

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157619	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2016
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NAME OF PROVIDER OR SUPPLIER  CORNERSTONE HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5 HIGH STREET MOORESVILLE, IN 46158
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G 0000  Bldg. 00	<p>This was a Federal recertification survey. The survey was extended on 07/20/16.</p> <p>Survey Dates: July 18 to July 22, 2016</p> <p>Facility #: 0126076</p> <p>Provider #: 157610</p> <p>Medicaid #: 200942300</p> <p>Current Census: 88</p> <p>Cornerstone Home Healthcare is precluded from providing its own training and competency evaluation program for a period of 2 years beginning July 22, 2016 to July 22, 2018, 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. 48 Clinical Records.</p>	G 0000		
G 0107  Bldg. 00	<p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made</p>			

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

TITLE

(X6) DATE

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

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	<p>by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on record review and interview, the agency failed to ensure all complaints and grievances made by patients and / or their families were documented and investigated with resolution in 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the entrance conference on 07/18/16 at 10:15 AM, the Administrator and Director of Clinical Services indicated they had received complaints from patients and / or their families in regards to tardiness of staff or not knowing when the staff was coming. Both indicated that these were minor issues.</li> <li>2. Review of the complaint / grievance binder on 07/18/16 at 12:00 PM, the binder contained only 2 complaints from the Deyta. (Deyta is a healthcare satisfaction management and clinical quality improvement program services). The complaint binder failed to include all complaints and grievances in relation to</li> </ol>	G 0107	<p>G0107On 08/19/2016 Director of Client Care Services and Administrator provided in-service training to clinical staff and office staff regarding Client Concerns/Grievances Policy 200.70. Reinforcing the procedure of documenting any client concerns, issues or problems in writing. Instructing staff that any concern, issue, or problem that can be resolved "On the Spot" should be resolved and documented in the visit note or communication note in the record and forwarded to the Cornerstone Office. Staff were informed that any concern, issue, or problem that cannot be resolved, is to be forwarded verbally or in writing on communication note or incident log to the Cornerstone Office to follow up. Field staff voiced understanding of this procedure. On 08/19/2016 Office staff were instructed to document all client concerns in communication note with documentation of "On the Spot" resolution when able. Office staff were instructed that when the issue or concern is not able to be resolved to forward all client concerns to administrative staff verbally or in writing on date</p>	08/19/2016

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G 0143 Bldg. 00	<p>tardiness and patients not knowing when the staff was coming to their home.</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 record review and interview, the agency failed to ensure that their efforts were coordinated effectively and support the objectives outlined in the plan of care in 1 of 1 records reviewed (# 9) of patient's who was receiving outside services with a Dialysis facility and with an Assisted Living Facility / Community in a sample of 12 and failed to follow up with medical social services in regards to discharge planning in 2 of 12 clinical record reviewed. (# 4 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16, with orders for skilled nursing.</p>	G 0143	<p>of receipt. Office staff verbalized understanding. Client Concerns/Grievances Policy 200.70 was amended to include Office staff documenting the concern/resolution in a communication note. Client concerns/grievances will be trended and reported through the performance improvement/risk management function.</p> <p>In order to maintain liaison to ensure coordinated care that effectively supports the objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained</p>	08/19/2016

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	<p>A. Two skilled nursing visit notes dated 06/06, 06/13, and 06/20/16, indicated in the discharge planning section "Ongoing, Spoke to [spouse] regarding [name of Employee G, a medical social worker] who will see him / her again to assist with community resources for future care."</p> <p>B. Three subsequent skilled nursing visit notes dated 06/27, 07/05, and 07/11/16, indicated in the discharge planning section "Ongoing. MSW has seen them and spoke to his / her son. He / She reports that his / her son is working on getting support for him / her when Home Care moves out."</p> <p>C. An OASIS comprehensive recertification assessment dated 07/19/16, indicated in the coordination of care section " ... Psychological support and therapy, MSW [medical social worker] visiting patient and his wife regarding future care options and community resources .... "</p> <p>D. Review of the electronic medical record and hard chart record, the clinical record failed to evidence that a medical social worker had made a visit due to no record of the visit. The skilled nursing visit notes were repetitive and failed to</p>		<p>inpatient hard chart. This process will begin at next case conference on August 31, 2016. On 08/03/2016 and 08/19/2016 Director of Client Care Services and Administrator educated clinical staff on importance of effective care coordination and communication between disciplines to ensure best outcomes for patients and the required documentation of this in the clinical record. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on care coordination with the physician. Staff were educated on reporting to the physician any changes, concerns, or discrepancies noted during visits to the physician for clarification of orders or to obtain new orders as indicated. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of dialysis patients, Cornerstone Home Healthcare will call or fax dialysis centers and/or nephrologists for medications and specific parameters for each patient. Cornerstone will make every effort to receive this information, any calls/faxes of requests will be retained in the clinical record. The information received will be implemented into the patient's plan of care upon receipt. On 08/03/2016 and 08/19/2016 Director of Client Care Services</p>	

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	<p>evidenced if skilled nursing had followed up with medical social services and the progress on discharge planning.</p> <p>2. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to do vital signs with each visit, assess patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is removed. The patient diagnoses included, but not limited to, aftercare following surgery for neoplasm and type 2 diabetes mellitus.</p> <p>A. Review of the skilled nursing visit note dated 06/03/16, the clinician failed to document the amount of drainage from the JP drain, failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment. The clinician also failed to educate the patient in documenting and measuring the drainage from the JP drains, so that the physician would know when to remove the drains.</p>		<p>educated clinical staff coordination and documentation of care with dialysis centers/nephrologist. Instructions were made to clinical staff to document all communication in the medical record. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of patients residing in congregated facilities, Cornerstone Home Healthcare will coordinate care with facility nursing staff regarding services provided to patients. Cornerstone Home Healthcare will continue its practice of noting on the 485 "ALF staff is responsible for" and note specific care the patient is receiving from the ALF. Cornerstone Home Healthcare staff will communicate and coordinate with ALF staff on, but not limited to, blood sugars, medication changes, labs and PT/INR results. Coordination of care will be documented and filed in patient clinical record. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated staff on coordination and documentation of care with patients residing in congregated facilities. The staff verbalized understanding. On 08/03/2016 and 08/19/2016 the Director of Client Care Services and Administrator instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for</p>				

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	<p>B. Review of the skilled nursing visit note dated 06/07/16, the clinician failed to failed to provide a measurement and the number of staples that was used to close the incision and failed to obtain a temperature with the vital sign assessment.</p> <p>C. Review of the skilled nursing visit note dated 06/09/16, the clinician failed to failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment.</p> <p>D. Review of the skilled nursing visit notes dated 06/13/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/15/16, the patient was transferred to the hospital and admitted for a urinary tract infection.</p> <p>E. Review of the resumption of care assessment dated 06/22/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/24/16, the patient's temperature was obtained and the patient had a low grade temperature of 99.1.</p> <p>F. Review of the skilled nursing visit notes in the diabetic section dated 06/03,</p>		<p>example documenting the number of staples in an incision, documenting drainage from a JP drain that patient is tracking in the clinical record, obtaining a temperature and obtaining blood sugar readings from the ALF. In order to capture patients that need specific care coordination with dialysis, ALF, or specialty groups, Cornerstone will be review all new admission weekly to ensure these patients are properly identified, clinical staff informed, and information has been requested. Administrator spoke with Community Liaison on 08/19/2016 and instructed her to notate on intake forms, when able, when a patient resides in a congregated living, or is on dialysis. Plan of Care Development and Review Policy 801.90 has been revised to reflect care coordination between various sources. The Director of Client Care Services/QA personal will monitor on an ongoing basis through chart audits, compliance to the policy for care coordination. 10% of all clinical records will be audited quarterly for evidence of care coordination. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse failed to accurately assess and document the patient diabetes at the time of the assessment.</p> <p>3. Clinical record number 9, SOC (start of care) 05/21/16, included a plan of care for the certification period of 05/21/16 to 07/19/16, with orders for skilled nursing, physical, and occupational therapy. The patient's primary diagnosis was cerebral infarction (stroke) followed by secondary diagnoses of general weakness, diabetes type 2, end stage renal disease, neuropathy, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and rheumatoid arthritis. The patient resides in an Assisted Living Facility / Community (ALF).</p> <p>A. Review of the OASIS start of care</p>			

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	<p>comprehensive assessment dated 05/21/16, the assessment indicated the patient was receiving hemodialysis, had a right port a cath [catheter used for hemodialysis] in the left chest wall, and a new av graft / fistula [accessible site in the arm used for dialysis] in the left upper arm. The clinical record failed to evidence coordination with the dialysis center, such as blood pressure parameters, management of port a cath, diet, fluid restrictions, and medications / flushes used during dialysis.</p> <p>B. Review of the skilled nursing visit notes dated 05/27, 06/04, 06/07, 06/14, 06/20, 06/27, 07/08, and 07/11/16, the diabetic care section under comments indicated "Patient reports that ALF personnel checks his / her blood sugar and administers insulin as ordered - see medication profile .... " The clinical record failed to evidence coordination with the ALF in regards to assessment of the patient's blood sugars as well as the services that the ALF were being provided to the patient.</p> <p>4. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p>			

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G 0144 Bldg. 00	<p>5. An undated policy titled "Plan of Care Development and Review" indicated "Multidisciplinary care conferences are held on clients as needed ... to promote coordination and continuity of care. The results are documented and a copy is retained in the client's medical record .... "</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. Based on record review and interview, the agency failed to ensure that their efforts were coordinated and documented effectively and support the objectives outlined in the plan of care in 1 of 1 records reviewed (# 9) of patient's who was receiving outside services with a Dialysis facility and with an Assisted Living Facility / Community in a sample of 12 and failed to follow up with medical social services in regards to discharge planning in 2 of 12 clinical record reviewed. (# 4 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16, with orders for skilled nursing.</p>	G 0144	In order to maintain liaison to ensure coordinated care that effectively support objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained in patient hard chart. This process	08/19/2016			

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	<p>evidenced if skilled nursing had followed up with medical social services and the progress on discharge planning.</p> <p>2. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to do vital signs with each visit, assess patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is removed. The patient diagnoses included, but not limited to, aftercare following surgery for neoplasm and type 2 diabetes mellitus.</p> <p>A. Review of the skilled nursing visit note dated 06/03/16, the clinician failed to document the amount of drainage from the JP drain, failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment. The clinician also failed to educate the patient in documenting and measuring the drainage from the JP drains, so that the physician would know when to remove the drains.</p>		<p>coordination and documentation of care with dialysis centers/nephrologist. Instructions were made to clinical staff to document all communication in the medical record. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of patients residing in congregated facilities, Cornerstone Home Healthcare will coordinate care with facility nursing staff regarding services provided to patients. Cornerstone Home Healthcare will continue its practice of noting on the 485 "ALF staff is responsible for" and note specific care the patient is receiving from the ALF. Cornerstone Home Healthcare staff will communicate and coordinate with ALF staff on, but not limited to, blood sugars, medication changes, labs and PT/INR results. Coordination of care will be documented and filed in patient clinical record. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated staff on coordination and documentation of care with patients residing in congregated facilities. The staff verbalized understanding. On 08/03/2016 and 08/19/2016 Director of Client Care Services and Administrator instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for example</p>	

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	<p>B. Review of the skilled nursing visit note dated 06/07/16, the clinician failed to failed to provide a measurement and the number of staples that was used to close the incision and failed to obtain a temperature with the vital sign assessment.</p> <p>C. Review of the skilled nursing visit note dated 06/09/16, the clinician failed to failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment.</p> <p>D. Review of the skilled nursing visit notes dated 06/13/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/15/16, the patient was transferred to the hospital and admitted for a urinary tract infection.</p> <p>E. Review of the resumption of care assessment dated 06/22/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/24/16, the patient's temperature was obtained and the patient had a low grade temperature of 99.1.</p> <p>F. Review of the skilled nursing visit notes in the diabetic section dated 06/03,</p>		<p>documenting the number of staples in an incision, documenting drainage from a JP drain that patient is tracking in the clinical record, obtaining a temperature and obtaining blood sugar readings from the ALF. In order to capture patients that need specific care coordination with dialysis, ALF, or specialty groups, Cornerstone will be review all new admission weekly to ensure these patients are properly identified, clinical staff informed, and information has been requested. Administrator spoke with Community Liaison on 08/19/2016 and instructed her to notate on intake forms, when able, when a patient resides in a congregated living, or is on dialysis. Plan of Care Development and Review Policy 801.90 has been revised to reflect care coordination between various sources. The Director of Client Care Services/QA personal will monitor on an ongoing basis through chart audits, compliance to the policy for care coordination. 10% of all clinical records will be audited quarterly for evidence of care coordination. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse failed to accurately assess and document the patient diabetes at the time of the assessment.</p> <p>3. Clinical record number 9, SOC (start of care) 05/21/16, included a plan of care for the certification period of 05/21/16 to 07/19/16, with orders for skilled nursing, physical, and occupational therapy. The patient's primary diagnosis was cerebral infarction (stroke) followed by secondary diagnoses of general weakness, diabetes type 2, end stage renal disease, neuropathy, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and rheumatoid arthritis. The patient resides in an Assisted Living Facility / Community (ALF).</p> <p>A. Review of the OASIS start of care</p>			

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	<p>comprehensive assessment dated 05/21/16, the assessment indicated the patient was receiving hemodialysis, had a right port a cath [catheter used for hemodialysis] in the left chest wall, and a new av graft / fistula [accessible site in the arm used for dialysis] in the left upper arm. The clinical record failed to evidence coordination with the dialysis center, such as blood pressure parameters, management of port a cath, diet, fluid restrictions, and medications / flushes used during dialysis.</p> <p>B. Review of the skilled nursing visit notes dated 05/27, 06/04, 06/07, 06/14, 06/20, 06/27, 07/08, and 07/11/16, the diabetic care section under comments indicated "Patient reports that ALF personnel checks his / her blood sugar and administers insulin as ordered - see medication profile .... " The clinical record failed to evidence coordination with the ALF in regards to assessment of the patient's blood sugars as well as the services that the ALF were being provided to the patient.</p> <p>4. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p>						

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G 0145 Bldg. 00	<p>5. An undated policy titled "Plan of Care Development and Review" indicated "Multidisciplinary care conferences are held on clients as needed ... to promote coordination and continuity of care. The results are documented and a copy is retained in the client's medical record .... "</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. Surveyor: Ford, Shannon Based on record review and interview, the agency failed to ensure the primary care physician received a written summary report on their patient at least every 60 days / in a timely manner for 2 of 7 records reviewed of patients who were recertified in a sample of 12. (#8 and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC (start of care) dated 01/13/16, included two plans of care for the certifications of 01/13/16 to 03/12/16 and 03/13/16 to 05/11/16 with orders for skilled nursing and home health aide services.</p>	G 0145	In order to ensure a written summary report for each patient is sent to the attending physician at least every 60 days, Cornerstone Home Healthcare will review upcoming recertification's weekly at regularly scheduled office staff meetings. 60 day summaries will be assigned in patient clinical record and appropriate clinical team member notified for completion within the week. At following weekly regularly scheduled office staff meeting the completed 60 day summaries will be printed and faxed to the physician for review to ensure that they have been faxed to the physician by day 60. On 08/19/2016 Director of Client Care Services and Administrator educated staff on the content of the 60 day summary and	08/19/2016	

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	<p>A. Review of a 60 day summary dated 03/10/16 for the certification 01/13/16 to 03/12/16, the summary was stapled to a fax cover sheet which indicated the summary was faxed to the physician on 05/03/16. The summary failed to be sent to the physician in a timely manner.</p> <p>B. Review of a 60 day summary dated 05/11/16 for the certification 03/13/16 to 05/11/16, the summary was stapled to a fax cover sheet which indicated the summary was faxed to the physician on 06/29/16. The summary failed to be sent to the physician in a timely manner.</p> <p>2. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>A. Review of the clinical record, the patient was transferred to the hospital on 05/23/16. The patient resumed services on 05/25/16. The OASIS comprehensive resumption of care assessment narrative note dated 05/25/16, indicated the patient was hospitalized for exacerbation of congestive heart failure. The note also indicated the patient would be having a pacemaker placed on 06/03/16. The 60</p>		<p>including summary of care provided, current status, and goals. Clinical staff were instructed on providing the physician with a comprehensive picture of the patient's services over the last 60 days and documentation as to the reasoning the patient continues to require services. Staff verbalized understanding. This will be monitored during the weekly staff meetings for compliance of staff and those who are not compliant will be counseled immediately and will request for the 60 day summary to be completed immediately. The Director of Client Care Services/QA personal will monitor on an ongoing basis through chart audits, compliance to the policy for care coordination. 10% of all clinical records will be audited quarterly for evidence of the 60 day summary being sent to the physician by day 60. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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G 0156 Bldg. 00	<p>day summary was sent to the primary care physician on 07/19/16. The 60 day summary dated 07/05/16, failed to include the patient's hospitalization, pacemaker procedure, any changes in interventions, and goals that have or have not been met. The 60 day summary failed to be sent to the physician within a timely manner.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. An undated policy titled "Medical Supervision of Client Care" indicated, "... Upon completion of the comprehensive assessment and development of the plan of care, the plan of care will be faxed and / or mailed to the ordering physician for final approval and signature. A written summary report for each client shall be sent to the ordering physician at least every 60 days .... "</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on observation, record review, and interview, the agency failed to ensure the home health aide failed to follow the plan</p>	G 0156	G158 Care follows a written plan of care established and periodically reviewed by a	08/19/2016

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	of care for 1 of 1 patient's observed with bathing and hygiene, failed to ensure the skilled nurse(s) assessed and instructed the patient / caregiver on care and management of diabetes in 1 of 5 records reviewed of patients with diabetes in a sample of 12, and failed to ensure orders were obtained prior to providing services in 2 of 12 records reviewed (See G 158); failed to ensure that the plan of care was updated and revised to include parameters for oxygen saturations for 12 of 12 records reviewed, failed to update and revise the medication profile in 2 of 12 records reviewed, failed to update and revise interventions and goals from previous plan of care to the current plan of care in 1 of 7 records reviewed of patient being recertified for an additional 60 days in a sample of 12, failed to update and revise wound treatment orders in 2 of 4 records reviewed of patient's with wounds in a sample of 12, and failed ensure the plan of care was updated and revised to be reflective of the patient's comprehensive assessment in 1 of 12 records reviewed in a sample of 12 (See G 159); failed to ensure that the Physical and Occupational Therapy orders included specific procedures and modalities to be used while providing therapy services in 7 of 10 records reviewed of patients receiving therapy services in a sample of 12 (See G 161); failed to ensure		<p><b>Doctor of medicine, osteopathy, orpodiatric medicine.</b></p> <p>On 08/03/2016 and 08/19/2016 Eachdiscipline within the Cornerstone staff were educated by the Director of ClientCare Services/Administrator in reviewing plan of care every visit, making sureall interventions are addressed at some point throughout the certificationperiod, addressing those interventions that are of priority each visit, progresstowards goals, and documenting education and patient response to thateducation. Home Health Aides present were instructed to follow their Plan ofCare. Home Health Aides were instructed to report changes to the Case Manageron the day of the change.</p> <p>Director of Client Care Services/QA personnelwill be auditing 10% of all clinical charts quarterly to verify the policy isbeing followed. Any staff memberdeficient in following the policy will be educated one on one. Review of these findings will be addressed atcase conference and education provided.</p> <p>TheDirector Client Care Services will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notoccur.</p>	

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	<p>clinicians obtained verbal orders prior to performing treatments in 1 of 4 records reviewed of patient receiving wound treatments in a sample of 12 (See G 165); and failed to ensure that clinicians who obtain verbal orders put them in writing with date of receipt and signature for 8 of 12 records reviewed (See G 166).</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 and therefore, being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care &amp; Medical Supervision.</p>		<p>On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines.</p> <p>Director of Client Care Services/QA personal will also be monitoring 10% of clinical records to ensure compliance.</p>	

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			<p>The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p> <p>484.18(a) Plan of Care G 159</p> <p><b>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</b></p> <p>On 08/03/2016 and 08/19/2016 staff were instructed to discontinue the routine use of pulse oximetry on all patients. Pulse oximetry will be obtained based in the individual needs of the patient. Pulse oximetry will be obtained only as needed for the following: patient is on oxygen, exhibits shortness of breath, diminished lung sounds, exhibits signs or symptoms of respiratory distress, as baseline</p>	

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			<p>at SOC, or as physician orders indicate otherwise. Pulse oximetry use and parameters will be clearly noted in each patient's plan of care. Director of Client Care Services/QA personal will be auditing charts on an ongoing basis and 10% of all clinical charts quarterly will be evaluated for compliance of this.</p> <p>On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Examples were given to</p>	

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			<p>the staff as follows: If a patient is to be checking blood sugars 3 times a day and only complete 2 times daily, educate patient on the ordered frequency and report to the physician, patient is not taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician.</p> <p>Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one.</p> <p>The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p> <p>G161 <b>Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.</b></p> <p>On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and</p>	

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			<p>treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personnel will also be monitoring 10% of clinical records to ensure compliance</p> <p>On 08/19/2016 each Axxess form was reviewed with staff/discipline as to the location of where the verbal order is to be documented and received.</p> <p>Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify verbal orders are being followed. Any</p>	

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			<p>staffmember deficient in following the plan of care will be educated one onone.</p> <p>The Director Client Care Serviceswill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not occur.</p> <p>484.18(c) Conformance with Physician Orders G 165</p> <p><b><i>(Rev. 11, Issued: 08-12-05; Effective/Implementation:08-12-05)</i></b></p> <p><b><i>Drugs and treatments are administered by agency staff only asordered by the physician with the exception of influenza and pneumococcalpolysaccharide vaccines, which may be administered per agency policy developed in consultationwith a physician, and after an assessment of considerations.</i></b></p> <p>On08/03/2016 Director of Client Care Services/Administrator educated staff onprocesses of receiving/documenting verbal orders prior to performing any careor treatments to the patient. Staff werealso educated on content of verbal orders, instructed staff the care andtreatment preformed must match the verbal order received from the physician. On</p>	

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			<p>08/19/2016, once the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be pulled on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines.</p> <p>Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p> <p>G166 <i>(Rev. 11, Issued: 08-12-05; Effective/Implementation: 08-12-05)</i> <i>Verbal orders are put in writing and signed and dated with the date of receipt by the</i></p>	

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NAME OF PROVIDER OR SUPPLIER  CORNERSTONE HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5 HIGH STREET MOORESVILLE, IN 46158
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			<p><b>registered nurse or qualified therapist (as defined in §484.4of this chapter) responsible for furnishing or supervising the ordered services.</b></p> <p>On08/03/2016 Director of Client Care Services/Administrator educated staff onprocesses of receiving/documenting verbal orders prior to performing any careor treatments to the patient. Staff werealso educated on content of verbal orders, instructed staff the care andtreatment preformed must match the verbal order received from thephysician. On 08/19/2016, once thewritten Statement of Deficiency and Plan of Correction was received, staff werefurther educated on verbal orders and changes in the following policies: Policy500.80, 500.30, 801.40. To ensurecompliance with the receipt and documentation of verbal orders, verbal orderswill be pulled on an ongoing basis, and compared to the clinical documentationfor the receipt of the verbal order and that it is signed and dated by thereceiving staff member. Orders will be monitored on an ongoing basis byauthorized clinical staff. Staff membersare to report discrepancies to Director of Client Care Services on an ongoingbasis and remediation training will be completed with</p>	

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			<p>staff members that arenot meeting the policy and regulatory guidelines.</p> <p>Effective 07/22/2016 Based on exit interview the Start ofCare order was amended to demonstrate the frequency of each ordered disciplineand that each discipline received verbal orders of their plan of care includinginterventions/goals/rehab potential/discharge plans, with a notation that "***Formalized485 to follow for MD signature for obtained verbal orders***". This was implemented and being used until thewritten Statement of Deficiency and Plan of Correction was received on08/18/2016. On 08/19/2016 after receipt of the written Statement ofDeficiency and Plan of Correction Cornerstone discontinued the use of the SOCorder due to the documented findings that the Director of Client Care Servicesshould not be signing the formalized Plan of Care which has encompassedmultidisciplinary orders. Also noted inthe Statement of Deficiency and Plan of Correction the SOC order cannot be signed by one clinical staff member with all received verbal orders, that itmust be separated and signed and dated by each staff member who received theverbal SOC order. As of 08/19/2016 the 485 will only contain the orders fromthe</p>	

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G 0158  Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on observation, record review, and interview, the agency failed to ensure the home health aide failed to follow the plan of care for 1 of 1 patient's observed with bathing and hygiene (# 1), failed to ensure the skilled nurse(s) assessed and instructed the patient / caregiver on care and management of diabetes in 1 of 5 records reviewed of patients with diabetes in a sample of 12 (# 6), and failed to ensure orders were obtained	G 0158	admitting clinician, including HHA orders if indicated, as well as anytherapy or medical social work services for evaluation. Once the staff havecompleted their evaluations these will be sent to the physician for signature. 08/19/2016, Staff members were educated on the change insending verbal orders to the physician. Director of Client Care Services/QA personal will also bemonitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not occur.  On 08/03/2016 and 08/19/2016 Each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting	08/19/2016	

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	<p>prior to providing services in 2 of 12 records reviewed. (# 2 and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included plans of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16, with orders for a home health aide to assist the patient with personal care and activities of daily living two times a week.</p> <p>A. During a home visit with Employee A, a home health aide, on 07/19/16 at 7:15 AM, the home health aide was observed bathing the patient entirely in the shower without the patient being encouraged to provide assistance with care. The home health aide failed to follow the plan of care.</p> <p>2. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 07/15/16 to 09/13/16, with orders for occupational therapy.</p> <p>A. Review of the Occupational Therapy notes, the Occupational Therapist provided services on 07/18/16.</p> <p>B. A signed physician order dated 07/19/16, indicated " ... Occupational</p>		<p>education and patient response to that education. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify the policy is being followed. Any staff member deficient in following the policy will be educated one on one. Review of these findings will be addressed at case conference and education provided. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of</p>	

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	<p>Therapy evaluation week of 07/12/16, Effective 07/15/16, 0w1, 2w3 frequency for goals and interventions as per initial evaluation .... " The physical therapist provided services absent of a written physicians order.</p> <p>3. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to assess and instruct the patient / caregiver in glucose monitoring 3 times per week, instruct patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed wound healing and medications, instruct patient / caregiver to keep glucose log and to take log to MD visits, and instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p> <p>A. Review of the skilled nursing visit notes dated 06/01, 06/07, 06/10, 06/13, 06/22, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, 07/06, 07/08, 07/11, 07/13, 07/15, 07/18, and 07/20/16, the clinical record failed to evidence that the skilled nurse(s) had instructed the patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed wound healing and medications, instruct patient / caregiver to keep glucose log</p>		<p>verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>and to take log to MD visits, instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p> <p>B. Review of the skilled nursing visit notes in the diabetic section dated 06/03, 06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse(s) failed to accurately assess and document the patient diabetes at the time of the assessment. The skilled nurse(s) failed to follow the plan of care.</p> <p>3. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification period of 07/14/16 to 09/11/16, with orders for physical and occupational therapy.</p> <p>A. Review of the plan of care, line 23 failed to evidence the name of the clinician who had obtained the verbal</p>				

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	<p>start of care order as well as the date of the verbal start of care.</p> <p>B. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4 [three time a week for four weeks], 2w5 [two times a week for five weeks] frequency for goals and interventions as per initial evaluation .... "</p> <p>1. Review of the physical and therapy notes, physical therapy provided services on 07/16 and 07/18/16. The physical therapist provided services absent of a written physicians order.</p> <p>4. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>5. An untitled policy titled "Plan of Care Development and Review" indicated, " ... The Registered Nurse and / or Licensed Therapist ... initiate a plan of care within 24 hours of completion of the start of care ...</p> <p>6. A book titled "Handbook of Home Health Standards, Quality,</p>			

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G 0159  Bldg. 00	<p>Documentation, and Reimbursement" 5th Edition, pg 33 Box 1 - 4 indicated " ... Documentation should include family / caregiver education and their responses to, and demonstration of, the specific education and objective results of the education. Document the patient's response to care interventions and other activities .... "</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure that the plan of care was updated and revised to include parameters for oxygen saturations for 12 of 12 records reviewed (#1 - 12), failed to update and revise the medication profile in 2 of 12 records reviewed (#1), failed to update and revise interventions and goals from previous plan of care to the current plan of care in 1 of 7 records reviewed (# 1) of patient being recertified for an additional 60 days in a sample of 12, failed to update and revise wound</p>	G 0159	<p>On 08/03/2016 and 08/19/2016 staff were instructed to discontinue the routine use of pulse oximetry on all patients. Pulse oximetry will be obtained based in the individual needs of the patient. Pulse oximetry will be obtained only as needed for the following: patient is on oxygen, exhibits shortness of breath, diminished lungs sounds, exhibits signs or symptoms of respiratory distress, as baseline at SOC, or as physician orders indicate otherwise. Pulse oximetry use</p>	08/19/2016			

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	<p>treatment orders in 2 of 4 records reviewed (#1 and 4) of patient's with wounds in a sample of 12, and failed ensure the plan of care was updated and revised to be reflective of the patient's comprehensive assessment in 1 of 12 records reviewed in a sample of 12. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included a written plan of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16.</p> <p>A. Both plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. Both plans of care failed to include parameters to obtain pulse oximetry.</p> <p>B. The OASIS start of care comprehensive assessment dated 04/30/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula.</p> <p>1. The initial plan of care (04/30/16 to 06/28/16) indicated the patient was to receive 2 - 5 liters of oxygen continuously per nasal cannula. The initial plan of care failed to be</p>		<p>and parameters will be clearly noted in each patient's plan of care. Director of Client Care Services/QA personal will be auditing charts on an ongoing basis and 10% of all clinical charts quarterly will be evaluated for compliance of this. On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Examples were given to the staff as follows: If a patient is to be checking blood sugars 3 times a day and only complete 2</p>	

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	<p>updated and revised to be reflective of the initial comprehensive assessment.</p> <p>C. The OASIS recertification comprehensive assessment dated 06/24/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula. The assessment also indicated that treatment had been provided to a coccyx wound, which included cleansing the area with wound cleanser, pat dry, cover with soft absorbent foam dressing, and secure with cover roll.</p> <p>1. Review of the medication section of the plan of care (06/29/16 to 08/27/16), failed to evidence the oxygen, liter flow, and route to be administered. The plan of care failed to be updated and revised.</p> <p>2. A physician's order dated 06/24/16, indicated for skilled nursing to provide treatment to the patient's coccyx wound three times a week by cleansing the wound with wound cleanser, pat dry, and cover with hydrocolloid dressing or soft absorbent foam dressing, secured with cover roll. Desitin Lotion to be applied if the dressing falls off. The current plan of care (06/29/16 to 08/27/16) failed to be updated and revised to include treatment orders for the</p>		<p>times daily, educate patient on the ordered frequency and report to the physician, patient is not taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>coccyx wound.</p> <p>D. The OASIS comprehensive recertification assessment dated 06/24/16, indicated the goals were stabilization of cardiovascular pulmonary condition by 08/26/16; Demonstrates compliance with medication by 08/26/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 08/26/16; Patient / caregiver verbalizes call orders and dehydration, weakness, infection signs / symptoms to report to the nurse and / or physician by 08/26/16; and wound healing without complications by 08/26/16.</p> <p>2. The plans of care for the certification period 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16, both indicated: Goals indicated stabilization of cardiovascular pulmonary condition by 06/28/16; Demonstrates compliance with medication by 06/28/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 06/28/16; Patient / caregiver verbalizes call orders and dehydration, weakness, infection signs / symptoms to report to the nurse and / or physician by 06/28/16; and wound healing without complications by 06/28/16. The goals in the plan of care (06/29/16 to 08/27/16) failed to be revised and updated to reflect</p>			

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	<p>the patient's current status at the time of the reassessment.</p> <p>2. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 05/16/16 to 07/14/16.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>3. Clinical record number 3, SOC 06/03/16, included a plan of care for the certification period of 06/03/16 to 08/01/16.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>4. Clinical record number 4, SOC 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16. The primary diagnosis on the plan of care indicated Furuncle of buttock (boil), followed by type 2 diabetes mellitus.</p> <p>A. The plan of care indicated skilled</p>			

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	<p>nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A skilled nursing visit note dated 05/17/16 and 05/31/16, indicated the patient was receiving treatment to a wound on the right buttock. The treatment that was being performed included to cleanse the area with normal saline, pat dry, place a small tip of gauze inside wound bed and dry gauze on top for drainage, and secure with tape. Skilled nursing to perform treatment at every visit weekly and spouse to do the treatment on all other days. The plan of care failed to revised and updated to include the treatment orders for the right buttock wound.</p> <p>The Director of Clinical Services was interviewed on 07/21/16 at 1:00 PM. The Director of Clinical Services was not able to provide an explanation of why the wound treatment was not added to the plan of care.</p> <p>5. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16.</p> <p>A. Both plans of care indicated</p>			

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	<p>skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>6. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16.</p> <p>A. The plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>7. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification period of 07/14/16 to 09/11/16.</p> <p>A. The plan of care indicated for the skilled clinician to a obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>8. Clinical record number 8, SOC 01/13/16, included a plans of care for the certification periods of 01/13/16 to 03/12/16, 03/13/16 to 05/11/16, 05/12/16 to 07/10/16, and 07/11/16 to 09/08/16.</p>			

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	<p>A. The plans of care indicated for the skilled clinician to obtain a pulse oximetry as needed per skilled clinician's discretion. The plans of care failed to include parameters to obtain pulse oximetry.</p> <p>9. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification of 05/21/16 to 07/19/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>11. Clinical record number 11, SOC 06/13/16, included two plans of care for the certification period of 06/13/16 to 08/11/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>12. Clinical record number 12, SOC 02/16/16, included a plan of care for the certification period 02/16/16 to 04/15/16.</p>			

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	<p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>13. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>14. An untitled policy titled "Plan of Care Development and Review" indicated, " ... The Case Manager / Director of Client Care Services is responsible for overseeing the care planning process to ensure that the plan is appropriate .... "</p> <p>15. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 Box 1 - 4 indicated, " ... the POC [plan of care] are the most important components of the home care clinical record - they must be complete, accurate, and the content should clearly describe the patient. All other information flow from the services and needs identified and ordered on the plan</p>			

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G 0161 Bldg. 00	<p>of care ... page 143 ... Present other objective, measurable information that assists in supporting skilled care and the need for intervention [oximetry results, etc] .... "</p> <p>484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on record review and interview, the agency failed to ensure that the Physical and Occupational Therapy orders included specific procedures and modalities to be used while providing therapy services in 7 of 10 records reviewed of patients receiving therapy services in a sample of 12. (#1, 2, 6, 7, 9, 10, 11)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included a plan of care for the certification period of 06/29/16 to 08/27/16, with orders for skilled nursing and home health aide services only.</p> <p>A. A physicians order dated 06/29/16, indicated "Physical Therapy evaluation week of 06/22/16, Effective 06/29/16, 2w6 [two times a week for six</p>	G 0161	<p>On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30,801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member.Orders will be</p>	08/19/2016

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	<p>weeks], 1w3, frequency for goals and interventions as per initial evaluation." The physician's order failed to include specific procedures and modalities to be used.</p> <p>2. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 07/15/16 to 09/13/16, with orders for occupational therapy.</p> <p>A. A signed physician order dated 07/19/16, indicated " ... Occupational Therapy evaluation week of 07/12/16, Effective 07/15/16, 0w1, 2w3 frequency for goals and interventions as per initial evaluation .... " The physician order failed to include specific procedures and modalities to be used.</p> <p>3. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for physical therapy.</p> <p>A. A physician's order dated 06/08/16, written by Employee H, a Registered Inure, indicated " ... Therapy evaluation week of 05/29/2016, Effective 06/02/2016, 1w1, 2w5 frequency for goals and interventions as per initial evaluation .... " The physician's order</p>		<p>monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records to ensure compliance On 08/19/2016 each Axxess form was reviewed with staff/discipline as to the location of where the verbal order is to be documented and received. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify verbal orders are being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>failed to include specific procedures and modalities to be used.</p> <p>4. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification period of 07/14/16 to 09/11/16, with orders for physical and occupational therapy.</p> <p>A. Review of the plan of care, line 23 was left blank. The plan of care failed to indicate the clinician who had obtained the verbal start of care order, as well as the date of the verbal start of care.</p> <p>1. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4, 2w5 frequency. Occupational Therapy evaluation week of 07/14/16, Effective 07/16/16, 1w1, 2w2, 1w2 frequency for goals and interventions as per initial evaluation .... " The physician's order failed to include specific procedures and modalities to be used.</p> <p>5. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification of 05/21/16 to 07/19/16, with orders for physical and occupational therapy.</p>			

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	<p>A. A physician order dated 05/26/16, written by Employee H, indicated " ... Physical Therapy evaluation week of 05/22/2016, Effective 05/23/16, 1w1, 2w7 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 05/22/2016, Effective 05/25/2016, 2w3 frequency for goals and interventions as per initial evaluation." The physician's order failed to include specific procedures and modalities to be used.</p> <p>B. A physician order dated 07/07/16, written by Employee H, indicated " ... Physical Therapy evaluation week of 07/03/16, Effective 07/06/16, 2w2 frequency for goals and interventions as per initial evaluation .... " The physician's order failed to include specific procedures and modalities to be used.</p> <p>6. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for physical, and occupational therapy.</p> <p>A. Review of the OASIS comprehensive resumption of care assessment dated 05/27/16, the Administrator, a Physical Therapist,</p>			

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	<p>indicated she had conference with the physician in the resumption of services.</p> <p>1. A physician order dated 06/02/16, written by Employee H, indicated "Effective 05/27/16 Physical Therapy Resumption of Care Evaluation for home care 1w1, 2w1, 3w2, 2w2, 1w1 frequency .... " The order failed to include if there were any changes with procedures and modalities for physical therapy.</p> <p>7. Clinical record number 11, SOC 06/13/16, included a plan of care for the certification period 06/13/16 to 08/11/16, with orders for skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services.</p> <p>A. A physician order dated 06/21/16, written by Employee H, indicated " ... Physical Therapy evaluation week of 06/19/2016, Effective 06/20/16, 2w6, 1w2 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 06/122016, Effective 06/16/2016, 1w4 frequency for goals and interventions as per initial evaluation .... " The order failed to include if there were any changes with procedures and modalities for physical and occupational therapy.</p>			

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G 0165 Bldg. 00	<p>8. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</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 clinicians obtained verbal orders prior to performing treatments in 1 of 4 records reviewed of patient receiving wound treatments in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC (start of care) 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16.</p> <p>A. Review of a skilled nursing visit note dated 06/13/16, the following was documented:</p> <p>1. The skin assessment narrative indicated "Advised patient to wash with soap and water and shower as he / she normally would. The note failed to include documentation that the clinician</p>	G 0165	On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, once the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30,801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be pulled on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member.Orders will be monitored on an ongoing basis by authorized clinical staff. Staff	08/19/2016

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G 0166 Bldg. 00	<p>spoke to the physician about treatment orders.</p> <p>2. The clinician documented in the "Treatment Provided" section that he / she cleansed an area of JP drain removal with soap and water, using clean wash cloth, patted dry using clean wash cloth, covered with non adhesive dressing followed by gauze, and secured with paper tape. The note indicated the clinician would be performing this treatment 3 times a week. The visit note failed to include documentation that the skilled nurse had spoken to the physician about treatment orders.</p> <p>a. A physician's order date 06/14/16, but signed by the clinician on 06/13/16, indicated "effective 06/13/16, skilled nursing to complete wound care .... " The physician order "Order read back and verified" was not checked off. The clinician provided wound treatment to the patient prior to obtaining orders.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p>		<p>members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>		

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	<p>Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on record review and interview, the agency failed to ensure that clinicians who obtain verbal orders put them in writing with date of receipt and signature for 8 of 12 records reviewed. (#1, 2, 6 - 11)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC 04/30/16, included plans of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16.</p> <p>A. Review of the OASIS comprehensive recertification reassessment dated 04/30/16, the assessment indicated Employee C, a Registered Nurse, coordinated services with the primary care physician and obtained orders for continued services.</p> <p>1. Review of the initial plan of care dated 04/30/16 to 06/28/16, line 23 indicated the Director of Clinical services had obtained verbal start of care orders. The agency failed to ensure the verbal order was put into writing upon receipt, signed, and dated by the receiving</p>	G 0166	<p>On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, once the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be pulled on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines.</p>	08/19/2016

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	<p>clinician who obtained the order.</p> <p>B. A signed physician order dated 06/28/16, indicated "Effective 06/29/2016, Skilled Nursing Recertification Evaluation for home care 2w1 [two times a week for one week], 3w8 frequency. Physical Therapy evaluation week of 06/22/2016, Effective 06/29/2016, 2w6, 1w3 frequency for goals and interventions as per initial evaluation. Home Health Aide Services Effective week of 06/29/2016, 1w1, 2w8 frequency for goals and interventions as per skilled clinician's evaluation." The physician order was electronically signed by Employee H.</p> <p>1. Review of the physical therapy reassessment dated 06/22/16, the assessment indicated Employee F, a Physical Therapist, coordinated services with the physician and the physician agreed with the plan of care, frequency, and duration.</p> <p>2. Review of the OASIS comprehensive recertification assessment dated 06/24/16, the assessment indicated Employee C, a Registered Nurse, coordinated services with the primary care physician in regards to recertification orders. The agency failed to ensure the verbal orders was put into</p>		<p>Effective 07/22/2016 Based on exit interview the Start of Care order was amended to demonstrate the frequency of each ordered discipline and that each discipline received verbal orders of their plan of care including interventions/goals/rehab potential/discharge plans, with a notation that "***Formalized 485 to follow for MD signature for obtained verbal orders***". This was implemented and being used until the written Statement of Deficiency and Plan of Correction was received on 08/18/2016. On 08/19/2016 after receipt of the written Statement of Deficiency and Plan of Correction Cornerstone discontinued the use of the SOC order due to the documented findings that the Director of Client Care Services should not be signing the formalized Plan of Care which has encompassed multidisciplinary orders. Also noted in the Statement of Deficiency and Plan of Correction the SOC order cannot be signed by one clinical staff member with all received verbal orders, that it must be separated and signed and dated by each staff member who received the verbal SOC order. As of 08/19/2016 the 485 will only contain the orders from the admitting clinician, including HHA orders if indicated, as well as any therapy or medical social work services for evaluation.</p>	

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	<p>writing upon receipt, signed, and dated by the receiving clinicians who obtained the order.</p> <p>2. Review of clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 07/15/16 to 09/13/16, with orders for skilled nursing, home health aide services, and occupational therapy.</p> <p>A. Review of the OASIS comprehensive recertification assessment dated 07/14/16, the assessment indicated Employee I coordinated services with the primary care physician in regards to recertification orders.</p> <p>1. A signed physician order dated 07/19/16, indicated "Effective 07/15/2016, Skilled Nursing Recertification Evaluation for home care 0w1, 1w8 frequency ... Home Health Aide Services Effective week of 07/15/2016, 0w1, 2w8 frequency for goals and interventions as per skilled clinician's evaluation." The physician order was electronically signed by Employee H. The agency failed to ensure the verbal order was put into writing upon receipt, signed, and dated by the receiving clinician who obtained the order.</p>		<p>Once the staff have completed their evaluations these will be sent to the physician for signature. 08/19/2016, Staff members were educated on the change in sending verbal orders to the physician. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>				

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	<p>3. Clinical record number 6, SOC (start of care) 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of a skilled nursing visit note dated 06/13/16, written by Employee C, a Registered Nurse, the narrative note indicated the patient was taking Miralax and Keflex. Employee C had notified the physician and had spoken to the physician's assistant, who indicated there wasn't a record of the patient taking Keflex. The note continued to indicate the physician had provided the patient with samples and the clinician observed only 2 pills left.</p> <p>1. Review of a physical therapy note dated 06/13/16, the narrative note indicated the patient was put on Keflex, the doctor had given the patient six pills to take once a day, and the pills were in an envelope with "Keflex" handwritten on it. The envelope had no other information on it.</p> <p>a. A physician's order dated 06/13/16, indicated the effective 06/10/16, the patient was to take Keflex 500 milligrams oral capsule daily by mouth for 7 days, Miralax oral powder for reconstitution 17 grams in 8 ounces of</p>			

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	<p>water or juice daily by mouth as needed for constipation. The order was electronically signed by the Director of Clinical Services. A check box with "read back and verified" was not checked off. The Director of Clinical Services failed to accurately transcribe the order based on the clinicians visit notes. The Director of Clinical Services failed to include / identify that she had obtained the order from the physician's office. The agency failed to ensure that the verbal order was put into writing, signed, and dated with the receipt of the clinician who clarified and obtained the order.</p> <p>B. A communication note dated 06/28/16, written by Employee C, a Registered Nurse, indicated that a physician office contacted him / her and gave a verbal order for a Fleet's enema, increase water intake, and for the patient to start taking over the counter stool softener 1 or 2 caps daily as needed.</p> <p>1. A physician's order dated 06/28/16, written by the Director of Clinical Services, indicated for the skilled nurse to "administer a fleet's enema and for the patient to start taking over the counter Docusate Sodium 100 milligrams 1 or 2 caps daily as needed - the following day and increase water intake." The agency failed to ensure that</p>			

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	<p>the verbal order was put into writing, signed, and dated with the receipt of the clinician who obtained the order.</p> <p>C. Review of the OASIS start of care comprehensive assessment dated 06/01/16, Employee C indicated he / she had coordinated with the physician for ongoing services.</p> <p>1. Review of the physical therapy initial assessment / plan of treatment dated 06/02/16, Employee F, a Physical Therapist, indicated he / she coordinated with the physician at the time of the assessment and that the physician was in agreement with the plan of care, frequency, and duration.</p> <p>2. Review of the occupational therapy initial assessment dated 06/03/16, Employee D, an Occupational Therapist, indicated he / she coordinated with the physician at the time of the assessment.</p> <p>a. A physician's order dated 06/08/16, written by Employee H, a Registered Nurse, indicated "Effective 06/01/2016, Skilled Nursing Start of Care Evaluation for home care 2w7, 1w7 frequency. Physical Therapy evaluation week of 05/29/2016, Effective 06/02/2016, 1w1, 2w5 frequency for goals and interventions as per initial</p>						

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	<p>evaluation. Occupational Therapy evaluation week of 05/029/2016, Effective 06/03/2016 - evaluation only - OT not recommend at this time. Speech Therapy - patient declines at this time. Home Health Aide services - patient declines at this time. The agency failed to ensure that the verbal order was put into writing, signed, and dated with the receipt of the clinicians who obtained his / her order.</p> <p>4. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification dated of 07/14/16 to 09/11/16, with orders for physical and occupational therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 07/14/16, Employee F, a Physical therapist, indicated that he / she had coordinated start of care services with the physician. The coordination also indicated that there was a concern of the patient taking Aspirin along with Xarelto [both used as blood thinners], and the therapist had received an order for the patient to stop taking aspirin while on Xarelto.</p> <p>1. A communication note dated 07/14/16, was written by Employee F. The note indicated the physician's office</p>						

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	<p>returned Employee F's phone call in regards to stopping the Aspirin while talking Xarelto.</p> <p>2. A physician order dated 07/14/16, was written by the Administrator and also a physical therapist. The order indicated "Effective 07/14/16, Discontinue Aspirin 81 mg [milligram] tablet and remain on Xarelto." The agency failed to ensure that the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order.</p> <p>B. The occupational therapy initial assessment and plan of treatment dated 07/16/16, was reviewed. Employee D, an occupational therapist, indicated that he / she had spoken with the physician and that the physician was in agreement with the plan of care.</p> <p>1. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4 [three times a week for four weeks], 2w5 frequency. Occupational Therapy evaluation week of 07/14/16, Effective 07/16/16, 1w1, 2w2, 1w2 frequency for goals and interventions as per initial evaluation .... " The agency failed to</p>			

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	<p>ensure that the verbal orders was put into writing upon receipt, signed and dated by the receiving clinician who obtained the verbal order.</p> <p>5. Clinical record number 8, SOC 01/13/16, included plans of care for the certification period of 05/12/16 to 07/10/16 and 07/11/16 to 09/08/16.</p> <p>A. Review of the OASIS comprehensive recertification reassessment dated 05/07/16, the assessment indicated Employee I, a Registered Nurse, coordinated services with the primary care physician.</p> <p>1. A physicians order dated 05/17/16, signed by Employee H, indicated "Effective 05/12/2016 Skilled Nursing Recertification Evaluation for home care 0w1, 1w8, 0w1 frequency. Home Health Aide services Effective week of 05/12/2016, 1w1, 2w8, 0w1 frequency for goals and interventions as assigned by skilled clinician's evaluation. The agency failed to ensure that the verbal order was put into writing upon receipt, signed and dated by the receiving clinician who obtained the verbal order. The order also failed to include interventions that were to be provided by the skilled nurse and home health aide.</p>			

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	<p>B. The plan of care for the certification period of 07/11/16 to 09/08/16, included orders for skilled nursing, home health aide, and medical social worker services. The plan of care indicated "Effective 07/15/16 through 09/08/16 comprehensive assessment and recommendations 1 - 3 visits during current certification period; Community Resource Planning Outreach." The plan of care was not signed by a physician.</p> <p>1. Review of the plan of care (3 pages), line 23 was left blank. The plan of care failed to indicate the clinician who had obtained the verbal orders as well as the date of the verbal order for continuing services.</p> <p>C. Review of the OASIS comprehensive recertification assessment dated 07/07/16, the Community Agencies / Social Service Screening narrative note indicated the patient would need rides to appointments and groceries, needed someone to cook for him / her or have meals delivered to his / her home. The patient had refused assistance in the past but was currently requesting assistance. The note also indicated the patient needed housekeeping services due to the patient's handicaps. The note indicated the skilled nurse would notify the agency and the medical social worker.</p>			
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	<p>1. The Care Coordination section of the comprehensive recertification assessment indicated Employee I coordinated with the physician and the medical social worker in regards to ongoing services.</p> <p>2. A signed physician order dated 07/11/16, indicated "Effective 07/11/16, skilled nursing ... Home Health Aide Services .... " The physician order was electronically signed by Employee H. The agency failed to ensure the verbal order was put into writing upon receipt, signed, and dated by the receiving clinician who obtained the order. The physician order also failed to include an order for medical social services.</p> <p>5. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification of 05/21/16 to 07/19/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of the OASIS comprehensive start of care assessment dated 05/21/16, Employee J, a Registered Nurse, indicated he / she had coordinated with the physician for ongoing services.</p> <p>1. A physician order dated 05/26/16, written by Employee H,</p>			
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	<p>indicated "Effective 05/21/2016 Skilled Nursing Start of Care Evaluation for home care 1w9, 0w1 frequency .... " The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order.</p> <p>B. Review of the OASIS comprehensive resumption of care assessment dated 07/05/16, Employee C, indicated he / she had coordinated with the physician for ongoing services.</p> <p>1. Review of physical therapy reassessment and plan of treatment dated 07/06/16, Employee F indicated he / she had conferenced with the physician for the resumption of services.</p> <p>a. A physician order dated 07/06/16, written by the Director of Clinical Services, indicated the physical therapy frequency, interventions and goals. A box next to "order read back and verified" was not checked off. The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order.</p> <p>b. A physician order dated 07/07/16, written by Employee H, indicated "Effective 07/05/16 Skilled</p>			

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	<p>Nursing Resumption of Care Evaluation for home care 2w2 frequency. Physical Therapy evaluation week of 07/03/16, Effective 07/06/16, 2w2 frequency for goals and interventions as per initial evaluation. Home Health Aide Services - patient declines at this time. A box next to "order read back and verified" was not checked off. The agency failed to ensure the verbal orders were put into writing, signed, and dated by the receiving clinician who obtained the order.</p> <p>6. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>A. A physician's order dated 06/16/16, indicated for the skilled nurse to obtain a urinalysis with a culture and sensitivity. The order failed to include how the specimen was to be obtained.</p> <p>B. Review of the OASIS comprehensive resumption of care assessment dated 05/27/16, the Administrator, a Physical Therapist, indicated he / she had conferenced with the physician for the resumption of services.</p> <p>1. A physician order dated</p>			

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	<p>06/02/16, written by Employee H, indicated "Effective 05/27/16 Physical Therapy Resumption of Care Evaluation for home care 1w1, 2w1, 3w2, 2w2, 1w1 frequency. Skilled nursing evaluation week of 05/30/16, Effective 05/31/16, 2w1, 1w4 frequency for goals and interventions as per initial evaluation. The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order.</p> <p>7. Clinical record number 11, SOC 06/13/16, included a plan of care for the certification period 06/13/16 to 08/11/16, with orders for skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services.</p> <p>A. Review of the OASIS comprehensive start of care assessment dated 06/13/16, Employee J, indicated she had conference with the physician for continuing start of care orders.</p> <p>1. A physician order dated 06/21/16, written by Employee H, indicated "Effective 06/13/2016, Skilled Nursing Start of Care Evaluation for home care 1w9 frequency. Physical Therapy evaluation week of 06/19/2016, Effective 06/20/16, 2w6, 1w2 frequency for goals and interventions as per initial</p>			

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	<p>evaluation. Occupational Therapy evaluation week of 06/12/2016, Effective 06/16/2016, 1w4 frequency for goals and interventions as per initial evaluation. Home Health Aide services Effective week of 06/13/2016, 2w8, 1w1 frequency for goals and interventions as assigned by skilled clinician's evaluation. The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order. The order failed to include nursing and home health aide interventions.</p> <p>8. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>9. An undated policy titled "Confirmation of Physician Telephone / Verbal Orders" indicated, " ... The staff member who accepts the order: reduces the order to writing, ensures the appropriateness, accuracy and completeness of the order, signs and dates the order .... "</p> <p>10. An undated policy titled "Verbal / Telephone Orders Read - Back" indicated, " ... Each verbal / telephone order is read - back by the licensed Cornerstone Home Healthcare staff</p>			

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	<p>member receiving the order. The order must be signed and dated with the date of receipt .... "</p> <p>11. An undated policy titled "Medication Orders and Administration" indicated " .... All medication orders must be verified with the ordering physician and must contain the phrase 'Orders read back and verified with _____ ', the date of verification and the signature of the nurse verifying the orders .... "</p> <p>12. A website at <a href="http://www.nursingcenter.com/journalarticle?Article_ID=800621&amp;Journal_ID=522928">http://www.nursingcenter.com/journalarticle?Article_ID=800621&amp;Journal_ID=522928</a> &amp;... Titled article "Charting Checkup: Documenting telephone orders, indicated " ... You should always get telephone orders directly; they should never go through a third party ... Record the order word - for - word on the health care provider's order sheet or enter it into a computer. First, note the date and time. On the next line, write "telephone order" ... Then write the health care provider's name, and sign your name. Read back the order and get confirmation from the person who gave the order ... If you're having trouble understanding the health care provider, ask another nurse to listen in as you take the order. Then have her read it back and sign the order too .... "</p>			

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G 0168 Bldg. 00	<p>13. An untitled policy titled "Plan of Care Development and Review" indicated, " ... Any physician approved changes to the plan of care are dated and signed by the appropriate discipline .... "</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on observation, record review, and interview, the Registered Nurse failed to assessed and instructed the patient / caregiver on care and management of diabetes in 1 of 5 records reviewed of patients with diabetes in a sample of 12 (See G 170); failed to ensure that the plan of care was updated and revised to include parameters for oxygen saturations for 12 of 12 records reviewed, failed to update and revise the medication profile in 2 of 12 records reviewed, failed to update and revise interventions and goals from previous plan of care to the current plan of care in 1 of 7 records reviewed of patient being recertified for an additional 60 days in a sample of 12, failed to update and revise wound treatment orders in 2 of 4 records reviewed of patient's with wounds in a sample of 12, and failed ensure the plan of care was updated and revised to be reflective of the patient's</p>	G 0168	<p>G 168 (G170, G173, G176) <b>§484.30 Condition of Participation: Skilled Nursing Services G 170 The HHA furnishes skilled nursing services (G 169. . . by or under the supervision of a registered nurse;) and in accordance with the plan of care.</b> On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point</p>	08/19/2016

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	<p>comprehensive assessment in 1 of 12 records reviewed in a sample of 12 (See G 173); failed to ensure that their efforts were coordinated effectively and support the objectives outlined in the plan of care in 1 of 1 records reviewed of patient's who was receiving outside services with a Dialysis facility and with an Assisted Living Facility / Community in a sample of 12 and failed to follow up with medical social services in regards to discharge planning in 2 of 12 clinical record reviewed (See G 176); and the Licensed Practical Nurse (LPN) failed to accurately educate the patient in 1 of 2 records reviewed of patients being seen by Licensed Practical Nurses in a sample of 12 (See G 183).</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 and therefore, being out of compliance with the Condition of Participation 48.30 Skilled Nursing Services.</p>		<p>throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. 484.30(a) Duties of Registered Nurse G 173 <b>initiates the plan of care and necessary revisions,</b> On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care (medications, diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the</p>		

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			comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Examples were given to the staff as follows: If a patient is to be checking blood sugars 3 times a day and only complete 2 times daily, educate patient on the ordered frequency and report to the physician, patient is not taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for	

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			<p>monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. On 08/03/2016 and 08/19/2016 staff were instructed to discontinue the routine use of pulse oximetry on all patients. Pulse oximetry will be obtained based in the individual needs of the patient. Pulse oximetry will be obtained only as needed for the following: patient is on oxygen, exhibits shortness of breath, diminished lungs sounds, exhibits signs or symptoms of respiratory distress, as baseline at SOC, or as physician orders indicate otherwise. Pulse oximetry use and parameters will be clearly noted in each patient's plan of care. Director of Client Care Services/QA personal will be auditing charts on an ongoing basis and 10% of all charts will be evaluated for compliance of this. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on making sure all visit notes are individualized for the day of service. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the</p>	

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			<p>physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records to ensure compliance On 08/19/216 Skilled nursing staff were educated in policy Plan of Care Development and Review Policy 801.90 and 802.40. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. G 176 prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in</p>	

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			<p><b>the patient's condition and needs,</b> In order to maintain liaison to ensure coordinated care that effectively support objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained inpatient hard chart. This process will begin at next case conference on August 31, 2016. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on importance of effective care coordination and communication between disciplines to ensure best outcomes for patients and the required documentation of this in the clinical record. In order to maintain liaison to ensure coordinated care that effectively support care of dialysis patients, Cornerstone Home</p>	

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			<p>Healthcare will call or fax dialysis centers and/or nephrologists for medications and specific parameters for each patient. Cornerstone will make every effort to receive this information, any calls/faxes of requests will be retained in the clinical record. The information received will be implemented into the patient's plan of care upon receipt. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated clinical staff coordination and documentation of care with dialysis centers/nephrologist. Instruction was made to clinical staff to document all communication in the medical record. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of patients residing in congregated facilities, Cornerstone Home Healthcare will coordinate care with facility nursing staff regarding services provided to patients. Cornerstone Home Healthcare will continue its practice of noting on the 485 "ALF staff is responsible for" and note specific care the patient is receiving from the ALF. Cornerstone Home Healthcare staff will communicate and coordinate with ALF staff on, but not limited to, blood sugars, medication changes, labs and PT/INR results. Coordination of care will be documented and filed in patient clinical record. On</p>	

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			08/03/2016 and 08/19/2016 Director of Client Care Services educated staff on coordination and documentation of care with patients residing in congregated facilities. The staff verbalized understanding. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on care coordination with the physician. Education with the Cornerstone staff on reporting discrepancies in the plan of care to what the patient is doing in the home and obtain either verbal orders to make changes to the plan of care or reinforce the education patient requires. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on making sure all visit notes are individualized for the day of service, reflecting the patient's current clinical status. Staff were educated at the 08/03/2016 and 08/19/2016 regarding the need to have complete documentation and reporting changes to the physician. Instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for example documenting the number of staples in an incision, documenting drainage from a JP drain that patient is monitoring in the clinical record, obtaining a temperature and obtaining blood sugar readings from the ALF.	

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			<p>Visits notes will be reviewed on an ongoing basis by office clinical staff for complete picture of the patient's status. On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care (medications, diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Examples were given to the staff as follows: If a patient is to be checking blood sugars 3</p>	

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G 0170 Bldg. 00	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on observation, record review, and interview, the Registered Nurse failed to assessed and instructed the patient / caregiver on care and management of diabetes in 1 of 5 records reviewed of patients with diabetes in a sample of 12. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC 06/01/16, included a plan of care for the</p>	G 0170	<p>times a day and only complete 2 times daily, educate patient on the ordered frequency and report to the physician, patient is not taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p> <p>On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care between patients and certification periods. Instructed staff that every</p>	08/19/2016

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	<p>certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to assess and instruct the patient / caregiver in glucose monitoring 3 times per week, instruct patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed wound healing and medications, instruct patient / caregiver to keep glucose log and to take log to MD visits, and instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p> <p>A. Review of the skilled nursing visit notes dated 06/01, 06/07, 06/10, 06/13, 06/22, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, 07/06, 07/08, 07/11, 07/13, 07/15, 07/18, and 07/20/16, the clinical record failed to evidence that the skilled nurse(s) had instructed the patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed wound healing and medications, instruct patient / caregiver to keep glucose log and to take log to MD visits, instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p> <p>B. Review of the skilled nursing visit notes in the diabetic section dated 06/03, 06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative</p>		<p>plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of</p>	

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	<p>note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse(s) failed to accurately assess and document the patient diabetes at the time of the assessment. The skilled nurse(s) failed to follow the plan of care.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 33 Box 1 - 4 indicated " ... Documentation should include family / caregiver education and their responses to, and demonstration of, the specific education and objective results of the education. Document the patient's response to care interventions and other activities .... "</p>		<p>the change. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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G 0173  Bldg. 00	<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 ensure that the plan of care was updated and revised to include parameters for oxygen saturations for 12 of 12 records reviewed (#1 - 12), failed to update and revise the medication profile in 2 of 12 records reviewed (#1), failed to update and revise interventions and goals from previous plan of care to the current plan of care in 1 of 7 records reviewed (# 1) of patient being recertified for an additional 60 days in a sample of 12, failed to update and revise wound treatment orders in 2 of 4 records reviewed (#1 and 4) of patient's with wounds in a sample of 12, and failed ensure the plan of care was updated and revised to be reflective of the patient's comprehensive assessment in 1 of 12 records reviewed in a sample of 12. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included a written plan of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16.</p> <p>A. Both plans of care indicated skilled nursing to obtain pulse oximetry</p>	G 0173	<p>On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care (medications, diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point</p>	08/19/2016

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	<p>as needed per skilled clinician's discretion. Both plans of care failed to include parameters to obtain pulse oximetry.</p> <p>B. The OASIS start of care comprehensive assessment dated 04/30/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula.</p> <p>1. The initial plan of care (04/30/16 to 06/28/16) indicated the patient was to receive 2 - 5 liters of oxygen continuously per nasal cannula. The initial plan of care failed to be updated and revised to be reflective of the initial comprehensive assessment.</p> <p>C. The OASIS recertification comprehensive assessment dated 06/24/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula. The assessment also indicated that treatment had been provided to a coccyx wound, which included cleansing the area with wound cleanser, pat dry, cover with soft absorbent foam dressing, and secure with cover roll.</p> <p>1. Review of the medication section of the plan of care (06/29/16 to 08/27/16), failed to evidence the oxygen, liter flow, and route to be administered.</p>		<p>throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Examples were given to the staff as follows: If a patient is to be checking blood sugars 3 times a day and only complete 2 times daily, educate patient on the ordered frequency</p>		

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	<p>The plan of care failed to be updated and revised.</p> <p>2. A physician's order dated 06/24/16, indicated for skilled nursing to provide treatment to the patient's coccyx wound three times a week by cleansing the wound with wound cleanser, pat dry, and cover with hydrocolloid dressing or soft absorbent foam dressing, secured with cover roll. Desitin Lotion to be applied if the dressing falls off. The current plan of care (06/29/16 to 08/27/16) failed to be updated and revised to include treatment orders for the coccyx wound.</p> <p>D. The OASIS comprehensive recertification assessment dated 06/24/16, indicated the goals were stabilization of cardiovascular pulmonary condition by 08/26/16; Demonstrates compliance with medication by 08/26/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 08/26/16; Patient / caregiver verbalizes call orders and dehydration, weakness, infection signs / symptoms to report to the nurse and / or physician by 08/26/16; and wound healing without complications by 08/26/16.</p> <p>2. The plans of care for the certification period 04/30/16 to 06/28/16</p>		<p>and report to the physician, patient is not taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. On 08/03/2016 and 08/19/2016 staff were instructed to discontinue the routine use of pulse</p>		

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	<p>and 06/29/16 to 08/27/16, both indicated: Goals indicated stabilization of cardiovascular pulmonary condition by 06/28/16; Demonstrates compliance with medication by 06/28/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 06/28/16; Patient / caregiver verbalizes call orders and dehydration, weakness, infection signs / symptoms to report to the nurse and / or physician by 06/28/16; and wound healing without complications by 06/28/16. The goals in the plan of care (06/29/16 to 08/27/16) failed to be revised and updated to reflect the patient's current status at the time of the reassessment.</p> <p>2. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 05/16/16 to 07/14/16.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>3. Clinical record number 3, SOC 06/03/16, included a plan of care for the certification period of 06/03/16 to 08/01/16.</p>		<p>oximetry on all patients. Pulse oximetry will be obtained based in the individual needs of thepatient. Pulse oximetry will be obtained only as needed for the following:patient is on oxygen, exhibits shortness of breath, diminished lungs sounds,exhibits signs or symptoms of respiratory distress, as baseline at SOC, or as physician orders indicate otherwise. Pulse oximetry use and parameters will be clearly noted in each patient's plan of care. Director of Client Care Services/QA personal will be auditing charts on an ongoing basis and 10% of all charts will be evaluated for compliance of this. On 08/03/2016 and 08/19/2016 Director of Client Care</p>	

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	<p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>4. Clinical record number 4, SOC 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16. The primary diagnosis on the plan of care indicated Furuncle of buttock (boil), followed by type 2 diabetes mellitus.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A skilled nursing visit note dated 05/17/16 and 05/31/16, indicated the patient was receiving treatment to a wound on the right buttock. The treatment that was being performed included to cleanse the area with normal saline, pat dry, place a small tip of gauze inside wound bed and dry gauze on top for drainage, and secure with tape. Skilled nursing to perform treatment at every visit weekly and spouse to do the treatment on all other days. The plan of care failed to revised and updated to include the treatment orders for the right</p>		<p>Services/Administrator educated clinical staff on making sure all visit notes are individualized for the day of service. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30,</p>	

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	<p>buttock wound.</p> <p>The Director of Clinical Services was interviewed on 07/21/16 at 1:00 PM. The Director of Clinical Services was not able to provide an explanation of why the wound treatment was not added to the plan of care.</p> <p>5. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16.</p> <p>A. Both plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>6. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16.</p> <p>A. The plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>7. Clinical record number 7, SOC 07/14/16, included a plan of care for the</p>		<p>801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records to ensure compliance On</p>	

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	<p>certification period of 07/14/16 to 09/11/16.</p> <p>A. The plan of care indicated for the skilled clinician to a obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>8. Clinical record number 8, SOC 01/13/16, included a plans of care for the certification periods of 01/13/16 to 03/12/16, 03/13/16 to 05/11/16, 05/12/16 to 07/10/16, and 07/11/16 to 09/08/16.</p> <p>A. The plans of care indicated for the skilled clinician to obtain a pulse oximetry as needed per skilled clinician's discretion. The plans of care failed to include parameters to obtain pulse oximetry.</p> <p>9. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification of 05/21/16 to 07/19/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p>		<p>08/19/216 Skilled nursing staff were educated in policy Plan of Care Development and Review Policy 801.90 and 802.40. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>11. Clinical record number 11, SOC 06/13/16, included two plans of care for the certification period of 06/13/16 to 08/11/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>12. Clinical record number 12, SOC 02/16/16, included a plan of care for the certification period 02/16/16 to 04/15/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>13. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>14. An untitled policy titled "Plan of Care Development and Review" indicated, " ... The Case Manager / Director of Client Care Services is</p>			

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G 0176  Bldg. 00	<p>responsible for overseeing the care planning process to ensure that the plan is appropriate .... "</p> <p>15. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 Box 1 - 4 indicated, " ... the POC [plan of care] are the most important components of the home care clinical record - they must be complete, accurate, and the content should clearly describe the patient. All other information flow from the services and needs identified and ordered on the plan of care .... "</p> <p>16. An undated policy titled "Skilled Services / Care Offered By Licensed Staff" indicated, " .... The Registered Nurse evaluates the client's response to the plan of care in a timely manner and initiates necessary revisions as required ... The Registered Nurse furnishes those services requiring substantial and specialized nursing skill such as, but not limited to: wound therapy ...</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p>			

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	<p>Based on record review and interview, the Registered Nurse failed to ensure that their efforts were coordinated effectively and support the objectives outlined in the plan of care in 1 of 1 records reviewed (# 9) of patient's who was receiving outside services with a Dialysis facility and with an Assisted Living Facility / Community in a sample of 12 and failed to follow up with medical social services in regards to discharge planning in 2 of 12 clinical record reviewed. (# 4 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16, with orders for skilled nursing.</p> <p>A. Two skilled nursing visit notes dated 06/06, 06/13, and 06/20/16, indicated in the discharge planning section "Ongoing, Spoke to [spouse] regarding [name of Employee G, a medical social worker] who will see him / her again to assist with community resources for future care."</p> <p>B. Three subsequent skilled nursing visit notes dated 06/27, 07/05, and 07/11/16, indicated in the discharge planning section "Ongoing. MSW has seen them and spoke to his / her son. He</p>	G 0176	<p>In order to maintain liaison to ensure coordinated care that effectively support objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained inpatient hard chart. This process will begin at next case conference on August 31, 2016. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on importance of effective care coordination and communication between disciplines to ensure best outcomes for patients and the required documentation of this in the clinical record. In order to maintain liaison to ensure coordinated care that effectively support care of dialysis patients, Cornerstone Home Healthcare will call or fax dialysis</p>	08/19/2016

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	<p>/ She reports that his / her son is working on getting support for him / her when Home Care moves out."</p> <p>C. An OASIS comprehensive recertification assessment dated 07/19/16, indicated in the coordination of care section " ... Psychological support and therapy, MSW [medical social worker] visiting patient and his wife regarding future care options and community resources .... "</p> <p>D. Review of the electronic medical record and hard chart record, the clinical record failed to evidence that a medical social worker had made a visit due to no record of the visit. The skilled nursing visit notes were repetitive and failed to evidenced if skilled nursing had followed up with medical social services and the progress on discharge planning.</p> <p>2. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to do vital signs with each visit, assess patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is</p>		<p>centers and/or nephrologists for medications and specific parameters for each patient. Cornerstone will make every effort to receive this information, any calls/faxes of requests will be retained in the clinical record. The information received will be implemented into the patient's plan of care upon receipt. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated clinical staff coordination and documentation of care with dialysis centers/nephrologist. Instruction was made to clinical staff to document all communication in the medical record. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of patients residing in congregated facilities, Cornerstone Home Healthcare will coordinate care with facility nursing staff regarding services provided to patients. Cornerstone Home Healthcare will continue its practice of noting on the 485 "ALF staff is responsible for" and note specific care the patient is receiving from the ALF. Cornerstone Home Healthcare staff will communicate and coordinate with ALF staff on, but not limited to, blood sugars, medication changes, labs and PT/INR results. Coordination of care will be documented and filed in patient clinical record. On 08/03/2016 and 08/19/2016</p>	

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	<p>removed. The patient diagnoses included, but not limited to, aftercare following surgery for neoplasm and type 2 diabetes mellitus.</p> <p>A. Review of the skilled nursing visit note dated 06/03/16, the clinician failed to document the amount of drainage from the JP drain, failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment. The clinician also failed to educate the patient in documenting and measuring the drainage from the JP drains, so that the physician would know when to remove the drains.</p> <p>B. Review of the skilled nursing visit note dated 06/07/16, the clinician failed to failed to provide a measurement and the number of staples that was used to close the incision and failed to obtain a temperature with the vital sign assessment.</p> <p>C. Review of the skilled nursing visit note dated 06/09/16, the clinician failed to failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign</p>		<p>Director of Client Care Services educated staff on coordination and documentation of care with patients residing in congregated facilities. The staff verbalized understanding. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on care coordination with the physician. Education with the Cornerstone staff on reporting discrepancies in the plan of care to what the patient is doing in the home and obtain either verbal orders to make changes to the plan of care or reinforce the education patient requires. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on making sure all visit notes are individualized for the day of service, reflecting the patient's current clinical status. Staff were educated at the 08/03/2016 and 08/19/2016 regarding the need to have complete documentation and reporting changes to the physician. Instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for example documenting the number of staples in an incision, documenting drainage from a JP drain that patient is monitoring in the clinical record, obtaining a temperature and obtaining blood sugar readings from the ALF. Visits notes will be reviewed on</p>	

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	<p>assessment.</p> <p>D. Review of the skilled nursing visit notes dated 06/13/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/15/16, the patient was transferred to the hospital and admitted for a urinary tract infection.</p> <p>E. Review of the resumption of care assessment dated 06/22/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/24/16, the patient's temperature was obtained and the patient had a low grade temperature of 99.1.</p> <p>F. Review of the skilled nursing visit notes in the diabetic section dated 06/03, 06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse failed to accurately assess and document the patient diabetes at the time of the</p>		<p>an ongoing basis by office clinical staff for complete picture of the patient's status. On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care (medications, diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Examples were given to the staff as follows: If a patient is to be checking blood sugars 3 times a day and only complete 2</p>	

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	<p>assessment.</p> <p>3. Clinical record number 9, SOC (start of care) 05/21/16, included a plan of care for the certification period of 05/21/16 to 07/19/16, with orders for skilled nursing, physical, and occupational therapy. The patient's primary diagnosis was cerebral infarction (stroke) followed by secondary diagnoses of general weakness, diabetes type 2, end stage renal disease, neuropathy, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and rheumatoid arthritis. The patient resides in an Assisted Living Facility / Community (ALF).</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/21/16, the assessment indicated the patient was receiving hemodialysis, had a right port a cath [catheter used for hemodialysis] in the left chest wall, and a new av graft / fistula [accessible site in the arm used for dialysis] in the left upper arm. The clinical record failed to evidence coordination with the dialysis center, such as blood pressure parameters, management of port a cath, diet, fluid restrictions, and medications / flushes used during dialysis.</p> <p>B. Review of the skilled nursing visit</p>		<p>times daily, educate patient on the ordered frequency and report to the physician, patient is not taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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G 0183 Bldg. 00	<p>notes dated 05/27, 06/04, 06/07, 06/14, 06/20, 06/27, 07/08, and 07/11/16, the diabetic care section under comments indicated "Patient reports that ALF personnel checks his / her blood sugar and administers insulin as ordered - see medication profile .... " The clinical record failed to evidence coordination with the ALF in regards to assessment of the patient's blood sugars as well as the services that the ALF were being provided to the patient.</p> <p>4. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>5. An undated policy titled "Plan of Care Development and Review" indicated "Multidisciplinary care conferences are held on clients as needed ... to promote coordination and continuity of care. The results are documented and a copy is retained in the client's medical record .... "</p> <p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the patient in learning appropriate self-care techniques.</p>			

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	<p>Based on record review and interview, the Licensed Practical Nurse (LPN) failed to accurately educate the patient in 1 of 2 records reviewed of patients being seen by Licensed Practical Nurses in a sample of 12. (#5)</p> <p>Findings include:</p> <p>1. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16.</p> <p>A. A skilled nursing visit note dated 07/19/16, but signed on 07/18/16, indicated CellCept was the only change in medications. The patient verbalized questions regarding the medication (its use and why ordered). The visit note indicated that the LPN educated the patient by informing him on "MG [myasthenia gravis] crisis, how the disease can but not always effects breathing causing use of temp [temporary] or permanent use of vent [ventilator], information packet left with patient, patient reads and looks for any info to help him / her better understand. Instructed pt [patient] that even a slight change in breathing to notify CHH [Cornerstone Home Health] / Neurologist even if he / she thinks it is a minor thing .... "</p>	G 0183	<p>On 08/19/2016 Director of Client Care Services educated clinical staff on all staff on educating patients on new medications the day the clinical staff are aware patient is taking the medications, and adding medication to the medication profile. Resources that are available for staff on the office issued tablets were reviewed and staff verbalized understanding. Charts will be reviewed for orders and all orders will be reviewed before sending. Orders will be evaluated in 10%of audits for compliance by Director of Client Care Services.The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	08/19/2016

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	<p>B. Review of the Nursing 2016 Drug Handbook, CellCept is an immunosuppressant that prevents organ rejection in patients receiving allogeneic renal transplants, cardiac transplant, hepatic transplants, to treat lupus nephritis, and idiopathic thrombocytopenic purpura. Drug alert indicated "drug is considered a potential mutagen [causes genetic mutation] and teratogen [causes malformation of an embryo]. Follow safe-handling procedures when preparing, administering, or dispensing. Don't crush tablets; don't open or crush capsules. Avoid inhaling powder in capsule or having it contact skin or mucous membranes ... Adverse reactions in bold that indicated life threatening: Central Nervous Systems [progressive multifocal leukoencephalopathy]; Cardiovascular [hemorrhage]; Gastrointestinal [hemorrhage]; Genitourinary [renal tubular necrosis, acute renal failure]; Hematologic [leukopenia and thrombocytopenia]; Metabolic [hyperkalemia]; Other [Sepsis]. Other interactions indicated to take the medication on an empty stomach 1 to 2 hours before meals to prevent delay of absorption. Black box warning for nursing considerations indicated "Increased risk of infection and</p>			
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G 0186	<p>lymphoma may result from immunosuppression .... " The LPN failed to properly address and educate the patient on the use and possible life threatening adverse reactions of the medication CellCept.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. An undated policy titled "Medication Orders and Administration" indicated " .... The nurse instructs the client / family / caregiver in an understandable format and language about any clinically significant adverse reaction, potential unanticipated outcomes or any other concerns about the medication to be administered, along with actions to be taken should any reaction or unanticipated outcomes occurs .... "</p> <p>4. An undated policy titled "Skilled Services / Care Offered By Licensed Staff" indicated, " .... The LPN / LVN assess the client in learning appropriate self - care techniques .... "</p> <p>484.32 THERAPY SERVICES</p>				

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Bldg. 00	<p>The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)</p> <p>Based on observation, record review, and interview, the Occupational and Physical Therapist failed to ensure orders were obtained prior to providing services in 2 of 10 records reviewed of patients with therapy services in a sample of 12. (# 2 and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 07/15/16 to 09/13/16, with orders for occupational therapy.</p> <p>A. Review of the Occupational Therapy notes, the Occupational Therapist provided services on 07/18/16.</p> <p>B. A signed physician order dated 07/19/16, indicated " ... Occupational Therapy evaluation week of 07/12/16, Effective 07/15/16, 0w1, 2w3 frequency for goals and interventions as per initial evaluation .... " The physical therapist provided services absent of a written physicians order.</p> <p>2. Clinical record number 7, SOC 07/14/16, included a plan of care for the</p>	G 0186	<p>On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be</p>	08/19/2016

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G 0225  Bldg. 00	<p>certification period of 07/14/16 to 09/11/16, with orders for physical and occupational therapy.</p> <p>A. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4 [three time a week for four weeks], 2w5 [two times a week for five weeks] frequency for goals and interventions as per initial evaluation .... "</p> <p>1. Review of the physical and therapy notes, physical therapy provided services on 07/16 and 07/18/16. The physical therapist provided services absent of a written physicians order.</p> <p>3. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on observation, record review, and interview, the home health aide failed to</p>	G 0225	<p>monitoring 10% of clinical records quarterly to ensure compliance The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p> <p>On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated</p>	08/19/2016			

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	<p>follow the plan of care for 1 of 1 patient's observed with bathing and hygiene (# 1).</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included plans of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16, with orders for a home health aide to assist the patient with personal care and activities of daily living two times a week.</p> <p>A. During a home visit with Employee A, a home health aide, on 07/19/16 at 7:15 AM, the home health aide was observed bathing the patient entirely in the shower without the patient being encouraged to provide assistance with care. The home health aide failed to follow the plan of care.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p>		<p>by the Director of Client Care Services/Administrator to individualize the plan of care (medications, diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Director of Client Care Services/QA personnel will be auditing 10% of all charts quarterly to verify the policy is being followed. Any staff member deficient in following the policy will be educated one on one. The Director Client Care Services will be responsible for monitoring</p>	

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G 0235 Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>Based on record review and interview, the agency failed to ensure the plan of care and all subsequent physician orders were written and completed at the time of the order, sent to the physician, returned and incorporated into the patients clinical record within a timely manner for 11 of 12 records reviewed, failed to ensure missed visit notes were faxed to the physician within a timely manner in 1 of 12 records reviewed, failed to ensure 60 day summaries were faxed to the physician in a timely manner in 1 of 7 patients who had been recertified for an additional 60 days in a sample of 12, failed to ensure medication reconciliation was faxed to the physician within a timely manner in 2 of 12 records reviewed, failed to ensure a home health aide supervisory visit was accurate in 1 of 5 records reviewed of patients with home health aide services, and failed to ensure each skilled nursing visit notes were updated to reflect the patient's current status and education provided at the time of the nursing visit in 2 of 12 records reviewed.</p>	G 0235	<p>these corrective actions to ensure that this deficiency is corrected and will not occur.</p> <p>During course of survey the timeliness of sending and retrieval of orders by Cornerstone Home Healthcare was discussed. With the Administrator and Director of Client Care Services reporting that with recent loss of QA nurse, and the recent loss, new hire and training of 2 key office positions and an increase in agency census from approximately 50 patients to approximately 100, the focus and efforts have been on hiring and training new clinical staff and maintaining the provision of quality care. The sending and retrieval of orders has been less timely then we prefer during these transitions. Even though Cornerstone's current practice does reflect the CMS standard as stated in the Medicare Integrity Program Manual and our internal policy, that all physician orders are signed and dated by physician prior to billing final claim, we now understand that there is an expectation of a more timely orders process. Therefore, on 08/18/2016, upon receipt and review of Statement of Deficiencies and Plan of Correction report and a citation regarding timeliness of orders,</p>	08/19/2016

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	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 and therefore, being out of compliance with the Condition of Participation 484.48: Clinical Records.		the Director of Client Care Services and Administrator conferenced to outline a plan for more timely submission and retrieval of physician orders. The following action plan will be put in place at scheduled bi-weekly office staff meetings to ensure a timelier processing of orders. Cornerstone Home Healthcare will utilize AXCESS Orders Management reports on an ongoing basis to track pending and outstanding orders. Office staff will be trained and educated on how to generate an Orders Pending Signature Report, Orders To Be Cosigned Report and Orders To Be Sent Report and be instructed to provide the report at regularly scheduled bi-weekly office staff meeting for review and proper action. During these meetings the orders will be reviewed and addressed for timeliness and proper action on all aging order swill be initiated. Office staff will be instructed to inform Director of Client Care Services of any issues of receiving orders and Director of Client Care Services will make determination on an individualized basis on handling the retrieval of orders by either calling, faxing, mailing, going by the Physician's office to pick up the orders. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any	

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			<p>care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. In order to maintain liaison to ensure coordinated care that effectively</p>	

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			support objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained in patient hard chart. This process will begin at next case conference on August 31, 2016. Missed visits will be sent to physician bi-weekly. QA will be used to monitor all missed visits and documentation of completion of missed visit being sent to the physician. Office staff were educated on this on 08/19/2016 On 08/19/2016 Office staff were educated on completeness and attention to details related to data entry on intake, verifying referral information. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance The Director Client Care Services will be responsible for monitoring these corrective	

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G 0236 Bldg. 00	<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 the plan of care and all subsequent physician orders were written and completed at the time of the order, sent to the physician, returned and incorporated into the patients clinical record within a timely manner for 11 of 12 records reviewed (#1 - 6, 8 - 12), failed to ensure missed visit notes were faxed to the physician within a timely manner in 1 of 12 records reviewed (# 4), failed to ensure 60 day summaries were faxed to the physician in a timely manner in 1 of 7 (# 8) patients who had been recertified for an additional 60 days in a sample of 12, failed to ensure medication reconciliation was faxed to the physician within a timely manner in 2 of 12 records reviewed (# 10 and 11), failed to ensure a</p>	G 0236	<p>actions to ensure that this deficiency is corrected and will not occur.</p> <p>During course of survey the timeliness of sending and retrieval of orders by Cornerstone Home Healthcare was discussed. With the Administrator and Director of Client Care Services reporting that with recent loss of QA nurse, and the recent loss, new hire and training of 2 key office positions and an increase in agency census from approximately 50 patients to approximately</p>	08/19/2016

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	<p>home health aide supervisory visit was accurate in 1 of 5 records reviewed (#11) of patients with home health aide services, and failed to ensure each skilled nursing visit notes were updated to reflect the patient's current status and education provided at the time of the nursing visit in 2 of 12 records reviewed. (# 7 and 8)</p> <p>Findings include:</p> <p>1. Review of clinical record number 1, SOC (start of care) 04/30/16, included a plan of care for the certification period of 04/30/16 to 06/28/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>A. The initial plan of care was observed to be four pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained verbal start of care orders on 04/30/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services 05/20/16. The physician signature line to the plan of care and the addendums, were blank. The initial plan of care addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p>		<p>100, the focus and efforts have been on hiring and training new clinical staff and maintaining the provision of quality care. The sending and retrieval of orders has been less timely then we prefer during these transitions. Even though Cornerstone's current practice does reflect the CMS standard as stated in the Medicare Integrity Program Manual and our internal policy, that all physician orders are signed and dated by physician prior to billing final claim,we now understand that there is an expectation of a more timely orders process. Therefore, on 08/18/2016, upon receipt and review of Statement of Deficiencies and Plan of Correction report and a citation regarding</p>	

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	<p>B. A physician's order dated 05/26, 06/07, 06/08 (x2 orders), 06/11, 06/15, 06/18/16, had not been signed by the physician. The physician orders failed to be signed by the physician in a timely manner.</p> <p>C. A physician's order dated 06/10/16, indicated the Director of Clinical Services electronically completed and signed the order on 06/15/16. The order had not been signed by the physician. A second physician's order dated 06/10/16, had not been signed by the physician. The 1st physician's order failed to be written upon receipt of obtaining the order. Both physician orders failed to be signed by the physician in a timely manner.</p> <p>D. The updated plan of care for the certification period of 06/29/16 to 08/27/16, included orders for skilled nursing and physical therapy.</p> <p>1. The plan of care was noted to be three pages. The Director of Clinical Services indicated on page 1, line 23, that she had obtained physician orders on 06/29/16. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of Treatment" indicated the Director of Clinical Services signed the orders on 07/10/16. The physician signature line to</p>		<p>timeliness of orders, the Director of Client Care Services and Administrator conferenced to outline a plan for more timely submission and retrieval of physician orders. The following action plan will be put in place at scheduled bi-weekly office staff meetings to ensure a timelier processing of orders. Cornerstone Home Healthcare will utilize AXXESS Orders Management reports on an ongoing basis to track pending and outstanding orders. Office staff will be trained and educated on how to generate an Orders Pending Signature Report, Orders To Be Cosigned Report and Orders To Be Sent Report and be instructed to provide the report at regularly scheduled bi-weekly office staff</p>		

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	<p>the plan of care and the addendums, were blank. The initial plan of care addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>The Director of Clinical Services was interviewed on 07/20/16 at 3:30 PM. The Director of Clinical Services was not able to indicate what was acceptable for "timely manner." The Director of Clinical Services indicated the plan of cares probably was not finished or completed as for the reason for the late signatures by the physician.</p> <p>2. Review of clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 05/16/16 to 07/14/16, with orders for skilled nursing, home health aide services, physical, and occupational therapy.</p> <p>A. The initial plan of care was observed to be four pages. Employee I, a Registered Nurse, documented on page 1, line 23, that she had obtained verbal start of care orders on 05/16/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by Employee I on 07/02/16. The physician signature line to the plan of care and the addendums, were blank.</p>		<p>meeting for review and proper action. During these meetings the orders will be reviewed and addressed for timeliness and proper action on all aging order swill be initiated. Office staff will be instructed to inform Director of Client Care Services of any issues of receiving orders and Director of Client Care Services will make determination on an individualized basis on handling the retrieval of orders by either calling, faxing, mailing, going by the Physician's office to pick up the orders. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also</p>		

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	<p>The initial plan of care addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>3. Review of clinical record number 3, SOC 06/03/16, included a plan of care for the certification period of 06/03/16 to 08/01/16, with orders for physical and occupational therapy.</p> <p>A. The initial plan of care was observed to be three pages. The Administrator documented on page 1, line 23, that she had obtained verbal start of care orders on 06/03/16. The subsequent pages (2 - 3) labeled "Addendum to Plan of Treatment" was signed by the Administrator on 07/15/16. The physician signature line to the plan of care and the addendums, were blank. The initial plan of care addendums failed to be completed and signed by the Administrator and sent to the physician for signature within a timely manner.</p> <p>4. Clinical record number 4, SOC 03/26/16, included a plan of care for the certification period of 03/26/16 to 05/24/16, with orders for skilled nursing, home health aide services, medical social services, physical, and occupational therapy.</p>		<p>educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by</p>		

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	<p>A. The initial plan of care was observed to be four pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained verbal start of care orders on 03/26/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services on 07/18/16. The physician signed the plan of care and the addendums on 07/19/16. The initial plan of care was observed stapled to a fax cover sheet dated 07/19/16. The initial plan of care and addendums failed to be completed and signed by the Administrator and sent to the physician for signature within a timely manner.</p> <p>B. A signed physician order dated 04/11/16, indicated "Effective 03/26/2016, Skilled Nursing Recertification Evaluation for home care 1w1, 2w1, 1w7 frequency. Physical Therapy evaluation week of 03/27/2016, Effective 03/28/16, 2w8 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 03/27/2016, Effective 03/31/2016, 1w1, 2w3 frequency for goals and interventions as per initial evaluation. MSW [Medical Social Worker] evaluation week of 04/30/16, Effective 04/05/2016, 2 - 4 visits</p>		<p>authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. In order to maintain liaison to ensure coordinated care that effectively support objective as outlined on the plan of care, Cornerstone Home</p>	

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	<p>throughout current certification period frequency for goals and interventions as per initial evaluation. Home Health Aide Services Effective week of 03/26/2016, 0w1, 2w8, 1w1 frequency for goals and interventions as per skilled clinician's evaluation." The physician order was electronically signed by the Director of Clinical Services. The physician order indicated the physician signed the order on 07/19/16. The physician order failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner</p> <p>C. A physician's order dated 03/28, 04/01, 04/21, 04/25, 05/01, 05/06, 05/10, 05/17, 05/20, and 05/25/16, indicated the physician signed all the orders on 07/19/16. The physician orders failed to be signed by the physician in a timely manner.</p> <p>D. An updated plan of care for the certification period of 05/25/16 to 07/23/16, with orders for skilled nursing and home health aide services.</p> <p>1. The updated plan of care was observed to be three pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained verbal orders on 05/25/16. The subsequent</p>		<p>Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained in patient hard chart. This process will begin at next case conference on August 31, 2016. Missed visits will be sent to</p>				

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	<p>pages (2 - 3) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services on 06/10/16. The physician signed the plan of care and the addendums on 07/19/16. The initial plan of care was observed stapled to a fax cover sheet dated 07/19/16. The initial plan of care and addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>E. A physician's order dated 06/13/16, indicated "Effective 06/09/16, Ciprofloxacin 600 mg [milligram oral tablet] 2 times per day for 10 days By mouth (po) New (UTI). Effect 06/20/16 Patient prescribed Valium and Trazodone. Patient / wife have decided not to give patient medication." The order was signed by the Director of Clinical Services on 06/20/16. The order indicated the physician had signed the order on 07/19/16. The Director of Clinical Services failed to write the orders on the date of receipt and have those orders sent to the physician for signature within a timely manner.</p> <p>F. A missed visit form dated 05/03, 05/13, and 05/20/16, was observed to be stapled to fax cover sheets dated 07/19/16. The agency failed to ensure</p>		<p>physician bi-weekly. QA will be used to monitor all missed visits and documentation of completion of missed visit being sent to the physician. Office staff were educated on this on 08/19/2016 On 08/19/2016 Office staff were educated on completeness and attention to details related to data entry on intake, verifying referral information. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>		

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	<p>the faxed missed visits forms was sent to the physician in a timely manner.</p> <p>G. Review of the physician orders page on the electronic medical record, as of 07/21/16, the following orders indicated the following:</p> <ol style="list-style-type: none"> <li>1. An entry for the 05/25/26 to 07/23/16 plan of care, indicated the plan of care was sent to the physician for signature on 07/20/16.</li> <li>2. One of two physician orders dated 05/23/16, had been sent to the physician for signature on 07/20/16. The other order failed to indicate that the order had been sent for signature.</li> <li>3. Two physician orders dated 05/25/16, indicated they had been sent to the physician for signatures on 07/20/16.</li> <li>4. A physician's order dated 06/06/16, indicated the order was waiting for a co-signature, therefore, failed to indicate that it had been sent to the physician for signature.</li> <li>5. A physician's order dated 06/13/16 and 07/05/16, indicated the orders had been sent to the physician for signature on 07/20/16.</li> </ol>			

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	<p>H. Two skilled nursing visit notes dated 06/13/16 and 06/20/16, indicated in the discharge planning section "Ongoing, Spoke to [spouse] regarding [name of Employee G, a medical social worker] who will see him / her again to assist with community resources for future care." The clinical record failed to evidence a physician order for the medical social services.</p> <p>I. Three skilled nursing visit notes dated 06/27, 07/05, and 07/11/16, indicated in the discharge planning section "Ongoing. MSW has seen them and spoke to his / her son. He / She reports that his / her son is working on getting support for him / her when Home Care moves out." The clinical record failed to evidence a medical social worker visit note.</p> <p>The Director of Clinical Services was interviewed on 07/21/16 at 1:00 PM. The Director of Clinical Services indicated the 05/25/16 to 07/23/16 plan of care had not been sent to the physician and was unable to provide a reason why the plan of care had not been sent to the physician when a new certification period was starting soon. The Director of Clinical Services was unable to provide an explanation for the missed visit forms not being sent to the physician sooner</p>			

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	<p>than 07/19/16. The Director of Clinical Services indicated she was not aware of the medical social worker need.</p> <p>5. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16, with orders for skilled nursing, physical, occupation, and speech therapy.</p> <p>A. The plan of care that was provided for home visits indicated a skilled nursing frequency of one time a week for eight weeks, then zero times a week for one week. The plan of care was four pages. The Director of Clinical Services documented on line 23 that she had obtained the verbal start of care orders on 06/10/16. The subsequent pages of the plan of care (addendums) was signed by the Director of Clinical Services with a date of 07/10/16.</p> <p>B. The plan of care that was copied from the patient's hard chart indicated a skilled nursing frequency of one time a week for nine weeks. The plan of care was also four pages. The Director of Clinical Services documented on line 23 that she had obtained the verbal start of care orders on 06/10/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director</p>			

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	<p>of Clinical Services on 07/18/16. The initial plan of care was observed stapled to a fax cover sheet dated 07/19/16. The initial plan of care and the addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>C. Review of the skilled nursing visit notes, a skilled nursing visit note was observed to have a visit date 07/19/16, but was electronically signed on 07/18/16, by the clinician. The visit note failed to be accurate and reflect the correct date of the assessment / signature.</p> <p>The Director of Clinical Services was interviewed on 07/21/16 at 12:30 PM. The Director of Clinical Services indicated she had to make some minor changes to the plan of care as to why there were changes in dates on the addendum pages.</p> <p>6. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing.</p> <p>A. The plan of care observed to be four pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained the verbal start of</p>			

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	<p>care orders on 06/01/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services on 06/20/16. The physician signature line was blank. The agency failed to have the plan of care and its subsequent addendums completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. The narrative note in the skilled nursing and interventions section of the OASIS start of care comprehensive assessment dated 06/01/16 and the OASIS resumption of care assessment dated 06/22/16, both indicated "Skilled nursing intervention and teaching noted in assessment. Instructed patient on calling Cornerstone Home Healthcare as needed for changes in condition, also that Cornerstone is available 24/7 and phone number on SOC packet left at patient's apartment. Instructed on medications, reviewed all medications with patient and family and instructed on filling a medication planner. Writer observed all medication in patient's presence. Instructed to call RN with any questions and concerns. Patient verbalized understanding. Informed patient that PT [physical therapy] would be calling for visits within the next week - and he / she is to call office if he / she does not hear</p>			

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	<p>from staff by beginning of next week. Instructed on date of SN return. Verbalized understanding. The narrative note failed to be updated to the patient's current status at the time of the assessment.</p> <p>C. The coordination note on the OASIS start of care comprehensive assessment dated 06/01/16 and the OASIS resumption of care assessment dated 06/22/16, both indicated "Writer called PCP [primary care physician] [Name of physician] with SOC [start of care] orders, PT [physical therapy] and OT [occupational therapy] services. SN [skilled nursing] to see patient 2w2, 1w7 [two times a week for two weeks then one time a week for seven weeks]. Informed of POC [plan of care] to follow. Informed of major interactions with medications and to call if any concerns, otherwise will keep medications as ordered and informed SN would be faxing information to office." The coordination note failed to be updated to the patient's current plan at the time of the assessment</p> <p>D. A home visit was conducted with physical therapy on 07/20/16 at 10:00 AM, at his / her home. The patient was observed to have lived in a ranch home in the country. Review of the address on</p>				

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	<p>the plan of care upon admission and recertification, the patient had always resided in his / her home. The plan of care indicated the patient resided in a major city when the patient actually resided in another town outside of the major city. The narrative note in the 06/01/16 start of care and the 06/22/16 resumption of care, indicated the "phone number on SOC packet left at patient's apartment." The plan of care failed to have the correct city of residence, the resumption of care note failed to be updated and both start of care and resumption of care failed to properly identify the patient's place of residence.</p> <p>G. Review of the physician orders page on the electronic medical record, as of 07/21/16, the plan of care dated 06/01/16, among other orders dated 06/10, 06/13, 06/15, 06/22, 06/27, and 06/28/16, indicated "To be sent to physician." The order dated 06/14/16 indicated "Submitted pending co-signature."</p> <p>1. Review of the patient hard chart, physician orders dated 06/13, 06/14 06/22, 06/27 and 06/28/16, failed to evidenced that the physician had signed the orders. The agency failed to ensure the physician signed the orders within a timely manner.</p>			

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	<p>H. Review of the skilled nursing visit notes on 06/03, 06/07, 06/10, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, 07/06, 07/08, 07/11, 07/13, 07/15, 07/18, and 07/20/16, indicated in the interventions section that patient / caregiver teaching was provided on "relation to kinds of food and urine ph, subcutaneous injection" and instructed on safety precautions such as "keeping pathway clear."</p> <p>1. On 06/22/16, the patient returned from the hospital with orders to discontinue the Lovenox injections. The skilled nursing visit notes failed to be updated and reflect the patient status and education provided at the time of each nursing visit / assessment.</p> <p>7. Clinical record number 8, SOC 01/13/16, included the following:</p> <p>A. Review of the plan of care dated 01/13/16 to 03/12/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 01/13/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of</p>			

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NAME OF PROVIDER OR SUPPLIER  CORNERSTONE HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5 HIGH STREET MOORESVILLE, IN 46158		
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	<p>Clinical Services signed the orders on 02/02/16.</p> <p>2. A fax cover sheet that was stapled to all 4 pages of the plan of care, indicated the fax was sent to the primary care physician on 05/03/16. The physician signed all 4 pages of the plan of care on 05/05/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. Review of the physician orders dated 01/20, 01/22, 02/23, 03/04/15, all orders were stapled to a fax cover sheet which indicated the orders were faxed to the physician on 05/03/16. The orders were signed by the physician on 05/05/16. The physician orders failed to be sent to the physician for signature in a timely manner.</p> <p>C. Review of a 60 day summary dated 03/10/16 for the certification 01/13/16 to 03/12/16, the summary was stapled to a fax cover sheet which indicated the summary was faxed to the physician on 05/03/16. The summary failed to be sent to the physician in a timely manner.</p>				

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	<p>D. Review of the plan of care dated 03/13/16 to 05/11/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 03/13/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 04/01/16.</p> <p>2. A fax cover sheet that was stapled to all 4 pages of the plan of care, indicated the fax was sent to the primary care physician on 06/30/16. The physician signed all 4 pages of the plan of care on 07/06/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>E. Review of the physician orders dated 03/13/16 and 04/22/16, both orders were stapled to a fax cover sheet which indicated the orders were faxed to the physician on 05/30/16. The orders were signed by the physician on 07/06/16. The physician orders failed to be sent to the physician for signature in a timely manner.</p>						

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	<p>F. Review of a 60 day summary dated 05/11/16 for the certification 03/13/16 to 05/11/16, the summary was stapled to a fax cover sheet which indicated the summary was faxed to the physician on 06/29/16. The summary failed to be sent to the physician in a timely manner.</p> <p>G. Review of Missed Visit forms indicated the following:</p> <p>1. A missed visit form dated 04/12/16, was attached to a fax cover sheet which indicated the form was faxed to the physician on 06/30/16.</p> <p>2. A missed visit form dated 05/13 05/17,05/31, and 06/10/16, were attached to a fax cover sheet which indicated the forms were faxed to the physician on 07/20/16.</p> <p>H. Review of the plan of care dated 05/12/16 to 07/10/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 05/12/16.</p> <p>1. The plan of care was noted to be 3 pages. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of treatment) indicated the Director of</p>			

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	<p>Clinical Services signed the orders on 06/20/16.</p> <p>2. A fax cover sheet that was stapled to all 3 pages of the plan of care, indicated the fax was sent to the primary care physician on 06/30/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>I. Review of the plan of care dated 07/11/16 to 09/08/16, line 23 and the subsequent 3 pages failed to indicate who obtained the verbal order as well as the date of the verbal order for continuing orders. The plan of care and the addendums to the plan of care failed to be completed and signed by the clinician who obtained the orders and failed to be sent to the physician for signature within a timely manner.</p> <p>J. Review of the physician orders dated 06/02, 06/12 (x2 orders), and 07/11/16, failed to have a physician signature. Review of an electronic physician order page, the entries indicated "to be sent." The physician orders failed to be sent to the physician for signature in a timely manner.</p>						

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	<p>K. Review of the skilled nursing visit notes dated 05/18/16, indicated in the Respiratory comment section "Pt [patient] is a current smoker; discussed smoking cessation with pt, is not interested. The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt is noncompliant with diet."</p> <p>1. Review of the skilled nursing visit notes dated 05/26/16, indicated in the Respiratory comment section "Pt [patient] is a current smoker; discussed smoking cessation with pt, is not interested." The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt is noncompliant with diet."</p> <p>2. Review of the skilled nursing visit note dated 06/02/16, indicated in the The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt continues to noncompliant with diet. Pt has been drinking a lot of Gatorade; encouraged</p>						

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	<p>him to drink water instead or diet drinks due to high sugar content; stated he would try." The LPN also indicated that the patient's wound had healed, the patient had very dry skin, assisted the patient with applying lotion, as well as encouraging the patient to do it daily. The visit note failed to evidence if the physician had been notified.</p> <p>a. Review of a physician's order dated 06/02/16, written by the Director of Clinical Services, the order indicated "Effective 06/02/16, wound resolved. Patient has very dry skin, skilled nursing to assist pt [patient] with applying lotion, encourage patient to apply daily. Skilled nursing to continue to monitor areas for changes." The box next to "order read back and verified" was not marked to indicate that the order had been verbally obtained by the Director of Clinical Services.</p> <p>3. Review of the skilled nursing visit notes dated 06/09/16, indicated in the The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt continues to noncompliant with diet. Pt has been drinking a lot of Gatorade; encouraged him to drink water instead or</p>			

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	<p>diet drinks due to high sugar content; stated he would try."</p> <p>4. Review of the skilled nursing visit notes dated 06/16/16, indicated in the The Dietary comment section indicated "Reinforced diet choices again with pt, should avoid sugary drinks, fried foods, fast foods; try to eat fruits and vegetables, whole grains, low fat foods; encouraged pt to try some of the healthy choice or weight watchers meals."</p> <p>5. Review of the skilled nursing visit notes dated 06/24/16, indicated in the The Dietary comment section indicated "Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt continues to be noncompliant with diet. Pt has been drinking a lot of Gatorade; encouraged him to drink water instead or diet drinks due to high sugar content; stated he would try."</p> <p>The skilled nursing visit notes dietary section were repetitive and failed to be updated and reflect the patient status and education provided at the time of each nursing visit / assessment.</p> <p>9. Clinical record number 9, SOC 05/21/16, included a plan of care for the</p>			

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	<p>certification period of 05/21/16 to 07/19/16, with orders for skilled nursing, physical and occupational therapy.</p> <p>A. Review of the plan of care, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 05/21/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 07/15/16.</p> <p>2. A fax cover sheet that was stapled to all 4 pages of the plan of care, indicated the fax was sent to the primary care physician on 07/19/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. Review of physician orders dated 05/26, 07/06, 07/07, physical therapy plan of treatment dated 07/06/16, were stapled to a fax sheet which indicated the fax was sent to the primary care physician on 07/19/16. The orders failed to be sent to the physician for signature in a timely manner.</p>				

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	<p>10. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for skilled nursing, physical and occupational therapy.</p> <p>A. Review of the plan of care, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 05/07/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 06/20/16. The plan of care was not signed by the attending physician. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. A urinalysis lab result that was obtained on 06/16/16, was faxed to the agency on 06/29/16. The lab result was stapled to a fax cover sheet and indicated it was faxed to the physician on 06/29/16. The agency failed to follow up with the patient's urinalysis at the laboratory and notify the physician of the result in a timely manner.</p>			
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	<p>C. Review of the physician orders dated 05/31, 06/09, 06/16/16, failed to have a physician signature. Review of an electronic physician order page, the entries indicated the orders were sent on 07/20/16. Review of the patient's hard chart, the orders were observed to be stapled to a fax sheet which indicated the fax was sent to the primary care physician on 07/20/16. The orders failed to be sent to the physician for signature in a timely manner.</p> <p>D. Review of the plan of care dated 07/05/16 to 09/03/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal orders on 07/06/16.</p> <p>1. The plan of care was noted to be 3 pages. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 07/19/16.</p> <p>2. A fax cover sheet that was stapled to all 3 pages of the plan of care, indicated the fax was sent to the primary care physician on 07/20/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent</p>			
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	<p>to the physician for signature within a timely manner.</p> <p>E. Review of a communication note dated 06/17/16, the Director of Clinical Services indicated "Resumption of Care Medication Reconciliation / New Major Medication Interactions" and attached was a current list of medications the patient was taking and there were major drug interactions identified.</p> <p>1. Review of the OASIS comprehensive resumption of care reassessment dated 05/27/16, the Administrator indicated the she had identified one major drug interaction and this was to be sent to the physician.</p> <p>2. Review of the attached fax cover sheet that was stapled with the communication note, medication profile, and the Drug to Drug interactions sheet, the fax cover sheet indicated the fax was sent to the physician on 06/17/16. The Administrator and the Director of Clinical Services failed to notify of the major drug interactions upon identification / timely manner.</p> <p>11. Clinical record number 11, SOC 06/13/16, included a plan of care for the certification period of 06/13/16 to 08/11/16, with orders for skilled nursing,</p>			

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	<p>physical therapy, occupational therapy, home health aide services, and medical social worker services.</p> <p>A. Review of the plan of care indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 06/13/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 07/01/16. The plan of care was not signed by the primary care physician. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. Review of physician orders dated 06/16/16, failed to be signed by the ordering physician. The orders failed to be sent to the physician for signature in a timely manner.</p> <p>C. A communication note dated 06/13/16, was completed and signed by the Director of Clinical Services dated 06/17/16, indicated attachments of major Drug to Drug interactions that was</p>				

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	<p>identified during the admission. The Director of Clinical Services failed to notify the physician of major Drug to Drug interactions in a timely manner.</p> <p>D. A home health aide supervisory visit was conducted on 06/27/16. Review of the clinical record, home health services was placed on hold on 06/25/16. The agency failed to ensure the clinical record contained accurate information.</p> <p>12. Clinical record number 12, SOC 02/16/16, included a plan of care for the certification period 02/16/16 to 04/15/16, with orders for physical therapy and home health aide services.</p> <p>A. Review of the plan of care, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 02/21/16.</p> <p>1. The plan of care was noted to be 3 pages. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 03/01/16. A fax cover sheet that was attached to the plan of care indicated the orders was sent to the physician on 03/22/16. The plan of care was signed by the attending physician on 03/25/16. The plan of care and the addendums to the</p>				

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	<p>plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>13. The Director of Clinical Services was interviewed again on 07/22/16 at 10:53 AM. The Director of Clinical Services indicated staff would obtain orders and document the orders in the record, then the office staff would pull the information from the notes, write the orders appropriately, then the Director of Clinical of Services would sign off on the orders, then fax the orders to the physician for signature.</p> <p>14. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>15. An undated policy titled "Confirmation of Physician Telephone / Verbal Orders" indicated, "...Physician verbal / telephone orders are accepted by qualified staff and submitted to the physician for his / her signature in a timely manner. Original and / or new / updated orders are transcribed onto an appropriate physician order form or a plan of treatment form, and mailed or</p>			

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	<p>faxed to the physician for signature within a timely manner of receipt of the order by Agency personnel. Verbal / telephone orders are to be signed by the physician in a timely manner upon receipt from Cornerstone Home Healthcare personnel ... The Agency monitors outstanding unsigned, physician orders and the orders are refaxed as deemed necessary. The Director of Client Care Services is notified of any issue associated with inability of obtaining signature for outstanding orders. Agency personnel may be assigned to visit physician offices to obtain the signed orders .... "</p> <p>16. An undated policy titled "Comprehensive Assessment" indicated " ... The registered nurse or skilled therapist completes the comprehensive initial assessment of the client's needs for care, treatment and / or services within five [5] days from start of care ... The Comprehensive Assessment ... Includes the following information ... A comprehensive review and history of prescribed, over the counter medications and herbal supplements, including Potential / actual drug interactions ... Duplicative drug therapy, potential and past adverse effects, significant sides effects and adverse effects .... "</p>			

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G 0323 Bldg. 00	<p>17. An undated policy titled "Medical Supervision of Client Care" indicated, "... Upon completion of the comprehensive assessment and development of the plan of care, the plan of care will be faxed and / or mailed to the ordering physician for final approval and signature. A written summary report for each client shall be sent to the ordering physician at least every 60 days .... "</p> <p>484.20(c)(1) TRANSMITTAL OF OASIS DATA The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly.</p> <p>Based on the Casper report, record review and interview, the agency failed to ensure that OASIS data for each patient was transmitted by the end of the following month between September 2105 to June 30, 2016.</p> <p>Findings include:</p> <p>1. Review of the CASPER report from 01/01/16 to 06/30/16, the agency failed to ensure that the OASIS data was transmitted at least monthly for the following patients:</p> <p>A. Approximately eighty nine (89) patient entries with an effective date / date of assessments from 09/11/15 to</p>	G 0323	<p>On 08/03/2016 and 08/19/2016 the Director of Client Care Services and Administrator met to discuss action plan to ensure more timely submissions of OASIS data. The following steps will be taken to monitor outstanding OASIS and promote timely submissions: On an ongoing basis, the administrator will utilize reports obtained from AXXESS system which will accurately reflect a listing of all outstanding OASIS(SOC/ROC/Transfer/Discharge). OASIS close to 30 submission timeline will be reviewed and submitted. The Administrator will track submissions and associated errors on a monthly basis utilizing CASPER reporting system and report findings to QA committee.</p>	08/19/2016

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	<p>12/31/15, were submitted on 03/11/16.</p> <p>B. Approximately twenty one (21) patient entries with an effective date / date of assessments from 01/05/16 to 01/30/16, were submitted on 03/11/16.</p> <p>C. Approximately twenty three (23) patient entries with an effective date / date of assessments from 01/11/16 to 02/27/16, were submitted on 05/11/16.</p> <p>D. Approximately twenty eight (28) patient entries were submitted between 50 - 120 days.</p> <p>2. Clinical record number 2, SOC (start of care) 05/16/16. The CASPER report failed to evidence that the start of care OASIS data had been submitted by June 30.</p> <p>3. Clinical record number 5, SOC 06/10/16. The CASPER report failed to evidence that the start of care OASIS data had been submitted by June 30.</p> <p>4. Clinical record number 9, SOC 05/21/16. The CASPER report failed to evidence that the start of care OASIS data had been submitted by June 30.</p> <p>5. Clinical record number 10, SOC 05/07/16. The CASPER report failed to</p>		Any employees not completing OASIS data collection and submitting for submission in a timely manner will receive one on one training by the administrator.		

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G 0334 Bldg. 00	<p>evidence that the start of care OASIS data, the transfer OASIS data dated 05/23/16, and the resumption of care OASIS data had been submitted by June 30.</p> <p>6. Clinical record number 11, SOC 06/13/16. The CASPER report failed to evidence that the start of care OASIS, the transfer / discharge OASIS data had been submitted by June 30.</p> <p>7. The Administrator was interviewed on 07/18/16 at 12:00 PM. The Administrator indicated the tardiness of the OASIS submissions was her fault due to staff changes and maternity leave of the Director of Clinical Services.</p> <p>8. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</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. Based on record review and interview,</p>	G 0334	On 08/19/2016 Director of Client	08/19/2016

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	<p>the agency failed to ensure that the admitting clinician completed the skin / wound assessment upon admission for 1 of 4 record reviewed of a patients with wounds in a sample of 12. (#6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to do vital signs with each visit, assess patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is removed. The patient diagnoses included, but not limited to, aftercare following surgery for neoplasm and type 2 diabetes mellitus.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 06/01/16, indicated the following:</p> <p>1. Question M1340 and M1342 indicated the patient had a surgical wound that was not healing. The narrative note indicated the patient had staples. The assessment failed to include the appearance of the surgical wound,</p>		<p>Care Services educated staff on comprehensive assessments. Making sure all points on the oasis were addressed and best practices were reviewed. Staff were educated on detailed assessments on wounds, drains, diabetes, and all aspects of the patients care needs. Staff were instructed on CMS guidelines of making sure a comprehensive assessment is complete in 5 days. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>		

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	<p>measurement of the incision, and the number of staples that was used to close the incision site.</p> <p>2. Question M1350 asked if the patient had a skin lesion or open wound that was receiving treatment by the agency. The answer was "yes". The note indicated the patient had two JP (jackson pratt) drains with staples. The assessment failed to include if the JP drain had any drainage, the amount of drainage, and color of drainage in the bulb.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. An undated policy titled "Comprehensive Assessments" indicated, " ... Data obtained during assessments / evaluation visits is used to determine the client's needs for care, treatment and / or services and to develop a plan of care .... "</p> <p>4. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 and 32 Box 1 - 4 indicated, " ... The comprehensive</p>			

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G 0337 Bldg. 00	<p>assessment, including OASIS items ... are the most important components of the home care clinical record, they must be complete, accurate, and the content should clearly describe the patient .... Use the OASIS items to effectively 'paint the picture' of the patient congruent with all other documentation .... "</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 profile was updated and accurate at the time of the assessment in 2 of 12 records reviewed.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included a written plan of care for the certification period of 04/30/16 to 06/28/16, with orders for oxygen 2 - 5 liters, continuously, per nasal cannula.</p> <p>A. Review of the OASIS comprehensive start of care assessment</p>	G 0337	<p>On 08/19/2016 Director of Client Care Services instructed staff on comprehensive assessment. Making sure all points on the oasis were addressed and best practices were reviewed. Instructed staff that part of the comprehensive assessment includes complete and up to date medication profiles, and education on drug regimen. Staff were instructed on reviewing all medications while in the home to be sure that a comprehensive medication list is compiled and submitted on the plan of care. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance The Director Client Care Services</p>	08/19/2016

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	<p>dated 04/30/16 and the comprehensive recertification reassessment dated 06/24/16, both assessments indicated the patient was receiving 1.5 liters of oxygen intermittently via nasal cannula.</p> <p>B. Review of the medication profile dated 05/01/16 and 06/25/16, the medication profile indicated the patient was receiving 2 liters of oxygen continuously via nasal cannula. The medication profile failed to accurately reflect the patient's liter flow of oxygen at the time of the reassessment.</p> <p>2. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16.</p> <p>A. A skilled nursing visit note dated 07/19/16, but signed on 07/18/16, indicated " ... CellCept is only change in medications .... " The medication profile was reviewed and the medication profile failed to evidence that the patient was ever taking CellCept. The medication profile failed to updated and accurately reflect the patient's current medications at the time of the assessment.</p> <p>3. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information</p>		will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.		

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G 0339 Bldg. 00	<p>in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>4. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 and 32 Box 1 - 4 indicated, " ... The comprehensive assessment, including OASIS items ... are the most important components of the home care clinical record, they must be complete, accurate, and the content should clearly describe the patient ... "</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT 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 the physical therapist reassessed the patient during the last 5 days of the 60 day certification period in 1 of 5 records reviewed of patients with physical therapy in a sample of 12. (#1)</p> <p>Findings include:</p>	G 0339	On 08/19/2016 all disciplines were educated by Director of Client Care Services that if continuing into the new certification, even though they are not the primary case manager they must be complete their reevaluation within the 5 day window prior to the new certification. Director of Client Care Services/QA personal will also be monitoring 10% of clinical	08/19/2016

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G 0340  Bldg. 00	<p>1. Clinical record number 1, SOC (start of care) 04/30/16, included a plan of care for the certification period of 04/30/16 to 06/28/16, with orders for physical therapy.</p> <p>A. Review of a physical therapy plan of care visit note dated 06/22/16, indicated the patient would receive therapy services two times a week for six weeks then one time a week to three weeks, effective 06/29/16. The physical therapist failed to reassess the patient in the last five days of the certification period (06/24/16 to 06/28/16).</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. An undated policy titled "Comprehensive Assessment" indicated " ... The comprehensive assessment is updated and revised by the appropriate skilled professional ... no less frequently than the last five [5] days [day 56 - 60] for every sixty [60] days beginning with the start of care date .... "</p> <p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be</p>		records quarterly to ensure complianceThe Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.	

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	<p>updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>Based on record review and interview, the agency failed to ensure that the clinician updated the patient's place of residence, obtained a temperature during the vital sign assessment, included an assessment of the area being treated by the agency, and update the coordination narrative as well as the skilled nursing interventions narrative upon return to home from a hospitalization in 1 of 1 record reviewed of a patient that was hospitalized during the 60 day certification period in a sample of 12. (#6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to do vital signs with each visit, assess patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is removed. The patient diagnoses included, but not limited to, aftercare</p>	G 0340	<p>On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care (medications, diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Director of Client</p>	08/19/2016

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	<p>following surgery for neoplasm and type 2 diabetes mellitus.</p> <p>A. An OASIS resumption of care comprehensive assessment dated 06/22/16, indicated the following:</p> <ol style="list-style-type: none"> <li>The patient had been hospitalized for a urinary tract infection and sepsis due to pseudomonas. Review of the vital signs, the clinician failed to ensure that a temperature was taken with the assessment.</li> <li>OASIS question M1340 and M1342, indicated the patient had a surgical wound and that the wound was not healing. Question M1350, indicated the patient had a skin lesion or open wound that was receiving interventions from the agency. The assessment failed to evidence an assessment of the area being treated by the agency and what that treatment entails.</li> <li>The narrative note on the OASIS start of care comprehensive assessment dated 06/01/16, indicated "Skilled nursing intervention and teaching noted in assessment. Instructed patient on calling Cornerstone Home Healthcare as needed for changes in condition, also that Cornerstone is available 24/7 and phone number on</li> </ol>		<p>Care Services/QA personnel will be auditing 10% of all charts quarterly to verify the policy is being followed. Any staff member deficient in following the policy will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. Staff were educated at the 08/03/2016 and 08/19/2016 instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for example documenting the number of staples in an incision, documenting drainage from a JP drain that patient is tracking in the clinical record, obtaining a temperature and obtaining blood sugar readings from the ALF. Director of Client Care Services/QA personnel will be auditing 10% of all charts to verify the policy is being followed. Any staff member deficient in following the policy will be educated one on one.</p>	

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	<p>SOC packet left at patient's apartment. Instructed on medications, reviewed all medications with patient and family and instructed on filling a medication planner. Writer observed all medication in patient's presence. Instructed to call RN with any questions and concerns. Patient verbalized understanding. Informed patient that PT would be calling for visits within the next week - and he is to call office if he does not hear from staff by beginning of next week. Instructed on date of SN return. Verbalized understanding. Review of the OASIS comprehensive resumption of care narrative note indicated the same verbiage as the start of care. The narrative note failed to be updated to the patient's current status at the time of the assessment.</p> <p>4. The coordination note on the OASIS start of care comprehensive assessment dated 06/01/16, indicated that the admitting clinician conference with the physician, physical and occupational therapy. The narrative portion indicated "writer called PCP [primary care physician] [Name of physician] with SOC [start of care] orders, PT [physical therapy] and OT [occupational therapy] services. SN [skilled nursing] to see patient 2w2, 1w7 [two times a week for two weeks then one time a week for</p>			

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	<p>seven weeks]. Informed of POC [plan of care] to follow. Informed of major interactions with medications and to call if any concerns, otherwise will keep medications as ordered and informed SN would be faxing information to office." Review of the OASIS comprehensive resumption of care narrative note indicated the same verbiage as the start of care. The narrative note in the coordination of care failed to be updated to the patient's current status at the time of the assessment.</p> <p>5. A home visit was conducted with physical therapy on 07/20/16 at 10:00 AM, at his / her home. The patient was observed to have lived in a ranch home in the country. Review of the address on the plan of care upon admission and recertification, the patient had always resided in his / her home. The narrative note failed to provide accurate information when the clinician indicated the "phone number on SOC packet left at patient's apartment."</p> <p>2. The Administrator and the Director of Clinical Services were interviewed during the exit conference on 07/22/16 at 2:15 PM. Both the Administrator and Director of Clinical Services indicated that obtaining a temperature was part of a vital sign assessment. No further</p>			

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N 0000 Bldg. 00	<p>documentation / information in reference to the above findings were provided at the end of the exit conference.</p> <p>3. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 and 32 Box 1 - 4 indicated, " ... The comprehensive assessment, including OASIS items ... are the most important components of the home care clinical record, they must be complete, accurate, and the content should clearly describe the patient .... Use the OASIS items to effectively 'paint the picture' of the patient congruent with all other documentation .... "</p> <p>This was a State relicensure survey.</p> <p>Survey dates: June 16, 17, 20, 21, and 22, 2016</p> <p>Facility ID#: 004282</p> <p>Provider #: 157560</p> <p>Census: 135</p>	N 0000		

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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 record review and interview, the agency failed to ensure that their efforts were coordinated and documented effectively and support the objectives outlined in the plan of care in 1 of 1 records reviewed (# 9) of patient's who was receiving outside services with a Dialysis facility and with an Assisted Living Facility / Community in a sample of 12 and failed to follow up with medical social services in regards to discharge planning in 2 of 12 clinical record reviewed. (# 4 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16, with orders for skilled nursing.</p> <p>A. Two skilled nursing visit notes dated 06/06, 06/13, and 06/20/16, indicated in the discharge planning section "Ongoing, Spoke to [spouse] regarding [name of Employee G, a medical social worker] who will see him / her again to assist with community</p>	N 0486	<p>In order to maintain liaison to ensure coordinated care that effectively supports the objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained inpatient hard chart. This process will begin at next case conference on August 31, 2016. On 08/03/2016 and 08/19/2016 Director of Client Care Services and Administrator educated clinical staff on importance of effective care coordination and communication between disciplines to ensure best outcomes for patients and the</p>	08/19/2019

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	<p>resources for future care."</p> <p>B. Three subsequent skilled nursing visit notes dated 06/27, 07/05, and 07/11/16, indicated in the discharge planning section "Ongoing. MSW has seen them and spoke to his / her son. He / She reports that his / her son is working on getting support for him / her when Home Care moves out."</p> <p>C. An OASIS comprehensive recertification assessment dated 07/19/16, indicated in the coordination of care section " ... Psychological support and therapy, MSW [medical social worker] visiting patient and his wife regarding future care options and community resources .... "</p> <p>D. Review of the electronic medical record and hard chart record, the clinical record failed to evidence that a medical social worker had made a visit due to no record of the visit. The skilled nursing visit notes were repetitive and failed to evidenced if skilled nursing had followed up with medical social services and the progress on discharge planning.</p> <p>2. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing</p>		<p>required documentation of this in the clinical record. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on care coordination with the physician. Staff were educated on reporting to the physician any changes, concerns, or discrepancies noted during visits to the physician for clarification of orders or to obtain new orders as indicated. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of dialysis patients, Cornerstone Home Healthcare will call or fax dialysis centers and/or nephrologists for medications and specific parameters for each patient. Cornerstone will make every effort to receive this information, any calls/faxes of requests will be retained in the clinical record. The information received will be implemented into the patient's plan of care upon receipt. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated clinical staff coordination and documentation of care with dialysis centers/nephrologist. Instructions were made to clinical staff to document all communication in the medical record. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of patients residing</p>	

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	<p>to do vital signs with each visit, assess patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is removed. The patient diagnoses included, but not limited to, aftercare following surgery for neoplasm and type 2 diabetes mellitus.</p> <p>A. Review of the skilled nursing visit note dated 06/03/16, the clinician failed to document the amount of drainage from the JP drain, failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment. The clinician also failed to educate the patient in documenting and measuring the drainage from the JP drains, so that the physician would know when to remove the drains.</p> <p>B. Review of the skilled nursing visit note dated 06/07/16, the clinician failed to failed to provide a measurement and the number of staples that was used to close the incision and failed to obtain a temperature with the vital sign assessment.</p>		<p>in congregated facilities, Cornerstone Home Healthcare will coordinate care with facility nursing staff regarding services provided to patients. Cornerstone Home Healthcare will continue its practice of noting on the 485 "ALF staff is responsible for" and note specific care the patient is receiving from the ALF. Cornerstone Home Healthcare staff will communicate and coordinate with ALF staff on, but not limited to, blood sugars, medication changes, labs and PT/INR results. Coordination of care will be documented and filed in patient clinical record. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated staff on coordination and documentation of care with patients residing in congregated facilities. The staff verbalized understanding. On 08/03/2016 and 08/19/2016 the Director of Client Care Services and Administrator instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for example documenting the number of staples in an incision, documenting drainage from a JP drain that patient is tracking in the clinical record, obtaining a temperature and obtaining blood sugar readings from the ALF. In order to capture patients that need specific care coordination with dialysis, ALF, or specialty groups,</p>		

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	<p>C. Review of the skilled nursing visit note dated 06/09/16, the clinician failed to failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment.</p> <p>D. Review of the skilled nursing visit notes dated 06/13/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/15/16, the patient was transferred to the hospital and admitted for a urinary tract infection.</p> <p>E. Review of the resumption of care assessment dated 06/22/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/24/16, the patient's temperature was obtained and the patient had a low grade temperature of 99.1.</p> <p>F. Review of the skilled nursing visit notes in the diabetic section dated 06/03, 06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative</p>		<p>Cornerstone will be review all new admission weekly to ensure these patients are properly identified, clinical staff informed, and information has been requested. Administrator spoke with Community Liaison on 08/19/2016 and instructed her to notate on intake forms, when able, when a patient resides in a congregated living, or is on dialysis. Plan of Care Development and Review Policy 801.90 has been revised to reflect care coordination between various sources. The Director of Client Care Services/QA personal will monitor on an ongoing basis through chart audits,compliance to the policy for care coordination. 10% of all clinical records will be audited quarterly for evidence of care coordination. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse failed to accurately assess and document the patient diabetes at the time of the assessment.</p> <p>3. Clinical record number 9, SOC (start of care) 05/21/16, included a plan of care for the certification period of 05/21/16 to 07/19/16, with orders for skilled nursing, physical, and occupational therapy. The patient's primary diagnosis was cerebral infarction (stroke) followed by secondary diagnoses of general weakness, diabetes type 2, end stage renal disease, neuropathy, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and rheumatoid arthritis. The patient resides in an Assisted Living Facility / Community (ALF).</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/21/16, the assessment indicated the patient was receiving hemodialysis, had a right port a cath [catheter used for hemodialysis] in the left chest wall, and a new av graft / fistula [accessible site in the arm used for dialysis] in the left upper arm. The clinical record failed to</p>						

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	<p>evidence coordination with the dialysis center, such as blood pressure parameters, management of port a cath, diet, fluid restrictions, and medications / flushes used during dialysis.</p> <p>B. Review of the skilled nursing visit notes dated 05/27, 06/04, 06/07, 06/14, 06/20, 06/27, 07/08, and 07/11/16, the diabetic care section under comments indicated "Patient reports that ALF personnel checks his / her blood sugar and administers insulin as ordered - see medication profile .... " The clinical record failed to evidence coordination with the ALF in regards to assessment of the patient's blood sugars as well as the services that the ALF were being provided to the patient.</p> <p>4. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>5. An undated policy titled "Plan of Care Development and Review" indicated "Multidisciplinary care conferences are held on clients as needed ... to promote coordination and continuity of care. The results are documented and a copy is retained in the client's medical record .... "</p>			

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N 0514 Bldg. 00	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the agency failed to ensure all complaints and grievances made by patients and / or their families were documented and investigated with resolution in 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>During the entrance conference on 07/18/16 at 10:15 AM, the Administrator and Director of Clinical Services indicated they had received complaints from patients and / or their families in regards to tardiness of staff or not knowing when the staff was coming. Both indicated that these were minor issues.</li> <li>Review of the complaint / grievance</li> </ol>			N 0514	<p>On 08/19/2016 Director of Client Care Services and Administrator provided in-service training to clinical staff and office staff regarding Client Concerns/Grievances Policy 200.70. Reinforcing the procedure of documenting any client concerns, issues or problems in writing. Instructing staff that any concern, issue, or problem that can be resolved "On the Spot"</p>		08/19/2016

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	binder on 07/18/16 at 12:00 PM, the binder contained only 2 complaints from the Deyta. (Deyta is a healthcare satisfaction management and clinical quality improvement program services). The complaint binder failed to include all complaints and grievances in relation to tardiness and patients not knowing when the staff was coming to their home.		should be resolved and documented in the visit note or communication note in the record and forwarded to the Cornerstone Office. Staff were informed that any concern, issue, or problem that cannot be resolved, is to be forwarded verbally or in writing on communication note or incident log to the Cornerstone Office to follow up. Field staff voiced understanding of this procedure. On 08/19/2016 Office staff were instructed to document all client concerns in communication note with documentation of "On the Spot" resolution when able. Office staff were instructed that when the issue or concern is not able to be resolved to forward all client concerns to	

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N 0522 Bldg. 00	<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 observation, record review, and interview, the agency failed to ensure the home health aide failed to follow the plan of care for 1 of 1 patient's observed with bathing and hygiene (# 1), failed to ensure the skilled nurse(s) assessed and instructed the patient / caregiver on care and management of diabetes in 1 of 5 records reviewed of patients with</p>	N 0522	<p>administrative staff verbally or in writing on date of receipt. Office staff verbalized understanding. Client Concerns/Grievances Policy 200.70 was amended to include Office staff documenting the concern/resolution in a communication note. Client concerns/grievances will be trended and reported through the performance improvement/risk management function.</p> <p>On 08/03/2016 and 08/19/2016 Each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority</p>	08/19/2016

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	<p>diabetes in a sample of 12 (# 6), and failed to ensure orders were obtained prior to providing services in 2 of 12 records reviewed. (# 2 and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included plans of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16, with orders for a home health aide to assist the patient with personal care and activities of daily living two times a week.</p> <p>A. During a home visit with Employee A, a home health aide, on 07/19/16 at 7:15 AM, the home health aide was observed bathing the patient entirely in the shower without the patient being encouraged to provide assistance with care. The home health aide failed to follow the plan of care.</p> <p>2. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 07/15/16 to 09/13/16, with orders for occupational therapy.</p> <p>A. Review of the Occupational Therapy notes, the Occupational Therapist provided services on 07/18/16.</p>		<p>each visit, progress towards goals, and documenting education and patient response to that education. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify the policy is being followed. Any staff member deficient in following the policy will be educated one on one. Review of these findings will be addressed at case conference and education provided. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40.</p>	

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	<p>B. A signed physician order dated 07/19/16, indicated " ... Occupational Therapy evaluation week of 07/12/16, Effective 07/15/16, 0w1, 2w3 frequency for goals and interventions as per initial evaluation .... " The physical therapist provided services absent of a written physicians order.</p> <p>3. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to assess and instruct the patient / caregiver in glucose monitoring 3 times per week, instruct patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed wound healing and medications, instruct patient / caregiver to keep glucose log and to take log to MD visits, and instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p> <p>A. Review of the skilled nursing visit notes dated 06/01, 06/07, 06/10, 06/13, 06/22, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, 07/06, 07/08, 07/11, 07/13, 07/15, 07/18, and 07/20/16, the clinical record failed to evidence that the skilled nurse(s) had instructed the patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed</p>		<p>To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>wound healing and medications, instruct patient / caregiver to keep glucose log and to take log to MD visits, instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p> <p>B. Review of the skilled nursing visit notes in the diabetic section dated 06/03, 06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse(s) failed to accurately assess and document the patient diabetes at the time of the assessment. The skilled nurse(s) failed to follow the plan of care.</p> <p>3. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification period of 07/14/16 to 09/11/16, with orders for physical and occupational therapy.</p> <p>A. Review of the plan of care, line</p>			

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	<p>23 failed to evidence the name of the clinician who had obtained the verbal start of care order as well as the date of the verbal start of care.</p> <p>B. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4 [three time a week for four weeks], 2w5 [two times a week for five weeks] frequency for goals and interventions as per initial evaluation .... "</p> <p>1. Review of the physical and therapy notes, physical therapy provided services on 07/16 and 07/18/16. The physical therapist provided services absent of a written physicians order.</p> <p>4. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>5. An untitled policy titled "Plan of Care Development and Review" indicated, " ... The Registered Nurse and / or Licensed Therapist ... initiate a plan of care within 24 hours of completion of the start of care ...</p>			

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N 0524  Bldg. 00	<p>6. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 33 Box 1 - 4 indicated " ... Documentation should include family / caregiver education and their responses to, and demonstration of, the specific education and objective results of the education. Document the patient's response to care interventions and other activities .... "</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. (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</p>			
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	<p>treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure that the plan of care was updated and revised to include parameters for oxygen saturations for 12 of 12 records reviewed (#1 - 12), failed to update and revise the medication profile in 2 of 12 records reviewed (#1), failed to update and revise interventions and goals from previous plan of care to the current plan of care in 1 of 7 records reviewed (# 1) of patient being recertified for an additional 60 days in a sample of 12, failed to update and revise wound treatment orders in 2 of 4 records reviewed (#1 and 4) of patient's with wounds in a sample of 12, failed ensure the plan of care was updated and revised to be reflective of the patient's comprehensive assessment in 1 of 12 records reviewed in a sample of 12 (# 1), and failed to ensure that the Physical and Occupational Therapy orders included specific procedures and modalities to be used while providing therapy services in 7 of 10 records reviewed of patients receiving therapy services in a sample of 12. (#1, 2, 6, 7, 9, 10, 11)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included a written plan</p>	N 0524	<p>On 08/03/2016 and 08/19/2016 staff were instructed to discontinue the routine use of pulse oximetry on all patients. Pulse oximetry will be obtained based in the individual needs of the patient. Pulse oximetry will be obtained only as needed for the following: patient is on oxygen, exhibits shortness of breath, diminished lungs sounds, exhibits signs or symptoms of respiratory distress, as baseline at SOC, or as physician orders indicate otherwise. Pulse oximetry use and parameters will be clearly noted in each patient's plan of care. Director of Client Care Services/QA personal will be auditing charts on an ongoing basis and 10% of all clinical charts quarterly will be evaluated for compliance of this. On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care</p>	08/19/2016

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	<p>of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16.</p> <p>A. Both plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. Both plans of care failed to include parameters to obtain pulse oximetry.</p> <p>B. The OASIS start of care comprehensive assessment dated 04/30/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula.</p> <p>1. The initial plan of care (04/30/16 to 06/28/16) indicated the patient was to receive 2 - 5 liters of oxygen continuously per nasal cannula. The initial plan of care failed to be updated and revised to be reflective of the initial comprehensive assessment.</p> <p>C. The OASIS recertification comprehensive assessment dated 06/24/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula. The assessment also indicated that treatment had been provided to a coccyx wound, which included cleansing the area with wound cleanser, pat dry,</p>		<p>every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Examples were given to the staff as follows: If a patient is to be checking blood sugars 3 times a day and only complete 2 times daily, educate patient on the ordered frequency and report to the physician, patient is not taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. On 08/03/2016 Director of Client Care Services/Administrator</p>	

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	<p>cover with soft absorbent foam dressing, and secure with cover roll.</p> <p>1. Review of the medication section of the plan of care (06/29/16 to 08/27/16), failed to evidence the oxygen, liter flow, and route to be administered. The plan of care failed to be updated and revised.</p> <p>2. A physician's order dated 06/24/16, indicated for skilled nursing to provide treatment to the patient's coccyx wound three times a week by cleansing the wound with wound cleanser, pat dry, and cover with hydrocolloid dressing or soft absorbent foam dressing, secured with cover roll. Desitin Lotion to be applied if the dressing falls off. The current plan of care (06/29/16 to 08/27/16) failed to be updated and revised to include treatment orders for the coccyx wound.</p> <p>D. The OASIS comprehensive recertification assessment dated 06/24/16, indicated the goals were stabilization of cardiovascular pulmonary condition by 08/26/16; Demonstrates compliance with medication by 08/26/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 08/26/16; Patient / caregiver verbalizes call orders and dehydration,</p>		<p>educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30,801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical</p>				

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	<p>weakness, infection signs / symptoms to report to the nurse and / or physician by 08/26/16; and wound healing without complications by 08/26/16.</p> <p>2. The plans of care for the certification period 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16, both indicated: Goals indicated stabilization of cardiovascular pulmonary condition by 06/28/16; Demonstrates compliance with medication by 06/28/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 06/28/16; Patient / caregiver verbalizes call orders and dehydration, weakness, infection signs / symptoms to report to the nurse and / or physician by 06/28/16; and wound healing without complications by 06/28/16. The goals in the plan of care (06/29/16 to 08/27/16) failed to be revised and updated to reflect the patient's current status at the time of the reassessment.</p> <p>E. A physicians order dated 06/29/16, indicated "Physical Therapy evaluation week of 06/22/16, Effective 06/29/16, 2w6 [two times a week for six weeks], 1w3, frequency for goals and interventions as per initial evaluation." The physician's order failed to include specific procedures and modalities to be used.</p>		<p>documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records to ensure compliance On 08/19/2016 each Axxess form was reviewed with staff/discipline as to the location of where the verbal order is to be documented and received. Director of Client Care Services/QA</p>		

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	<p>2. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 05/16/16 to 07/14/16.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A signed physician order dated 07/19/16, indicated " ... Occupational Therapy evaluation week of 07/12/16, Effective 07/15/16, 0w1, 2w3 frequency for goals and interventions as per initial evaluation .... " The physician order failed to include specific procedures and modalities to be used.</p> <p>3. Clinical record number 3, SOC 06/03/16, included a plan of care for the certification period of 06/03/16 to 08/01/16.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>4. Clinical record number 4, SOC 03/26/16, included a plan of care for the</p>		<p>personnel will be auditing 10% of all clinical charts quarterly to verify verbal orders are being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>		

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	<p>certification period of 05/25/16 to 07/23/16. The primary diagnosis on the plan of care indicated Furuncle of buttock (boil), followed by type 2 diabetes mellitus.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A skilled nursing visit note dated 05/17/16 and 05/31/16, indicated the patient was receiving treatment to a wound on the right buttock. The treatment that was being performed included to cleanse the area with normal saline, pat dry, place a small tip of gauze inside wound bed and dry gauze on top for drainage, and secure with tape. Skilled nursing to perform treatment at every visit weekly and spouse to do the treatment on all other days. The plan of care failed to revised and updated to include the treatment orders for the right buttock wound.</p> <p>The Director of Clinical Services was interviewed on 07/21/16 at 1:00 PM. The Director of Clinical Services was not able to provide an explanation of why the wound treatment was not added to the plan of care.</p>			

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	<p>5. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16.</p> <p>A. Both plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>6. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16.</p> <p>A. The plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A physician's order dated 06/08/16, written by Employee H, a Registered Nurse, indicated " ... Therapy evaluation week of 05/29/2016, Effective 06/02/2016, 1w1, 2w5 frequency for goals and interventions as per initial evaluation .... " The physician's order failed to include specific procedures and modalities to be used.</p>			

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	<p>7. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification period of 07/14/16 to 09/11/16.</p> <p>A. The plan of care indicated for the skilled clinician to a obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4, 2w5 frequency. Occupational Therapy evaluation week of 07/14/16, Effective 07/16/16, 1w1, 2w2, 1w2 frequency for goals and interventions as per initial evaluation .... " The physician's order failed to include specific procedures and modalities to be used.</p> <p>8. Clinical record number 8, SOC 01/13/16, included a plans of care for the certification periods of 01/13/16 to 03/12/16, 03/13/16 to 05/11/16, 05/12/16 to 07/10/16, and 07/11/16 to 09/08/16.</p> <p>A. The plans of care indicated for the skilled clinician to obtain a pulse oximetry as needed per skilled clinician's</p>			

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	<p>discretion. The plans of care failed to include parameters to obtain pulse oximetry.</p> <p>9. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification of 05/21/16 to 07/19/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A physician order dated 05/26/16, written by Employee H, indicated " ... Physical Therapy evaluation week of 05/22/2016, Effective 05/23/16, 1w1, 2w7 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 05/22/2016, Effective 05/25/2016, 2w3 frequency for goals and interventions as per initial evaluation." The physician's order failed to include specific procedures and modalities to be used.</p> <p>C. A physician order dated 07/07/16, written by Employee H, indicated " ... Physical Therapy evaluation week of 07/03/16, Effective 07/06/16, 2w2 frequency for goals and interventions as per initial evaluation .... "</p>			

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	<p>The physician's order failed to include specific procedures and modalities to be used.</p> <p>10. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for physical, and occupational therapy.</p> <p>A. Review of the OASIS comprehensive resumption of care assessment dated 05/27/16, the Administrator, a Physical Therapist, indicated she had conference with the physician in the resumption of services.</p> <p>1. A physician order dated 06/02/16, written by Employee H, indicated "Effective 05/27/16 Physical Therapy Resumption of Care Evaluation for home care 1w1, 2w1, 3w2, 2w2, 1w1 frequency .... " The order failed to include if there were any changes with procedures and modalities for physical therapy.</p> <p>11. Clinical record number 11, SOC 06/13/16, included two plans of care for the certification period of 06/13/16 to 08/11/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry</p>			

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	<p>as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A physician order dated 06/21/16, written by Employee H, indicated " ... Physical Therapy evaluation week of 06/19/2016, Effective 06/20/16, 2w6, 1w2 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 06/12/2016, Effective 06/16/2016, 1w4 frequency for goals and interventions as per initial evaluation .... " The order failed to include if there were any changes with procedures and modalities for physical and occupational therapy.</p> <p>12. Clinical record number 12, SOC 02/16/16, included a plan of care for the certification period 02/16/16 to 04/15/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>13. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above</p>			

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N 0529  Bldg. 00	<p>findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>14. An untitled policy titled "Plan of Care Development and Review" indicated, " ... The Case Manager / Director of Client Care Services is responsible for overseeing the care planning process to ensure that the plan is appropriate .... "</p> <p>15. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 Box 1 - 4 indicated, " ... the POC [plan of care] are the most important components of the home care clinical record - they must be complete, accurate, and the content should clearly describe the patient. All other information flow from the services and needs identified and ordered on the plan of care ... page 143 ... Present other objective, measurable information that assists in supporting skilled care and the need for intervention [oximetry results, etc] .... "</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor;</p>			

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	<p>(D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure the primary care physician received a written summary report on their patient at least every 60 days / in a timely manner for 2 of 7 records reviewed of patients who were recertified in a sample of 12. (#8 and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC (start of care) dated 01/13/16, included two plans of care for the certifications of 01/13/16 to 03/12/16 and 03/13/16 to 05/11/16 with orders for skilled nursing and home health aide services.</p> <p>A. Review of a 60 day summary dated 03/10/16 for the certification 01/13/16 to 03/12/16, the summary was stapled to a fax cover sheet which indicated the summary was faxed to the physician on 05/03/16. The summary failed to be sent to the physician in a timely manner.</p> <p>B. Review of a 60 day summary dated 05/11/16 for the certification 03/13/16 to 05/11/16, the summary was stapled to a fax cover sheet which</p>	N 0529	In order to ensure a written summary report for each patient is sent to the attending physician at least every 60 days, Cornerstone Home Healthcare will review upcoming recertification's weekly at regularly scheduled office staff meetings. 60 day summaries will be assigned in patient clinical record and appropriate clinical team member notified for completion within the week. At following weekly regularly scheduled office staff meeting the completed 60 day summaries will be printed and faxed to the physician for review to ensure that they have been faxed to the physician by day 60. On 08/19/2016 Director of Client Care Services and Administrator educated staff on the content of the 60 day summary and including summary of care provided, current status, and goals. Clinical staff were instructed on providing the physician with a comprehensive picture of the patient's services over the last 60 days and documentation as to the reasoning the patient continues to require services. Staff verbalized understanding. This will be monitored during the weekly staff meetings for compliance of staff and those who are not compliant will be counseled immediately	08/19/2016

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	<p>indicated the summary was faxed to the physician on 06/29/16. The summary failed to be sent to the physician in a timely manner.</p> <p>2. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>A. Review of the clinical record, the patient was transferred to the hospital on 05/23/16. The patient resumed services on 05/25/16. The OASIS comprehensive resumption of care assessment narrative note dated 05/25/16, indicated the patient was hospitalized for exacerbation of congestive heart failure. The note also indicated the patient would be having a pacemaker placed on 06/03/16. The 60 day summary was sent to the primary care physician on 07/19/16. The 60 day summary dated 07/05/16, failed to include the patient's hospitalization, pacemaker procedure, any changes in interventions, and goals that have or have not been met. The 60 day summary failed to be sent to the physician within a timely manner.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information</p>		<p>and will request for the 60 day summary to be completed immediately. The Director of Client Care Services/QA personal will monitor on an ongoing basis through chart audits, compliance to the policy for care coordination. 10% of all clinical records will be audited quarterly for evidence of the 60 day summary being sent to the physician by day 60. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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N 0537 Bldg. 00	<p>in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. An undated policy titled "Medical Supervision of Client Care" indicated, "... Upon completion of the comprehensive assessment and development of the plan of care, the plan of care will be faxed and / or mailed to the ordering physician for final approval and signature. A written summary report for each client shall be sent to the ordering physician at least every 60 days .... "</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on record review and interview, the agency failed to ensure clinicians obtained verbal orders prior to performing treatments in 1 of 4 records reviewed of patient receiving wound treatments in a sample of 12 and failed to assessed and instructed the patient / caregiver on care and management of diabetes in 1 of 5 records reviewed of patients with diabetes in a sample of 12. (# 6)</p> <p>Findings include:</p>	N 0537	On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment preformed must match the verbal order received from the physician. On 08/19/2016, once the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and	08/19/2016	

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	<p>1. Clinical record number 6, SOC (start of care) 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to assess and instruct the patient / caregiver in glucose monitoring 3 times per week, instruct patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed wound healing and medications, instruct patient / caregiver to keep glucose log and to take log to MD visits, and instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p> <p>A. Review of a skilled nursing visit note dated 06/13/16, the following was documented:</p> <p>1. The skin assessment narrative indicated "Advised patient to wash with soap and water and shower as he / she normally would. The note failed to include documentation that the clinician spoke to the physician about treatment orders.</p> <p>2. The clinician documented in the "Treatment Provided" section that he / she cleansed an area of JP drain removal with soap and water, using clean wash cloth, patted dry using clean wash cloth,</p>		<p>changes in the following policies: Policy 500.80, 500.30,801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be pulled on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>covered with non adhesive dressing followed by gauze, and secured with paper tape. The note indicated the clinician would be performing this treatment 3 times a week. The visit note failed to include documentation that the skilled nurse had spoken to the physician about treatment orders.</p> <p>a. A physician's order date 06/14/16, but signed by the clinician on 06/13/16, indicated "effective 06/13/16, skilled nursing to complete wound care .... " The physician order "Order read back and verified" was not checked off. The clinician provided wound treatment to the patient prior to obtaining orders.</p> <p>B. Review of the skilled nursing visit notes dated 06/01, 06/07, 06/10, 06/13, 06/22, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, 07/06, 07/08, 07/11, 07/13, 07/15, 07/18, and 07/20/16, the clinical record failed to evidence that the skilled nurse(s) had instructed the patient / caregiver in diabetic care such as disease process, hypo / hyperglycemia, foot care, delayed wound healing and medications, instruct patient / caregiver to keep glucose log and to take log to MD visits, instruct patient / caregiver to call physician if blood sugar is greater than 170 or less than 70.</p>						

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	<p>C. Review of the skilled nursing visit notes in the diabetic section dated 06/03, 06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse(s) failed to accurately assess and document the patient diabetes at the time of the assessment. The skilled nurse(s) failed to follow the plan of care.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 33 Box 1 - 4 indicated " ... Documentation should include family / caregiver education and their responses to, and demonstration of, the specific education and objective results of the</p>			

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N 0541  Bldg. 00	<p>education. Document the patient's response to care interventions and other activities .... "</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.</p> <p>Based on record review and interview, the agency failed to ensure that the clinician updated the patient's place of residence, obtained a temperature during the vital sign assessment, included an assessment of the area being treated by the agency, and update the coordination narrative as well as the skilled nursing interventions narrative upon return to home from a hospitalization in 1 of 1 record reviewed of a patient that was hospitalized during the 60 day certification period in a sample of 12. (#6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to do vital signs with each visit, assess</p>	N 0541	<p>On 08/03/2016 and 08/19/2016 each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care (medications, diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period, addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on</p>	08/19/2016	

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	<p>patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is removed. The patient diagnoses included, but not limited to, aftercare following surgery for neoplasm and type 2 diabetes mellitus.</p> <p>A. An OASIS resumption of care comprehensive assessment dated 06/22/16, indicated the following:</p> <p>1. The patient had been hospitalized for a urinary tract infection and sepsis due to pseudomonas. Review of the vital signs, the clinician failed to ensure that a temperature was taken with the assessment.</p> <p>2. OASIS question M1340 and M1342, indicated the patient had a surgical wound and that the wound was not healing. Question M1350, indicated the patient had a skin lesion or open wound that was receiving interventions from the agency. The assessment failed to evidence an assessment of the area being treated by the agency and what that treatment entails.</p> <p>3. The narrative note on the</p>		<p>evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change. Director of Client Care Services/QA personnel will be auditing 10% of all charts quarterly to verify the policy is being followed. Any staff member deficient in following the policy will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. Staff were educated at the 08/03/2016 and 08/19/2016 instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for example documenting the number of staples in an incision, documenting drainage from a JP drain that patient is tracking in the clinical record, obtaining a temperature and obtaining blood sugar readings from the ALF. Director of Client Care Services/QA personnel will be auditing 10% of all charts to verify the policy is being followed. Any staff member deficient in following the policy will be educated one on one.</p>	

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	<p>OASIS start of care comprehensive assessment dated 06/01/16, indicated "Skilled nursing intervention and teaching noted in assessment. Instructed patient on calling Cornerstone Home Healthcare as needed for changes in condition, also that Cornerstone is available 24/7 and phone number on SOC packet left at patient's apartment. Instructed on medications, reviewed all medications with patient and family and instructed on filling a medication planner. Writer observed all medication in patient's presence. Instructed to call RN with any questions and concerns. Patient verbalized understanding. Informed patient that PT would be calling for visits within the next week - and he is to call office if he does not hear from staff by beginning of next week. Instructed on date of SN return. Verbalized understanding. Review of the OASIS comprehensive resumption of care narrative note indicated the same verbiage as the start of care. The narrative note failed to be updated to the patient's current status at the time of the assessment.</p> <p>4. The coordination note on the OASIS start of care comprehensive assessment dated 06/01/16, indicated that the admitting clinician conference with the physician, physical and occupational</p>			

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	<p>therapy. The narrative portion indicated "writer called PCP [primary care physician] [Name of physician] with SOC [start of care] orders, PT [physical therapy] and OT [occupational therapy] services. SN [skilled nursing] to see patient 2w2, 1w7 [two times a week for two weeks then one time a week for seven weeks]. Informed of POC [plan of care] to follow. Informed of major interactions with medications and to call if any concerns, otherwise will keep medications as ordered and informed SN would be faxing information to office." Review of the OASIS comprehensive resumption of care narrative note indicated the same verbiage as the start of care. The narrative note in the coordination of care failed to be updated to the patient's current status at the time of the assessment.</p> <p>5. A home visit was conducted with physical therapy on 07/20/16 at 10:00 AM, at his / her home. The patient was observed to have lived in a ranch home in the country. Review of the address on the plan of care upon admission and recertification, the patient had always resided in his / her home. The narrative note failed to provide accurate information when the clinician indicated the "phone number on SOC packet left at patient's apartment."</p>			

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N 0542 Bldg. 00	<p>2. The Administrator and the Director of Clinical Services were interviewed during the exit conference on 07/22/16 at 2:15 PM. Both the Administrator and Director of Clinical Services indicated that obtaining a temperature was part of a vital sign assessment. No further documentation / information in reference to the above findings were provided at the end of the exit conference.</p> <p>3. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 and 32 Box 1 - 4 indicated, " ... The comprehensive assessment, including OASIS items ... are the most important components of the home care clinical record, they must be complete, accurate, and the content should clearly describe the patient .... Use the OASIS items to effectively 'paint the picture' of the patient congruent with all other documentation .... "</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,</p>	N 0542	On 08/03/2016 and 08/19/2016	08/19/2016			

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	<p>the Registered Nurse failed to ensure that the plan of care was updated and revised to include parameters for oxygen saturations for 12 of 12 records reviewed (#1 - 12), failed to update and revise the medication profile in 2 of 12 records reviewed (#1), failed to update and revise interventions and goals from previous plan of care to the current plan of care in 1 of 7 records reviewed (# 1) of patient being recertified for an additional 60 days in a sample of 12, failed to update and revise wound treatment orders in 2 of 4 records reviewed (#1 and 4) of patient's with wounds in a sample of 12, and failed ensure the plan of care was updated and revised to be reflective of the patient's comprehensive assessment in 1 of 12 records reviewed in a sample of 12. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/30/16, included a written plan of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16.</p> <p>A. Both plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. Both plans of care failed to include parameters to obtain pulse oximetry.</p>		<p>each discipline within the Cornerstone staff were educated by the Director of Client Care Services/Administrator to individualize the plan of care (medications,diagnoses, interventions, and goals) between patients and certification periods. Instructed staff that every plan of care should reflect the changes in the patient's status, whether improved or declined and interventions and goals must be reflective of the findings of the comprehensive assessment. Instruction was also provided in reviewing plan of care every visit, making sure all interventions are addressed at some point throughout the certification period,addressing those interventions that are of priority each visit, progress towards goals, and documenting education and patient response to that education. Instructed staff on evaluating the patient's response to the plan of care and making necessary revisions with coordination of physician. Home Health Aides present were instructed to follow their Plan of Care. Home Health Aides were instructed to report changes to the Case Manager on the day of the change.Examples were given to the staff as follows: If a patient is to be checking blood sugars 3 times a day and only complete 2 times daily, educate patient on the ordered frequency and report to the physician, patient is not</p>	

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	<p>B. The OASIS start of care comprehensive assessment dated 04/30/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula.</p> <p>1. The initial plan of care (04/30/16 to 06/28/16) indicated the patient was to receive 2 - 5 liters of oxygen continuously per nasal cannula. The initial plan of care failed to be updated and revised to be reflective of the initial comprehensive assessment.</p> <p>C. The OASIS recertification comprehensive assessment dated 06/24/16, indicated the patient had intermittent oxygen at 1.5 liters per nasal cannula. The assessment also indicated that treatment had been provided to a coccyx wound, which included cleansing the area with wound cleanser, pat dry, cover with soft absorbent foam dressing, and secure with cover roll.</p> <p>1. Review of the medication section of the plan of care (06/29/16 to 08/27/16), failed to evidence the oxygen, liter flow, and route to be administered. The plan of care failed to be updated and revised.</p> <p>2. A physician's order dated</p>		<p>taking ordered medication, educate patient on taking the medications and if patient is not following the ordered plan of care, report to the physician. Director of Client Care Services/QA personnel will be auditing 10% of all clinical charts quarterly to verify plan of care is being followed. Any staff member deficient in following the plan of care will be educated one on one. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. On 08/03/2016 and 0819/2016 staff were instructed to discontinue the routine use of pulse oximetry on all patients. Pulse oximetry will be obtained based in the individual needs of the patient. Pulse oximetry will be obtained only as needed for the following: patient is on oxygen, exhibits shortness of breath, diminished lungs sounds, exhibits signs or symptoms of respiratory distress, as baseline at SOC, or as physician orders indicate otherwise. Pulse oximetry use and parameters will be clearly noted in each patient's plan of care. Director of Client Care Services/QA personal will be auditing charts on an ongoing basis and 10% of all charts will be evaluated for compliance of this. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated</p>	

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	<p>06/24/16, indicated for skilled nursing to provide treatment to the patient's coccyx wound three times a week by cleansing the wound with wound cleanser, pat dry, and cover with hydrocolloid dressing or soft absorbent foam dressing, secured with cover roll. Desitin Lotion to be applied if the dressing falls off. The current plan of care (06/29/16 to 08/27/16) failed to be updated and revised to include treatment orders for the coccyx wound.</p> <p>D. The OASIS comprehensive recertification assessment dated 06/24/16, indicated the goals were stabilization of cardiovascular pulmonary condition by 08/26/16; Demonstrates compliance with medication by 08/26/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 08/26/16; Patient / caregiver verbalizes call orders and dehydration, weakness, infection signs / symptoms to report to the nurse and / or physician by 08/26/16; and wound healing without complications by 08/26/16.</p> <p>2. The plans of care for the certification period 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16, both indicated: Goals indicated stabilization of cardiovascular pulmonary condition by 06/28/16; Demonstrates compliance with</p>		<p>clinical staff on making sure all visit notes are individualized for the day of service. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records</p>	

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	<p>medication by 06/28/16; Patient/caregiver verbalizes an understanding safety, pressure ulcer prevention instructions provided by 06/28/16; Patient / caregiver verbalizes call orders and dehydration, weakness, infection signs / symptoms to report to the nurse and / or physician by 06/28/16; and wound healing without complications by 06/28/16. The goals in the plan of care (06/29/16 to 08/27/16) failed to be revised and updated to reflect the patient's current status at the time of the reassessment.</p> <p>2. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 05/16/16 to 07/14/16.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>3. Clinical record number 3, SOC 06/03/16, included a plan of care for the certification period of 06/03/16 to 08/01/16.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include</p>		<p>to ensure compliance On 08/19/216 Skilled nursing staff were educated in policy Plan of Care Development and Review Policy 801.90 and 802.40. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>	

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	<p>parameters to obtain pulse oximetry.</p> <p>4. Clinical record number 4, SOC 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16. The primary diagnosis on the plan of care indicated Furuncle of buttock (boil), followed by type 2 diabetes mellitus.</p> <p>A. The plan of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>B. A skilled nursing visit note dated 05/17/16 and 05/31/16, indicated the patient was receiving treatment to a wound on the right buttock. The treatment that was being performed included to cleanse the area with normal saline, pat dry, place a small tip of gauze inside wound bed and dry gauze on top for drainage, and secure with tape. Skilled nursing to perform treatment at every visit weekly and spouse to do the treatment on all other days. The plan of care failed to revised and updated to include the treatment orders for the right buttock wound.</p> <p>The Director of Clinical Services was interviewed on 07/21/16 at 1:00 PM.</p>			

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	<p>The Director of Clinical Services was not able to provide an explanation of why the wound treatment was not added to the plan of care.</p> <p>5. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16.</p> <p>A. Both plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>6. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16.</p> <p>A. The plans of care indicated skilled nursing to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>7. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification period of 07/14/16 to 09/11/16.</p> <p>A. The plan of care indicated for the</p>			

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	<p>skilled clinician to a obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>8. Clinical record number 8, SOC 01/13/16, included a plans of care for the certification periods of 01/13/16 to 03/12/16, 03/13/16 to 05/11/16, 05/12/16 to 07/10/16, and 07/11/16 to 09/08/16.</p> <p>A. The plans of care indicated for the skilled clinician to obtain a pulse oximetry as needed per skilled clinician's discretion. The plans of care failed to include parameters to obtain pulse oximetry.</p> <p>9. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification of 05/21/16 to 07/19/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>11. Clinical record number 11, SOC 06/13/16, included two plans of care for the certification period of 06/13/16 to 08/11/16.</p>			

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	<p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>12. Clinical record number 12, SOC 02/16/16, included a plan of care for the certification period 02/16/16 to 04/15/16.</p> <p>A. The plan of care indicated for the skilled clinician to obtain pulse oximetry as needed per skilled clinician's discretion. The plan of care failed to include parameters to obtain pulse oximetry.</p> <p>13. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>14. An untitled policy titled "Plan of Care Development and Review" indicated, " ... The Case Manager / Director of Client Care Services is responsible for overseeing the care planning process to ensure that the plan is appropriate .... "</p>			

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N 0545 Bldg. 00	<p>15. A book titled "Handbook of Home Health Standards, Quality, Documentation, and Reimbursement" 5th Edition, pg 31 Box 1 - 4 indicated, " ... the POC [plan of care] are the most important components of the home care clinical record - they must be complete, accurate, and the content should clearly describe the patient. All other information flow from the services and needs identified and ordered on the plan of care .... "</p> <p>16. An undated policy titled "Skilled Services / Care Offered By Licensed Staff" indicated, " .... The Registered Nurse evaluates the client's response to the plan of care in a timely manner and initiates necessary revisions as required ... The Registered Nurse furnishes those services requiring substantial and specialized nursing skill such as, but not limited to: wound therapy ... "</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 setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the agency failed to ensure that their efforts were coordinated and documented effectively and support the objectives</p>	N 0545	In order to maintain liaison to ensure coordinated care that	08/19/2016			

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	<p>outlined in the plan of care in 1 of 1 records reviewed (# 9) of patient's who was receiving outside services with a Dialysis facility and with an Assisted Living Facility / Community in a sample of 12 and failed to follow up with medical social services in regards to discharge planning in 2 of 12 clinical record reviewed. (# 4 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/26/16, included a plan of care for the certification period of 05/25/16 to 07/23/16, with orders for skilled nursing.</p> <p>A. Two skilled nursing visit notes dated 06/06, 06/13, and 06/20/16, indicated in the discharge planning section "Ongoing, Spoke to [spouse] regarding [name of Employee G, a medical social worker] who will see him / her again to assist with community resources for future care."</p> <p>B. Three subsequent skilled nursing visit notes dated 06/27, 07/05, and 07/11/16, indicated in the discharge planning section "Ongoing. MSW has seen them and spoke to his / her son. He / She reports that his / her son is working on getting support for him / her when Home Care moves out."</p>		<p>effectively supports the objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained inpatient hard chart. This process will begin at</p>	

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	<p>C. An OASIS comprehensive recertification assessment dated 07/19/16, indicated in the coordination of care section " ... Psychological support and therapy, MSW [medical social worker] visiting patient and his wife regarding future care options and community resources .... "</p> <p>D. Review of the electronic medical record and hard chart record, the clinical record failed to evidence that a medical social worker had made a visit due to no record of the visit. The skilled nursing visit notes were repetitive and failed to evidenced if skilled nursing had followed up with medical social services and the progress on discharge planning.</p> <p>2. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing to do vital signs with each visit, assess patient / caregiver in glucose monitoring, assess condition of stoma and ability of patient to manage care - instruct on care and management of stoma, and assess JP drain and instruct patient / caregiver in management of JP drain until it is removed. The patient diagnoses included, but not limited to, aftercare following surgery for neoplasm and type</p>		<p>next case conference on August 31, 2016. On 08/03/2016 and 08/19/2016 Director of Client Care Services and Administrator educated clinical staff on importance of effective care coordination and communication between disciplines to ensure best outcomes for patients and the required documentation of this in the clinical record. On 08/03/2016 and 08/19/2016 Director of Client Care Services/Administrator educated clinical staff on care coordination with the physician. Staff were educated on reporting to the physician any changes, concerns, or discrepancies noted during visits to the physician for clarification of orders or to obtain new orders as indicated. The staff verbalized</p>	

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	<p>2 diabetes mellitus.</p> <p>A. Review of the skilled nursing visit note dated 06/03/16, the clinician failed to document the amount of drainage from the JP drain, failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment. The clinician also failed to educate the patient in documenting and measuring the drainage from the JP drains, so that the physician would know when to remove the drains.</p> <p>B. Review of the skilled nursing visit note dated 06/07/16, the clinician failed to failed to provide a measurement and the number of staples that was used to close the incision and failed to obtain a temperature with the vital sign assessment.</p> <p>C. Review of the skilled nursing visit note dated 06/09/16, the clinician failed to failed to assess and provide an amount of staples used to close the incision, failed to include a measurement of the incision, and failed to obtain a temperature with the vital sign assessment.</p> <p>D. Review of the skilled nursing visit</p>		<p>understanding. In order to maintain liaison to ensure coordinated care that effectively support care of dialysis patients, Cornerstone Home Healthcare will call or fax dialysis centers and/or nephrologists for medications and specific parameters for each patient. Cornerstone will make every effort to receive this information, any calls/faxes of requests will be retained in the clinical record. The information received will be implemented into the patient's plan of care upon receipt. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated clinical staff coordination and documentation of care with dialysis centers/nephrologist. Instructions were made to clinical staff to</p>	

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	<p>notes dated 06/13/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/15/16, the patient was transferred to the hospital and admitted for a urinary tract infection.</p> <p>E. Review of the resumption of care assessment dated 06/22/16, the clinician failed to obtain a temperature with the vital sign assessment. On 06/24/16, the patient's temperature was obtained and the patient had a low grade temperature of 99.1.</p> <p>F. Review of the skilled nursing visit notes in the diabetic section dated 06/03, 06/07, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, and 07/06/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119." Review of the skilled nursing visit notes in the diabetic section dated 07/08, 07/11, 07/13, 07/15, and 07/18/16, the narrative note indicated "Patient reports that he / she checks his / her blood sugar 3 times per week and it is on average 119. Checked today at time of visit it was 159." The skilled nurse failed to accurately assess and document the patient diabetes at the time of the assessment.</p> <p>3. Clinical record number 9, SOC (start</p>		document all communication in the medical record. The staff verbalized understanding. In order to maintain liaison to ensure coordinated care that effectively support care of patients residing in congregated facilities, Cornerstone Home Healthcare will coordinate care with facility nursing staff regarding services provided to patients. Cornerstone Home Healthcare will continue its practice of noting on the 485 "ALF staff is responsible for" and note specific care the patient is receiving from the ALF. Cornerstone Home Healthcare staff will communicate and coordinate with ALF staff on, but not limited to, blood sugars, medication changes, labs and PT/INR results.	

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	<p>of care) 05/21/16, included a plan of care for the certification period of 05/21/16 to 07/19/16, with orders for skilled nursing, physical, and occupational therapy. The patient's primary diagnosis was cerebral infarction (stroke) followed by secondary diagnoses of general weakness, diabetes type 2, end stage renal disease, neuropathy, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and rheumatoid arthritis. The patient resides in an Assisted Living Facility / Community (ALF).</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/21/16, the assessment indicated the patient was receiving hemodialysis, had a right port a cath [catheter used for hemodialysis] in the left chest wall, and a new av graft / fistula [accessible site in the arm used for dialysis] in the left upper arm. The clinical record failed to evidence coordination with the dialysis center, such as blood pressure parameters, management of port a cath, diet, fluid restrictions, and medications / flushes used during dialysis.</p> <p>B. Review of the skilled nursing visit notes dated 05/27, 06/04, 06/07, 06/14, 06/20, 06/27, 07/08, and 07/11/16, the diabetic care section under comments</p>		<p>Coordination of care will be documented and filed in patient clinical record. On 08/03/2016 and 08/19/2016 Director of Client Care Services educated staff on coordination and documentation of care with patients residing in congregated facilities. The staff verbalized understanding. On 08/03/2016 and 08/19/2016 the Director of Client Care Services and Administrator instructed staff on the "Best Practices" and on documentation that is required to meet "Best Practices", for example documenting the number of staples in an incision, documenting drainage from a JP drain that patient is tracking in the clinical record, obtaining a temperature and obtaining blood</p>	

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	<p>indicated "Patient reports that ALF personnel checks his / her blood sugar and administers insulin as ordered - see medication profile .... " The clinical record failed to evidence coordination with the ALF in regards to assessment of the patient's blood sugars as well as the services that the ALF were being provided to the patient.</p> <p>4. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>5. An undated policy titled "Plan of Care Development and Review" indicated "Multidisciplinary care conferences are held on clients as needed ... to promote coordination and continuity of care. The results are documented and a copy is retained in the client's medical record .... "</p>		<p>sugar readings from the ALF. In order to capture patients that need specific care coordination with dialysis, ALF, or specialty groups, Cornerstone will be review all new admission weekly to ensure these patients are properly identified, clinical staff informed, and information has been requested. Administrator spoke with Community Liaison on 08/19/2016 and instructed her to notate on intake forms, when able, when a patient resides in a congregated living, or is on dialysis. Plan of Care Development and Review Policy 801.90 has been revised to reflect care coordination between various sources. The Director of Client Care Services/QA personal will monitor on</p>		

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N 0547 Bldg. 00	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 that clinicians who obtain verbal orders put them in writing with date of receipt and signature for 8 of 12 records reviewed. (#1, 2, 6 - 11)	N 0547	an ongoing basis through chart audits, compliance to the policy for care coordination. 10% of all clinical records will be audited quarterly for evidence of care coordination. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.  On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting	08/19/2016

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	<p>Findings include:</p> <p>1. Clinical record number 1, SOC 04/30/16, included plans of care for the certification period of 04/30/16 to 06/28/16 and 06/29/16 to 08/27/16.</p> <p>A. Review of the OASIS comprehensive recertification reassessment dated 04/30/16, the assessment indicated Employee C, a Registered Nurse, coordinated services with the primary care physician and obtained orders for continued services.</p> <p>1. Review of the initial plan of care dated 04/30/16 to 06/28/16, line 23 indicated the Director of Clinical services had obtained verbal start of care orders. The agency failed to ensure the verbal order was put into writing upon receipt, signed, and dated by the receiving clinician who obtained the order.</p> <p>B. A signed physician order dated 06/28/16, indicated "Effective 06/29/2016, Skilled Nursing Recertification Evaluation for home care 2w1 [two times a week for one week], 3w8 frequency. Physical Therapy evaluation week of 06/22/2016, Effective 06/29/2016, 2w6, 1w3 frequency for goals and interventions as per initial evaluation. Home Health Aide Services</p>		<p>verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment preformed must match the verbal order received from the physician. On 08/19/2016, once the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be pulled on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is</p>	

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	<p>Effective week of 06/29/2016, 1w1, 2w8 frequency for goals and interventions as per skilled clinician's evaluation." The physician order was electronically signed by Employee H.</p> <p>1. Review of the physical therapy reassessment dated 06/22/16, the assessment indicated Employee F, a Physical Therapist, coordinated services with the physician and the physician agreed with the plan of care, frequency, and duration.</p> <p>2. Review of the OASIS comprehensive recertification assessment dated 06/24/16, the assessment indicated Employee C, a Registered Nurse, coordinated services with the primary care physician in regards to recertification orders. The agency failed to ensure the verbal orders was put into writing upon receipt, signed, and dated by the receiving clinicians who obtained the order.</p> <p>2. Review of clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 07/15/16 to 09/13/16, with orders for skilled nursing, home health aide services, and occupational therapy.</p> <p>A. Review of the OASIS</p>		<p>signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Effective 07/22/2016 Based on exit interview the Start of Care order was amended to demonstrate the frequency of each ordered discipline and that each discipline received verbal orders of their plan of care including interventions/goals/rehab potential/discharge plans, with a notation that "***Formalized 485 to follow for MD signature</p>	

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	<p>comprehensive recertification assessment dated 07/14/16, the assessment indicated Employee I coordinated services with the primary care physician in regards to recertification orders.</p> <p>1. A signed physician order dated 07/19/16, indicated "Effective 07/15/2016, Skilled Nursing Recertification Evaluation for home care 0w1, 1w8 frequency ... Home Health Aide Services Effective week of 07/15/2016, 0w1, 2w8 frequency for goals and interventions as per skilled clinician's evaluation." The physician order was electronically signed by Employee H. The agency failed to ensure the verbal order was put into writing upon receipt, signed, and dated by the receiving clinician who obtained the order.</p> <p>3. Clinical record number 6, SOC (start of care) 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of a skilled nursing visit note dated 06/13/16, written by Employee C, a Registered Nurse, the narrative note indicated the patient was taking Miralax and Keflex. Employee C had notified the physician and had</p>		<p>for obtained verbal orders**". This was implemented and being used until the written Statement of Deficiency and Plan of Correction was received on 08/18/2016. On 08/19/2016 after receipt of the written Statement of Deficiency and Plan of Correction Cornerstone discontinued the use of the SOC order due to the documented findings that the Director of Client Care Services should not be signing the formalized Plan of Care which has encompassed multidisciplinary orders. Also noted in the Statement of Deficiency and Plan of Correction the SOC order cannot be signed by one clinical staff member with all received verbal orders, that it must be separated and signed and dated by each staff member who</p>	

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	<p>spoken to the physician's assistant, who indicated there wasn't a record of the patient taking Keflex. The note continued to indicate the physician had provided the patient with samples and the clinician observed only 2 pills left.</p> <p>1. Review of a physical therapy note dated 06/13/16, the narrative note indicated the patient was put on Keflex, the doctor had given the patient six pills to take once a day, and the pills were in an envelope with "Keflex" handwritten on it. The envelope had no other information on it.</p> <p>a. A physician's order dated 06/13/16, indicated the effective 06/10/16, the patient was to take Keflex 500 milligrams oral capsule daily by mouth for 7 days, Miralax oral powder for reconstitution 17 grams in 8 ounces of water or juice daily by mouth as needed for constipation. The order was electronically signed by the Director of Clinical Services. A check box with "read back and verified" was not checked off. The Director of Clinical Services failed to accurately transcribe the order based on the clinicians visit notes. The Director of Clinical Services failed to include / identify that she had obtained the order from the physician's office. The agency failed to ensure that the verbal</p>		<p>received the verbal SOC order. As of 08/19/2016 the 485 will only contain the orders from the admitting clinician, including HHA orders if indicated, as well as any therapy or medical social work services for evaluation. Once the staff have completed their evaluations these will be sent to the physician for signature. 08/19/2016, Staff members were educated on the change in sending verbal orders to the physician. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this</p>	

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	<p>order was put into writing, signed, and dated with the receipt of the clinician who clarified and obtained the order.</p> <p>B. A communication note dated 06/28/16, written by Employee C, a Registered Nurse, indicated that a physician office contacted him / her and gave a verbal order for a Fleet's enema, increase water intake, and for the patient to start taking over the counter stool softener 1 or 2 caps daily as needed.</p> <p>1. A physician's order dated 06/28/16, written by the Director of Clinical Services, indicated for the skilled nurse to "administer a fleet's enema and for the patient to start taking over the counter Docusate Sodium 100 milligrams 1 or 2 caps daily as needed - the following day and increase water intake." The agency failed to ensure that the verbal order was put into writing, signed, and dated with the receipt of the clinician who obtained the order.</p> <p>C. Review of the OASIS start of care comprehensive assessment dated 06/01/16, Employee C indicated he / she had coordinated with the physician for ongoing services.</p> <p>1. Review of the physical therapy initial assessment / plan of treatment</p>		deficiency is corrected and will not occur.				

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	<p>dated 06/02/16, Employee F, a Physical Therapist, indicated he / she coordinated with the physician at the time of the assessment and that the physician was in agreement with the plan of care, frequency, and duration.</p> <p>2. Review of the occupational therapy initial assessment dated 06/03/16, Employee D, an Occupational Therapist, indicated he / she coordinated with the physician at the time of the assessment.</p> <p>a. A physician's order dated 06/08/16, written by Employee H, a Registered Nurse, indicated "Effective 06/01/2016, Skilled Nursing Start of Care Evaluation for home care 2w7, 1w7 frequency. Physical Therapy evaluation week of 05/29/2016, Effective 06/02/2016, 1w1, 2w5 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 05/029/2016, Effective 06/03/2016 - evaluation only - OT not recommend at this time. Speech Therapy - patient declines at this time. Home Health Aide services - patient declines at this time. The agency failed to ensure that the verbal order was put into writing, signed, and dated with the receipt of the clinicians who obtained his / her order.</p>			

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	<p>4. Clinical record number 7, SOC 07/14/16, included a plan of care for the certification dated of 07/14/16 to 09/11/16, with orders for physical and occupational therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 07/14/16, Employee F, a Physical therapist, indicated that he / she had coordinated start of care services with the physician. The coordination also indicated that there was a concern of the patient taking Aspirin along with Xarelto [both used as blood thinners], and the therapist had received an order for the patient to stop taking aspirin while on Xarelto.</p> <p>1. A communication note dated 07/14/16, was written by Employee F. The note indicated the physician's office returned Employee F's phone call in regards to stopping the Aspirin while talking Xarelto.</p> <p>2. A physician order dated 07/14/16, was written by the Administrator and also a physical therapist. The order indicated "Effective 07/14/16, Discontinue Aspirin 81 mg [milligram] tablet and remain on Xarelto." The agency failed to ensure that the verbal order was put into writing,</p>			

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	<p>signed, and dated by the receiving clinician who obtained the order.</p> <p>B. The occupational therapy initial assessment and plan of treatment dated 07/16/16, was reviewed. Employee D, an occupational therapist, indicated that he / she had spoken with the physician and that the physician was in agreement with the plan of care.</p> <p>1. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4 [three times a week for four weeks], 2w5 frequency. Occupational Therapy evaluation week of 07/14/16, Effective 07/16/16, 1w1, 2w2, 1w2 frequency for goals and interventions as per initial evaluation .... " The agency failed to ensure that the verbal orders was put into writing upon receipt, signed and dated by the receiving clinician who obtained the verbal order.</p> <p>5. Clinical record number 8, SOC 01/13/16, included plans of care for the certification period of 05/12/16 to 07/10/16 and 07/11/16 to 09/08/16.</p> <p>A. Review of the OASIS comprehensive recertification</p>						

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	<p>reassessment dated 05/07/16, the assessment indicated Employee I, a Registered Nurse, coordinated services with the primary care physician.</p> <p>1. A physicians order dated 05/17/16, signed by Employee H, indicated "Effective 05/12/2016 Skilled Nursing Recertification Evaluation for home care 0w1, 1w8, 0w1 frequency. Home Health Aide services Effective week of 05/12/2016, 1w1, 2w8, 0w1 frequency for goals and interventions as assigned by skilled clinician's evaluation. The agency failed to ensure that the verbal order was put into writing upon receipt, signed and dated by the receiving clinician who obtained the verbal order. The order also failed to include interventions that were to be provided by the skilled nurse and home health aide.</p> <p>B. The plan of care for the certification period of 07/11/16 to 09/08/16, included orders for skilled nursing, home health aide, and medical social worker services. The plan of care indicated "Effective 07/15/16 through 09/08/16 comprehensive assessment and recommendations 1 - 3 visits during current certification period; Community Resource Planning Outreach." The plan of care was not signed by a physician.</p>			

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	<p>1. Review of the plan of care (3 pages), line 23 was left blank. The plan of care failed to indicate the clinician who had obtained the verbal orders as well as the date of the verbal order for continuing services.</p> <p>C. Review of the OASIS comprehensive recertification assessment dated 07/07/16, the Community Agencies / Social Service Screening narrative note indicated the patient would need rides to appointments and groceries, needed someone to cook for him / her or have meals delivered to his / her home. The patient had refused assistance in the past but was currently requesting assistance. The note also indicated the patient needed housekeeping services due to the patient's handicaps. The note indicated the skilled nurse would notify the agency and the medical social worker.</p> <p>1. The Care Coordination section of the comprehensive recertification assessment indicated Employee I coordinated with the physician and the medical social worker in regards to ongoing services.</p> <p>2. A signed physician order dated 07/11/16, indicated "Effective 07/11/16, skilled nursing ... Home Health Aide Services .... " The physician order was</p>						

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	<p>electronically signed by Employee H. The agency failed to ensure the verbal order was put into writing upon receipt, signed, and dated by the receiving clinician who obtained the order. The physician order also failed to include an order for medical social services.</p> <p>5. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification of 05/21/16 to 07/19/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of the OASIS comprehensive start of care assessment dated 05/21/16, Employee J, a Registered Nurse, indicated he / she had coordinated with the physician for ongoing services.</p> <p>1. A physician order dated 05/26/16, written by Employee H, indicated "Effective 05/21/2016 Skilled Nursing Start of Care Evaluation for home care 1w9, 0w1 frequency .... " The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order.</p> <p>B. Review of the OASIS comprehensive resumption of care assessment dated 07/05/16, Employee C, indicated he / she had coordinated with</p>			

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	<p>the physician for ongoing services.</p> <p>1. Review of physical therapy reassessment and plan of treatment dated 07/06/16, Employee F indicated he / she had conferenced with the physician for the resumption of services.</p> <p>a. A physician order dated 07/06/16, written by the Director of Clinical Services, indicated the physical therapy frequency, interventions and goals. A box next to "order read back and verified" was not checked off. The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order.</p> <p>b. A physician order dated 07/07/16, written by Employee H, indicated "Effective 07/05/16 Skilled Nursing Resumption of Care Evaluation for home care 2w2 frequency. Physical Therapy evaluation week of 07/03/16, Effective 07/06/16, 2w2 frequency for goals and interventions as per initial evaluation. Home Health Aide Services - patient declines at this time. A box next to "order read back and verified" was not checked off. The agency failed to ensure the verbal orders were put into writing, signed, and dated by the receiving clinician who obtained the order.</p>			

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	<p>6. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>A. A physician's order dated 06/16/16, indicated for the skilled nurse to obtain a urinalysis with a culture and sensitivity. The order failed to include how the specimen was to be obtained.</p> <p>B. Review of the OASIS comprehensive resumption of care assessment dated 05/27/16, the Administrator, a Physical Therapist, indicated he / she had conferenced with the physician for the resumption of services.</p> <p>1. A physician order dated 06/02/16, written by Employee H, indicated "Effective 05/27/16 Physical Therapy Resumption of Care Evaluation for home care 1w1, 2w1, 3w2, 2w2, 1w1 frequency. Skilled nursing evaluation week of 05/30/16, Effective 05/31/16, 2w1, 1w4 frequency for goals and interventions as per initial evaluation. The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order.</p>			

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	<p>7. Clinical record number 11, SOC 06/13/16, included a plan of care for the certification period 06/13/16 to 08/11/16, with orders for skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services.</p> <p>A. Review of the OASIS comprehensive start of care assessment dated 06/13/16, Employee J, indicated she had conference with the physician for continuing start of care orders.</p> <p>1. A physician order dated 06/21/16, written by Employee H, indicated "Effective 06/13/2016, Skilled Nursing Start of Care Evaluation for home care 1w9 frequency. Physical Therapy evaluation week of 06/19/2016, Effective 06/20/16, 2w6, 1w2 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 06/122016, Effective 06/16/2016, 1w4 frequency for goals and interventions as per initial evaluation. Home Health Aide services Effective week of 06/13/2016, 2w8, 1w1 frequency for goals and interventions as assigned by skilled clinician's evaluation. The agency failed to ensure the verbal order was put into writing, signed, and dated by the receiving clinician who obtained the order. The order failed to include nursing</p>			

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	<p>and home health aide interventions.</p> <p>8. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>9. An undated policy titled "Confirmation of Physician Telephone / Verbal Orders" indicated, " ... The staff member who accepts the order: reduces the order to writing, ensures the appropriateness, accuracy and completeness of the order, signs and dates the order .... "</p> <p>10. An undated policy titled "Verbal / Telephone Orders Read - Back" indicated, " ... Each verbal / telephone order is read - back by the licensed Cornerstone Home Healthcare staff member receiving the order. The order must be signed and dated with the date of receipt .... "</p> <p>11. An undated policy titled "Medication Orders and Administration" indicated " .... All medication orders must be verified with the ordering physician and must contain the phrase 'Orders read back and verified with _____ ', the date of verification and the signature of the nurse verifying the orders .... "</p>			

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N 0557 Bldg. 00	<p>12. A website at <a href="http://www.nursingcenter.com/journalarticle?Article_ID=800621&amp;Journal_ID=522928">http://www.nursingcenter.com/journalarticle?Article_ID=800621&amp;Journal_ID=522928</a> &amp;... Titled article "Charting Checkup: Documenting telephone orders, indicated " ... You should always get telephone orders directly; they should never go through a third party ... Record the order word - for - word on the health care provider's order sheet or enter it into a computer. First, note the date and time. On the next line, write "telephone order" ... Then write the health care provider's name, and sign your name. Read back the order and get confirmation from the person who gave the order ... If you're having trouble understanding the health care provider, ask another nurse to listen in as you take the order. Then have her read it back and sign the order too .... "</p> <p>13. An untitled policy titled "Plan of Care Development and Review" indicated, " ... Any physician approved changes to the plan of care are dated and signed by the appropriate discipline .... "</p> <p>410 IAC 17-14-1(a)(2)(E) Scope of Services Rule 14 Sec. 1(a) (2)(E) For purposes of practice in the home health setting, the licensed practical nurse shall do the following:</p>			

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	<p>(E) Assist the patient in learning appropriate self-care techniques.</p> <p>Based on record review and interview, the Licensed Practical Nurse (LPN) failed to accurately educate the patient in 1 of 2 records reviewed of patients being seen by Licensed Practical Nurses in a sample of 12. (#5)</p> <p>Findings include:</p> <p>1. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16.</p> <p>A. A skilled nursing visit note dated 07/19/16, but signed on 07/18/16, indicated CellCept was the only change in medications. The patient verbalized questions regarding the medication (its use and why ordered). The visit note indicated that the LPN educated the patient by informing him on "MG [myasthenia gravis] crisis, how the disease can but not always effects breathing causing use of temp [temporary] or permanent use of vent [ventilator], information packet left with patient, patient reads and looks for any info to help him / her better understand. Instructed pt [patient] that even a slight change in breathing to notify CHH [Cornerstone Home Health] / Neurologist</p>	N 0557	<p>On 08/19/2016 Director of Client Care Services educated clinical staff on all staff on educating patients on new medications the day the clinical staff are aware patient is taking the medications, and adding medication to the medication profile. Resources that are available for staff on the office issued tablets were reviewed and staff verbalized understanding. Charts will be reviewed for orders and all orders will be reviewed before sending. Orders will be evaluated in 10%of audits for compliance by Director of Client Care Services.The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this</p>	08/19/2016

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	<p>even if he / she thinks it is a minor thing .... "</p> <p>B. Review of the Nursing 2016 Drug Handbook, CellCept is an immunosuppressant that prevents organ rejection in patients receiving allogeneic renal transplants, cardiac transplant, hepatic transplants, to treat lupus nephritis, and idiopathic thrombocytopenic purpura. Drug alert indicated "drug is considered a potential mutagen [causes genetic mutation] and teratogen [causes malformation of an embryo]. Follow safe-handling procedures when preparing, administering, or dispensing. Don't crush tablets; don't open or crush capsules. Avoid inhaling powder in capsule or having it contact skin or mucous membranes ... Adverse reactions in bold that indicated life threatening: Central Nervous Systems [progressive multifocal leukoencephalopathy]; Cardiovascular [hemorrhage]; Gastrointestinal [hemorrhage]; Genitourinary [renal tubular necrosis, acute renal failure]; Hematologic [leukopenia and thrombocytopenia]; Metabolic [hyperkalemia]; Other [Sepsis]. Other interactions indicated to take the medication on an empty stomach 1 to 2 hours before meals to prevent delay of absorption. Black box warning for</p>		deficiency is corrected and will not occur.				

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N 0565	<p>nursing considerations indicated "Increased risk of infection and lymphoma may result from immunosuppression .... " The LPN failed to properly address and educate the patient on the use and possible life threatening adverse reactions of the medication CellCept.</p> <p>2. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p> <p>3. An undated policy titled "Medication Orders and Administration" indicated " .... The nurse instructs the client / family / caregiver in an understandable format and language about any clinically significant adverse reaction, potential unanticipated outcomes or any other concerns about the medication to be administered, along with actions to be taken should any reaction or unanticipated outcomes occurs .... "</p> <p>4. An undated policy titled "Skilled Services / Care Offered By Licensed Staff" indicated, " .... The LPN / LVN assess the client in learning appropriate self - care techniques .... "</p> <p>410 IAC 17-14-1(c)(4)</p>			

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Bldg. 00	<p>Scope of Services</p> <p>Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:</p> <p>(4) help develop the plan of care (revising as necessary);</p> <p>Based on observation, record review, and interview, the Occupational and Physical Therapist failed to ensure orders were obtained prior to providing services in 2 of 10 records reviewed of patients with therapy services in a sample of 12. (# 2 and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 07/15/16 to 09/13/16, with orders for occupational therapy.</p> <p>A. Review of the Occupational Therapy notes, the Occupational Therapist provided services on 07/18/16.</p> <p>B. A signed physician order dated 07/19/16, indicated " ... Occupational Therapy evaluation week of 07/12/16, Effective 07/15/16, 0w1, 2w3 frequency for goals and interventions as per initial evaluation .... " The physical therapist provided services absent of a written physicians order.</p> <p>2. Clinical record number 7, SOC</p>	N 0565	<p>On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the</p>	08/19/2016
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	<p>07/14/16, included a plan of care for the certification period of 07/14/16 to 09/11/16, with orders for physical and occupational therapy.</p> <p>A. A physician order dated 07/19/16, was written by Employee I, a Registered Nurse. The order indicated "Effective 07/14/16 Physical Therapy Start of Care evaluation for home care 3w4 [three time a week for four weeks], 2w5 [two times a week for five weeks] frequency for goals and interventions as per initial evaluation .... "</p> <p>1. Review of the physical and therapy notes, physical therapy provided services on 07/16 and 07/18/16. The physical therapist provided services absent of a written physicians order.</p> <p>3. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</p>		<p>receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis, and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure complianceThe Director</p>		

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N 0608 Bldg. 00	<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:</p> <p>(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 the plan of care and all subsequent physician orders were written and completed at the time of the order, sent to the physician, returned and incorporated into the patients clinical record within a timely manner for 11 of 12 records reviewed (#1 - 6, 8 - 12),</p>	N 0608	<p>Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p> <p>During course of survey the timeliness of sending and retrieval of orders by Cornerstone Home Healthcare was discussed. With the Administrator and Director of Client Care Services reporting that with recent loss of QA nurse, and the recent loss, new hire and training of 2 key office positions and an increase in</p>	08/19/2016

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	<p>failed to ensure missed visit notes were faxed to the physician within a timely manner in 1 of 12 records reviewed (# 4), failed to ensure 60 day summaries were faxed to the physician in a timely manner in 1 of 7 (# 8) patients who had been recertified for an additional 60 days in a sample of 12, failed to ensure medication reconciliation was faxed to the physician within a timely manner in 2 of 12 records reviewed (# 10 and 11), failed to ensure a home health aide supervisory visit was accurate in 1 of 5 records reviewed (#11) of patients with home health aide services, and failed to ensure each skilled nursing visit notes were updated to reflect the patient's current status and education provided at the time of the nursing visit in 2 of 12 records reviewed. (# 7 and 8)</p> <p>Findings include:</p> <p>1. Review of clinical record number 1, SOC (start of care) 04/30/16, included a plan of care for the certification period of 04/30/16 to 06/28/16, with orders for skilled nursing, physical, and occupational therapy.</p> <p>A. The initial plan of care was observed to be four pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained verbal start of care orders on 04/30/16. The</p>		<p>agency census from approximately 50 patients to approximately 100, the focus and efforts have been on hiring and training new clinical staff and maintaining the provision of quality care. The sending and retrieval of orders has been less timely then we prefer during these transitions. Even though Cornerstone's current practice does reflect the CMS standard as stated in the Medicare Integrity Program Manual and our internal policy, that all physician orders are signed and dated by physician prior to billing final claim,we now understand that there is an expectation of a more timely orders process. Therefore, on 08/18/2016, upon receipt and review of Statement of Deficiencies and Plan of Correction report and a citation regarding timeliness of orders, the Director of Client Care Services and Administrator conferenced to outline a plan for more timely submission and retrieval of physician orders. The following action plan will be put in place at scheduled bi-weekly office staff meetings to ensure a timelier processing of orders. Cornerstone Home Healthcare will utilize AXCESS Orders Management reports on an ongoing basis to track pending and outstanding orders. Office staff will be trained and educated on how to generate an Orders Pending Signature Report,</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>subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services 05/20/16. The physician signature line to the plan of care and the addendums, were blank. The initial plan of care addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. A physician's order dated 05/26, 06/07, 06/08 (x2 orders), 06/11, 06/15, 06/18/16, had not been signed by the physician. The physician orders failed to be signed by the physician in a timely manner.</p> <p>C. A physician's order dated 06/10/16, indicated the Director of Clinical Services electronically completed and signed the order on 06/15/16. The order had not been signed by the physician. A second physician's order dated 06/10/16, had not been signed by the physician. The 1st physician's order failed to be written upon receipt of obtaining the order. Both physician orders failed to be signed by the physician in a timely manner.</p> <p>D. The updated plan of care for the certification period of 06/29/16 to 08/27/16, included orders for skilled</p>		<p>Orders To Be Cosigned Report and Orders To Be Sent Report and be instructed to provide the report at regularly scheduled bi-weekly office staff meeting for review and proper action. During these meetings the orders will be reviewed and addressed for timeliness and proper action on all aging order swill be initiated. Office staff will be instructed to inform Director of Client Care Services of any issues of receiving orders and Director of Client Care Services will make determination on an individualized basis on handling the retrieval of orders by either calling, faxing, mailing, going by the Physician's office to pick up the orders. On 08/03/2016 Director of Client Care Services/Administrator educated staff on processes of receiving/documenting verbal orders prior to performing any care or treatments to the patient. Staff were also educated on content of verbal orders, instructed staff the care and treatment performed must match the verbal order received from the physician. On 08/19/2016, after the written Statement of Deficiency and Plan of Correction was received, staff were further educated on verbal orders and changes in the following policies: Policy 500.80, 500.30, 801.40. To ensure compliance with the receipt and documentation of verbal orders, verbal orders will be reviewed on an ongoing basis,</p>		

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	<p>nursing and physical therapy.</p> <p>1. The plan of care was noted to be three pages. The Director of Clinical Services indicated on page 1, line 23, that she had obtained physician orders on 06/29/16. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of Treatment" indicated the Director of Clinical Services signed the orders on 07/10/16. The physician signature line to the plan of care and the addendums, were blank. The initial plan of care addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>The Director of Clinical Services was interviewed on 07/20/16 at 3:30 PM. The Director of Clinical Services was not able to indicate what was acceptable for "timely manner." The Director of Clinical Services indicated the plan of cares probably was not finished or completed as for the reason for the late signatures by the physician.</p> <p>2. Review of clinical record number 2, SOC 05/16/16, included a plan of care for the certification period of 05/16/16 to 07/14/16, with orders for skilled nursing, home health aide services, physical, and occupational therapy.</p>		<p>and compared to the clinical documentation for the receipt of the verbal order and that it is signed and dated by the receiving staff member. Orders will be monitored on an ongoing basis by authorized clinical staff. Staff members are to report discrepancies to Director of Client Care Services on an ongoing basis and remediation training will be completed with staff members that are not meeting the policy and regulatory guidelines. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance. The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur. In order to maintain liaison to ensure coordinated care that effectively support objective as outlined on the plan of care, Cornerstone Home Healthcare will utilize the 60-Day Summary/Case Conference form at each Case Conference meeting. Each discipline present at conference and involved in patient care will give a summary of care being provided, current condition, future recommendations and any other information pertinent to patient care. Any staff member that is not able to be present at case conference will be responsible for communicating patient status at time of or prior to case</p>	

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	<p>A. The initial plan of care was observed to be four pages. Employee I, a Registered Nurse, documented on page 1, line 23, that she had obtained verbal start of care orders on 05/16/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by Employee I on 07/02/16. The physician signature line to the plan of care and the addendums, were blank. The initial plan of care addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>3. Review of clinical record number 3, SOC 06/03/16, included a plan of care for the certification period of 06/03/16 to 08/01/16, with orders for physical and occupational therapy.</p> <p>A. The initial plan of care was observed to be three pages. The Administrator documented on page 1, line 23, that she had obtained verbal start of care orders on 06/03/16. The subsequent pages (2 - 3) labeled "Addendum to Plan of Treatment" was signed by the Administrator on 07/15/16. The physician signature line to the plan of care and the addendums, were blank. The initial plan of care addendums failed</p>		<p>conference. All notes from case conference will be scanned into electronic medical record and hard copy will be retained in patient hard chart. This process will begin at next case conference on August 31, 2016. Missed visits will be sent to physician bi-weekly. QA will be used to monitor all missed visits and documentation of completion of missed visit being sent to the physician. Office staff were educated on this on 08/19/2016 On 08/19/2016 Office staff were educated on completeness and attention to details related to data entry on intake, verifying referral information. Director of Client Care Services/QA personal will also be monitoring 10% of clinical records quarterly to ensure compliance The Director Client Care Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>		

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	<p>to be completed and signed by the Administrator and sent to the physician for signature within a timely manner.</p> <p>4. Clinical record number 4, SOC 03/26/16, included a plan of care for the certification period of 03/26/16 to 05/24/16, with orders for skilled nursing, home health aide services, medical social services, physical, and occupational therapy.</p> <p>A. The initial plan of care was observed to be four pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained verbal start of care orders on 03/26/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services on 07/18/16. The physician signed the plan of care and the addendums on 07/19/16. The initial plan of care was observed stapled to a fax cover sheet dated 07/19/16. The initial plan of care and addendums failed to be completed and signed by the Administrator and sent to the physician for signature within a timely manner.</p> <p>B. A signed physician order dated 04/11/16, indicated "Effective 03/26/2016, Skilled Nursing Recertification Evaluation for home care</p>			

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	<p>1w1, 2w1, 1w7 frequency. Physical Therapy evaluation week of 03/27/2016, Effective 03/28/16, 2w8 frequency for goals and interventions as per initial evaluation. Occupational Therapy evaluation week of 03/27/2016, Effective 03/31/2016, 1w1, 2w3 frequency for goals and interventions as per initial evaluation. MSW [Medical Social Worker] evaluation week of 04/30/16, Effective 04/05/2016, 2 - 4 visits throughout current certification period frequency for goals and interventions as per initial evaluation. Home Health Aide Services Effective week of 03/26/2016, 0w1, 2w8, 1w1 frequency for goals and interventions as per skilled clinician's evaluation." The physician order was electronically signed by the Director of Clinical Services. The physician order indicated the physician signed the order on 07/19/16. The physician order failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner</p> <p>C. A physician's order dated 03/28, 04/01, 04/21, 04/25, 05/01, 05/06, 05/10, 05/17, 05/20, and 05/25/16, indicated the physician signed all the orders on 07/19/16. The physician orders failed to be signed by the physician in a timely manner.</p>						

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	<p>D. An updated plan of care for the certification period of 05/25/16 to 07/23/16, with orders for skilled nursing and home health aide services.</p> <p>1. The updated plan of care was observed to be three pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained verbal orders on 05/25/16. The subsequent pages (2 - 3) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services on 06/10/16. The physician signed the plan of care and the addendums on 07/19/16. The initial plan of care was observed stapled to a fax cover sheet dated 07/19/16. The initial plan of care and addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>E. A physician's order dated 06/13/16, indicated "Effective 06/09/16, Ciprofloxacin 600 mg [milligram oral tablet] 2 times per day for 10 days By mouth (po) New (UTI). Effect 06/20/16 Patient prescribed Valium and Trazodone. Patient / wife have decided not to give patient medication." The order was signed by the Director of Clinical Services on 06/20/16. The order</p>			
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	<p>indicated the physician had signed the order on 07/19/16. The Director of Clinical Services failed to write the orders on the date of receipt and have those orders sent to the physician for signature within a timely manner.</p> <p>F. A missed visit form dated 05/03, 05/13, and 05/20/16, was observed to be stapled to fax cover sheets dated 07/19/16. The agency failed to ensure the faxed missed visits forms was sent to the physician in a timely manner.</p> <p>G. Review of the physician orders page on the electronic medical record, as of 07/21/16, the following orders indicated the following:</p> <ol style="list-style-type: none"> <li>1. An entry for the 05/25/26 to 07/23/16 plan of care, indicated the plan of care was sent to the physician for signature on 07/20/16.</li> <li>2. One of two physician orders dated 05/23/16, had been sent to the physician for signature on 07/20/16. The other order failed to indicate that the order had been sent for signature.</li> <li>3. Two physician orders dated 05/25/16, indicated they had been sent to the physician for signatures on 07/20/16.</li> </ol>			

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	<p>4. A physician's order dated 06/06/16, indicated the order was waiting for a co-signature, therefore, failed to indicate that it had been sent to the physician for signature.</p> <p>5. A physician's order dated 06/13/16 and 07/05/16, indicated the orders had been sent to the physician for signature on 07/20/16.</p> <p>H. Two skilled nursing visit notes dated 06/13/16 and 06/20/16, indicated in the discharge planning section "Ongoing, Spoke to [spouse] regarding [name of Employee G, a medical social worker] who will see him / her again to assist with community resources for future care." The clinical record failed to evidence a physician order for the medical social services.</p> <p>I. Three skilled nursing visit notes dated 06/27, 07/05, and 07/11/16, indicated in the discharge planning section "Ongoing. MSW has seen them and spoke to his / her son. He / She reports that his / her son is working on getting support for him / her when Home Care moves out." The clinical record failed to evidence a medical social worker visit note.</p> <p>The Director of Clinical Services was</p>			

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	<p>interviewed on 07/21/16 at 1:00 PM. The Director of Clinical Services indicated the 05/25/16 to 07/23/16 plan of care had not been sent to the physician and was unable to provide a reason why the plan of care had not been sent to the physician when a new certification period was starting soon. The Director of Clinical Services was unable to provide an explanation for the missed visit forms not being sent to the physician sooner than 07/19/16. The Director of Clinical Services indicated she was not aware of the medical social worker need.</p> <p>5. Clinical record number 5, SOC 06/10/16, included two plans of care for the same certification period of 06/10/16 to 08/08/16, with orders for skilled nursing, physical, occupation, and speech therapy.</p> <p>A. The plan of care that was provided for home visits indicated a skilled nursing frequency of one time a week for eight weeks, then zero times a week for one week. The plan of care was four pages. The Director of Clinical Services documented on line 23 that she had obtained the verbal start of care orders on 06/10/16. The subsequent pages of the plan of care (addendums) was signed by the Director of Clinical Services with a date of 07/10/16.</p>						

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	<p>B. The plan of care that was copied from the patient's hard chart indicated a skilled nursing frequency of one time a week for nine weeks. The plan of care was also four pages. The Director of Clinical Services documented on line 23 that she had obtained the verbal start of care orders on 06/10/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services on 07/18/16. The initial plan of care was observed stapled to a fax cover sheet dated 07/19/16. The initial plan of care and the addendums failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>C. Review of the skilled nursing visit notes, a skilled nursing visit note was observed to have a visit date 07/19/16, but was electronically signed on 07/18/16, by the clinician. The visit note failed to be accurate and reflect the correct date of the assessment / signature.</p> <p>The Director of Clinical Services was interviewed on 07/21/16 at 12:30 PM. The Director of Clinical Services indicated she had to make some minor changes to the plan of care as to why there were changes in dates on the</p>						

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	<p>addendum pages.</p> <p>6. Clinical record number 6, SOC 06/01/16, included a plan of care for the certification period of 06/01/16 to 07/30/16, with orders for skilled nursing.</p> <p>A. The plan of care observed to be four pages. The Director of Clinical Services documented on page 1, line 23, that she had obtained the verbal start of care orders on 06/01/16. The subsequent pages (2 - 4) labeled "Addendum to Plan of Treatment" was signed by the Director of Clinical Services on 06/20/16. The physician signature line was blank. The agency failed to have the plan of care and its subsequent addendums completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. The narrative note in the skilled nursing and interventions section of the OASIS start of care comprehensive assessment dated 06/01/16 and the OASIS resumption of care assessment dated 06/22/16, both indicated "Skilled nursing intervention and teaching noted in assessment. Instructed patient on calling Cornerstone Home Healthcare as needed for changes in condition, also that Cornerstone is available 24/7 and phone number on SOC packet left at patient's</p>				

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	<p>apartment. Instructed on medications, reviewed all medications with patient and family and instructed on filling a medication planner. Writer observed all medication in patient's presence. Instructed to call RN with any questions and concerns. Patient verbalized understanding. Informed patient that PT [physical therapy] would be calling for visits within the next week - and he / she is to call office if he / she does not hear from staff by beginning of next week. Instructed on date of SN return. Verbalized understanding. The narrative note failed to be updated to the patient's current status at the time of the assessment.</p> <p>C. The coordination note on the OASIS start of care comprehensive assessment dated 06/01/16 and the OASIS resumption of care assessment dated 06/22/16, both indicated "Writer called PCP [primary care physician] [Name of physician] with SOC [start of care] orders, PT [physical therapy] and OT [occupational therapy] services. SN [skilled nursing] to see patient 2w2, 1w7 [two times a week for two weeks then one time a week for seven weeks]. Informed of POC [plan of care] to follow. Informed of major interactions with medications and to call if any concerns, otherwise will keep medications as</p>			

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	<p>ordered and informed SN would be faxing information to office." The coordination note failed to be updated to the patient's current plan at the time of the assessment</p> <p>D. A home visit was conducted with physical therapy on 07/20/16 at 10:00 AM, at his / her home. The patient was observed to have lived in a ranch home in the country. Review of the address on the plan of care upon admission and recertification, the patient had always resided in his / her home. The plan of care indicated the patient resided in a major city when the patient actually resided in another town outside of the major city. The narrative note in the 06/01/16 start of care and the 06/22/16 resumption of care, indicated the "phone number on SOC packet left at patient's apartment." The plan of care failed to have the correct city of residence, the resumption of care note failed to be updated and both start of care and resumption of care failed to properly identify the patient's place of residence.</p> <p>G. Review of the physician orders page on the electronic medical record, as of 07/21/16, the plan of care dated 06/01/16, among other orders dated 06/10, 06/13, 06/15, 06/22, 06/27, and 06/28/16, indicated "To be sent to</p>				

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	<p>physician." The order dated 06/14/16 indicated "Submitted pending co-signature."</p> <p>1. Review of the patient hard chart, physician orders dated 06/13, 06/14 06/22, 06/27 and 06/28/16, failed to evidenced that the physician had signed the orders. The agency failed to ensure the physician signed the orders within a timely manner.</p> <p>H. Review of the skilled nursing visit notes on 06/03, 06/07, 06/10, 06/13, 06/24, 06/27, 06/28, 06/29, 07/01, 07/04, 07/06, 07/08, 07/11, 07/13, 07/15, 07/18, and 07/20/16, indicated in the interventions section that patient / caregiver teaching was provided on "relation to kinds of food and urine ph, subcutaneous injection" and instructed on safety precautions such as "keeping pathway clear."</p> <p>1. On 06/22/16, the patient returned from the hospital with orders to discontinue the Lovenox injections. The skilled nursing visit notes failed to be updated and reflect the patient status and education provided at the time of each nursing visit / assessment.</p> <p>7. Clinical record number 8, SOC 01/13/16, included the following:</p>				

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	<p>A. Review of the plan of care dated 01/13/16 to 03/12/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 01/13/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 02/02/16.</p> <p>2. A fax cover sheet that was stapled to all 4 pages of the plan of care, indicated the fax was sent to the primary care physician on 05/03/16. The physician signed all 4 pages of the plan of care on 05/05/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>B. Review of the physician orders dated 01/20, 01/22, 02/23, 03/04/15, all orders were stapled to a fax cover sheet which indicated the orders were faxed to the physician on 05/03/16. The orders were signed by the physician on 05/05/16. The physician orders failed to be sent to the physician for signature in a</p>			

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	<p>timely manner.</p> <p>C. Review of a 60 day summary dated 03/10/16 for the certification 01/13/16 to 03/12/16, the summary was stapled to a fax cover sheet which indicated the summary was faxed to the physician on 05/03/16. The summary failed to be sent to the physician in a timely manner.</p> <p>D. Review of the plan of care dated 03/13/16 to 05/11/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 03/13/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 04/01/16.</p> <p>2. A fax cover sheet that was stapled to all 4 pages of the plan of care, indicated the fax was sent to the primary care physician on 06/30/16. The physician signed all 4 pages of the plan of care on 07/06/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a</p>				

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	<p>timely manner.</p> <p>E. Review of the physician orders dated 03/13/16 and 04/22/16, both orders were stapled to a fax cover sheet which indicated the orders were faxed to the physician on 05/30/16. The orders were signed by the physician on 07/06/16. The physician orders failed to be sent to the physician for signature in a timely manner.</p> <p>F. Review of a 60 day summary dated 05/11/16 for the certification 03/13/16 to 05/11/16, the summary was stapled to a fax cover sheet which indicated the summary was faxed to the physician on 06/29/16. The summary failed to be sent to the physician in a timely manner.</p> <p>G. Review of Missed Visit forms indicated the following:</p> <ol style="list-style-type: none"> <li>1. A missed visit form dated 04/12/16, was attached to a fax cover sheet which indicated the form was faxed to the physician on 06/30/16.</li> <li>2. A missed visit form dated 05/13 05/17,05/31, and 06/10/16, were attached to a fax cover sheet which indicated the forms were faxed to the physician on 07/20/16.</li> </ol>				

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	<p>H. Review of the plan of care dated 05/12/16 to 07/10/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 05/12/16.</p> <p>1. The plan of care was noted to be 3 pages. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 06/20/16.</p> <p>2. A fax cover sheet that was stapled to all 3 pages of the plan of care, indicated the fax was sent to the primary care physician on 06/30/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>I. Review of the plan of care dated 07/11/16 to 09/08/16, line 23 and the subsequent 3 pages failed to indicate who obtained the verbal order as well as the date of the verbal order for continuing orders. The plan of care and the addendums to the plan of care failed to be completed and signed by the clinician who obtained the orders and failed to be sent to the physician for signature within</p>			

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	<p>a timely manner.</p> <p>J. Review of the physician orders dated 06/02, 06/12 (x2 orders), and 07/11/16, failed to have a physician signature. Review of an electronic physician order page, the entries indicated "to be sent." The physician orders failed to be sent to the physician for signature in a timely manner.</p> <p>K. Review of the skilled nursing visit notes dated 05/18/16, indicated in the Respiratory comment section "Pt [patient] is a current smoker; discussed smoking cessation with pt, is not interested. The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt is noncompliant with diet."</p> <p>1. Review of the skilled nursing visit notes dated 05/26/16, indicated in the Respiratory comment section "Pt [patient] is a current smoker; discussed smoking cessation with pt, is not interested." The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt is noncompliant with</p>				

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	<p>diet."</p> <p>2. Review of the skilled nursing visit note dated 06/02/16, indicated in the The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt continues to noncompliant with diet. Pt has been drinking a lot of Gatorade; encouraged him to drink water instead or diet drinks due to high sugar content; stated he would try." The LPN also indicated that the patient's wound had healed, the patient had very dry skin, assisted the patient with applying lotion, as well as encouraging the patient to do it daily. The visit note failed to evidence if the physician had been notified.</p> <p>a. Review of a physician's order dated 06/02/16, written by the Director of Clinical Services, the order indicated "Effective 06/02/16, wound resolved. Patient has very dry skin, skilled nursing to assist pt [patient] with applying lotion, encourage patient to apply daily. Skilled nursing to continue to monitor areas for changes." The box next to "order read back and verified" was not marked to indicate that the order had been verbally obtained by the Director of Clinical Services.</p>						

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	<p>3. Review of the skilled nursing visit notes dated 06/09/16, indicated in the The Dietary comment section indicated "Reinforced diet with pt. Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt continues to noncompliant with diet. Pt has been drinking a lot of Gatorade; encouraged him to drink water instead or diet drinks due to high sugar content; stated he would try."</p> <p>4. Review of the skilled nursing visit notes dated 06/16/16, indicated in the The Dietary comment section indicated "Reinforced diet choices again with pt, should avoid sugary drinks, fried foods, fast foods; try to eat fruits and vegetables, whole grains, low fat foods; encouraged pt to try some of the healthy choice or weight watchers meals."</p> <p>5. Review of the skilled nursing visit notes dated 06/24/16, indicated in the The Dietary comment section indicated "Encouraged pt to eat fruits and vegetable, low fat meats, whole grains, low or sugar free items; voiced understanding. pt continues to be noncompliant with diet. Pt has been drinking a lot of Gatorade; encouraged him to drink water instead or diet drinks</p>			

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	<p>due to high sugar content; stated he would try."</p> <p>The skilled nursing visit notes dietary section were repetitive and failed to be updated and reflect the patient status and education provided at the time of each nursing visit / assessment.</p> <p>9. Clinical record number 9, SOC 05/21/16, included a plan of care for the certification period of 05/21/16 to 07/19/16, with orders for skilled nursing, physical and occupational therapy.</p> <p>A. Review of the plan of care, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 05/21/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 07/15/16.</p> <p>2. A fax cover sheet that was stapled to all 4 pages of the plan of care, indicated the fax was sent to the primary care physician on 07/19/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent</p>			

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	<p>to the physician for signature within a timely manner.</p> <p>B. Review of physician orders dated 05/26, 07/06, 07/07, physical therapy plan of treatment dated 07/06/16, were stapled to a fax sheet which indicated the fax was sent to the primary care physician on 07/19/16. The orders failed to be sent to the physician for signature in a timely manner.</p> <p>10. Clinical record number 10, SOC 05/07/16, included a plan of care for the certification period of 05/07/16 to 07/05/16, with orders for skilled nursing, physical and occupational therapy.</p> <p>A. Review of the plan of care, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 05/07/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 06/20/16. The plan of care was not signed by the attending physician. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for</p>				

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	<p>signature within a timely manner.</p> <p>B. A urinalysis lab result that was obtained on 06/16/16, was faxed to the agency on 06/29/16. The lab result was stapled to a fax cover sheet and indicated it was faxed to the physician on 06/29/16. The agency failed to follow up with the patient's urinalysis at the laboratory and notify the physician of the result in a timely manner.</p> <p>C. Review of the physician orders dated 05/31, 06/09, 06/16/16, failed to have a physician signature. Review of an electronic physician order page, the entries indicated the orders were sent on 07/20/16. Review of the patient's hard chart, the orders were observed to be stapled to a fax sheet which indicated the fax was sent to the primary care physician on 07/20/16. The orders failed to be sent to the physician for signature in a timely manner.</p> <p>D. Review of the plan of care dated 07/05/16 to 09/03/16, indicated on page 1, line 23, the Director of Clinical Services obtained verbal orders on 07/06/16.</p> <p>1. The plan of care was noted to be 3 pages. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of</p>						

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	<p>treatment) indicated the Director of Clinical Services signed the orders on 07/19/16.</p> <p>2. A fax cover sheet that was stapled to all 3 pages of the plan of care, indicated the fax was sent to the primary care physician on 07/20/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>E. Review of a communication note dated 06/17/16, the Director of Clinical Services indicated "Resumption of Care Medication Reconciliation / New Major Medication Interactions" and attached was a current list of medications the patient was taking and there were major drug interactions identified.</p> <p>1. Review of the OASIS comprehensive resumption of care reassessment dated 05/27/16, the Administrator indicated the she had identified one major drug interaction and this was to be sent to the physician.</p> <p>2. Review of the attached fax cover sheet that was stapled with the communication note, medication profile, and the Drug to Drug interactions sheet,</p>			

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	<p>the fax cover sheet indicated the fax was sent to the physician on 06/17/16. The Administrator and the Director of Clinical Services failed to notify of the major drug interactions upon identification / timely manner.</p> <p>11. Clinical record number 11, SOC 06/13/16, included a plan of care for the certification period of 06/13/16 to 08/11/16, with orders for skilled nursing, physical therapy, occupational therapy, home health aide services, and medical social worker services.</p> <p>A. Review of the plan of care indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 06/13/16.</p> <p>1. The plan of care was noted to be 4 pages. The subsequent pages (2 - 4) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 07/01/16. The plan of care was not signed by the primary care physician. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p>			

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	<p>B. Review of physician orders dated 06/16/16, failed to be signed by the ordering physician. The orders failed to be sent to the physician for signature in a timely manner.</p> <p>C. A communication note dated 06/13/16, was completed and signed by the Director of Clinical Services dated 06/17/16, indicated attachments of major Drug to Drug interactions that was identified during the admission. The Director of Clinical Services failed to notify the physician of major Drug to Drug interactions in a timely manner.</p> <p>D. A home health aide supervisory visit was conducted on 06/27/16. Review of the clinical record, home health services was placed on hold on 06/25/16. The agency failed to ensure the clinical record contained accurate information.</p> <p>12. Clinical record number 12, SOC 02/16/16, included a plan of care for the certification period 02/16/16 to 04/15/16, with orders for physical therapy and home health aide services.</p> <p>A. Review of the plan of care, indicated on page 1, line 23, the Director of Clinical Services obtained verbal start of care orders on 02/21/16.</p>			

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	<p>1. The plan of care was noted to be 3 pages. The subsequent pages (2 - 3) labeled at the "Addendum to Plan of treatment) indicated the Director of Clinical Services signed the orders on 03/01/16. A fax cover sheet that was attached to the plan of care indicated the orders was sent to the physician on 03/22/16. The plan of care was signed by the attending physician on 03/25/16. The plan of care and the addendums to the plan of care failed to be completed and signed by the Director of Clinical Services and sent to the physician for signature within a timely manner.</p> <p>13. The Director of Clinical Services was interviewed again on 07/22/16 at 10:53 AM. The Director of Clinical Services indicated staff would obtain orders and document the orders in the record, then the office staff would pull the information from the notes, write the orders appropriately, then the Director of Clinical of Services would sign off on the orders, then fax the orders to the physician for signature.</p> <p>14. The Administrator and the Director of Clinical Services were unable to provide any further documentation / information in reference to the above findings by the exit conference on 07/22/16 at 2:15 PM.</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>15. An undated policy titled "Confirmation of Physician Telephone / Verbal Orders" indicated, " ...Physician verbal / telephone orders are accepted by qualified staff and submitted to the physician for his / her signature in a timely manner. Original and / or new / updated orders are transcribed onto an appropriate physician order form or a plan of treatment form, and mailed or faxed to the physician for signature within a timely manner of receipt of the order by Agency personnel. Verbal / telephone orders are to be signed by the physician in a timely manner upon receipt from Cornerstone Home Healthcare personnel ... The Agency monitors outstanding unsigned, physician orders and the orders are refaxed as deemed necessary. The Director of Client Care Services is notified of any issue associated with inability of obtaining signature for outstanding orders. Agency personnel may be assigned to visit physician offices to obtain the signed orders .... "</p> <p>16. An undated policy titled "Comprehensive Assessment" indicated " ... The registered nurse or skilled therapist completes the comprehensive initial assessment of the client's needs for care, treatment and / or services within</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157619	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2016
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	<p>five [5] days from start of care ... The Comprehensive Assessment ... Includes the following information ... A comprehensive review and history of prescribed, over the counter medications and herbal supplements, including Potential / actual drug interactions ... Duplicative drug therapy, potential and past adverse effects, significant sides effects and adverse effects .... "</p> <p>17. An undated policy titled "Medical Supervision of Client Care" indicated, " ... Upon completion of the comprehensive assessment and development of the plan of care, the plan of care will be faxed and / or mailed to the ordering physician for final approval and signature. A written summary report for each client shall be sent to the ordering physician at least every 60 days .... "</p>			