p>			

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	<p>therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively.</p>			

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	<p>b. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively.</p> <p>5. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.</p> <p>6. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes ... F. Coummunicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided "</p> <p>7. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences "</p>			

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N 0486 Bldg. 00	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services for 2 of 2 records reviewed (# 2 and 11) of patients receiving outside services in a sample of 12.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had a plan of care established by a physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. <ul style="list-style-type: none"> a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to 	N 0486	No Report	03/23/2016

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	<p>whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p> <p>2. Clinical record number 11, SOC 10/18/15, included a plan of care established by the physician for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p> <p>3. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic."</p> <p>4. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes ... F. Coummunicating between multiple disciplines to optimize visit schedules for</p>			

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N 0504 Bldg. 00	<p>the benefit of the patient and the care to be provided "</p> <p>5. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences "</p> <p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on record review and interview, the agency failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 6 of 12 records reviewed (# 1, 3, 6, 7, 11, and 12)</p> <p>Findings include:</p>	N 0504	No Report	03/23/2016

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	<p>1. Clinical record number 1, SOC (start of care) 05/15/15, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" section failed to evidence a frequency for skilled nursing.</p> <p>2. Clinical record number 3, SOC 01/18/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" section indicated skilled nursing, home health aide, physical therapy and occupational therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse and home health aide.</p> <p>3. Clinical record number 6, SOC 02/17/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 02/17/16. The "Consent For Treatment" section indicated skilled nursing, physical therapy and occupational therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the</p>			

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	<p>patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse.</p> <p>4. Clinical record number 7, SOC 01/27/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/27/16. The "Consent For Treatment" section indicated skilled nursing two times a week for six weeks, physical therapy and occupational therapy two times a week for six weeks.</p> <p>a. The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the home health aide.</p> <p>b. Review of the OASIS comprehensive admission assessment dated 01/27/16, the narrative note indicated the patient refused skilled nursing services. The admitting clinician also failed to change the frequency proposed to a one time visit on the Admission Consent Service Agreement.</p> <p>c. Review of the physical therapy initial evaluation visit note dated 01/27/16, the physical therapy assessment plan failed to include the frequency of the proposed visits and failed to include if</p>			

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	<p>the patient / representative was in agreement with the plan of care.</p> <p>d. Review of the occupational therapy initial evaluation visit note dated 02/03/16, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>5. Clinical record number 11, SOC 10/18/15, had an established plan of care by a physician for the certifying period 10/18/15 to 12/16/15, with orders for skilled nursing, physical and occupational therapy services. The "Consent for Treatment" section failed to include physical an occupational therapy services. The admitting clinician failed to inform the patient / representative in advance about the proposed physical and occupational therapy services.</p> <p>6. Clinical record number 12, SOC 11/10/15, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 11/10/15. The "Consent For Treatment" section indicated skilled nursing, physical therapy, occupational therapy, and speech therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to</p>			

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N 0522 Bldg. 00	<p>inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse.</p> <p>a. Review of the occupational therapy initial evaluation visit note dated 11/13/15, the occupational therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>b. Review of the speech therapy initial evaluation visit note dated 11/13/15, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>7. The Administrator was unable to provide any additional documentation and/or information when asked on 2/19/16 at 2:50 PM.</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 record review and interview,</p>	N 0522	No Report	03/23/2016

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	<p>the agency failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed (# 3), failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed (# 3); skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed (# 8, 9, 10); occupational and physical therapy follow the therapy frequency in the plan of care for 2 of 9 records reviewed (# 9, 11), failed to obtain PT/INR as ordered in the plan of care for 1 of 2 records reviewed of patients with PT/INR orders (# 9), and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds. (#10)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease,</p>			

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	<p>restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.</p> <p>b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency.</p> <p>c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care</p>			

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	<p>established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks and occupational therapy</p>			

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	<p>two times a week for four weeks starting week starting 01/17/16.</p> <p>a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The occupational therapist failed to follow the plan of care.</p> <p>c. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care</p>			

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	<p>established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p> <p>5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for physical therapy one time a week for one week and occupational therapy one time a week for one week. Physical and Occupation therapy failed to follow the plan of care.</p>			

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N 0524 Bldg. 00	<p>6. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>7. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential.</p>			

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	<p>(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 record review and interview, the agency failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks.</p> <p>a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the</p>	N 0524	No Report	03/23/2016

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	<p>her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. The OASIS dated 02/13/16, states in a narrative, "Patient has renal failure and has dialysis on Monday Wednesday and Friday." The Plan of Care (POC) failed to indicate that the patient was receiving dialysis treatments.</p> <p>b. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient stated that she was on a 1500 calorie diet with fluid restrictions. The plan of care (POC) indicated that the patient was on a regular diet.</p> <p>c. A physician order dated 1/26, 2/2, and 2/16/16 from the wound clinic and a physician order from a coagulation clinic dated 2/5/16 were reviewed. The plan of care failed to be updated to include acceptance of physician orders from the outside clinics / facilities</p> <p>2. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16.</p>			

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	<p>a. Section 14 of the DME (durable medical equipment) and supplies portion of the plan of care, indicated the patient was being supplied foam dressings. The clinical record failed to evidence a wound or skin condition warranting the need for foam dressings. The agency failed to update and revise the plan of care.</p> <p>b. After a home visit with the patient on 02/18/16, the patient's clinical record with the Assisted Living Facility was reviewed. An order dated 08/07/16, indicated the patient's Atorvastatin had been discontinued. Section 10 of the medication section continued to indicate the patient was taking Atorvastatin 10 milligrams daily. The plan of care failed to be revised and updated to reflect the patient's current medication list.</p> <p>3. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16.</p> <p>1. Section 10 of the medication portion of the plan of care indicated the patient was taking Creon [medication for pancreatitis] 24,000 - 76,000 - 120,000 units, 2 tabs 3 times a day, Saccharomyces Boulardii oral, 250 mg [milligrams] 1 tab daily, acetaminophen</p>			

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	<p>325 mg every 6 hours as needed for pain. Section 17 of the allergy portion indicated the patient was allergic to neomycin sulfate and niaspan.</p> <p>2. A hospital discharge summary dated 12/29/15, indicated the patient discharged home with Creon 24,000 3 tabs 3 times a day, no saccharomyces was listed on the discharged list of medications, and acetaminophen 2 - 500 mg tabs every 6 hours three times a day. The summary also indicated the patient was allergic to not only neomycin sulfate and niaspan, but also to neomycin otic and neosporin.</p> <p>3. During a home visit with the patient on 02/18/16 at 10:30 a.m., the patient stated he / she was not familiar nor did he / she know what saccharomyces medication was. The plan of care failed to be updated and revised to include all allergies and correct medications with accurate dosages and frequency.</p> <p>4. Clinical record number 5, SOC 02/01/16, included an established plan of care by a physician for the certification period of 02/01/16 to 03/31/16.</p> <p>a. Review of the discharge paperwork from a skilled nursing facility</p>			

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	<p>dated 01/14/16, indicated the patient was allergic to Albuterol, Lexapro, and Duricef.</p> <p>b. Section 17 of the Allergy section of the plan of care indicated the patient was only allergic to Duricef. The plan of care failed to include allergies to Albuterol and Lexapro.</p> <p>5. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 02/08/16, the Registered Nurse indicated the main focus of the patient's care, was to assess / evaluate cardiovascular and respiratory status, monitor daily weights, edema, and shortness of breath due to the patient has a history of congestive heart failure and atrial fibrillation.</p> <p>a. The cardiovascular assessment indicated the patient's had a trace of edema to the bilateral lower extremities. In reviewing the plan of care, the Registered failed to include interventions such as obtaining / assessing the patient's</p>			

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	<p>weight at each visit, when to notify the physician for increase in weight due to fluid retention, and educate the patient on sodium restrictions / diet and measurable goals.</p> <p>b. The Registered Nurse also had indicated the patient was not taking an anticoagulant. In reviewing of the plan of care and medication profile, the patient was taking Xarelto (anticoagulant medication) 15 mg (milligrams) daily. The plan of care failed to include interventions such as education, assessment, and safety measures and measurable goals.</p> <p>c. M1302 asked if the patient was at risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16, which indicated the patient is at a low risk of developing pressure ulcers. The plan of care failed to include interventions to prevent skin breakdown and measurable goals.</p>			

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	<p>d. M1350 asked if the patient had a skin lesion or open wound that was receiving interventions by the agency. The OASIS assessment was reviewed by quality assurance nurse within the office and the question was changed from "no" to "yes". The admitting nurse agreed to the change of answers. The plan of care failed to include the cite of the skin lesion being treated, failed to include the interventions for the skin lesion and measurable goals.</p> <p>6. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/27/16, line M1730 asked if the patient had been screened for depression, using a standardized validated depression screening tool. The answer provided indicated "yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression." The plan of care failed to be revised and updated to include interventions and goals for depression.</p> <p>7. Clinical record number 11, SOC (start</p>			

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	<p>of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing 2 times a week for 5 weeks to " ... perform / teach wound care to the patient and caregiver, wound vac to RLE diabetic " The plan of care failed to include the type of foam dressing to be used, draping, and the suction settings for the wound vac to be used upon admission.</p> <p>a. Review of the patient's most recent Podiatry visit note dated 10/13/15, included, but not limited to the following medications: Combigan 0.2 - 0.5 % 45 grams APP AA solution twice a day; Glucosamine - Chondroitin 500 400 mg two tablets twice a day; Nitro Bid 2% apply 1" twice a day, Imdur ER 60 mg daily, and a Multivitamin daily. Section 10 of the plan of care failed to evidence the prescribed medications listed.</p> <p>b. The podiatry visit note dated 10/13/15, also indicated the patient was taking Lopressor 50 mg, 1/2 tab twice a day, Vitamin D3 daily, and Vitamin E 200 U, 2 capsules daily. Section 10 of the plan of care indicated the patient was taking 50 mg of Lopressor twice a day, Vitamin D2 & K - Berberine - Hops orally 500 units - 500 mcg (micrograms) - 90 mg - 370 mg daily, and Vitamin E -</p>			

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	<p>Vitamin C - Magnesium - Zinc oral 100 Units - 100 mg - 10 mg - 18 mg. The medications on the plan of care failed to provide accurate medications and their dosage.</p> <p>8. The agency policy and procedure for contents of clinical record (Policy No. HH:2-055.1; revised December, 2012) states as follows: "A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel." The procedure related to said policy indicates that "[r]elevant diet or dietary restrictions, in any" be included in the clinical record for skilled patients.</p> <p>9. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>10. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ...</p>			

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N 0532 Bldg. 00	<p>supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on record review and interview, the agency failed to ensure primary care physicians are notified within a timely manner of missed visits in 2 of 12 records reviewed (# 9 and 11) and failed to notify the physician of a patient's significant weight loss in 1 of 12 record reviewed. (# 9)</p> <p>Findings include:</p> <p>1. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.</p>	N 0532	No Report	03/23/2016

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	<p>a. The plan of care indicated the frequency for occupational therapy was two times a week for four weeks starting week starting 01/17/16. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits.</p> <p>b. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss.</p> <p>2. Clinical record number 11, SOC (start of care) 10/18/15, with an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing two times a week for five weeks, physical therapy one time a week for one week, and occupational therapy one time a week for one week.</p> <p>a. Review of the "Visits to Orders Comparison Report", the skilled nurse had attempted to schedule visits on 10/20 (patient hospitalized), 10/24 (patient / caregiver refused), 10/28 (patient /</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157582	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2016
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	<p>caregiver refused), 10/30 (scheduling error), and 11/03/15 (patient declined skilled nursing service). The only visit made was the admission assessment on 10/18/15.</p> <p>b. A "Client Coordination Note Report" dated 10/28/15, indicated care was projected to continue, but the patient had been refusing visits. The note indicated the case manager was to follow up with primary care physician.</p> <p>c. A "Client Coordination Note Report" dated 11/05,15, indicated that the primary care physician was notified of the patient's refusal and was being discharged from services. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>4. A policy titled "Nutritional Assessment" dated 12/2012, indicated " ... When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care</p>			

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N 0537 Bldg. 00	<p>professional for further nutritional assessment ... 3. Documentation in the clinical record will reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult "</p> <p>5. A policy titled "Assessing Patient's Response / Reporting To Physician" dated 12/2012, indicated " ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient "</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 record review and interview, the Registered Nurse failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed (# 3); failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed (# 3); skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed (# 8, 9, 10); failed to obtain PT/INR as ordered in the plan of care for 1 of 2 records</p>	N 0537	No Report	03/23/2016

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	<p>reviewed of patients with PT/INR orders (# 9); and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds. (#10)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.</p> <p>b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of</p>			

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	<p>care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency.</p> <p>c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care.</p>			

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	<p>b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks.</p> <p>a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care.</p>			

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	<p>b. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p>			

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N 0541 Bldg. 00	<p>5. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>6. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>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. Based on record review and interview, the Registered Nurse failed to assess patient wounds within a timely manner and per agency policy for 4 of 5 records</p>	N 0541	No Report	03/23/2016

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	<p>reviewed of patients with wounds in a sample of 12. (# 3, 8, 9 and 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16. <ol style="list-style-type: none"> a. A physician order from the wound clinic dated 02/02/16, indicated for skilled nursing to provide wound treatment to the bilateral lower extremities daily for 2 weeks. b. Review of the skilled nursing visit notes, the clinical record evidenced a LPN (Licensed Practical Nurse) made daily visits to the patient between 02/04/16 to 02/15/16. The last assessment by registered nurse was made on 1/27/16. The registered nurse failed to reassess the patient's wounds between 01/27/16 to 02/15/16. 2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one 			

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	<p>week.</p> <p>a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing wound to the left lower leg. A skilled nursing visit note dated 12/14/15, indicated the patient requested Employee L, a Registered Nurse / Wound Nurse, assess her wound. Employee L did not see the patient until 12/21/15. Between 12/10/15 to 12/21/15, the patient developed three areas, two partial thickness wounds to the mid - pretibial lower leg and one to the left lateral ankle. The registered nurse failed to follow up and assess the patient's left lower leg wounds within a timely manner.</p> <p>b. A skilled nursing visit note dated 12/28/16, indicated the patient's had two left partial thickness wound to the mid - pretibial lower leg and a trauma wound to the left lateral ankle. The wounds were measured during this time.</p> <p>c. A skilled nursing visit note dated 01/04/16, indicated the registered nurse provided treatment to the three wounds, but failed to evidence that the wounds had not been measured.</p> <p>d. A skilled nursing visit note dated 01/07/16, indicated skilled nursing was going to continue with visits and was not</p>			

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	<p>discharging at the present time due to a wound that was not completely healed. The visit note failed to evidence that the wounds had not been measured.</p> <p>e. Review of the skilled nursing visit notes, the clinical record failed to evidence a visit by the registered nurse for reassessment of the wounds between 01/10/16 to 01/16/16.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16, with orders for skilled nursing.</p> <p>a. A physician order dated 01/20/16, indicated the skilled nurse was to perform wound treatments to an unknown area.</p> <p>b. Review of skilled nursing visit notes dated 02/08/16 and 02/11/16, indicated the registered nurse performed treatment to the right anterior mid pretibial area. The visits notes failed to evidence measurements of the wound for both nursing visit. The clinical record failed to evidenced wound measurements between 02/07/16 to 02/15/16.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the</p>			

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N 0542 Bldg. 00	<p>certification period of 02/09/16 to 04/04/16, with orders for skilled nursing to perform / teach decubitus care to the left upper buttock.</p> <p>a. Review of the skilled nursing visits, the clinical record evidenced a LPN made visits twice a week between 02/09/16 and 2/19/16. The registered nurse failed to reassess the patient's wound between 02/09/16 to 02/19/16.</p> <p>5. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the Registered Nurse failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records</p>	N 0542	No Report	03/23/2016

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	<p>reviewed. (# 1, 2, 3, 5, 6, 7, and 11)</p> <p>Findings include:</p> <p>1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks.</p> <p>a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. The OASIS dated 02/13/16, states in a narrative, "Patient has renal failure and has dialysis on Monday Wednesday and Friday." The Plan of Care (POC) failed to indicate that the patient was receiving dialysis treatments.</p> <p>b. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient stated that she was on a 1500 calorie diet with</p>			

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	<p>fluid restrictions. The plan of care (POC) indicated that the patient was on a regular diet.</p> <p>c. A physician order dated 1/26, 2/2, and 2/16/16 from the wound clinic and a physician order from a coagulation clinic dated 2/5/16 were reviewed. The plan of care failed to be updated to include acceptance of physician orders from the outside clinics / facilities.</p> <p>2. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16.</p> <p>a. Section 14 of the DME (durable medical equipment) and supplies portion of the plan of care, indicated the patient was being supplied foam dressings. The clinical record failed to evidence a wound or skin condition warranting the need for foam dressings. The agency failed to update and revise the plan of care.</p> <p>b. After a home visit with the patient on 02/18/16, the patient's clinical record with the Assisted Living Facility was reviewed. An order dated 08/07/16, indicated the patient's Atorvastatin had been discontinued. Section 10 of the medication section continued to indicate</p>			

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	<p>the patient was taking Atorvastatin 10 milligrams daily. The plan of care failed to be revised and updated to reflect the patient's current medication list.</p> <p>3. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16.</p> <p>1. Section 10 of the medication portion of the plan of care indicated the patient was taking Creon [medication for pancreatitis] 24,000 - 76,000 - 120,000 units, 2 tabs 3 times a day, Saccharomyces Boulardii oral, 250 mg [milligrams] 1 tab daily, acetaminophen 325 mg every 6 hours as needed for pain. Section 17 of the allergy portion indicated the patient was allergic to neomycin sulfate and niaspan.</p> <p>2. A hospital discharge summary dated 12/29/15, indicated the patient discharged home with Creon 24,000 3 tabs 3 times a day, no saccharomyces was listed on the discharged list of medications, and acetaminophen 2 - 500 mg tabs every 6 hours three times a day. The summary also indicated the patient was allergic to not only neomycin sulfate and niaspan, but also to neomycin otic and neosporin.</p>			

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	<p>3. During a home visit with the patient on 02/18/16 at 10:30 a.m., the patient stated he / she was not familiar nor did he / she know what saccharomyces medication was. The plan of care failed to be updated and revised to include all allergies and correct medications with accurate dosages and frequency.</p> <p>4. Clinical record number 5, SOC 02/01/16, included an established plan of care by a physician for the certification period of 02/01/16 to 03/31/16.</p> <p>a. Review of the discharge paperwork from a skilled nursing facility dated 01/14/16, indicated the patient was allergic to Albuterol, Lexapro, and Duricef.</p> <p>b. Section 17 of the Allergy section of the plan of care indicated the patient was only allergic to Duricef. The plan of care failed to include allergies to Albuterol and Lexapro.</p> <p>5. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16, with orders for skilled nursing, physical, and occupational therapy.</p>			

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	<p>a. Review of the OASIS comprehensive admission assessment dated 02/08/16, the Registered Nurse indicated the main focus of the patient's care, was to assess / evaluate cardiovascular and respiratory status, monitor daily weights, edema, and shortness of breath due to the patient has a history of congestive heart failure and atrial fibrillation.</p> <p>a. The cardiovascular assessment indicated the patient's had a trace of edema to the bilateral lower extremities. In reviewing the plan of care, the Registered failed to include interventions such as obtaining / assessing the patient's weight at each visit, when to notify the physician for increase in weight due to fluid retention, and educate the patient on sodium restrictions / diet and measurable goals.</p> <p>b. The Registered Nurse also had indicated the patient was not taking an anticoagulant. In reviewing of the plan of care and medication profile, the patient was taking Xarelto (anticoagulant medication) 15 mg (milligrams) daily. The plan of care failed to include interventions such as education, assessment, and safety measures and measurable goals.</p>			

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	<p>c. M1302 asked if the patient was at risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16, which indicated the patient is at a low risk of developing pressure ulcers. The plan of care failed to include interventions to prevent skin breakdown and measurable goals.</p> <p>d. M1350 asked if the patient had a skin lesion or open wound that was receiving interventions by the agency. The OASIS assessment was reviewed by quality assurance nurse within the office and the question was changed from "no" to "yes". The admitting nurse agreed to the change of answers. The plan of care failed to include the cite of the skin lesion being treated, failed to include the interventions for the skin lesion and measurable goals.</p> <p>6. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the</p>			

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	<p>certification period of 01/27/16 to 03/26/16.</p> <p>a. Review of the OASIS comprehensive admission assessment dated 01/27/16, line M1730 asked if the patient had been screened for depression, using a standardized validated depression screening tool. The answer provided indicated "yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression." The plan of care failed to be revised and updated to include interventions and goals for depression.</p> <p>7. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing 2 times a week for 5 weeks to " ... perform / teach wound care to the patient and caregiver, wound vac to RLE diabetic " The plan of care failed to include the type of foam dressing to be used, draping, and the suction settings for the wound vac to be used upon admission.</p> <p>a. Review of the patient's most recent Podiatry visit note dated 10/13/15, included, but not limited to the following medications: Combigan 0.2 - 0.5 % 45</p>			

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	<p>grams APP AA solution twice a day; Glucosamine - Chondroitin 500 400 mg two tablets twice a day; Nitro Bid 2% apply 1" twice a day, Imdur ER 60 mg daily, and a Multivitamin daily. Section 10 of the plan of care failed to evidence the prescribed medications listed.</p> <p>b. The podiatry visit note dated 10/13/15, also indicated the patient was taking Lopressor 50 mg, 1/2 tab twice a day, Vitamin D3 daily, and Vitamin E 200 U, 2 capsules daily. Section 10 of the plan of care indicated the patient was taking 50 mg of Lopressor twice a day, Vitamin D2 & K - Berberine - Hops orally 500 units - 500 mcg (micrograms) - 90 mg - 370 mg daily, and Vitamin E - Vitamin C - Magnesium - Zinc oral 100 Units - 100 mg - 10 mg - 18 mg. The medications on the plan of care failed to provide accurate medications and their dosage.</p> <p>8. The agency policy and procedure for contents of clinical record (Policy No. HH:2-055.1; revised December, 2012) states as follows: "A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately document care provided and results in</p>			

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	<p>detail, and facilitate continuity of care among organization and contract personnel." The procedure related to said policy indicates that "[r]elevant diet or dietary restrictions, in any" be included in the clinical record for skilled patients.</p> <p>9. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>10. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>11. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care</p>			

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N 0543 Bldg. 00	<p>decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes "</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review and interview, the Registered Nurse failed to address / consult with a dietician in regards to a patient's significant weight loss for 1 of 1 record reviewed of a patient with weight loss in a sample of 12. (# 9)</p> <p>Findings include:</p> <p>1. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. Patient diagnoses include but not limited to, heart failure, atrial fibrillation, diabetes mellitus II, and chronic kidney disease stage five.</p> <p>a. A skilled nursing visit note dated</p>	N 0543	No Report	03/23/2016

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N 0545 Bldg. 00	<p>01/22/16, indicated the patient had a weight of 197 pounds..</p> <p>b. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss.</p> <p>2. The Administrator was unable to provide any additional documentation and/or information when asked on 2/19/16 at 2:50 PM.</p> <p>3. A policy titled "Nutritional Assessment" dated 12/2012, indicated " ... When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment ... 3. Documentation in the clinical record will reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult "</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health</p>			

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	<p>setting, the registered nurse shall do the following: (F) Coordinate services. Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services for 2 of 2 records reviewed (# 2 and 11) of patients receiving outside services, and failed to ensure all disciplines providing service to patients coordinated effectively for 3 of 9 patients receiving therapy services in a sample of 12. (# 7, 8, and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had a plan of care established by a physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. <ul style="list-style-type: none"> A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she 	N 0545	No Report	03/23/2016

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	<p>received dialysis on Monday, Wednesday, and Friday. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p> <p>2. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p>			

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	<p>3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.</p> <p>a. A skilled nursing visit note dated</p>			

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	<p>01/29/16, indicated that the RN obtained a verbal order from the physician office to repeat an INR on 2/2/16.</p> <p>b. A skilled nursing visit note dated 02/04/16, indicated that the LPN obtained a PT/INR from the patient. The clinical record failed to evidence written documentation of the coordination of services related to correct date of the lab specimen to be obtained.</p> <p>c. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>d. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The agency failed to ensure efforts were coordinated effectively. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p>			

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	<p>5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center.</p> <p>6. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic."</p> <p>7. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.</p> <p>8. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes ... F. Communicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to</p>			

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N 0546 Bldg. 00	<p>be provided "</p> <p>9. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences "</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on record review and interview, the agency failed to ensure primary care physicians are notified within a timely manner of missed visits in 2 of 12 records reviewed (# 9 and 11) and failed to notify the physician of a patient's significant weight loss in 1 of 12 record reviewed. (# 9)</p> <p>Findings include:</p> <p>1. Clinical record number 9, SOC</p>	N 0546	No Report	03/23/2016

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	<p>01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.</p> <p>a. The plan of care indicated the frequency for occupational therapy was two times a week for four weeks starting week starting 01/17/16. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits.</p> <p>b. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss.</p> <p>2. Clinical record number 11, SOC (start of care) 10/18/15, with an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing two times a week for five weeks, physical therapy one time a week for one week, and occupational therapy one time a week for one week.</p> <p>a. Review of the "Visits to Orders Comparison Report", the skilled nurse</p>			

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	<p>had attempted to schedule visits on 10/20 (patient hospitalized), 10/24 (patient / caregiver refused), 10/28 (patient / caregiver refused), 10/30 (scheduling error), and 11/03/15 (patient declined skilled nursing service). The only visit made was the admission assessment on 10/18/15.</p> <p>b. A "Client Coordination Note Report" dated 10/28/15, indicated care was projected to continue, but the patient had been refusing visits. The note indicated the case manager was to follow up with primary care physician.</p> <p>c. A "Client Coordination Note Report" dated 11/05,15, indicated that the primary care physician was notified of the patient's refusal and was being discharged from services. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>4. A policy titled "Nutritional Assessment" dated 12/2012, indicated " ... When the initial and comprehensive</p>			

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N 0547 Bldg. 00	<p>assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment ... 3. Documentation in the clinical record will reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult "</p> <p>5. A policy titled "Assessing Patient's Response / Reporting To Physician" dated 12/2012, indicated " ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient "</p> <p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview, the agency failed to ensure orders provided by outside facilities were clarified and had all pertinent and specific information including route, rate, and strength within the order for 1 of 1 patient record reviewed with Intravenous fluids (#12); failed to include include if a</p>	N 0547	No Report	03/23/2016

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	<p>PT/INR was to be obtained peripherally or by finger stick for 1 of 2 patient records reviewed getting PT/INRs (#9); failed to include all locations of wounds in a physician's order for 1 of 5 records reviewed (# 9) of patient's with wounds, and failed to write an order for speech therapy for 1 of 2 patient's receiving speech therapy (# 9) in a sample of 12 patient records.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 9, SOC (start of care) 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. <ol style="list-style-type: none"> a. A physician's order dated 01/20/16, indicated for the skilled nurse to "remove old dressing, cleanse wound with normal saline, pat dry, cover with foam dressings." The physicians order failed to include location of the wound. b. A skilled nursing visit note dated 01/29/16, indicated in the narrative note "Repeat INR next Tuesday 2/2/16." The verbal order failed to be put into writing, signed, and dated by the skilled nurse. c. A physician order dated 02/09/16, indicated for a skilled nurse to obtain a PT/INR on 02/23/16. The order failed to 			

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	<p>include if the PT/INR was to be obtained by peripheral stick or by finger stick.</p> <p>d. Review of the therapy visit notes, the clinical record evidence speech therapy visits dated 01/25, 01/27, 02/03, and 02/08/16. The clinical record failed to evidence an order for speech therapy.</p> <p>2. Clinical record number 12, SOC 11/10/15, included an established plan of care for the certification periods of 11/10/15 to 01/08/16.</p> <p>a. A physician order dated 11/19/15, indicated "HH [home health] nurse to administer 500 ml [milliliters] NS [normal saline] now, then repeat tomorrow." The order was taken by the residential living nurse. The agency failed to have the ordered clarified to include the strength of the normal saline, rate of infusion, and if the patient needed a peripheral IV started for infusion or if the patient already had an implanted port / central line for route.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>4. A policy titled "Intravenous</p>			

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N 0550 Bldg. 00	<p>Administration of Medications / Solutions" dated 12/2012, indicated " ... All orders for IV medications and solutions will specify medication name and dosage, diluent type and amount, route, frequency of administration, and rate of infusion ... IV medications and solutions will only be administered through a peripheral or central venous line "</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on record review and interview, the agency failed to ensure that the home health aide written instructions were accurate in relation to the patient's performance abilities. (#3)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with</p>	N 0550	No Report	03/23/2016

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N 0553 Bldg. 00	<p>personal care and activities of daily living.</p> <p>a. A home health aide written plan of instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks.</p> <p>b. During a home visit on 02/16/16 at 10:30 AM, the patient verbalized that he / she had his / her first bath in 6 months recently. The patient verbalized he / she had been afraid to get into the shower due to his illness, weakness, and unsteady gait. The patient indicated he / she had been getting sponge bathes at the sink. The home health aide written care instructions failed to be specific to the patient needs.</p> <p>2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with</p>			

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	<p>agency policies.</p> <p>Based on record review and interview, the agency failed to ensure the LPN [Licensed Practical Nurse] followed the agency administrative policy / job description in regards to communicating with the RN [registered nurse] and / or Director of Professional Services and the physician in relation to a patient developing integumentary changes to his / her lower extremity for 1 of 5 records reviewed with a patient receiving services from a LPN. (# 8)</p> <p>Finding include:</p> <p>1. A job description for an LPN dated 12/2012, indicated " ... Essential functions ... 3. Performs an ongoing assessment during each visit and documents data inpatient medical records. Communicates significant findings, problems, or changes in the patient's condition to the supervising RN and / or Director of Professional Services and the physician and documents all findings, communications and appropriate interventions. Documents nursing interventions including patient response "</p> <p>2. Clinical record number 8, SOC (start of care) 11/18/15, included a plan of care established by a physician for the</p>	N 0553	No Report	03/23/2016

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	<p>certification period 11/18/15 to 01/16/16.</p> <p>a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing area on LLE [left lower extremity] anterior lower half was noted. SN [skilled nurse] offered to interfere and help in taking care of that wound but the pt [patient] refused completely and stated that his / her dermatologist said that this is contact dermatitis and it will heal by self." The clinical record failed to evidence that the LPN notified the RN / Director of Professional Services.</p> <p>3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>4. A policy titled "Scope of Service" dated 12/2012, indicated " ... 2. Licensed practical / vacation nurses supplement the nursing care needs of the patient as provided by the registered nurse. These include ... Providing services in accordance with organization policies ... Preparing clinical and progress notes ... Assisting the registered nurse or physician in performing specialized procedures and duties ... Assisting the registered nurse in carrying out the plan of care "</p>			

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N 0555 Bldg. 00	<p>410 IAC 17-14-1(a)(2)(C) Scope of Services Rule 14 Sec. 1(a) (2)(C) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (C) Assist the physician and/or registered nurse in performing specialized procedures. Based on record review and interview, the LPN (Licensed Practical Nurse) failed to include a description of wounds being observed and failed to document treatments that were being provided in accordance to physician orders in 3 of 5 records reviewed of patients with wounds. (# 3, 8, and 10)</p> <p>Finding include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16, with orders for skilled nursing 2 times a week for 6 weeks.</p> <p>a. A physician order from the wound clinic dated 01/26/16, indicated three ulcer areas to be treated. 1. An ulcer to the right anterior leg measuring 3.5 cm x 1 cm x 0.1 cm. The treatment included to cleanse the per i- ulcer area with sterile water and moisturize the dry skin 3 times a week for 1 week. 2. An ulcer to the</p>	N 0555	No Report	03/23/2016

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	<p>left heel measuring 1.8 cm x 1.3 cm x 0.1 cm. The treatment included to cleanse the peri - ulcer area with plain water and moisturize the heels and legs, apply a nickel thick layer of Santyl [debrding agent] to the wound, followed by 4 x 4 gauze, foam heel, hydrogel, kerlix, and paper tape daily for 1 week. 3. An ulcer to the right 2nd toe measuring 1.7 cm x 0.8 cm x 0.1 cm. The treatment included to cleanse the wound with plain water. Use vicks vapor rub as the primary dressing, place a pad between left 3rd and 4th toes, daily for 1 week.</p> <p>1. A skilled nursing visit note dated 01/28/16, indicated the LPN provided wound care to the bilateral lower extremity wounds under aseptic technique per orders. The skilled nursing assessment failed to evidence the specific location (left heels, right anterior leg, and right 2nd digit toe), assessment, and treatment provided to the bilateral extremity wounds.</p> <p>2. A skilled nursing visit note dated 01/30/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p>			

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	<p>3.. A skilled nursing visit note dated 01/31/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>4. A skilled nursing visit note dated 02/01/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>b. A physician order from the wound clinic dated 02/02/16, indicated the right anterior leg ulcer measured 3 cm x 1 cm x 0.1 cm. The treatment included to cleanse the per i- ulcer area with sterile water and moisturize the dry skin 3 times a week for 1 week. The order also indicated an ulcer to the left heel measuring 1.5 cm x 0.8 cm x 0.1 cm. The treatment included to cleanse the peri - ulcer area with sterile water and moisturize the heels and legs, apply PRISMA [medicated dressing], followed by 4 x 4 gauze, foam heel, kerlix and tape daily for two weeks. The right 2nd digit</p>			

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	<p>toe ulcer measured 0.8 cm x 0.6 cm x 0.1 cm. The treatment included to cleanse the wound with plain water. Use vicks vapor rub as the primary dressing, place a pad between left 3rd and 4th toes, daily for 2 weeks.</p> <p>1. A skilled nursing visit note dated 02/04/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>2. A skilled nursing visit note dated 02/05/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>3. A skilled nursing visit note dated 02/06/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p>			

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	<p>4. A skilled nursing visit note dated 02/07/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).</p> <p>5. A skilled nursing visit note dated 02/08/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>6. A skilled nursing visit note dated 02/09/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>7. A skilled nursing visit note dated 02/10/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their</p>			

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	<p>treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>8. A skilled nursing visit note dated 02/11/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>9. A skilled nursing visit note dated 02/12/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>10. A skilled nursing visit note dated 02/13/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p>			

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	<p>11. A skilled nursing visit note dated 02/14/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>12. A skilled nursing visit note dated 02/15/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing area on LLE [left lower extremity] anterior lower half was noted.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A skilled nursing visit note dated 12/14/15, indicated the patient had a wound, but failed to evidence an assessment of the wound.</p> <p>3. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p> <p>4. The Administrator and Director of Clinical Services was unable to provide</p>			

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N 0560 Bldg. 00	<p>any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>410 IAC 17-14-1(b) Scope of Services Rule 14 Sec. 1(b) Any therapy services furnished by the home health agency shall be provided by: (1) a physical therapist or physical therapist assistant supervised by a licensed physical therapist in accordance with IC 25-27-1; or (2) an occupational therapist or occupational therapist assistant supervised by an occupational therapist in accordance with IC 25-23.5. (3) a speech-language pathologist or audiologist in accordance with IC 25-35.6. Based on record review and interview, the agency failed to ensure the occupational and physical therapy follow the therapy frequency in the plan of care for 5 of 9 records reviewed in a sample of 12. (# 3, 8, 9, 10, and 11)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.</p> <p>a. Review of the OASIS comprehensive admission assessment</p>	N 0560	No Report	03/23/2016

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	<p>dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.</p> <p>b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency.</p> <p>c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the</p>			

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	<p>acceptance of physician orders.</p> <p>2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the</p>			

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	<p>certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks and occupational therapy two times a week for four weeks starting week starting 01/17/16.</p> <p>a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The occupational therapist failed to follow the plan of care.</p> <p>c. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse</p>			

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	<p>failed to follow the plan of care.</p> <p>4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing.</p> <p>a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care.</p> <p>5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for physical therapy one time a week for one</p>			

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N 0563 Bldg. 00	<p>week and occupational therapy one time a week for one week. Physical and Occupation therapy failed to follow the plan of care.</p> <p>6. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>410 IAC 17-14-1(c)(2) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months; Based on record review and interview, the agency failed to ensure that the registered nurse performed a comprehensive assessment for recertification in the last 5 days of the 60 day certification period for 1 of 2 patient record reviewed who was recertified for an additional 60 days. (# 8)</p> <p>Finding include:</p> <p>1. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16.</p>	N 0563	No Report	03/23/2016

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	<p>a. The clinical record evidenced a comprehensive reassessment dated 01/21/16. The skilled nurse failed to complete the comprehensive assessment for recertification between the dates of 01/12/16 to 01/16/16.</p> <p>2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>3. A policy titled "Initial and Comprehensive Assessment" dated 12/2012, indicated "A comprehensive patient assessment will be completed ... The last five (5) days of every 60 - day episode beginning with the start of care date (recertification) "</p> <p>4. A policy titled "Reassessments / Recertification" dated 12/2012, indicated " ... The comprehensive assessment must be updated and revised every 60 days from the start of care ... OASIS assessments within the mandated time frames: A. recertification day 56 - 60 of the current certification period ... 2. For each new episode of care, a comprehensive assessment will be completed no earlier than five (5) days before and no later than one (1) day</p>			

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N 0565 Bldg. 00	<p>before the calendar day on which the new episode of care will begin "</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on record review and interview, the therapist failed to include frequency of proposed visits with speech, physical, and occupational therapy and if the patient / representative was in agreement with the plan of care in 3 of 9 records reviewed of patients receiving therapy in a sample of 12. (# 8, 9, and 12)</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC (start of care) 11/18/15, included a plan of care established by a physician for the certification period of 11/18/15 to 01/16/16, with orders for physical and occupational therapy services.</p> <p>a. Review of the physical therapy initial evaluation visit dated 11/18/15, the physical therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p>	N 0565	No Report	03/23/2016

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	<p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, the occupational assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>2. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for physical and occupational therapy services.</p> <p>a. Review of the occupational therapy initial evaluation visit dated 01/18/16, failed to include the frequency of the proposed visits.</p> <p>b. Review of the physical therapy initial evaluation visit dated 01/19/16, failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>3. Clinical record number 12, SOC 11/10/15, included a plan of care established by a physician for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services.</p>			

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N 0566 Bldg. 00	<p>a. Review of the occupational therapy initial evaluation visit note dated 11/13/15, the occupational therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>b. Review of the speech therapy initial evaluation visit note dated 11/13/15, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.</p> <p>4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p> <p>410 IAC 17-14-1(c)(5) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes; Based on record review and interview, Occupational and Speech therapy failed to ensure that a discharge summary had been completed at the end of services that were provide for 1 of 4 records reviewed</p>	N 0566	No Report	03/23/2016

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N 0567 Bldg. 00	<p>of patient with discharged therapy services in a sample of 12. (# 12)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record number 12, SOC (start of care) 11/10/15, included an established plan of care for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services. <ol style="list-style-type: none"> Review of the occupational therapy visit notes, the occupational therapist last visit was made on 12/03/15. The occupational therapist failed to complete a discharge summary. Review of the speech therapy visit notes the speech therapist last visit was made on 12/01/15. The speech therapist failed to complete a discharge summary. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. <p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel;</p>			

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	<p>Based on record review and interview, the Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12. (# 7, 8, and 9)</p> <p>Findings include:</p> <p>Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his /</p>	N 0567	No Report	03/23/2016

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	<p>her coordination efforts with the physical therapist and with the case manager.</p> <p>3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.</p> <p>4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the</p>			

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	<p>certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy.</p> <p>a. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>b. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager.</p> <p>5. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.</p>			

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N 0570 Bldg. 00	<p>410 IAC 17-14-1(d) Scope of Services Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may:</p> <p>(1) direct the activities of any therapy assistant; or (2) delegate duties and tasks to other individuals as appropriate.</p> <p>Based on record review and interview, the Physical Therapist and Occupational Therapist failed to provide supervision of the physical therapy assistance according to Article 6 and certified occupational therapy assistant according to Article 10 for 1 of 1 patient who had therapy assistants in a sample of 12. (# 7)</p> <p>Findings include:</p> <p>1. Article 6. Physical Therapists and Physical Therapists' Assistants, 844 IAC (Indiana Administrative Code) 6 - 1 - 2 Definitions indicated " ... [g] ... With respect to the supervision of physical therapist's assistants under IC [Indiana Code] 25 - 27 - 1 - 2 [c], unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments ... [3] A consultation between a supervising physical therapist or a physician and the</p>	N 0570	No Report	03/23/2016

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NAME OF PROVIDER OR SUPPLIER BROOKDALE HOME HEALTH INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST INDIANAPOLIS, IN 46268
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	<p>physical therapist's assistant may be in person, by telephone, or by a telecommunications device for the deaf [TDD], so long as there is interactive communication concerning patient care "</p> <p>2. Article 10. Occupational Therapists and Occupational Therapy Assistants, 844 IAC 10 - 5 - 6 Documentation Sec. 6 indicated "Thee occupational therapist shall countersign within seven [7] calendar days all documentation written by the occupational therapy assistant, which will become part of the patient's permanent record."</p> <p>3. Clinical record number 7, SOC 01/27/16 (start of care), included a plan of care established by the physician for the certification period of 01/27/16 to 03/26/16, with orders for physical therapy one time a week for one week then two times a week for six weeks, and occupational therapy one time a week for one week then two times a week for five weeks.</p> <p>a. Review of supervisory visit report completed by a registered nurse on 02/09 and 02/23/16, asked for the name of therapist being evaluated. The registered nurse indicated Employee A, PT [physical therapist] Employee F, OT</p>			

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	<p>[occupational therapist], Employee G, COTA [certified occupational therapy assistant], Employee K, PT, and Employee H, PTA [physical therapy assistant].</p> <p>b. Review of the physical therapy assistant notes dated 02/05, 02/17, and 02/19/16, the visit note and the clinical record failed to evidence that the physical therapist and the physical therapy assistant communicated with each other after the visit was.</p> <p>c. Review of the certified occupational therapy assistant note dated 02/12/16, the visit note and clinical record failed to evidence co-signature / communication between the occupational therapist and the certified occupational therapy assistant.</p> <p>4. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated physical / occupational therapist and physical therapy assistants / certified occupational therapy assistants would email and / or text each other if there was a need but was not aware of the of the daily communication to be documented between PT and PTA, as well as weekly signatures between OT and COTA.</p>			

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N 0608 Bldg. 00	<p>5. The Administrator and Director of Clinical Services was interviewed on 2/24/16 at 2:00 PM. The Administrator and Director of Clinical Services stated PT / OT only supervises the PTA / COTA.</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on record review and interview, the agency failed to ensure that clinical visit notes were truthful and accurate for 2 of 12 records reviewed (# 1 and 3), failed to ensure the clinical record include discharge summaries from speech and occupational therapy for 1 of 9 record reviewed of patients receiving therapy. (# 12)</p>	N 0608	No Report	03/23/2016

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	<p>Findings include:</p> <p>1. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16. The patient has a known history of a sacral debubitous ulcer that was treated by the agency in September, 2015.</p> <p>a. A home visit was made with the LPN (licensed practical nurse) on 02/18/16 at 8:15 a.m. The LPN was observed to calibrate the patient's glucometer, obtain blood sugar, inject insulin, obtained vital signs, and ask generalized assessments. The LPN did not assess the patient's skin in the coccyx area. The skilled nursing visit note indicated the LPN had performed a skin assessment. The LPN inaccurately documented an assessment that was not performed.</p> <p>2. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with personal care and activities of daily living.</p>			

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	<p>a. A home health aide written plan of instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks.</p> <p>b. Review of the home health aide visit notes, that are being performed by a licensed practical nurse, indicated the patient had received a shower on 01/28, 02/02, 02/09, 02/16/16.</p> <p>c. During a home visit on 02/16/16 at 10:30 AM, the patient verbalized that he / she had his / her first bath in 6 months recently. The patient verbalized he / she had been afraid to get into the shower due to his illness, weakness, and unsteady gait. The patient indicated he / she had been getting sponge bathes at the sink. The LPN acting as a home health aide inaccurately documented the bathing task that was not performed.</p> <p>3. Clinical record number 12, SOC (start of care) 11/10/15, included an established plan of care for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services.</p> <p>a. Review of the occupational therapy visit notes, the occupational</p>			

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	<p>therapist last visit was made on 12/03/15. The occupational therapist failed to complete a discharge summary.</p> <p>b. Review of the speech therapy visit notes the speech therapist last visit was made on 12/01/15. The speech therapist failed to complete a discharge summary.</p> <p>4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.</p>				