

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157560	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/22/2016
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NAME OF PROVIDER OR SUPPLIER BEST CHOICE HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 ELMWOOD AVE STE N INDIANAPOLIS, IN 46203
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G 0000 Bldg. 00	<p>This is a Federal recertification 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> <p>Best Choice Home Care, LLC is precluded from providing its own training and competency evaluation program for a period of 2 years beginning June 22, 2016 to June 22, 2018, for being found out of compliance with the Conditions of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision, 484.30 Skilled Nursing Services, 484.32: Therapy Services, and 484.48: Clinical Records.</p>	G 0000		

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

TITLE

(X6) DATE

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

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G 0143 Bldg. 00	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services in 1 of 1 records reviewed (# 10), failed to ensure coordination of services in 1 of 2 records reviewed of patients receiving services from an outside home health agency (# 8) and failed to ensure disciplines providing service to patients coordinated effectively in 7 of 10 active records reviewed in a sample of 12. (#2, 3, 4, 5, 6, 8, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care.</p> <p>B. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to</p>	G 0143	<p>Our Director of Clinical Services shall meet with all clinical staff on 07/20/2016 to re-educate on the policy and principles related to care coordination. Additional oversight of this deficiency shall occur through monthly clinical record reviews focusing on coordination efforts. These monthly reviews shall occur the 3rd Friday of each month. Our Director of Clinical Services shall lead this utilization review. Care Coordination will be added as an indicator on our Clinical Record Reviews with 100% threshold. Once the threshold is met for 3 consecutive months - the review focus shall move to quarterly reviews. All outcomes shall be shared with our Professional Advisory Committee and Governing Body Members. Staff failure to show documentation improvement in this initiative shall receive coaching and counseling to assure accomplishment. The DCS will be responsible for ensuring ongoing compliance with G143. Agency ensures compliance with care coordination.</p>	07/20/2016

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	<p>evidence that care coordination had been provided with the physician.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing, home health aide, physical and occupational therapy.</p> <p>A. The plan of care failed to indicate that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to evidence that care coordination had been provided with the physician, home health aide, physical therapist and occupational therapist.</p> <p>B. Review of the physical therapy evaluation dated 03/23/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide and the occupational therapist.</p> <p>C. Review of the occupational therapy evaluation dated 03/25/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, home health aide, and the physical therapist.</p>			

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	<p>D. Review of the physical therapy visit notes, a missed visit form dated 04/27/16, indicated the patient declined a visit due to having an increase in pain and wanted to rest his / her hip. The note also indicated the patient declined a visit for 04/29/16, and physical therapy would see the patient on the next scheduled visit on 05/02/16. The note indicated the physician's office was not notified. The physical therapist failed to notify and coordinate with the skilled nurse in regards to the patients missed visit due to pain.</p> <p>3. Clinical record number 4, SOC 04/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. The plan of care failed to indicate that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/19/16, the re-assessment failed to evidence that care coordination had been provided with the physician, home health aide, and physical therapist.</p> <p>B. Review of a physical therapy evaluation note dated 04/20/16, the note indicated a recommendation for occupational therapy to assess the patient.</p>			

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	<p>The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide and the occupational therapist.</p> <p>C. Review of a occupational therapy evaluation note dated 05/06/16, the visit failed to evidence care coordination with the skilled nurse, home health aide, and physical therapist.</p> <p>D. Review of a physical therapy visit note dated 05/23/16, the physical therapist indicated that the patient was newly diagnosed with Parkinson's disease and was started on a new medication. The visit note failed to evidence that the skilled nurse, home health aide, and the occupational therapist had been informed of the patient's new diagnosis and medication.</p> <p>4. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing, home health aide, physical, occupational, and speech therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/04/16, the assessment failed to evidence that care coordination had been provided with the home health aide,</p>			

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	<p>physical, occupational, and speech therapist.</p> <p>B. Review of the physical therapy evaluation dated 05/05/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide, speech and occupational therapist.</p> <p>C. Review of the occupational therapy evaluation dated 05/05/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, home health aide, physical and speech therapist.</p> <p>D. Review of the speech therapy evaluation dated 05/11/16, the assessment failed to evidence that care coordination had been provided with the physician, the skilled nurse, home health aide, physical and occupational therapist.</p> <p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been</p>			

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	<p>provided with the physician, home health aide and the physical therapist.</p> <p>B. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, indicated the physical therapist had a recommendation for speech therapy to assess the patient. The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide, and speech therapist.</p> <p>6. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech therapy.</p> <p>A. On 06/16/16, the Director of Clinical services provided a list of patient's who was receiving services from outside agencies. Patient number 8 was listed and was receiving outside services from two separate agencies.</p> <p>B. Review of the case communication / coordination notes, the clinical record failed to evidence coordination of services with one of the two agencies.</p> <p>C. Review of the physical therapy</p>			

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	<p>evaluation and plan of treatment dated 04/07/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, occupational, and speech therapist.</p> <p>D. Review of the occupational therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and speech therapy.</p> <p>E. Review of the speech therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and occupational therapy.</p> <p>7. Clinical record number 10, SOC 06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of the case communication / coordination note dated 06/14/16, the agency had contacted a dialysis center to inform them of the agency services to the patient. The communication note failed to evidence if the agency inquired about the patient's diet restrictions, fluid restrictions, and the</p>			
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G 0145	<p>medications / flushes that the patient would receive during dialysis.</p> <p>8. Employee A, a Registered Nurse, was interviewed on 06/21/16 at 2:30 PM. Employee A indicated he / she did not notify the physician upon the start of care and did not always converse with therapy after the start of care, and therapy did not converse with him / her after their evaluation.</p> <p>9. The Director of Clinical Services was interviewed on 06/22/16 at 9:40 AM and was unable to provide any further documentation upon request.</p> <p>10. A policy titled "Staff Communication Process" dated 10/2004, indicated " ... The Agency is committed to ensuring that all communication regarding patient care and concerns is accurate, efficient and prompt ... The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care ... All communication with other staff, patient, patient representative and professional and public community is documented in the patient's clinical record."</p>			

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Bldg. 00	<p>COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on record review and interview, the agency failed to ensure that a written summary report had been sent to the attending physician at least every 60 days in 4 of 4 records reviewed of patient's on service for longer than 60 days in a sample of 12. (#2, 3, 8, and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16 and 04/17/16 to 06/15/16, with orders for skilled nursing to provide treatments to the right and left toe wounds. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been sent to the attending physician. 2. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16 and 05/21/16 to 07/19/16, with orders for skilled nursing, home health aide, physical and occupational therapy. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been 	G 0145	<p>Clinical staff received re-education on 7/19/2016 on providing written summary to attending physician of what services were provided, goals met and plan. Our Director of Clinical Services or her designee shall monitor this deficiency for our failure to provide a written report for each patient by sending the summary of care to the attending physician at least every 60 days. The DCS shall provide weekly monitoring of this standard. After 100% compliance achieved for 3 months review will be moved to quarterly. Results shall be shared with our PAC and Governing body members. Administrator will be responsible for continued compliance with G145 to ensure ongoing compliance is corrected and will not occur again.</p>	07/20/2016

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G 0156 Bldg. 00	<p>sent to the attending physician.</p> <p>3. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech therapy. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been sent to the attending physician.</p> <p>4. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been sent to the attending physician.</p> <p>5. The Director of Clinical Services was interviewed on 06/22/16 at 9:40 AM and was unable to provide any further documentation upon request.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on record review and interview, the agency failed to ensure skilled nurses assessed patients as ordered per the plan of care in 3 of 10 active records reviewed in a sample of 12, failed to provide</p>	G 0156	Agency Director of Clinical Services scheduled a re-education session for all nursing staff on the importance of following policy, prudent clinical practice and adherence to physician	07/20/2016

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	<p>wound treatment as ordered per the plan of care for 1 of 2 records reviewed of patients with wounds in a sample of 12, failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing visits in 7 of 10 active records reviewed in a sample of 12, failed to ensure visits were made as ordered for 2 of 10 active records reviewed in a sample of 12, and failed to ensure the plan of care included therapy frequencies only after the therapy assessment had been completed for 2 of 10 active records reviewed in a sample of 12 (See G 158); failed to update and revise the plan of care to include diagnosis and parameters for oxygen saturations, location of wounds to be treated, size and maintenance of foley catheters, the amount / frequency / type of fluid for irrigation of foley catheters, route of how to obtain lab specimans, and measurable goals, for 5 of 10 active records reviewed in a sample of 12 (See G 159); failed to ensure that the physician was notified of a new wound for 1 of 2 records of patient's with wounds in a sample of 12, failed to ensure that the physician was informed of missed visits in 4 of 10 records reviewed of active patients in a sample of 12, and failed to ensure that the physician was notified in a timely manner of a patient in</p>		<p>orders. Each nurse shall sign an attestation to adhere to the expected practice. The DCS assumes responsibility for daily documentation review. Should a nurse deviate from policy/practice, that nurse shall be subjected to progressive discipline up to and including termination. The DCS will be responsible for ensuring ongoing compliance with G156. Agency ensures compliance with receipt of clinical documents and physician orders.</p>	

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	<p>need of additional services in 2 of 10 records reviewed of active patients in a sample of 12 (See G 164); failed to ensure treatments were provided as ordered by a physician in 2 of 2 records reviewed of patient's with wounds, failed to ensure that lab specimen obtained were ordered by the physician in 1 of 1 record reviewed of patient's with labs in a sample of 12, and failed to ensure orders were obtained prior to recommending treatments to caregivers for 1 of 2 patients with catheters in a sample of 12 (See G 165); and failed to ensure that verbal orders were put into writing, signed and dated with the date of receipt by the accepting clinician in 2 of 12 records reviewed (See G 166).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p>			

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G 0158 Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on record review and interview, the agency failed to ensure skilled nurses assessed patients as ordered per the plan of care in 3 of 10 active records reviewed (#1, 2, and 9) in a sample of 12, failed to provide wound treatment as ordered per the plan of care for 1 of 2 records reviewed of patients with wounds (# 2) in a sample of 12, failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing visits in 7 of 10 active records reviewed (#2, 3, 4, 5, 6, 8, and 9) in a sample of 12, failed to ensure visits were made as ordered for 2 of 10 active records reviewed (#6 and 8) in a sample of 12, and failed to ensure the plan of care included therapy frequencies only after the therapy assessment had been completed for 2 of 10 active records reviewed (#5 and 8) in a sample of 12.</p>	G 0158	<p>Skilled nursing received re-education on 07/19/2016 providing wound treatment as ordered per plan of care and head to toe assessment, inclusive of complete physical assessment to include blood sugars if patient is diabetic. Agency provided digital thermometers for staff field usage on 07/19/2016 with the clinician signing receipt of same. Staff received directives to use this equipment in the taking of temperatures same day as re-education session or 07/19/2016 Clinical staff received re-education on 07/19/2016 on obtaining verbal orders for plan of care and providing care/visits as ordered. Documentation effective 07/19/2016 includes care coordination with the physician and all clinicians providing care for the patient. Clinical staff have already demonstrated care coordination</p>	07/20/2016

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	<p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing three times a week for nine weeks, to provide treatments to the left lower extremity wounds. The skilled nurse was to assess wounds for signs and symptoms of infection, healing status, wound deterioration, and complications.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/30/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p> <p>B. Review of the skilled nursing visit note dated 06/03/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p> <p>C. Review of the skilled nursing visit note dated 06/10/16, the note failed to evidence a temperature and skin assessment.</p> <p>D. During a home visit with Employee B, a Registered Nurse, on 06/17/16 at 10:00 AM, Employee B</p>		<p>at start of care, and therapy frequency has been present based upon the plan of care. Clinical staff received re-education on 07/19/2016 to provide patient specific plan of care. All staff educated on missed visit policy on 07/19/2016 to include notification to ordering physician, appropriate reasons for missed visit, and actions to take when visits are not accomplished. Documentation review of patient temperature, missed visit, skilled nursing following wound orders, complete nursing assessments, care coordination between MD and all disciplines, verbal orders for start of care and patient specific care plans shall be reviewed weekly by the DCS or designate. This weekly review shall occur for 3 consecutive months with a 100% threshold for compliance. Clinicians deviating from this practice standard shall be subjected to progressive discipline up to and including termination. Administrator will be responsible for continued compliance with G158 to ensure deficiency is corrected and will not reoccur.</p>				

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	<p>failed to obtain a temperature while obtaining the patient's vital signs.</p> <p>2. Clinical record number 2, SOC 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing two times a week for nine weeks, to provide treatments to the right and left toe wounds. The skilled nurse was also to assess skin for breakdown every visit and signs / symptoms of infection, healing status, wound deterioration, and complications. The patient's diagnoses included, but were not limited to: pressure ulcer, type II diabetes with diabetic peripheral angiopath without gangrene, and peripheral vascular disease.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The physician signed the plan of care and returned to the agency on 03/25/16. The skilled nurse provided services on 02/17, 02/19, 02/25, 03/01, 03/07, 03/15, and 03/22/16, without a</p>			

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	<p>physicians order.</p> <p>2. The vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The assessment also failed to provide an assessment of the patient's blood sugars.</p> <p>B. Review of the skilled nursing visit note dated 03/1/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's blood sugars.</p> <p>C. Review of the skilled nursing visit note dated 03/07/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's blood sugars.</p> <p>D. Review of the skilled nursing visit note dated 03/15/16, the vital sign section failed to evidence that a temperature, blood pressure, and pulse had been obtained. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>E. Review of the skilled nursing visit note dated 03/22/16, the vital sign section failed to evidence that a temperature and blood pressure had been obtained with</p>			

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	<p>the remaining vital signs. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>F. Review of the skilled nursing visit note dated 03/29/16, the note indicated the patient had 3+ pitting edema to the right lower extremity and was started on antibiotics. The vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>G. Review of the skilled nursing visit note dated 04/01/16, the vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's skin, cardiovascular, nutrition, and blood sugars.</p> <p>H. Review of the skilled nursing visit note dated 04/08/16, the note indicated the patient had developed red tiny bumps to the bilateral lower extremities continued to have 2+ pitting edema to the right lower extremity with warmth and redness, and continued on antibiotics for the right lower extremity. The vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's</p>			

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	<p>blood sugars.</p> <p>3. Clinical record number 3, SOC 03/22/16, included a plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing one time a week for three weeks then every other week, physical and occupational therapy one to three times a week for nine weeks. Physical and Occupational therapy were to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The physician signed the plan of care and returned to the agency on 04/21/16. The skilled nurse provided services on 03/22, 03/29, 04/05, and 04/19/16, without a physicians order.</p> <p>B. Review of a physical therapy evaluation dated 03/23/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided</p>			

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	<p>treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 03/22, 03/25, 03/28, 04/01, 04/04, 04/06, 04/11, 04/13, 04/18, 04/22, 04/25, 05/02, 05/09, 05/11, and 05/16/16, without a physician's approval for the plan of treatment.</p> <p>4. Clinical record number 4, SOC 04/19/15, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for home health aide and physical therapy one to three times a week. Physical therapy was to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of a physical therapy evaluation dated 04/20/16, the physical therapist indicated on the evaluation, that</p>			

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	<p>visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals. The plan of care failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/20, 04/22, 04/25, 05/11, 05/16, 05/20, 05/23, 05/25, 05/30, 06/01, 06/06, 06/08, 06/15, and 06/20/16, without a physician's approval for the plan of treatment.</p> <p>5. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for occupational therapy and speech therapy one to three times a week for eight weeks. Occupational and speech therapy were to evaluate and submit a plan of treatment to the attending physician.</p>			

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	<p>A. Review of the speech therapy evaluation and plan of treatment dated 05/11/16, the speech therapist indicated that visits would be two times a week for eight weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record indicated the plan of treatment was sent to the physician on 06/01/16. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been returned and signed by the physician.</p> <p>3. Review of the speech therapy visit notes, speech therapy had provided services on 05/11, 05/12, 05/18, 05/19, 05/23, 05/26, 06/01, 06/02, 06/08, 06/09, 06/13, 06/16 and 06/20/16, without a physician's approval for the plan of treatment.</p> <p>B. Review of the occupational therapy visit notes, a missed visit form dated 05/10/16, indicated the patient had a missed visit due to the therapist being</p>			

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	<p>ill. The agency failed to ensure that another occupational therapist provided the therapy visit versus having a missed visit.</p> <p>6. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing one time a month for 3 months and physical therapy one to three times a week for nine weeks.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The plan of care was signed by the physician on 05/31/16 and received by the agency on 06/01/16. The skilled nurse provided services on 04/27/16 and 05/25/16, without a physicians order.</p> <p>2. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, both forms failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p>			

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	<p>3. The plan of treatment was signed by the physician on 05/24/16 and received by the agency on 05/25/16. The physical therapist provided services on 04/29, 05/02, 05/04, 05/11, 05/13, 05/18, and 05/23/16, without a physicians order.</p> <p>4. Review of the physical therapy notes, the physical therapist failed to make a visit between 05/29/16 to 06/04/16.</p> <p>7. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for physical, occupational, and speech therapy one to three times a week for eight weeks.</p> <p>A. Review of a physician order dated 04/05/16, the order indicated for speech therapy to evaluate and treat as indicated. Review of the speech therapy visit notes, the speech evaluation was not completed until 04/12/16, and recommended speech therapy visits one time a week for nine weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs. The speech therapist failed to evaluate the patient within a timely manner.</p> <p>B. Review of the speech therapy visit</p>			

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	<p>notes, the speech therapist failed to make a visit between 05/01/16 to 05/07/16 and 05/08/16 to 05/14/16.</p> <p>C. Review of occupational therapy notes, the occupational therapy evaluation was not completed until 04/12/16. The plan of care was developed prior to the occupational therapy evaluation and failed to be specific to the patient needs. The occupational therapist failed to evaluate the patient within a timely manner.</p> <p>D. An occupational therapy missed visit form was written on 05/10/16 due to the occupational therapist was ill. The agency failed to ensure that another therapist was available to see the patient as planned and ordered.</p> <p>E. Review of a physical therapy evaluation dated 04/07/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p>			

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	<p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician immediately after the evaluation. The fax was sent to the physician on 04/27/16 and returned signed by the physician on 04/28/16.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/07, 04/14, 04/19, 04/21, and 04/26/16, without a physician's approval for the plan of treatment.</p> <p>8. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing to assess the patient's general systems status every visit.</p> <p>A. Review of the skilled nursing visit note dated 06/11/16, the note failed to include an assessment of the patient's vital signs, respiratory, cardiovascular, and gastrointestinal systems.</p> <p>B. Review of a skilled nursing visit note dated 06/21/16, the note failed to include an assessment of the patient's vital signs, respiratory, cardiovascular, gastrointestinal systems, and diabetes.</p>			

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G 0159 Bldg. 00	<p>9. The Director of Clinical Services was interviewed on 06/20/16 at 9:10 AM. The Director of Clinical Services indicated that the company did not have the funds to purchase temporal thermometers. The Director of Clinical Services had an infection control concern with oral thermometers.</p> <p>10. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM. The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p> <p>11. A policy titled "Vital Sign Parameters" dated 02/09/16, indicated "Vital signs are to be completed during any visit requiring an OASIS. Vital will be performed on a weekly basis and with any change in condition "</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</p>			

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	<p>discharge or referral, and any other appropriate items.</p> <p>Based on record review and interview, the agency failed to update and revise the plan of care to include diagnosis and parameters for oxygen saturations, location of wounds to be treated, size and maintenance of foley catheters, the amount / frequency / type of fluid for irrigation of foley catheters, route of how to obtain lab specimens, and measurable goals, for 5 of 10 active records reviewed in a sample of 12. (# 1, 2, 5, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing to provide treatments to three wounds to the left lower extremity and orders for skilled nursing to assess oxygen saturation on room air "prn" [as needed].</p> <p>A. The patient diagnoses on the plan of care, included but not limited to, non pressure chronic ulcer, falls, localized edema, arthropathy, and hypertension. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a</p>	G 0159	<p>Agency DCS re-educated all nursing staff on 07/19/2016 on the importance of maintaining current information on all Plans of Care. The re-education sessions included prudent skill care practices inclusive of descriptive documentation that reflects the current status of the patient. The DCS shall implement weekly monitoring of all clinical documentation to assist in identifying deviations from acceptable practice by 07/19/2016. The threshold of the maintenance of current Plans of Care information and updates is set at 100% with the weekly monitoring continuation effective 07/19/2016 for 3 months. After 3 months and if 100% compliance has been achieved, the review will be moved to quarterly. Administrator will be responsible for continued compliance with G159 to ensure the deficiency of monitoring to ensure compliant and ongoing compliance is corrected and will not reoccur.</p>	07/20/2016			

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	<p>measurement of oxygen saturations, as well as measurable goals.</p> <p>B. Review of a skilled nursing visit note dated 6/6/16, the narrative note indicated the patient had five small open areas on the left lower extremity near the ankle.</p> <p>1. Review of a physician's order dated 6/6/16, indicated a treatment order to the "new small open areas" on the left lower extremity. The order failed to include a location of the new wounds to the left lower extremity.</p> <p>C. Review of a physician's order from the assisted living facility dated 06/16/16, indicated for a foley catheter to be placed and changed monthly.</p> <p>1. Review of a physician's order dated 06/16/16, indicated an extra skilled nurse visit to anchor a foley catheter. The order failed to include size of foley catheter, amount to instill sterile water for bulb inflation, frequency to change the foley catheter, and measurable goals.</p> <p>2. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing to assess oxygen</p>			

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	<p>saturation on room air as needed.</p> <p>A. The patient's diagnoses on the plan of care, included but not limited to, pressure ulcer, type 2 diabetes with diabetic peripheral neuropathy, and peripheral vascular disease. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>3. Clinical record number 5, SOC 05/04/16, included a plan of care established by the physician for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The OASIS start of care comprehensive assessment dated 05/04/16, M1400 asked when was the patient dyspneic or noticeably short of breath. The answer provided was "0 - Patient is not short of breath".</p> <p>1. The patient's diagnoses on the plan of care, included but not limited to, muscle weakness, other abnormalities of gait and mobility, cognitive communication deficit, cerebrovascular disease, therapeutic drug level</p>			

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	<p>monitoring, and chronic atrial fib. The plan of care failed to be updated and revised to include a description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>B. Review of the physician orders dated 05/09, 05/18, 05/25, 06/01, 06/08, and 06/15/16, the order indicated for the skilled nurse to obtain an INR lab specimens from the patient. The order failed to include if the lab specimens were to be obtained by fingerstick and / or by venipuncture.</p> <p>4. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing to assess oxygen saturation on room air as needed and to change the patient's catheter every month using an 18 French catheter.</p> <p>A. The patient's diagnoses on the plan of care, included but not limited to, attention to cystostomy, enlarged prostate with lower urinary tract symptoms, and diabetes mellitus. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen</p>			

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	<p> saturations.</p> <p> B. Review of the OASIS recertification dated 05/10/16, indicated the patient has an 18 Fr 10 cc suprapubic catheter. The note indicated the patient's spouse had been flushing the patient's catheter every other day.</p> <p> C. A skilled nursing visit note dated 05/24/16, indicated the patient's spouse flushes the patient's suprapubic catheter 4 to 5 times a week.</p> <p> The plan of care failed to include the patient's catheter was a suprapubic catheter and the bulb needs to be inflated with 10 cc of sterile water. The plan of care failed to include the patient's suprapubic catheter flushes, with amount of flush, the type of fluid to flush the catheter, and frequency of flushes to be provided.</p> <p> 5. Clinical record number 10, SOC 06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p> A. The patient diagnoses on the plan of care included repeated falls, unsteady with feet, end stage renal disease /</p>			

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G 0164 Bldg. 00	<p>dialysis, type 2 diabetes, depression, polyneuropathy, chronic pain, and rheumatoid arthritis. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on record review and interview, the agency failed to ensure that the physician was notified of a new wound for 1 of 2 records of patient's with wounds (#2) in a sample of 12, failed to ensure that the physician was informed of missed visits in 4 of 10 records reviewed of active patients (#3, 4, 5, and 6) in a sample of 12, and failed to ensure that the physician was notified in a timely manner of a patient in need of additional services in 2 of 10 records reviewed of active patients (#4 and 6) in a sample of 12.</p> <p>Findings include:</p>	G 0164	The agency Director of Clinical Services assumes responsibility for staff re-education, documentation monitoring, and strategies required to assure a sustained resolution of this deficiency. The clinical staff re-education initiatives include reinforcing agency related policies and to remind all clinical staff of their individual role responsibilities. Wound care, missed visits, recommending additional care and services, failure to notify the physician of missed visits and lack of care coordination, among other topics, are talking points. This re-education session is scheduled	07/20/2016			

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	<p>1. Clinical record number 2, SOC (start of care) 02/17/16, included a plan of care established by a physician for the certification periods of 02/17/16 to 04/17/16, with orders for skilled nursing to provide wound treatments to the right 2nd toe, left 2nd toe and to the left 3rd toe, two times a week for nine weeks. The patient has a past medical history of diabetic peripheral neuropathy, amputation of toes, and peripheral vascular disease.</p> <p>A. Review of a skilled nursing visit note dated 03/22/16, indicated the patient developed a new wound to the left great toe. The clinical note failed to evidence that the physician had been notified of the wound.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a plan of care established by a physician for the certification periods of 03/22/16 to 05/20/16 with orders for physical and occupational therapy.</p> <p>A. Review of the physical therapy visit notes, a missed visit form dated 04/29/16, indicated the patient declined a visit on 04/27/16 due to having an increase in pain and wanted to rest his / her hip. The note also indicated the</p>		<p>to occur no later than 07/20/2016. The DCS shall assure daily monitoring of all clinical documentation to assist in identifying deviations from acceptable practices. The threshold is set at 100%with the monitoring continuation for 3 consecutive months. At the end of the 3 month study and IF the threshold has been met for the 3 previous months, the study will be moved to every other month. Results shall be shared with the agency PAC and Governing Body Committee members. This study initiative shall be added to the agency Quality Assurance/Performance Improvement Plan with results documented in the agency Annual Report. Deviations from expected staff documentation shall result in progressive discipline up to and including termination. The DCS will be responsible for ensuring ongoing compliance with G164.</p>	

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	<p>patient declined a visit for 04/29/16, and physical therapy would see the patient on the next scheduled visit on 05/02/16. The note indicated the physician's office was not notified. The physical therapist failed to notify the physician of the missed visits due to the increase in pain.</p> <p>B. Review of the occupational therapy visit notes, a missed visit form dated 04/06/16, indicated the patient was not available and the occupational therapist planned to see the patient again on 04/12/16. The note indicated the physician's office was not notified. The occupational therapist failed to notify the physician of the missed visit.</p> <p>3. Clinical record number 4, SOC 12/09/15, included a plan of care established by the physician for the certification period of 04/22/16 to 06/20/16, with orders skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of a physical therapy evaluation dated 04/20/16, the physical therapist indicated a recommendation for occupational therapy to assess the patient. The physical therapist failed to evidence in the evaluation that the physician had been notified and agreed with the plan of treatment / recommendation and failed to evidence coordination with the case</p>			

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	<p>manager.</p> <p>1. Review of the physician orders, the occupational therapy evaluation was written on 05/06/16, by an skilled nurse. The agency failed to ensure a clinician notified the physician and obtain an order for the occupational therapy evaluation in a timely manner.</p> <p>B. Review of the physical therapy visit notes, a missed visit form dated 06/17/16, indicated the patient declined a visit due to a friend visiting from out of town and asked to wait to be seen until the next visit scheduled on 06/20/16. The note indicated the physician's office was not notified. The physical therapist failed to notify the physician of the missed visit.</p> <p>4. Clinical record number 5, SOC 05/04/16, included a plan of care established by a physician for the certification periods of 05/04/16 to 07/02/16 with orders for occupational therapy.</p> <p>A. Review of the occupational therapy visit notes, a missed visit form dated 05/10/16, indicated the patient had a missed visit due to the therapist being ill. The note indicated the physician's office was not notified. The occupational therapist failed to notify the physician of</p>			

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	<p>the missed visit.</p> <p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of a physical therapy evaluation dated 04/29/16, the physical therapist indicated a recommendation for speech therapy to assess the patient. The physical therapist failed to evidence in the evaluation that the physician had been notified and agreed with the plan of treatment / recommendation and failed to evidence coordination with the case manager.</p> <p>1. Review of the physician orders, the agency failed to ensure a clinician notified the physician and obtain an order for the speech therapy evaluation in a timely manner.</p> <p>2. Review of a physical therapy visit notes, a missed visit form dated 05/16/16, indicated the patient did not feel well and asked to skip physical therapy. The note indicated the physician was not notified. The physical therapist failed to notify the physician of the missed visit.</p>			

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G 0165 Bldg. 00	<p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</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 treatments were provided as ordered by a physician in 2 of 2 records reviewed of patient's with wounds (#1 and 2, failed to ensure that lab specimen obtained were ordered by the physician in 1 of 1 record reviewed of patient's with labs (#5) in a sample of 12, and failed to ensure orders were obtained prior to recommending treatments to caregivers for 1 of 2 patients with catheters (#9) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 05/30/16, included a written plan of care for the certification period of 05/30/16 to 07/28/16, with orders for skilled nursing three times a week for 9</p>	G 0165	<p>The agency DCS shall meet with all clinical nursing staff to advise of this survey finding. Re-education of policy, industry best practices, and obtaining and following physician orders shall be the focus of the educational session. This initiative shall be added to the agency focus review with a 100% threshold for compliance. Each visit documentation shall be reviewed by the DCS or designee to evaluate if the clinician is adhering to the practice expectations related to wound care orders, labs, and following physician ordered care instructions. Staff shall sign an attestation that he/she shall follow ordered care instructions, concentrate on documenting best practice initiatives and to be cognizant of progressive discipline procedures up to and including termination. DCS will be responsible for ensuring ongoing</p>	07/20/2016

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	<p>weeks, to provide treatments to the left lower extremity wounds. The skilled nurse was to cleanse the left leg ulcer with wound cleanser or normal saline, apply manuka to large wound bed, pack adjacent two wounds with prisma, drape around wound, cut foam to fit each wound and bridge together, drape over foam, apply drain and initiate wound vac suction at 125 mmHg continuous.</p> <p>A. Review of the skilled nursing visits dated 06/03/16, 06/06/16, 06/13/16, and 06/15/16, the notes indicated skin prep was applied to the peri wound.</p> <p>B. Review of the physician orders dated 06/03/16, 06/06/16, 06/08/16, 06/10/16, and 06/15/16, failed to evidence an order for the application of skin prep.</p> <p>2. Clinical record number 2, SOC (start of care) 2/17/16, included a written plan of care for the certification period of 2/17/16 to 4/16/16, with orders for skilled nursing to provide wound care.</p> <p>A. The treatment orders on the plan of care instructed to cleanse the right 2nd toe and left 3rd toe with wound cleanser, apply calcium alginate AG, cover with gauze and secure with tape and to cleanse the left 2nd toe with wound cleanser and</p>		compliance with G165. Agency ensures compliance with receipt of physician orders.	

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	<p>apply polymem with adhesive border.</p> <ol style="list-style-type: none"> 1. Review of a physician's order dated 02/16/16, was faxed to the agency on 02/16/16. The order indicated to cleanse the left lateral 3rd toe and right distal 2nd toe with normal saline or wound cleanser, apply silver alginate to both wounds. Cover right 2nd toe wound with 2 x 2 gauze. 2. Review of the OASIS start of care comprehensive assessment dated 02/17/16, failed to evidence coordination with the physician. 3. Review of section 23 of the plan of care, (Nurse's signature and date of verbal start of care), the plan of care failed to evidence a verbal start of care date. The admitting nurse failed to notify and obtain approval for the new treatment orders. 4. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to educate patient / caregiver and to check INR's per orders. <p>A. Review of the OASIS comprehensive start of care dated 05/04/16, the registered nurse obtained a</p>			

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	<p>blood sample via fingerstick to obtain an INR specimen. The electronic medical record and the paper clinical record failed to evidence orders for an INR lab specimen via finger stick to be done upon admission.</p> <p>B. Review of a skilled nursing visit note dated 05/09/16, the registered nurse obtained a blood sample via fingerstick to obtain an INR. The electronic medical record and the paper clinical record failed to evidence orders for an INR lab specimen via finger stick to be done upon admission.</p> <p>5. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing.</p> <p>A. A skilled nursing visit note dated 05/24/16, indicated the patient's spouse flushes the patient's suprapubic catheter 4 to 5 times a week. The note indicated the skilled nurse was encouraging the spouse to flush the patient's suprapubic catheter daily. The skilled nurse was recommending treatments without a physician's order.</p> <p>B. A skilled nursing visit note dated 06/20/16, indicated the skilled nurse was encouraging the spouse to flush the</p>			

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G 0166 Bldg. 00	<p>patient's suprapubic catheter twice a day. The skilled nurse was recommending treatments without a physician's order.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on record review and interview, the agency failed to ensure that verbal orders were put into writing, signed and dated with the date of receipt by the accepting clinician in 2 of 12 records reviewed. (#2 and 5)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC 2/17/16, included a plan of care established by a physician for the certification periods of 02/17/16 to 04/17/16, with orders for skilled nursing to provide wound treatments two times a week for nine weeks.</p>			G 0166	<p>The agency DCS shall include this survey finding when re-educating clinical staff on the importance of obtaining a verbal (interim) order to justify any home care alteration from previously received physician orders. Clinical visit staff will be informed that their visit documentation will be scrutinized daily by the DCS or designee to assure adherence to expected performances. Also, these staff shall sign an attestation promising to perform expected clinical practices or be subjected to progressive discipline up to and including termination. This study initiative has a 100% threshold and shall continue for 3 consecutive months. After the 3 month</p>		07/20/2016

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	<p>A. Review of the skilled nursing visit note dated 03/15/16, the note indicated new orders had been received by the physician. The electronic clinical record and the paper clinical record failed to evidence the written verbal order that was obtained by the registered nurse.</p> <p>B. Review of the skilled nursing visit note dated 03/29/16, the note indicated the skilled nurse had notified the physician of changes to the patient's right lower extremity and that the physician had ordered new antibiotics for the patient.</p> <p>1. Review of the medication profile, indicated that Keflex 500 milligrams, to be taken orally twice a day for ten days, had been prescribed to the patient on 3/29/16. The electronic medical record and the patient's paper clinical record failed to evidence the written verbal order that was obtained by the registered nurse.</p> <p>C. Review of the skilled nursing visit note dated 04/01/16, the note indicated the physician was made aware of the patient's right lower extremity and antibiotics had been started.</p> <p>1. The medication profile indicated that the patient started on</p>		<p>review, the study frequency will be moved to quarterly, but only if the threshold has been met. The DCS will be responsible for ensuring ongoing compliance with G166. Agency ensures compliance with the receipt of physician orders.</p>	

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	<p>Bactrim DS 800 milligrams - 160 milligrams, to be taken orally twice a day and hydrocortisone 0.5% topical cream to be applied to the bilateral lower extremities as needed on 04/01/16. The electronic medical record and the patient's paper clinical record failed to evidence if the new order was obtained verbally by the physician and / or failed to evidence in a nursing visit note that the new medication orders were from labels of the filled prescriptions.</p> <p>2. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to educate patient / caregiver and to check INR's per orders.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/04/16, the registered nurse documented that he / she received verbal orders for the patient to hold the coumadin on 05/04/16, start coumadin 2.5 milligrams on Monday and Thursday, 5 milligrams on all other days, and to recheck the patient's INR on 05/09/16. The electronic medical record and the patient's paper clinical record failed to evidence the written verbal order that was obtained by the registered nurse.</p>			

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G 0168 Bldg. 00	<p>B. Review of the skilled nursing visit note dated 05/09/16, the skilled nurse indicated "I made the changes with the metoprolol in med box."</p> <p>1. Review of the medication profile, a new entry dated 05/09/16, indicated the patient had a new order for metoprolol 50 mg to be taken by mouth twice a day. The electronic medical record and the patient's paper clinical record failed to evidence the written order for the new dose of medication. The skilled nursing visit note failed to evidence if the new dosage was obtained from a filled prescription bottle.</p> <p>3. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on record review and interview, the Registered Nurse failed to assess patients as ordered per the plan of care in 3 of 10 active records reviewed in a sample of 12, failed to provide wound treatment as ordered per the plan of care for 1 of 2 records reviewed of patients with wounds in a sample of 12, and failed</p>	G 0168	The DCS shall explain the cumulative effects of certain G Tags having the potential of elevating to a Condition Level finding. Our agency recognizes that both clinical and administrative staff failed to follow CMS performance standards and caused this citation. Our agency has an obligation to both patients	07/20/2016

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	to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing visits in 3 of 10 active records reviewed in a sample of 12 (See G 170); failed to re-evaluate the patient's nursing needs for 1 of 10 active records reviewed in a sample of 12 (See G 172); failed to update and revise the plan of care to include diagnosis and parameters for oxygen saturations, location of wounds to be treated, size and maintenance of foley catheters, the amount / frequency / type of fluid for irrigation of foley catheters, route of how to obtain lab specimans, and measurable goals, for 5 of 10 active records reviewed in a sample of 12 (See G 173); failed to include an assessment of wounds being treated with each nursing visit for 2 of 2 records reviewed of patients with wounds in a sample of 12 (See G 174); and failed to ensure their efforts were coordinated effectively with the dialysis centers that was furnishing services in 1 of 1 records reviewed, failed to ensure coordination of services in 1 of 2 records reviewed of patients receiving services from an outside home health agency, failed to ensure disciplines providing service to patients coordinated effectively in 7of 10 active records, and failed to ensure that the physician was notified of a new wound for 1 of 2		and staff to correct behaviors associated with these multiple deficiencies. Re-education on policies,best practice principles, CMS standards of performance and our state practice acts are all talking points for this staff educational session scheduled to occur before 07/20/2016. A 100% threshold has been set for this compilation of deficiencies with daily reviews. Reviews are scheduled for 3 consecutive months. Results shall be shared with all staff, PAC and GB membership. DCS will be responsible for ensuring ongoing compliance with G168. Agency ensures compliance with CMS performance standards.	

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G 0170 Bldg. 00	<p>records of patient's with wounds in a sample of 12 (See G 176).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.30 Skilled Nursing Services.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview, the Registered Nurse failed to assess patients as ordered per the plan of care in 3 of 10 active records reviewed (#1, 2, and 9) in a sample of 12, failed to provide wound treatment as ordered per the plan of care for 1 of 2 records reviewed of patients with wounds (# 2) in a sample of 12, and failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were</p>	G 0170	The agency will ensure that all patients are assessed appropriately, will provide wound care as ordered by the physician and follow all other physician orders on the plan of care and/or supplemental physician orders. Nurses educated on following wound care orders, physician orders on plan of care and/or supplemental physician orders on 07/19/2016. The DCS has assumed responsibility for educating staff about corrective	07/20/2016			

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	<p>obtained prior to making ongoing visits in 3 of 10 active records reviewed (#2, 3, and 6) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing three times a week for nine weeks, to provide treatments to the left lower extremity wounds. The skilled nurse was to assess wounds for signs and symptoms of infection, healing status, wound deterioration, and complications.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/30/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p> <p>B. Review of the skilled nursing visit note dated 06/03/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p> <p>C. Review of the skilled nursing visit note dated 06/10/16, the note failed to evidence a temperature and skin assessment.</p>		<p>clinical behaviors and the monitoring of documentation related to this deficiency. Nursing staff completed head to toe skill check off and comprehension test to ensure education was successful. The staff education sessions occurred 07/19/2016. Staff reviewed comprehensive assessment procedure and policies 484.30. Staff educated on always following the plan of care. Documentation review monitoring shall occur weekly by the DCS with 100% threshold for compliance. This review shall continue for 3 consecutive months and move to quarterly reviews if the threshold is consistently met. Staff shall be subjected to progressive discipline for failure to adhere to the improved practice principles. Administrator will be responsible for continued compliance with G170 to ensure deficiency is corrected and will not reoccur.</p>		

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	<p>D. During a home visit with Employee B, a Registered Nurse, on 06/17/16 at 10:00 AM, Employee B failed to obtain a temperature while obtaining the patient's vital signs.</p> <p>2. Clinical record number 2, SOC 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing two times a week for nine weeks, to provide treatments to the right and left toe wounds. The skilled nurse was also to assess skin for breakdown every visit and signs / symptoms of infection, healing status, wound deterioration, and complications.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The physician signed the plan of care and returned to the agency on 03/25/16. The skilled nurse provided services on 02/17, 02/19, 02/25, 03/01, 03/07, 03/15, and 03/22/16, without a physicians order.</p>			

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	<p>2. The vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The assessment also failed to provide an assessment of the patient's blood sugars.</p> <p>B. Review of the skilled nursing visit note dated 03/1/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's blood sugars.</p> <p>C. Review of the skilled nursing visit note dated 03/07/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's blood sugars.</p> <p>D. Review of the skilled nursing visit note dated 03/15/16, the vital sign section failed to evidence that a temperature, blood pressure, and pulse had been obtained. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>E. Review of the skilled nursing visit note dated 03/22/16, the vital sign section failed to evidence that a temperature and blood pressure had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the</p>			

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	<p>patient's skin and blood sugars.</p> <p>F. Review of the skilled nursing visit note dated 03/29/16, the note indicated the patient had 3+ pitting edema to the right lower extremity and was started on antibiotics. The vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>G. Review of the skilled nursing visit note dated 04/01/16, the vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's skin, cardiovascular, nutrition, and blood sugars.</p> <p>H. Review of the skilled nursing visit note dated 04/08/16, the note indicated the patient had developed red tiny bumps to the bilateral lower extremities continued to have 2+ pitting edema to the right lower extremity with warmth and redness, and continued on antibiotics for the right lower extremity. The vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's blood sugars.</p>			

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	<p>3. Clinical record number 3, SOC 03/22/16, included a plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing one time a week for three weeks then every other week.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The physician signed the plan of care and returned to the agency on 04/21/16. The skilled nurse provided services on 03/22, 03/29, 04/05, and 04/19/16, without a physicians order.</p> <p>4. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing one time a month for 3 months.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to</p>			

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	<p>evidence that care coordination had been provided with the physician.</p> <p>1. The plan of care was signed by the physician on 05/31/16 and received by the agency on 06/01/16. The skilled nurse provided services on 04/27/16 and 05/25/16, without a physicians order.</p> <p>5. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing to assess the patient's general systems status every visit.</p> <p>A. Review of the skilled nursing visit note dated 06/11/16, the note failed to include an assessment of the patient's vital signs, respiratory, cardiovascular, and gastrointestinal systems.</p> <p>B. Review of a skilled nursing visit note dated 06/21/16, the note failed to include an assessment of the patient's vital signs, respiratory, cardiovascular, gastrointestinal systems, and diabetes.</p> <p>6. The Director of Clinical Services was interviewed on 06/20/16 at 9:10 AM. The Director of Clinical Services indicated that the company did not have the funds to purchase temporal thermometers. The Director of Clinical</p>			

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G 0172 Bldg. 00	<p>Services had an infection control concern with oral thermometers.</p> <p>7. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM. The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p> <p>8. A policy titled "Vital Sign Parameters" dated 02/09/16, indicated "Vital signs are to be completed during any visit requiring an OASIS. Vital will be performed on a weekly basis and with any change in condition "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on record review and interview, the Registered Nurse failed to re-evaluate the patient's nursing needs for 1 of 10 active records reviewed (#8) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing every other week for three weeks then</p>	G 0172	The DCS will re-educate clinical staff on the need to adjust the Plan of Care in the event of utilizing PRN visits at a frequency that dictate a need to request physician orders for a visit frequency and duration change. The DCS shall review all daily documentation to research if this initiative has been corrected. This review is set for 3 consecutive months with a 100% threshold. The DCS will be responsible for ensuring ongoing compliance with	07/20/2016

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	<p>one time a month for two months.</p> <p>A. Review of a skilled nursing visit note dated 04/27/16, the note indicated the visit was a prn (as needed) visit due to the patient's left eye was red and draining.</p> <p>B. Review of a skilled nursing visit note dated 05/03/16, the note indicated the visit was a prn visit due to a significant change in condition. The patient was sent to the ER.</p> <p>C. Review of a skilled nursing visit note dated 05/05/16, the note indicated the visit was a prn visit due to the patient returned from the ER the previous day. The note indicated the patient was provided with IV fluids for dehydration. The note also indicated a neurologist at the hospital was recommending IV fluids to be done in the home weekly but the daughter was trying to increase oral fluid intake during the day.</p> <p>D. Review of a skilled nursing visit note dated 05/13/16, the note indicated the visit was a prn visit due to the patient complaining of burning, inability to urinate and very strong odor with urination. A urinalysis with a culture and sensitivity was obtained.</p>		G172.	

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G 0173 Bldg. 00	<p>The skilled nurse failed to re-evaluate the patient's nursing needs and adjust the skilled nursing frequency due to the frequent prn visits related to the patient's constant change in conditions.</p> <p>2. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on record review and interview, the Registered Nurse failed to update and revise the plan of care to include diagnosis and parameters for oxygen saturations, location of wounds to be treated, size and maintenance of foley catheters, the amount / frequency / type of fluid for irrigation of foley catheters, route of how to obtain lab specimans, and measurable goals, for 5 of 10 active records reviewed in a sample of 12. (# 1, 2, 5, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled</p>	G 0173	<p>This standard level deficiency is a compilation of various citations related to updating the plan of care, O2 saturation values and orders, and other care orders. Skilled nurses received re-education on providing wound treatment as ordered per plan of care on 07/19/2016. Skilled nursing re-educated on head to toe assessment, and complete physical assessment to include blood sugars if patient is diabetic on 07/19/2016. Clinical staff re-educated on 07/19/2016 for obtaining verbal orders for plan of care and providing care/visits as ordered. Documentation is required to include care coordination with physician and all clinicians providing care for the patient. Clinical staff will show care coordination at start of</p>	07/20/2016

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	<p>nursing to provide treatments to three wounds to the left lower extremity and orders for skilled nursing to assess oxygen saturation on room air "prn" [as needed].</p> <p>A. The patient diagnoses on the plan of care, included but not limited to, non pressure chronic ulcer, falls, localized edema, arthropathy, and hypertension. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations, as well as measurable goals.</p> <p>B. Review of a skilled nursing visit note dated 6/6/16, the narrative note indicated the patient had five small open areas on the left lower extremity near the ankle.</p> <p>1. Review of a physician's order dated 6/6/16, indicated a treatment order to the "new small open areas" on the left lower extremity. The order failed to include a location of the new wounds to the left lower extremity.</p> <p>C. Review of a physician's order from the assisted living facility dated 06/16/16, indicated for a foley catheter to be placed and changed monthly.</p>		<p>care, and therapy frequency will be present on the plan of care. Clinical staff re-educated to provide patient specific plan of care on 07/19/2016. All cited deficiencies shall receive a focus weekly documentation review with a 100% threshold for 3 consecutive months. If the threshold is met, the reviews shall be moved to quarterly reviews. Staff shall be re-educated and then counseled for failure to adhere to expected practices. Administrator will be responsible for continued compliance with G173 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>1. Review of a physician's order dated 06/16/16, indicated an extra skilled nurse visit to anchor a foley catheter. The order failed to include size of foley catheter, amount to instill sterile water for bulb inflation, frequency to change the foley catheter, and measurable goals.</p> <p>2. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The patient's diagnoses on the plan of care, included but not limited to, pressure ulcer, type 2 diabetes with diabetic peripheral neuropathy, and peripheral vascular disease. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>3. Clinical record number 5, SOC 05/04/16, included a plan of care established by the physician for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p>			

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	<p>A. The OASIS start of care comprehensive assessment dated 05/04/16, M1400 asked when was the patient dyspneic or noticeably short of breath. The answer provided was "0 - Patient is not short of breath".</p> <p>1. The patient's diagnoses on the plan of care, included but not limited to, muscle weakness, other abnormalities of gait and mobility, cognitive communication deficit, cerebrovascular disease, therapeutic drug level monitoring, and chronic atrial fib. The plan of care failed to be updated and revised to include a description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>B. Review of the physician orders dated 05/09, 05/18, 05/25, 06/01, 06/08, and 06/15/16, the order indicated for the skilled nurse to obtain an INR lab specimens from the patient. The order failed to include if the lab specimens were to be obtained by fingerstick and / or by venipuncture.</p> <p>4. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing</p>			

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	<p>to assess oxygen saturation on room air as needed and to change the patient's catheter every month using an 18 French catheter.</p> <p>A. The patient's diagnoses on the plan of care, included but not limited to, attention to cystostomy, enlarged prostate with lower urinary tract symptoms, and diabetes mellitus. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>B. Review of the OASIS recertification dated 05/10/16, indicated the patient has an 18 Fr 10 cc suprapubic catheter. The note indicated the patient's spouse had been flushing the patient's catheter every other day.</p> <p>C. A skilled nursing visit note dated 05/24/16, indicated the patient's spouse flushes the patient's suprapubic catheter 4 to 5 times a week.</p> <p>The plan of care failed to include the patient's catheter was a suprapubic catheter and the bulb needs to be inflated with 10 cc of sterile water. The plan of care failed to include the patient's suprapubic catheter flushes, with amount</p>			

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G 0174 Bldg. 00	<p>of flush, the type of fluid to flush the catheter, and frequency of flushes to be provided.</p> <p>5. Clinical record number 10, SOC 06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The patient diagnoses on the plan of care included repeated falls, unsteady with feet, end stage renal disease / dialysis, type 2 diabetes, depression, polyneuropathy, chronic pain, and rheumatoid arthritis. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. Based on record review and interview,</p>	G 0174	The DCS meet with all nursing staff for the survey finding results	07/20/2016

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	<p>the Registered Nurse failed to include an assessment of wounds being treated with each nursing visit for 2 of 2 records reviewed of patients with wounds in a sample of 12. (#1 and 2)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 05/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing three times a week for 9 weeks, to provide treatments to the left lower extremity wounds.</p> <p>A. Review of the skilled nursing visit note dated 06/01/16, the note failed to evidence a description of the wound bed to wound #1, failed to provide a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3.</p> <p>B. Review of the skilled nursing visit note dated 06/06/16, the note failed to evidence a description of the wound bed to wound #1, failed to provide a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3.</p> <p>C. Review of the skilled nursing visit note dated 06/08/16, the note failed to</p>		<p>on 07/19/2016 indicating the need to perform wound assessments in accordance with best practice principles with inclusion o freports to the prescribing physician. Nurses re-educated to provide description of wound bed,surrounding tissue, drainage and odor noted with each visit and weekly measurements and documentation of any changes. When wound patient's are seen by two different nurses, the nurses will compare documentation and technique.Discrepancies in documentation or technique will be shared with DCS and Administrator. Clinical records with wounds will be reviewed weekly with focus on wound assessments, description and measurements for 3 consecutive months with 100% threshold. The record review will move to quarterly once threshold is met for 3 month. Administrator will be responsible for continued compliance with G174to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>evidence a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3. The clinical note also failed to evidence if treatment had been provided to the new wounds near the patient left ankle as well as the description of the wounds.</p> <p>D. Review of the skilled nursing visit note dated 06/10/16, the note failed to evidence a description of the wound bed to wounds #1, #2, and #3.</p> <p>E. Review of the skilled nursing visit note dated 06/13/16, the note failed to evidence a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3.</p> <p>F. Review of the skilled nursing visit note dated 06/15/16, the note failed to evidence a description of the wound bed, surrounding tissue, drainage, and odor to wounds #1, #2, and #3. The narrative note indicated a new wound to the right lower extremity. The note failed to evidence a description of the wound bed.</p> <p>2. Clinical record number 2, SOC 2/17/16, included a written plan of care for the certification period of 2/17/16 to 4/16/16, with orders for skilled nursing to provide wound care. The treatment orders on the plan of care instructed to</p>			

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	<p>cleanse the right 2nd toe and left 3rd toe with wound cleanser, apply calcium alginate AG, cover with gauze and secure with tape and to cleanse the left 2nd toe with wound cleanser and apply polymem with adhesive border.</p> <p>A. Review of the OASIS comprehensive start of care assessment dated 02/17/16, the assessment identified wound #1 as the left 2nd toe, wound #2 as the left third toe, and wound #3 as the right 2nd toe.</p> <p>1. Review of the skilled nursing visit note dated 02/19/16, the note identified wound #1 as the left 3rd toe and wound #2 as the right 2nd toe. The visit note also failed to correctly identify the wounds, failed to evidenced a description of the wound bed, surrounding tissue, drainage, and odor to the reported wounds #1 and #2, and failed to identify and evidenced if treatment had been provided to the left 2nd toe.</p> <p>2. Review of the skilled nursing visit note dated 02/25/16, the visit note failed to evidenced a description of the wound bed, surrounding tissue, drainage, and odor to wounds #1, #2, and #3.</p> <p>3. Review of the skilled nursing</p>			

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	<p>visit note dated 03/01/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 2nd toe, and wound #3 as the left 3rd toe. The visit note failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wounds #1, #2, and #3.</p> <p>4. Review of the skilled nursing visit note dated 03/07/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 3rd toe, and wound #3 as the left 2nd toe. The visit note failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wounds #1, #2, and #3.</p> <p>5. Review of the skilled nursing visit note dated 03/15/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 2nd toe, and wound #3 as the left 3rd toe. The visit note failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wound #2. The note indicated wounds #1 and #3 were closed.</p> <p>6. Review of the skilled nursing visit note dated 03/22/16, the note identified wound #1 as the right 2nd toes, wound #2 as the left 2nd toe, wound #3</p>			

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	<p>as the left 3rd toe, and a new wound #4 as the left great toe. The visit note failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wound #1, #2, #3, and #4.</p> <p>7. Review of the skilled nursing visit note dated 03/29/16, the note identified wound #1 as the left 2nd toe, wound #2 as the left 3rd toe, and wound #3 as the right 2nd toe. The visit note failed to evidenced a description of the wound bed to the reported wound #1, #2, and #3. The visit note also failed to identify and evidenced an assessment to wound #4.</p> <p>8. Review of the skilled nursing visit note dated 04/01/16, the note identified wound #1 as the left 2nd toe and wound #2 as the left 3rd toe. The registered nurse applied calcium alginate to the left 2nd toe. The visit note failed to provide the correct treatment to the left 2nd toe, and failed to evidence a description of the wound bed, surrounding tissue, drainage, and odor to wound #1 and #2. The visit note also failed to identify and evidenced an assessment and treatment to the right 2nd toe wound and failed to identify and evidenced an assessment to the left great toe (wound #4).</p>			

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G 0176 Bldg. 00	<p>9. Review of the skilled nursing visit note dated 04/08/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 3rd toe, and wound #3 as the left 2nd toe. The visit note also failed to correctly identify the wounds and failed to evidenced a description of the wound bed, surrounding tissue, drainage, and odor to the reported wounds #1, #2, and #3. The visit note also failed to identify and evidenced an assessment of the left great toe (wound #4).</p> <p>3. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on interview and record review, the Registered Nurses failed to ensure their efforts were coordinated effectively with the dialysis centers that was furnishing services in 1 of 1 records</p>	G 0176	The DCS shall meet with all clinical visit staff on 07/19/2016 to re-educate on obtaining physician orders for all care and documenting coordination of care efforts with members of the	07/20/2016

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	<p>reviewed (# 10), failed to ensure coordination of services in 1 of 2 records reviewed of patients receiving services from an outside home health agency (# 8), failed to ensure disciplines providing service to patients coordinated effectively in 7 of 10 active records (#2, 3, 4, 5, 6, 8, and 10), and failed to ensure that the physician was notified of a new wound for 1 of 2 records of patient's with wounds (#2) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care.</p> <p>B. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>C. Review of a skilled nursing visit note dated 03/22/16, indicated the patient developed a new wound to the left great toe. The clinical note failed to evidence</p>		<p>visiting team. The re-education meeting included expectations for care coordination with outside providers including but not limited to dialysis providers, companion care and state Medicaid companies. Weekly record review by the DCS or designee with focus on coordination of care with all disciplines, physician and outside agencies and obtaining physician orders for 3 consecutive months with 100%threshold. Weekly record review will move to quarterly reviews once the 100% threshold is met for 3 consecutive months. Administrator will be responsible for continued compliance with G176 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>that the physician had been notified of the wound.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing, home health aide, physical and occupational therapy.</p> <p>A. The plan of care failed to indicate that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to evidence that care coordination had been provided with the physician, home health aide, physical therapist and occupational therapist.</p> <p>3. Clinical record number 4, SOC 04/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. The plan of care failed to indicate that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/19/16, the re-assessment failed to evidence that care coordination had been provided with the physician, home health aide, and physical therapist.</p>			

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	<p>4. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing, home health aide, physical, occupational, and speech therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/04/16, the assessment failed to evidence that care coordination had been provided with the home health aide, physical, occupational, and speech therapist.</p> <p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been provided with the physician, home health aide and the physical therapist.</p> <p>6. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech</p>			

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	<p>therapy.</p> <p>A. On 06/16/16, the Director of Clinical services provided a list of patient's who was receiving services from outside agencies. Patient number 8 was listed and was receiving outside services from two separate agencies.</p> <p>B. Review of the case communication / coordination notes, the clinical record failed to evidence coordination of services with one of the two agencies.</p> <p>7. Clinical record number 10, SOC 06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of the case communication / coordination note dated 06/14/16, the agency had contacted a dialysis center to inform them of the agency services to the patient. The communication note failed to evidence if the agency inquired about the patient's diet restrictions, fluid restrictions, and the medications / flushes that the patient would receive during dialysis.</p> <p>8. Employee A, a Registered Nurse, was interviewed on 06/21/16 at 2:30 PM.</p>			

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G 0184 Bldg. 00	<p>Employee A indicated he / she did not notify the physician upon the start of care and did not always converse with therapy after the start of care, and therapy did not converse with him / her after their evaluation.</p> <p>9. A policy titled "Staff Communication Process" dated 10/2004, indicated " ... The Agency is committed to ensuring that all communication regarding patient care and concerns is accurate, efficient and prompt ... The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care ... All communication with other staff, patient, patient representative and professional and public community is documented in the patient's clinical record."</p> <p>484.32 THERAPY SERVICES</p> <p>Based on record review and interview, the Physical, Occupational, and Speech Therapist failed to ensure visits were made as ordered for 3 of 10 active records reviewed in a sample of 12 (See G 185); failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing</p>	G 0184	The DCS shall meet with all field therapy staff to advise of this survey finding inclusive of the need for physician orders for care/services and need to adjust the therapy plans of care, if applicable. The compilation of these deficiencies resulted in a Condition Level deficiency. This initiative shall receive a daily review by the DCS or designee to	07/20/2016

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G 0185 Bldg. 00	<p>visits in 5 of 8 records reviewed of patients having therapy services in a sample of 12 (See G 186); and failed to ensure to coordinate with other therapists and case managers and document their efforts in 5 of 8 records reviewed of patients with multiple disciplines providing services in a sample of 12 (See G 188).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.32: Therapy Services.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p> <p>484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. Based on record review and interview, the Physical, Occupational, and Speech Therapist failed to ensure visits were</p>	G 0185	<p>assure therapy staff adherence to the expectation. The threshold is set for 100% compliance for 3 consecutive months with reviews moving to quarterly if the threshold is met. The therapy meeting shall occur prior to 07/20/2016. The DCS will be responsible for ensuring ongoing compliance with G184.</p> <p>The DCS shall assume responsibility for re-educating therapy staff on the need to follow physician orders for visit</p>	07/20/2016

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	<p>made as ordered for 3 of 10 active records reviewed in a sample of 12. (# 5, 6 and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for occupational therapy one to three times a week for eight weeks.</p> <p>A. Review of the occupational therapy visit notes, a missed visit form dated 05/10/16, indicated the patient had a missed visit due to the therapist being ill. The agency failed to ensure that another occupational therapist provided the therapy visit versus having a missed visit.</p> <p>2. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for physical therapy one to three times a week for nine weeks.</p> <p>A. Review of the physical therapy notes, the physical therapist failed to make a visit between 05/29/16 to 06/04/16.</p> <p>3. Clinical record number 8, SOC</p>		<p>frequency and duration with notification to the prescribing physician of any missed visits. This survey finding shall be shared with all therapy staff prior to 07/20/2016. This initiative shall be monitored by the DCS for 3 consecutive months with a 100% threshold. After the 3 months, the daily review shall move to quarterly if the threshold has been consistently met. The DCS will be responsible for ensuring ongoing compliance with G185. The agency ensures compliance with receipt of receipt of physician orders.</p>	

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	<p>04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for occupational, and speech therapy one to three times a week for eight weeks.</p> <p>A. Review of a physician order dated 04/05/16, the order indicated for speech therapy to evaluate and treat as indicated. Review of the speech therapy visit notes, the speech evaluation was not completed until 04/12/16, and recommended speech therapy visits one time a week for nine weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs. The speech therapist failed to evaluate the patient within a timely manner.</p> <p>B. Review of the speech therapy visit notes, the speech therapist failed to make a visit between 05/01/16 to 05/07/16 and 05/08/16 to 05/14/16.</p> <p>C. Review of occupational therapy notes, the occupational therapy evaluation was not completed until 04/12/16. The plan of care was developed prior to the occupational therapy evaluation and failed to be specific to the patient needs. The occupational therapist failed to evaluate the patient within a timely manner.</p>			

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G 0186 Bldg. 00	<p>D. An occupational therapy missed visit form was written on 05/10/16 due to the occupational therapist was ill. The agency failed to ensure that another therapist was available to see the patient as planned and ordered.</p> <p>4. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM. The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p> <p>484.32 THERAPY SERVICES 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.) Based on record review and interview, the Physical, Occupational, and Speech Therapist failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing visits in 5 of 8 records reviewed of patients having therapy services in a sample of 12. (# 3, 4, 5, 6, and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 03/22/16, included a plan of care for the certification period of 03/22/16 to</p>			G 0186	<p>The DCS shall assume responsibility for therapy staff re-education on the need to obtain physician orders for care and services inclusive of treatment modalities, visit frequencies and coordination efforts. These initiatives shall receive daily documentation review by the DCS to assure therapy staff adhere to practice expectations. The study has a threshold of 100% and will occur for 3 consecutive months with study continuation quarterly if the threshold is met. Staff re-education shall occur prior to 07/20/2016. The DCS will</p>		07/20/2016

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	<p>05/20/16, with orders for physical and occupational therapy one to three times a week for nine weeks. Physical and Occupational therapy were to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of a physical therapy evaluation dated 03/23/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 03/22, 03/25, 03/28, 04/01, 04/04, 04/06, 04/11, 04/13, 04/18, 04/22, 04/25, 05/02, 05/09, 05/11, and 05/16/16, without a physician's approval for the plan of treatment.</p>		<p>be responsible for ensuring ongoing compliance with G186. The agency ensures compliance with receipt of physician orders.</p>	

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	<p>2. Clinical record number 4, SOC 04/19/15, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for physical therapy one to three times a week. Physical therapy was to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of a physical therapy evaluation dated 04/20/16, the physical therapist indicated on the evaluation, that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals. The plan of care failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/20, 04/22, 04/25, 05/11, 05/16, 05/20, 05/23, 05/25, 05/30, 06/01, 06/06, 06/08, 06/15, and 06/20/16, without a physician's approval for the plan of treatment.</p>			

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	<p>3. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for speech therapy one to three times a week for eight weeks. Speech therapy was to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of the speech therapy evaluation and plan of treatment dated 05/11/16, the speech therapist indicated that visits would be two times a week for eight weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record indicated the plan of treatment was sent to the physician on 06/01/16. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been returned and signed by the physician.</p> <p>3. Review of the speech therapy visit notes, speech therapy had provided</p>			

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	<p>services on 05/11, 05/12, 05/18, 05/19, 05/23, 05/26, 06/01, 06/02, 06/08, 06/09, 06/13, 06/16 and 06/20/16, without a physician's approval for the plan of treatment.</p> <p>4. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for physical therapy one to three times a week for nine weeks.</p> <p>A. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, both forms failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>B. The plan of treatment was signed by the physician on 05/24/16 and received by the agency on 05/25/16. The physical therapist provided services on 04/29, 05/02, 05/04, 05/11, 05/13, 05/18, and 05/23/16, without a physicians order.</p> <p>5. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for physical therapy one to three times a week for eight weeks.</p> <p>A. Review of a physical therapy</p>			

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	<p>evaluation dated 04/07/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician immediately after the evaluation. The fax was sent to the physician on 04/27/16 and returned signed by the physician on 04/28/16.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/07, 04/14, 04/19, 04/21, and 04/26/16, without a physician's approval for the plan of treatment.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM. The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p>			

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G 0188 Bldg. 00	<p>484.32 THERAPY SERVICES</p> <p>The qualified therapist advises and consults with the family and other agency personnel. Based on record review and interview, the Physical, Occupational and Speech therapist failed to ensure to coordinate with other therapists and case managers and document their efforts in 5 of 8 records reviewed of patients with multiple disciplines providing services in a sample of 12. (# 3, 4, 5, 6, and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing, home health aide, physical and occupational therapy.</p> <p>A. Review of the physical therapy evaluation dated 03/23/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide and the occupational therapist.</p> <p>B. Review of the occupational therapy evaluation dated 03/25/16, the assessment failed to evidence that care</p>	G 0188	The DCS shall assume responsibility for therapy staff re-education on care coordination efforts both with other agency team members and the prescribing physician. The DCS shall review all therapy documentation daily for 3 consecutive months with a 100% threshold for compliance. This study shall be extended if the threshold is not met. The therapy education session shall occur prior to 7/20/2016. The DCS will be responsible for ensuring ongoing compliance with G188.	07/20/2016

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	<p>coordination had been provided with the skilled nurse, home health aide, and the physical therapist.</p> <p>C. Review of the physical therapy visit notes, a missed visit form dated 04/27/16, indicated the patient declined a visit due to having an increase in pain and wanted to rest his / her hip. The note also indicated the patient declined a visit for 04/29/16, and physical therapy would see the patient on the next scheduled visit on 05/02/16. The note indicated the physician's office was not notified. The physical therapist failed to notify and coordinate with the skilled nurse in regards to the patients missed visit due to pain.</p> <p>2. Clinical record number 4, SOC 04/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of a physical therapy evaluation note dated 04/20/16, the note indicated a recommendation for occupational therapy to assess the patient. The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide and the occupational therapist.</p>			

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	<p>B. Review of a occupational therapy evaluation note dated 05/06/16, the visit failed to evidence care coordination with the skilled nurse, home health aide, and physical therapist.</p> <p>C. Review of a physical therapy visit note dated 05/23/16, the physical therapist indicated that the patient was newly diagnosed with Parkinson's disease and was started on a new medication. The visit note failed to evidence that the skilled nurse, home health aide, and the occupational therapist had been informed of the patient's new diagnosis and medication.</p> <p>3. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing, home health aide, physical, occupational, and speech therapy.</p> <p>A. Review of the physical therapy evaluation dated 05/05/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide, speech and occupational therapist.</p> <p>B. Review of the occupational therapy evaluation dated 05/05/16, the assessment failed to evidence that care</p>			

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	<p>coordination had been provided with the skilled nurse, home health aide, physical and speech therapist.</p> <p>C. Review of the speech therapy evaluation dated 05/11/16, the assessment failed to evidence that care coordination had been provided with the physician, the skilled nurse, home health aide, physical and occupational therapist.</p> <p>4. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, indicated the physical therapist had a recommendation for speech therapy to assess the patient. The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide, and speech therapy.</p> <p>5. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech therapy.</p>			

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	<p>A. Review of the physical therapy evaluation and plan of treatment dated 04/07/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, occupational, and speech therapist.</p> <p>B. Review of the occupational therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and speech therapy.</p> <p>C. Review of the speech therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and occupational therapy.</p> <p>6. Employee A, a Registered Nurse, was interviewed on 06/21/16 at 2:30 PM. Employee A indicated he / she did not notify the physician upon the start of care and did not always converse with therapy after the start of care, and therapy did not converse with him / her after their evaluation.</p> <p>7. A policy titled "Staff Communication Process" dated 10/2004, indicated " ... The Agency is committed to ensuring that all communication regarding patient</p>			

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G 0235 Bldg. 00	<p>care and concerns is accurate, efficient and prompt ... The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care ... All communication with other staff, patient, patient representative and professional and public community is documented in the patient's clinical record."</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on record review and interview, the agency failed to ensure that care was coordinated with the physician, verbal orders obtained, and written orders faxed to the physician in a timely manner in 5 of 10 active records reviewed in a sample of 12.</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48: Clinical Records.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.</p>	G 0235	<p>Our DCS shall be responsible for staff re-education of this compilation of deficiencies elevating to a Condition Level offense. Therapy staff shall be required to demonstrate corrective behaviors related to the therapy plans of care, missed visits, timely orders for care and services, and care coordination techniques. The DCS shall review all documentation daily to assure re-education strategies are effective. The daily review has a threshold of 100% for compliance. Should corrective performances occur, the review shall move to quarterly. Staff failing to adhere to the new expectations shall be subjected to progressive discipline up to and including termination. The DCS will be responsible for ensuring ongoing</p>	07/20/2016

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G 0236 Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on record review and interview, the agency failed to ensure that care was coordinated with the physician, verbal orders obtained, and written orders faxed to the physician in a timely manner in 5 of 10 active records reviewed in a sample of 12. (#2, 3, 4, 6, and 8)</p> <p>1. Clinical record number 2, SOC (start of care) 2/17/16, included a written plan of care for the certification period of 2/17/16 to 4/16/16, with orders for skilled nursing to provide wound care.</p> <p>A. The treatment orders on the plan of care instructed to cleanse the right 2nd toe and left 3rd toe with wound cleanser, apply calcium alginate AG, cover with gauze and secure with tape and to cleanse the left 2nd toe with wound cleanser and apply polymem with adhesive border.</p>	G 0236	<p>compliance with G235.</p> <p>The DCS shall be responsible to re-educate all staff on the expectation of care coordination with the physician and the need to obtain medical orders for all clinical care rendered. Daily documentation reviews shall provide a glimpse into the performance improvement initiatives spearheaded by the DCS. This review shall have a 100% threshold for compliance. Staff failing to follow the expected behaviors shall be subjected to progressive discipline up to and including termination. The DCS will be responsible for ensuring ongoing compliance with G236. Agency ensures compliance with receipt of clinical documents,</p>	07/20/2016
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	<p>1. Review of a physician's order dated 02/16/16, was faxed to the agency on 02/16/16. The order indicated to cleanse the left lateral 3rd toe and right distal 2nd toe with normal saline or wound cleanser, apply silver alginate to both wounds. Cover right 2nd toe wound with 2 x 2 gauze.</p> <p>2. Review of the OASIS start of care comprehensive assessment dated 02/17/16, failed to evidence coordination with the physician.</p> <p>3. Review of section 23 of the plan of care, (Nurse's signature and date of verbal start of care), the plan of care failed to evidence a verbal start of care date. The clinical record failed to evidence clear and accurate treatment orders for patient #2 wounds.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a plan of care established by the physician for the certification period of 03/22/16 to 05/20/16, with orders for physical and occupational therapy 1 - 3 times a week for 9 weeks, evaluate and submit a plan of treatment.</p> <p>A. Review of a physical therapy evaluation dated 03/23/16, the physical</p>		physician orders and care coordination.	

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	<p>therapist indicated that visits would be 2 times a week for 9 weeks. The evaluation provided the treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician for signature.</p> <p>B. Review of the occupational therapy evaluation dated 03/25/16, the occupational therapist indicated that visits would be 1 to 3 times per week for 9 weeks and that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>1. Review of the electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician for signature.</p> <p>3. Clinical record number 4, SOC 04/19/15, included a plan of care established by the physician for the certification period of 04/19/16 to</p>			

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	<p>06/17/16.</p> <p>A. Review of an Occupational therapy evaluation and plan of treatment dated 05/06/16, the occupational therapist indicated that visits would be 1 to 3 times per week for 9 weeks and that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>1. Review of the electrical medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician for signature.</p> <p>4. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing one time a month for 3 months and physical therapy one to three times a week for nine weeks.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The plan of care was signed by</p>			

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	<p>the physician on 05/31/16 and received by the agency on 06/01/16.</p> <p>2. Review of the electronic medication record, the plan of treatment dated 04/29/16, was sent to the physician on 05/24/16. The plan of treatment was signed by the physician on 05/24/16 and received by the agency on 05/25/16. The agency failed to ensure verbal orders were obtained and the written orders were faxed to the physician for signature in a timely manner.</p> <p>5. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for physical, occupational, and speech therapy one to three times a week for eight weeks.</p> <p>A. Review of a physician order dated 04/05/16, the order indicated for speech therapy to evaluate and treat as indicated. Review of the speech therapy visit notes, the speech evaluation was not completed until 04/12/16, and recommended speech therapy visits one time a week for nine weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs. The speech therapist failed to evaluate the patient within a timely manner.</p>			

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	<p>B. Review of occupational therapy notes, the occupational therapy evaluation was not completed until 04/12/16. The plan of care was developed prior to the occupational therapy evaluation and failed to be specific to the patient needs. The occupational therapist failed to evaluate the patient within a timely manner.</p> <p>C. Review of a physical therapy evaluation dated 04/07/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician immediately after the evaluation. The fax was sent to the physician on 04/27/16 and returned signed by the physician on 04/28/16.</p> <p>3. Review of the physical therapy</p>			

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G 0250 Bldg. 00	<p>visit notes, physical therapy had provided services on 04/07, 04/14, 04/19, 04/21, and 04/26/16, without a physician's approval for the plan of treatment.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>Based on record review and interview, the agency failed to ensure samples of both active and inactive clinical records were reviewed to determine if appropriate care had been provided, ensure plan of care / physician orders were being followed, ensure coordination of care was being maintained between staff involved with patient care, ensure orders were being faxed to the physician within a timely manner, ensure physicians were notified at the start of care for continuing orders of all disciplines and informed of</p>	G 0250	The DCS sits on the agency QA/PI Committee. Since this recent 2016 survey report, the DCS scheduled a QA/PI Committee meeting on 07/14/2016 to review clinical records with a focus on certain survey findings inclusive of wound care protocol, vital sign documentation, coordination of care, obtaining physician orders for care and services, medication reconciliation, and 60 day summaries. This list of record review initiatives is not all inclusive and ongoing reviews include additional criteria.	07/20/2016

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	<p>adverse drug to drug interactions, which had the potential to affect all 135 patients of the agency..</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QAPI (Quality Assessment Performance Improvement) binder was provided on 06/16/16, and reviewed on 06/22/16. The last QAPI meeting was held on May 25, 2016, and topics included Administration / Management, Infection Control, Incidents / Accidents, Reports of Concerns / Grievances and Miscellaneous Concerns. 2. The QAPI meeting / minutes failed to identify the following: <ol style="list-style-type: none"> A. All wounds being identified during nursing visits / treatment and wound identification being inconsistent. B. All clinicians providing services communicated and participated in the comprehensive assessment and in the development of the plan of care. C. All orders was submitted to the physician in a timely manner. D. Attending physicians was notified after the initial assessment and verbal start of care orders was obtained and 		<p>Results of this record review was incorporated within our agency QA/PI Plan and the results shared with our PAC and GB membership. Weekly record review will be analyzed and deficiency shared with staff. Improvement or deficiency will be reported to quality board. Administrator and governing body will review the clinical record sample before each quarterly meeting to ensure compliance with G250. Administrator will be responsible for continued compliance with G250 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>documented.</p> <p>E. Adverse drug to drug interactions was completed and the physician notified of major interactions with in five days of the comprehensive assessment.</p> <p>F. Complete assessments being performed, including temperatures, diet, blood sugars, and skin for patients with wounds.</p> <p>G. 60 Day Summaries to be sent to the attending physician.</p> <p>2. The Director of Nursing was interviewed on 06/22/16 at 1:00 PM. The Director of Clinical Services indicated she was aware of some of the issues and had indicated some OBQI scores had poor outcomes.</p> <p>3. A document titled "Best Choice Home Care Outcome Based Quality Improvement Process" dated 2004, indicated "The Conditions of Participation for Medicare certified home health agencies require an overall evaluation of the agency's total program at least annually and clinical record review quarterly. Patient care services are identified as one component of the agency's total program, and will be addressed in this plan "</p>			

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G 0251 Bldg. 00	484.52(b) CLINICAL RECORD REVIEW There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.	G 0251	no citation present	07/20/2016
G 0322 Bldg. 00	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the agency failed to ensure encoded OASIS data accurately reflected the patient's status at the time of the assessment for 6 of 10 active records reviewed in a sample of 12. (#1, 2, 3, 4, 5, and 6) Findings include: 1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16. A. Review of the OASIS start of care comprehensive assessment dated 05/30/16, question M2000, the question asked if a complete drug regimen review indicate potential clinically significant	G 0322	The DCS met with all professional staff to reinforce the teachings on the Comprehensive Assessment and completion of the OASIS Data-Set. A focus was stressed that related to medication review/reconciliation, OASIS accuracy completion, inconsistent OASIS responses, full health system checks, and accuracy of responses. This meeting took place on 07/19/2016. Effective the same date, the DCS initiated weekly review of admission/readmission assessments to determine if the teachings were effective. In addition to weekly record review Oasis scrubber-on-software has been increased to improve consistency with Oasis data. Weekly record review of Oasis has an additional focus on medication profile, drug regimen review, pressure	07/20/2016

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	<p>medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug interactions dated 6/16/16, the form indicated a major drug interaction between the following: bupropion and venlafaxine, bupropion and acetaminophen - oxycodone, spironolactone and losartan, and bupropion and dayquil.</p> <p>B. Review of OASIS question M2250d, the question asked if depression intervention(s) such as medication, referral for other treatment, or a monitoring plan of current treatment and / or physician notified that patient screened positive for depression. The answer indicated "NA - Patient has no diagnosis of depression and depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.</p> <p>1. Review of the assisted living facesheet that was faxed to the agency on 5/27/16, the facesheet indicated the patient had a diagnosis of depression.</p> <p>2. Review of the medication profile indicated the patient was taking</p>		<p>ulcer assessment,pain assessment, respiratory status, cognitive status, complete Oasis documentation and consistent documentation across disciplines.Nursing received re-education on Oasis documentation. Therapy staff received re-education on OASIS information pertinent to each discipline to ensure communication at the time of evaluation is pertinent to the completion of the Oasis data set. A threshold of 100% compliance for 3 months then move to quarterly. Staff failing to adhere to the new expectations of OASIS documentation improvement shall be subjected to progressive discipline up to and including termination. Administrator will be responsible for continued compliance with G322 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>bupropion and venlafaxine for depression.</p> <p>C. Review of OASIS question M2250f, the question asked if interventions to prevent pressure ulcers. The answer indicated "NA - Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers."</p> <p>1. Review of the Braden Skin Assess, the patient scored a 17 which indicated the patient was at risk for pressure ulcers. Review of OASIS question M1302, the question asked if the patient was at risk for developing pressure ulcers. The answer indicated "yes".</p> <p>The encoded OASIS data accurately reflected the patient's status at the time of the assessment.</p> <p>2. Clinical record number 2, SOC 2/17/16, included a written plan of care established by a physician for the certification period of 2/17/16 to 4/16/16. The patient has a diagnosis of pressure ulcers, type 2 diabetes, and peripheral vascular disease.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated</p>			

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	<p>02/17/16, The Braden scale (skin assessment) indicated the patient scored a 19, which indicated the patient was not at risk for pressure ulcers.</p> <p>1. Question M1302 asked if the patient was at risk for developing pressure ulcers. The answer indicated "no".</p> <p>2. Question M2250f asked if intervention(s) to prevent pressure ulcers were included on the plan of care. The answer indicated "yes".</p> <p>3. Question M2250g asked if intervention(s) for pressure ulcer treatment based on principles of moist wound healing or order for treatment based on moist wound healing has been requested from a physician. The answer indicated "NA - Patient has no pressure ulcers or has no pressure ulcers for which moist wound healing is indicated".</p> <p>The encoded OASIS data accurately reflected the patient's status at the time of the assessment.</p> <p>3. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16.</p>			

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	<p>A. Review of the OASIS start of care comprehensive assessment dated 03/22/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found".</p> <p>1. Review of the Drug - Drug interactions dated 04/07/16, the form indicated a major drug interaction between ondansetron and tramadol.</p> <p>The encoded OASIS data accurately reflected the patient's status at the time of the assessment.</p> <p>4. Clinical record number 4, SOC 4/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/19/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug interactions dated 05/04/16, the form indicated a major drug interaction between bupropion and sertraline.</p>			

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	<p>The encoded OASIS data accurately reflected the patient's status at the time of the assessment.</p> <p>5. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16.</p> <p>A. Review of the face to face encounter with the attending physician on 04/21/16, the form indicated the patient had dyspnea on exertion, pain on ambulation, unsteady / unsafe gait requiring an assistance of a device or person, needs physical assistance to leave the home, and poor endurance.</p> <p>B. Review of the OASIS start of care comprehensive assessment dated 05/04/16, indicated the following:</p> <p>1. M1242 questioned if the frequency of pain interfering with patient's activity or movement. The answer provided indicated "0 - Patient has no pain."</p> <p>a. Review of the pain assessment, the registered nurse indicated the patient had denied pain during the visit.</p>			

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	<p>b. Review of the physical therapy evaluation dated 05/05/16, the note indicated the patient had a pain level of 3 (on a scale from one to ten with ten being the worst pain) to the left hip and groin area that would increase with mobility and decrease with rest.</p> <p>c. Review of the medication profile, the patient has acetaminophen and norco listed as pain medication.</p> <p>2. M1400 asked when was the patient dyspneic or noticeably short of breath. The answer provided was "0 - Patient is not short of breath."</p> <p>3. M1700 asked if the patient's current level of alertness / orientation / comprehension / concentration / immediate memory for simple commands. The answer provided indicated "0 - Alert / oriented, able to focus and shift attention, comprehends and recalls task directions independently."</p> <p>a. The plan of care indicated one of the secondary diagnosis was Cognitive Communication Deficit (results from impaired functioning of one or more cognitive processes, including the following: Attention and Memory.) The fall risk assessment failed to indicate</p>			

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	<p>that the patient had a cognitive impairment.</p> <p>b. Review of the patient's mental status, the registered nurse indicated the patient was oriented but forgetful.</p> <p>4. M1820 asked if the patient current ability to dress the lower body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes. The answer provided indicated "2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes."</p> <p>5. M1840 asked if the patient's current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode. The answer provided "1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer."</p> <p>6. M1845 asked if the patient's currently ability to maintain perineal hygiene safely, adjust clothes and / or incontinence pads before and after using toilet, commode, bedpan, urinal. The answer provided "1 - Able to manage toileting hygiene and clothing management without assistance if</p>			

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	<p>supplies / implements are laid out for the patient."</p> <p>7. M1850 asked if the patient's current ability to move safely from bed to chair, or ability to run and position self in bed if patient is bedfast. The answer provided indicated "1 - Able to transfer with minimal human assistance or with use of an assistive device."</p> <p>a. Review of the physical therapy evaluation dated 05/05/16, the note indicated the patient needed moderate assistance with rolling right to left and left to right, max assistance with sit to stand, moderate assistance with lying to sitting, and moderate assistance with all transfers, including bed to chair, chair to bed, chair to wheel chair, wheel chair to toilet / bedside commode.</p> <p>b. Review of the occupational therapy evaluation dated 05/05/16, the note indicated the patient need moderate assistance with bed mobility, max assistance with bed / wheelchair transfers and toilet transfers, minimal assistance with grooming, max assistance with toileting and lower body dressing, and moderate assistance with upper body bathing, lower body bathing, and upper body dressing. The occupational therapist failed to obtain a pain</p>			

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	<p>assessment.</p> <p>8. M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found".</p> <p>a. Review of the Drug - Drug interactions printout, the form indicated a major drug interaction between warfarin (blood thinner) and aspirin. The complete drug regimen review was completed on 05/31/16, and the physician was notified by fax at that time.</p> <p>The encoded OASIS data accurately reflected the patient's status at the time of the assessment.</p> <p>6. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/27/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug</p>			

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G 0334 Bldg. 00	<p>interactions dated 05/23/16, the form indicated a major drug interaction between trazodone (antidepressant and sedative) and sertraline (treatment for depression, obsessive - compulsive disorder, posttraumatic stress disorder, and social anxiety and panic disorder).</p> <p>2. The Drug - Drug interactions indicated a major drug interactions between sertraline and dextromethorphan - guaifenesin (expectorant and cough suppressant).</p> <p>The encoded OASIS data accurately reflected the patient's status at the time of the assessment.</p> <p>7. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</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, the agency failed to ensure the</p>	G 0334	The DCS included in the professional staff teaching session on 07/19/2016, the need	07/20/2016

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	<p>comprehensive assessment was completed but no later than 5 calendar days after the start of care and failed to ensure the comprehensive assessment accurately reflected the patient's status at the time of the assessment for 6 of 10 active records reviewed in a sample of 12. (#1, 2, 3, 4, 5, 6)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/30/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found".</p> <p>1. Review of the Drug - Drug interactions printout dated 6/16/16, the form indicated a major drug interaction between the following: bupropion and venlafaxine, bupropion and acetaminophen - oxycodone, spironolactone and losartan, and bupropion and dayquil. The complete drug regimen review was completed on 06/16/16, and the physician was notified</p>				<p>for the clinician to improve review and documentation for evaluation of vision status, ulcers (present or potential risk), blood sugar ranges to establish a baseline for diabetic patients, pain parameters with medication usage for same, mental status, and ADL and IADL specifics upon each admission. Nursing received re-education on Oasis documentation on 07/19/2016. Therapy staff received re-education on OASIS information involving each discipline to ensure communication at evaluation is pertinent to the completion of the Oasis data set. Weekly review of submitted OASIS data shall be reviewed by the DCS or designee with a 100% threshold for adherence to this expected documentation standard. In addition to weekly record review Oasis scrubber-on-software has been increased to improve consistency with Oasis data. Weekly record review of Oasis data now has a focus on medication profile, drug regimen review, pressure ulcer assessment, pain assessment, respiratory status, cognitive status, vision, complete Oasis documentation and consistent documentation across disciplines. Medication interactions will be completed within the 5 day window allowance with</p>		

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	<p>by fax at that time. The registered nurse failed to review the drug to drug interactions and notify the physician during the 5 day assessment period</p> <p>2. Clinical record number 2, SOC 02/17/16, included a written plan of care established by a physician for the certification period of 02/17/16 to 04/16/16. The patient has a diagnosis of pressure ulcers, type 2 diabetes, and peripheral vascular disease.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 02/17/16, M1200 indicated the patient's vision was partially impaired, cannot see medication labels or newsprint, but can see obstacles in path / surrounding layout; can count fingers at arm's length.</p> <p>1. Review of the sensory assessment, the registered nurse indicated the patient worn glasses's but failed to include a reason for the impairment of vision, such as glaucoma, cataracts, macular degeneration, or other reasons not indicated.</p> <p>2. The Fall Assessment section provided an option for visual impairment as a risk for falls. The visual impairment box failed to be checked off to be included as a risk for falls.</p>		<p>physician notification of any medication related issues. Administrator will be responsible for weekly monitoring of drug regimen review and notification to the physician. A threshold of 100% will be achieved for 3 months then move to quarterly. Staff informed they must adhere to improvement in documentation or be subjected to progressive discipline up to and including termination. Administrator will be responsible for continued compliance with G334 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>B. The Braden scale (skin assessment) indicated the patient scored a 19, which indicated the patient was not at risk for pressure ulcers.</p> <p>1. Question M1302 asked if the patient was at risk for developing pressure ulcers, and the answer indicated "no".</p> <p>2. Question M2250f asked if intervention(s) to prevent pressure ulcers were included on the plan of care, and the answer indicated "yes".</p> <p>3. Question M2250g asked if intervention(s) for pressure ulcer treatment based on principles of moist wound healing or order for treatment based on moist wound healing has been requested from a physician. The answer indicated "NA - Patient has no pressure ulcers or has no pressure ulcers for which moist wound healing is indicated." The patient's primary diagnosis on the plan of care indicated pressure ulcers and the plan of care included treatment orders". The skin assessments were inconsistent and failed to be accurate with the patient's present findings.</p> <p>C. The Endocrine section indicated the patient was a diabetic, on oral</p>			

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	<p>hypoglycemic, and was independent with glucometer use. The assessment failed to include a range / measurement of the patient's routine blood sugars and the frequency of how often the patient checks his / her blood sugars.</p> <p>3. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 03/22/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found".</p> <p>1. Review of the Drug - Drug interactions printout dated 04/07/16, the form indicated a major drug interaction between ondansetron and tramadol. The physician was notified by fax at that time. The registered nurse failed to review the drug to drug interactions and notify the physician during the 5 day assessment period</p> <p>4. Clinical record number 4, SOC 04/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16.</p>			

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	<p>A. Review of the OASIS start of care comprehensive assessment dated 04/19/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found".</p> <p>1. Review of the Drug - Drug interactions printout dated 05/04/16, the form indicated a major drug interaction between bupropion and sertraline. The physician was notified by fax at that time. The registered nurse failed to review the drug to drug interactions and notify the physician during the 5 day assessment period</p> <p>5. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16.</p> <p>A. Review of the face to face encounter with the attending physician on 04/21/16, the form indicated the patient had dyspnea on exertion, pain on ambulation, unsteady / unsafe gait requiring an assistance of a device or person, needs physical assistance to leave the home, and poor endurance.</p> <p>B. Review of the OASIS start of</p>			

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	<p>care comprehensive assessment dated 05/04/16, indicated the following:</p> <ol style="list-style-type: none"> 1. Review of the vital signs on the comprehensive assessment, the registered nurse failed to obtain and / or include a temperature at the start of care. 2. M1242 questioned if the frequency of pain interfering with patient's activity or movement. The answer provided indicated "0 - Patient has no pain." <ol style="list-style-type: none"> a. Review of the pain assessment, the registered nurse indicated the patient had denied pain during the visit. b. Review of the physical therapy evaluation dated 05/05/16, the note indicated the patient had a pain level of 3 (on a scale from one to ten with ten being the worst pain) to the left hip and groin area that would increase with mobility and decrease with rest. c. Review of the medication profile, the patient has acetaminophen and norco listed as pain medication. 3. M1400 asked when was the patient dyspneic or noticeably short of breath. The answer provided was "0 - 			

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	<p>Patient is not short of breath."</p> <p>4. Review of the Nutritional assessment and the diet requirements, the registered nurse failed to evidence an assessment of the patient's diet at the start of care.</p> <p>5. Review of the Genitourinary assessment, the registered nurse indicated the patient was incontinent of urine. The fall risk assessment failed to indicate that the patient was incontinent.</p> <p>6. M1700 asked if the patient's current level of alertness / orientation / comprehension / concentration / immediate memory for simple commands. The answer provided indicated "0 - Alert / oriented, able to focus and shift attention, comprehends and recalls task directions independently."</p> <p>a. The plan of care indicated one of the secondary diagnosis was Cognitive Communication Deficit (results from impaired functioning of one or more cognitive processes, including the following: Attention and Memory.) The fall risk assessment failed to indicate that the patient had a cognitive impairment.</p>			

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	<p>b. Review of the patient's mental status, the registered nurse indicated the patient was oriented but forgetful.</p> <p>7. Review of the Safety / Sanitation Hazards, the registered nurse indicated there were no hazards identified.</p> <p>a. Review of the physical therapy evaluation dated 05/05/16, the note indicated the patient's safety awareness was poor and indicated the patient had approximately 16 stair steps from the ground floor to the upstairs bedroom.</p> <p>b. During a home visit on 06/21/16, the patient was observed to be living in a 2 story home and the patient was observed to be in his / her bedroom, which was located upstairs. The registered nurse failed to select stairs as a safety hazard.</p> <p>8. M1820 asked if the patient current ability to dress the lower body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes. The answer provided indicated "2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes."</p>			

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	<p>9. M1840 asked if the patient's current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode. The answer provided "1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer."</p> <p>10. M1845 asked if the patient's currently ability to maintain perineal hygiene safely, adjust clothes and / or incontinence pads before and after using toilet, commode, bedpan, urinal. The answer provided "1 - Able to manage toileting hygiene and clothing management without assistance if supplies / implements are laid out for the patient."</p> <p>11. M1850 asked if the patient's current ability to move safely from bed to chair, or ability to run and position self in bed if patient is bedfast. The answer provided indicated "1 - Able to transfer with minimal human assistance or with use of an assistive device."</p> <p>a. Review of the physical therapy evaluation dated 05/05/16, the note indicated the patient needed moderate assistance with rolling right to left and left to right, max assistance with</p>			

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	<p>sit to stand, moderate assistance with lying to sitting, and moderate assistance with all transfers, including bed to chair, chair to bed, chair to wheel chair, wheel chair to toilet / bedside commode.</p> <p>b. Review of the occupational therapy evaluation dated 05/05/16, the note indicated the patient need moderate assistance with bed mobility, max assistance with bed / wheelchair transfers and toilet transfers, minimal assistance with grooming, max assistance with toileting and lower body dressing, and moderate assistance with upper body bathing, lower body bathing, and upper body dressing. The occupational therapist failed to obtain a pain assessment.</p> <p>12. M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found".</p> <p>a. Review of the Drug - Drug interactions printout dated 05/31/16, the form indicated a major drug interaction between warfarin (blood thinner) and aspirin. The physician was notified by fax at that time.</p> <p>The registered nurse failed to review the</p>			

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	<p>drug to drug interactions and notify the physician during the 5 day assessment period and failed to coordinate with physical therapy, and occupational therapy in regards to their assessment findings and failed to ensure the comprehensive assessment accurately reflected the patient's status at the time of the assessment.</p> <p>6. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/27/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug interactions print out dated 05/23/16, the form indicated a major drug interaction between trazodone (antidepressant and sedative) and sertraline (treatment for depression, obsessive - compulsive disorder, posttraumatic stress disorder, and social anxiety and panic disorder) and a major drug interactions between sertraline and dextromethorphan - guaifenesin (expectorant and cough</p>			

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G 0337 Bldg. 00	<p>suppressant). The physician was notified by fax at that time. The registered nurse failed to review the drug to drug interactions and notify the physician during the 5 day assessment period</p> <p>7. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</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 evidence that all medications had been reviewed and failed to identify any potential adverse effects, drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy in 5 of 10 active records reviewed in a sample of 12. (#1, 3, 4, 5, and 6)</p> <p>Findings include:</p>	G 0337	Agency director of clinical services in-serviced all nursing staff on medication review policy/standard on 07/19/2016. This re-education included the need for a comprehensive review of medications for the potential for adverse effects, medication interactions inclusive of ineffective medication therapy, significant side effects, significant medication interactions, duplicate medication therapy and patient non-compliance. Medication interaction reviews will be completed within the 5 day	07/20/2016

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	<p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/30/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug interactions dated 6/16/16, the form indicated a major drug interaction between bupropion and venlafaxine and between bupropion and acetaminophen - oxycodone. The description indicated bupropion (wellbutrin - antidepressant) was associated with a dose - related risk of seizures and that the risk may be further increased when coadministered with selective serotonin reuptake inhibitors (venlafaxine - antidepressant and nerve pain medication) and opioids (acetaminophen / oxycodone - narcotic pain medication).</p> <p>2. The Drug - Drug interactions indicated a major drug interactions between spironolactone and losartan, indicating an increase risk of</p>		<p>window allowance for completion of the comprehensive assessment with physician notification of any medication related issues. Our Administrator will be responsible for weekly monitoring of drug regimen review at start of care and every comprehensive assessment/Oasis notification to the prescribing physician of any medication related issues. A threshold of 100% compliance is set. Complete record reviews will be performed on the last Friday of each month to ensure compliance with this standard. Included in this expectation is for the medication profile to reflect accurate and current medication information. Oasis data set comprehensive assessments shall be reviewed by the DCS or designee for 3 consecutive months until 100% compliance is maintained. Once compliance is maintained, quarterly record reviews will be performed to ensure ongoing compliance. Administrator will be responsible for continued compliance with G337 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>hyperkalemia (abnormal high potassium). Symptoms include, but not limited to, nausea, vomiting, weakness, confusion, tingling of the hands and feet, feelings of heaviness in the legs, a weak pulse, or a slow or irregular heartbeat.</p> <p>3. The Drug - Drug interactions indicated a major drug interaction between wellbutrin and dayquil. The description indicated the combination may potentiate the risk of serotonin syndrome, which is a rare but serious and potentially fatal condition thought to result from hyperstimulation of brainstem and receptors. Symptoms include, but not limited to, mental status changes such as irritability, altered consciousness, confusion, hallucination, coma, tachycardia, hyperthermia, diaphoresis, shivering, blood pressure lability, hyperreflexia, tremor, rigidity, ataxia, abdominal cramping, nausea, vomiting, and diarrhea.</p> <p>The comprehensive assessment failed to evidence that all medications had been reviewed and failed to identify any potential adverse effects, drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p>			

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	<p>2. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 03/22/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found".</p> <p>1. The Drug - Drug interactions indicated a major drug interaction between ondansetron (anti-nausea medication) and tramadol (narcotic pain medication). The description indicated the combination may potentiate the risk of serotonin syndrome, which is a rare but serious and potentially fatal condition thought to result from hyperstimulation of brainstem and receptors. Symptoms include, but not limited to, mental status changes such as irritability, altered consciousness, confusion, hallucination, coma, tachycardia, hyperthermia, diaphoresis, shivering, blood pressure lability, hyperreflexia, tremor, rigidity, ataxia, abdominal cramping, nausea, vomiting, and diarrhea.</p> <p>The comprehensive assessment failed to evidence that all medications had been</p>			

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	<p>reviewed and failed to identify any potential adverse effects, drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>3. Clinical record number 4, SOC 4/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/19/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug interactions dated 06/21/16, the form indicated a major drug interaction between bupropion (anti-depressant) and sertraline (treatment for depression, obsessive - compulsive disorder, posttraumatic stress disorder, and social anxiety and panic disorder). The description indicated the combination may potentiate the risk of serotonin syndrome, which is a rare but serious and potentially fatal condition thought to result from hyperstimulation of brainstem and receptors. Symptoms include, but</p>			

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	<p>not limited to, mental status changes such as irritability, altered consciousness, confusion, hallucination, coma, tachycardia, hyperthermia, diaphoresis, shivering, blood pressure lability, hyperreflexia, tremor, rigidity, ataxia, abdominal cramping, nausea, vomiting, and diarrhea.</p> <p>The comprehensive assessment failed to evidence that all medications had been reviewed and failed to identify any potential adverse effects, drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>4. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16.</p> <p>A. Review of the skilled nursing visit note dated 05/09/16, the skilled nurse indicated "I made the changes with the metoprolol in med box."</p> <p>1. Review of the medication profile, a new entry dated 05/09/16, indicated the patient had a new order for metoprolol 50 mg to be taken by mouth twice a day. The electronic medical record and the patient's paper clinical</p>			

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	<p>record failed to evidence if the previous dosage of 100 milligrams had been discontinued or if the 50 milligrams was in addition to the 100 milligram dosage.</p> <p>B. Review of a physician's order dated 05/09/16, the order indicated the patient's to hold the coumadin for 2 days, then "restart the coumadin on Wednesday with the following dosing. 2.5 milligrams on Sunday, Tuesday, Thursday and 5 milligrams on all other days."</p> <p>1. Review of the medication profile, the coumadin read 5 milligrams on Sunday, Tuesday, Wednesday, Friday, and Saturday with 2.5 milligrams on Monday and Thursday. The medication failed to be updated with the new coumadin dosage.</p> <p>C. Review of the OASIS start of care comprehensive assessment dated 05/04/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug interactions dated 05/31/16, the form indicated a major drug interaction between warfarin and aspirin. The</p>			

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	<p>description indicated small doses of aspirin may increase the risk of bleeding inpatients on oral anticoagulants by inhibiting platelet aggregation, prolonging bleeding time, and inducing gastrointestinal lesions.</p> <p>The comprehensive assessment failed to evidence that all medications had been reviewed and failed to identify any potential adverse effects, drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/27/16, question M2000 asked if a complete drug regimen review indicate potential clinically significant medications issues. The answer indicated "No problems found."</p> <p>1. Review of the Drug - Drug interactions dated 05/23/16, the form indicated a major drug interaction between trazodone (antidepressant and sedative) and sertraline (treatment for</p>			

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	<p>depression, obsessive - compulsive disorder, posttraumatic stress disorder, and social anxiety and panic disorder). The description indicated the combination may potentiate the risk of serotonin syndrome, which is a rare but serious and potentially fatal condition thought to result from hyperstimulation of brainstem and receptors. Symptoms include, but not limited to, mental status changes such as irritability, altered consciousness, confusion, hallucination, coma, tachycardia, hyperthermia, diaphoresis, shivering, blood pressure lability, hyperreflexia, tremor, rigidity, ataxia, abdominal cramping, nausea, vomiting, and diarrhea.</p> <p>2. The Drug - Drug interactions indicated a major drug interactions between sertraline and dextromethorphan - guaifenesin (expectorant and cough suppressant). The description indicated the combination may potentiate the risk of serotonin syndrome, which is a rare but serious and potentially fatal condition thought to result from hyperstimulation of brainstem and receptors. Symptoms include, but not limited to, mental status changes such as irritability, altered consciousness, confusion, hallucination, coma, tachycardia, hyperthermia, diaphoresis, shivering, blood pressure lability, hyperreflexia, tremor, rigidity,</p>			

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	<p>ataxia, abdominal cramping, nausea, vomiting, and diarrhea.</p> <p>The comprehensive assessment failed to evidence that all medications had been reviewed and failed to identify any potential adverse effects, drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>6. The Director of Clinical Services was interviewed on 06/20/16 at 2:40 PM. The Director of Clinical Services indicated that nursing judgement was used at the time of the assessment and was aware that the Drug to Drug Interactions were printed out and faxed to the physician late.</p> <p>7. An OASIS Q and A (questions and answers) was provided by the Director of Clinical services on 06/16/16 at PM. The form titled "CoP 484.55 Comprehensive Assessment of Patients Drug Regimen Review - Standard (C)" indicated, "Every comprehensive assessment must include review of all medications patient currently taking to identify: Potential adverse effects, Drug reactions, Ineffective drug therapy, Significant drug interactions and side effects, Duplicate drug therapy, and</p>			

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N 0000 Bldg. 00	Noncompliance with drug therapy ... M2000 and M2002 relate to Drug Regimen Review." This is a State relicensure survey. Survey dates: June 16, 17, 20, 21, and 22, 2016 Facility ID#: 004282 Provider #: 157560 Census: 135	N 0000		
N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview,	N 0472	The DCS sits on the agency	07/20/2016

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	<p>the agency failed to ensure samples of both active and inactive clinical records were reviewed to determine if appropriate care had been provided, ensure plan of care / physician orders were being followed, ensure coordination of care was being maintained between staff involved with patient care, ensure orders were being faxed to the physician within a timely manner, ensure physicians were notified at the start of care for continuing orders of all disciplines and informed of adverse drug to drug interactions, which had the potential to affect all 135 patients of the agency..</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QAPI (Quality Assessment Performance Improvement) binder was provided on 06/16/16, and reviewed on 06/22/16. The last QAPI meeting was held on May 25, 2016, and topics included Administration / Management, Infection Control, Incidents / Accidents, Reports of Concerns / Grievances and Miscellaneous Concerns. 2. The QAPI meeting / minutes failed to identify the following: <ul style="list-style-type: none"> A. All wounds being identified during nursing visits / treatment and wound identification being inconsistent. 				<p>QA/PI Committee. Since this recent 2016 survey report, the DCS scheduled a QA/PI Committee meeting on 07/14/2016 to review clinical records with a focus on certain survey findings inclusive of wound care protocol, coordination of care, obtaining physician orders for care and services, medication reconciliation, and 60 day summaries. This list of record review initiatives is not all inclusive and shall include additional criteria. Results of this record review shall be incorporated within our agency QA/PI Plan and the results were shared with our PAC and GB membership. A threshold of 100% compliance is set for each quarterly meeting. The Administrator and governing body will review the clinical record sample before each quarterly meeting to ensure compliance with G250. The Administrator is responsible for continued compliance with N472 to ensure this deficiency is corrected and will not reoccur.</p>		

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	<p>B. All clinicians providing services communicated and participated in the comprehensive assessment and in the development of the plan of care.</p> <p>C. All orders was submitted to the physician in a timely manner.</p> <p>D. Attending physicians was notified after the initial assessment and verbal start of care orders was obtained and documented.</p> <p>E. Adverse drug to drug interactions was completed and the physician notified of major interactions with in five days of the comprehensive assessment.</p> <p>F. Complete assessments being performed, including temperatures, diet, blood sugars, and skin for patients with wounds.</p> <p>G. 60 Day Summaries to be sent to the attending physician.</p> <p>2. The Director of Nursing was interviewed on 06/22/16 at 1:00 PM. The Director of Clinical Services indicated she was aware of some of the issues and had indicated some OBQI scores had poor outcomes.</p>			

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N 0484 Bldg. 00	<p>3. A document titled "Best Choice Home Care Outcome Based Quality Improvement Process" dated 2004, indicated "The Conditions of Participation for Medicare certified home health agencies require an overall evaluation of the agency's total program at least annually and clinical record review quarterly. Patient care services are identified as one component of the agency's total program, and will be addressed in this plan "</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with all disciplines providing service to patients in 7 of 10 active records reviewed in a sample of 12. (#2, 3, 4, 5, 6, 8, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start</p>	N 0484	The DCS shall be responsible to re-educate all staff on the expectation of care coordination with the physician and the need to obtain medical orders for all clinical care rendered. Daily documentation reviews shall provide a glimpse into the performance improvement initiatives spearheaded by the DCS. This review shall have a 100%threshold for compliance. Staff failing to follow the	07/20/2016

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	<p>of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care.</p> <p>B. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing, home health aide, physical and occupational therapy.</p> <p>A. The plan of care failed to indicate that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to evidence that care coordination had been provided with the physician, home health aide, physical therapist and occupational therapist.</p> <p>B. Review of the physical therapy evaluation dated 03/23/16, the</p>		<p>expected behaviors shall be subjected to progressive discipline up to and including termination. The DCS will be responsible for ensuring ongoing compliance with N484. Agency ensures compliance with clinical documents, physician orders and care coordination.</p>	

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	<p>assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide and the occupational therapist.</p> <p>C. Review of the occupational therapy evaluation dated 03/25/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, home health aide, and the physical therapist.</p> <p>D. Review of the physical therapy visit notes, a missed visit form dated 04/27/16, indicated the patient declined a visit due to having an increase in pain and wanted to rest his / her hip. The note also indicated the patient declined a visit for 04/29/16, and physical therapy would see the patient on the next scheduled visit on 05/02/16. The note indicated the physician's office was not notified. The physical therapist failed to notify and coordinate with the skilled nurse in regards to the patients missed visit due to pain.</p> <p>3. Clinical record number 4, SOC 04/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. The plan of care failed to indicate</p>			

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	<p>that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/19/16, the re-assessment failed to evidence that care coordination had been provided with the physician, home health aide, and physical therapist.</p> <p>B. Review of a physical therapy evaluation note dated 04/20/16, the note indicated a recommendation for occupational therapy to assess the patient. The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide and the occupational therapist.</p> <p>C. Review of a occupational therapy evaluation note dated 05/06/16, the visit failed to evidence care coordination with the skilled nurse, home health aide, and physical therapist.</p> <p>D. Review of a physical therapy visit note dated 05/23/16, the physical therapist indicated that the patient was newly diagnosed with Parkinson's disease and was started on a new medication. The visit note failed to evidence that the skilled nurse, home health aide, and the occupational therapist had been informed of the patient's new diagnosis and medication.</p>			

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	<p>4. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing, home health aide, physical, occupational, and speech therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/04/16, the assessment failed to evidence that care coordination had been provided with the home health aide, physical, occupational, and speech therapist.</p> <p>B. Review of the physical therapy evaluation dated 05/05/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide, speech and occupational therapist.</p> <p>C. Review of the occupational therapy evaluation dated 05/05/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, home health aide, physical and speech therapist.</p> <p>D. Review of the speech therapy evaluation dated 05/11/16, the assessment failed to evidence that care coordination had been provided with the physician, the skilled nurse, home health</p>			

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	<p>aide, physical and occupational therapist.</p> <p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been provided with the physician, home health aide and the physical therapist.</p> <p>B. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, indicated the physical therapist had a recommendation for speech therapy to assess the patient. The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide, and speech therapist.</p> <p>6. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech therapy.</p> <p>A. Review of the physical therapy evaluation and plan of treatment dated</p>			

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	<p>04/07/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, occupational, and speech therapist.</p> <p>B. Review of the occupational therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and speech therapy.</p> <p>C. Review of the speech therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and occupational therapy.</p> <p>7. Employee A, a Registered Nurse, was interviewed on 06/21/16 at 2:30 PM. Employee A indicated he / she did not notify the physician upon the start of care and did not always converse with therapy after the start of care, and therapy did not converse with him / her after their evaluation.</p> <p>8. The Director of Clinical Services was interviewed on 06/22/16 at 9:40 AM and was unable to provide any further documentation upon request.</p> <p>9. A policy titled "Staff Communication</p>			

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N 0486 Bldg. 00	<p>Process" dated 10/2004, indicated " ... The Agency is committed to ensuring that all communication regarding patient care and concerns is accurate, efficient and prompt ... The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care ... All communication with other staff, patient, patient representative and professional and public community is documented in the patient's clinical record."</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services in 1 of 1 records reviewed (# 10) and failed to ensure coordination of services in 1 of 2 records reviewed of patients receiving services from an outside home health agency (# 8) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC 04/05/16, included a written plan of care</p>	N 0486	<p>The DCS shall be responsible to re-educate all staff on the expectation of care coordination with all others in the provision of care inclusive of wound clinic and other supporting agency staff for all clinical care rendered. Daily documentation reviews shall provide a glimpse into the performance improvement initiatives spearheaded by the DCS. This review shall have a 100%threshold for compliance. Staff failing to follow the expected behaviors shall be subjected to progressive discipline up to and including</p>	07/20/2016

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	<p>for the certification period of 04/05/16 to 06/03/16.</p> <p>A. On 06/16/16, the Director of Clinical services provided a list of patient's who was receiving services from outside agencies. Patient number 8 was listed and was receiving outside services from two separate agencies.</p> <p>B. Review of the case communication / coordination notes, the clinical record failed to evidence coordination of services with one of the two agencies.</p> <p>2. Clinical record number 10, SOC 06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of the case communication / coordination note dated 06/14/16, the agency had contacted a dialysis center to inform them of the agency services to the patient. The communication note failed to evidence if the agency inquired about the patient's diet restrictions, fluid restrictions, and the medications / flushes that the patient would receive during dialysis.</p> <p>3. The Director of Clinical Services was</p>		<p>termination. The DCS will be responsible for ensuring ongoing compliance with N486.</p>	

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N 0522 Bldg. 00	<p>interviewed on 06/22/16 at 9:40 AM and was unable to provide any further documentation upon request.</p> <p>4. A policy titled "Staff Communication Process" dated 10/2004, indicated " ... The Agency is committed to ensuring that all communication regarding patient care and concerns is accurate, efficient and prompt ... The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care ... All communication with other staff, patient, patient representative and professional and public community is documented in the patient's clinical record."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to ensure skilled nurses assessed patients as ordered per the plan of care in 3 of 10 active records reviewed (#1, 2, and 9) in a sample of 12, failed to provide wound treatment as ordered per the plan of care for 1 of 2 records reviewed of patients with wounds (# 2) in</p>	N 0522	The agency DCS shall meet with all clinical nursing staff to advise of this survey finding. Re-education of policy, industry best practices, and obtaining and following physician orders and state standards of practice, shall be the focus of the educational session. This initiative shall be	07/20/2016

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	<p>a sample of 12, failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing visits in 7 of 10 active records reviewed (#2, 3, 4, 5, 6, 8, and 9) in a sample of 12, failed to ensure visits were made as ordered for 2 of 10 active records reviewed (#6 and 8) in a sample of 12, and failed to ensure the plan of care included therapy frequencies only after the therapy assessment had been completed for 2 of 10 active records reviewed (#5 and 8) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing three times a week for nine weeks, to provide treatments to the left lower extremity wounds. The skilled nurse was to assess wounds for signs and symptoms of infection, healing status, wound deterioration, and complications.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/30/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p>		<p>added to the agency focus review with a 100% threshold for compliance. Each visit documentation shall be reviewed by the DCS or designee to evaluate if the clinician is adhering to the practice expectations related to assessment/care evaluation techniques, wound care orders, labs, the taking of vital signs per orders and following all other physician ordered care instructions. Staff shall sign an attestation that he/she shall follow ordered care instructions, concentrate on documenting best practice initiatives and to be cognizant of progressive discipline procedures up to and including termination.The DCS will be responsible for ensuring ongoing compliance with N522. Agency ensures compliance with receipt of clinical documents, physician orders and care coordination.</p>				

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	<p>B. Review of the skilled nursing visit note dated 06/03/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p> <p>C. Review of the skilled nursing visit note dated 06/10/16, the note failed to evidence a temperature and skin assessment.</p> <p>D. During a home visit with Employee B, a Registered Nurse, on 06/17/16 at 10:00 AM, Employee B failed to obtain a temperature while obtaining the patient's vital signs.</p> <p>2. Clinical record number 2, SOC 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing two times a week for nine weeks, to provide treatments to the right and left toe wounds. The skilled nurse was also to assess skin for breakdown every visit and signs / symptoms of infection, healing status, wound deterioration, and complications. The patient's diagnoses included, but were not limited to: pressure ulcer, type II diabetes with diabetic peripheral angiopath without gangrene, and peripheral vascular disease.</p>			

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	<p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The physician signed the plan of care and returned to the agency on 03/25/16. The skilled nurse provided wound care on 02/17, 02/19, 02/25, 03/01, 03/07, 03/15, and 03/22/16, without a physicians order.</p> <p>2. The vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The assessment also failed to provide an assessment of the patient's blood sugars.</p> <p>B. Review of the skilled nursing visit note dated 03/1/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's blood sugars.</p> <p>C. Review of the skilled nursing visit note dated 03/07/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an</p>			

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	<p>assessment of the patient's blood sugars.</p> <p>D. Review of the skilled nursing visit note dated 03/15/16, the vital sign section failed to evidence that a temperature, blood pressure, and pulse had been obtained. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>E. Review of the skilled nursing visit note dated 03/22/16, the vital sign section failed to evidence that a temperature and blood pressure had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>F. Review of the skilled nursing visit note dated 03/29/16, the note indicated the patient had 3+ pitting edema to the right lower extremity and was started on antibiotics. The vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>G. Review of the skilled nursing visit note dated 04/01/16, the vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's skin,</p>			

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	<p>cardiovascular, nutrition, and blood sugars.</p> <p>H. Review of the skilled nursing visit note dated 04/08/16, the note indicated the patient had developed red tiny bumps to the bilateral lower extremities continued to have 2+ pitting edema to the right lower extremity with warmth and redness, and continued on antibiotics for the right lower extremity. The vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's blood sugars.</p> <p>3. Clinical record number 3, SOC 03/22/16, included a plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing one time a week for three weeks then every other week, physical and occupational therapy one to three times a week for nine weeks. Physical and Occupational therapy were to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to</p>			

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	<p>evidence that care coordination had been provided with the physician.</p> <p>1. The physician signed the plan of care and returned to the agency on 04/21/16. The skilled nurse provided services on 03/22, 03/29, 04/05, and 04/19/16, without a physicians order.</p> <p>B. Review of a physical therapy evaluation dated 03/23/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 03/22, 03/25, 03/28, 04/01, 04/04, 04/06, 04/11, 04/13, 04/18, 04/22, 04/25, 05/02, 05/09, 05/11, and 05/16/16, without a physician's approval for the</p>			

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	<p>plan of treatment.</p> <p>4. Clinical record number 4, SOC 04/19/15, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for home health aide and physical therapy one to three times a week. Physical therapy was to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of a physical therapy evaluation dated 04/20/16, the physical therapist indicated on the evaluation, that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals. The plan of care failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/20, 04/22, 04/25, 05/11, 05/16, 05/20, 05/23, 05/25, 05/30, 06/01,</p>			

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	<p>06/06, 06/08, 06/15, and 06/20/16, without a physician's approval for the plan of treatment.</p> <p>5. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for occupational therapy and speech therapy one to three times a week for eight weeks. Occupational and speech therapy were to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of the speech therapy evaluation and plan of treatment dated 05/11/16, the speech therapist indicated that visits would be two times a week for eight weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record indicated the plan of treatment was sent to the physician on 06/01/16. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been returned and</p>			

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	<p>signed by the physician.</p> <p>3. Review of the speech therapy visit notes, speech therapy had provided services on 05/11, 05/12, 05/18, 05/19, 05/23, 05/26, 06/01, 06/02, 06/08, 06/09, 06/13, 06/16 and 06/20/16, without a physician's approval for the plan of treatment.</p> <p>B. Review of the occupational therapy visit notes, a missed visit form dated 05/10/16, indicated the patient had a missed visit due to the therapist being ill. The agency failed to ensure that another occupational therapist provided the therapy visit versus having a missed visit.</p> <p>6. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing one time a month for 3 months and physical therapy one to three times a week for nine weeks.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been</p>			

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	<p>provided with the physician.</p> <p>1. The plan of care was signed by the physician on 05/31/16 and received by the agency on 06/01/16. The skilled nurse provided services on 04/27/16 and 05/25/16, without a physicians order.</p> <p>2. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, both forms failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>3. The plan of treatment was signed by the physician on 05/24/16 and received by the agency on 05/25/16. The physical therapist provided services on 04/29, 05/02, 05/04, 05/11, 05/13, 05/18, and 05/23/16, without a physicians order.</p> <p>4. Review of the physical therapy notes, the physical therapist failed to make a visit between 05/29/16 to 06/04/16.</p> <p>7. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for physical, occupational, and speech therapy one to three times a week for eight weeks.</p>			

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	<p>A. Review of a physician order dated 04/05/16, the order indicated for speech therapy to evaluate and treat as indicated. Review of the speech therapy visit notes, the speech evaluation was not completed until 04/12/16, and recommended speech therapy visits one time a week for nine weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs. The speech therapist failed to evaluate the patient within a timely manner.</p> <p>B. Review of the speech therapy visit notes, the speech therapist failed to make a visit between 05/01/16 to 05/07/16 and 05/08/16 to 05/14/16.</p> <p>C. Review of occupational therapy notes, the occupational therapy evaluation was not completed until 04/12/16. The plan of care was developed prior to the occupational therapy evaluation and failed to be specific to the patient needs. The occupational therapist failed to evaluate the patient within a timely manner.</p> <p>D. An occupational therapy missed visit form was written on 05/10/16 due to the occupational therapist was ill. The agency failed to ensure that another therapist was available to see the patient as planned and ordered.</p>			

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	<p>E. Review of a physical therapy evaluation dated 04/07/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician immediately after the evaluation. The fax was sent to the physician on 04/27/16 and returned signed by the physician on 04/28/16.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/07, 04/14, 04/19, 04/21, and 04/26/16, without a physician's approval for the plan of treatment.</p> <p>8. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing</p>			

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	<p>to assess the patient's general systems status every visit.</p> <p>A. Review of the skilled nursing visit note dated 06/11/16, the note failed to include an assessment of the patient's vital signs, respiratory, cardiovascular, and gastrointestinal systems.</p> <p>B. Review of a skilled nursing visit note dated 06/21/16, the note failed to include an assessment of the patient's vital signs, respiratory, cardiovascular, gastrointestinal systems, and diabetes.</p> <p>9. The Director of Clinical Services was interviewed on 06/20/16 at 9:10 AM. The Director of Clinical Services indicated that the company did not have the funds to purchase temporal thermometers. The Director of Clinical Services had an infection control concern with oral thermometers.</p> <p>10. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM. The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p> <p>11. A policy titled "Vital Sign Parameters" dated 02/09/16, indicated "Vital signs are to be completed during</p>			

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N 0524 Bldg. 00	<p>any visit requiring an OASIS. Vital will be performed on a weekly basis and with any change in condition "</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 treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to update and revise the plan of care to include diagnosis and parameters for oxygen saturations, location of wounds to be treated, size and maintenance of foley catheters, the amount / frequency / type of fluid for</p>			N 0524	The agency DCS met with all clinical nursing staff to advise of this survey finding. Re-education of policy, industry best practices, and obtaining and following physician orders and state standards of practice, remained the focus of the		07/20/2016

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	<p>irrigation of foley catheters, route of how to obtain lab specimens, and measurable goals, for 5 of 10 active records reviewed in a sample of 12. (# 1, 2, 5, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing to provide treatments to three wounds to the left lower extremity and orders for skilled nursing to assess oxygen saturation on room air "prn" [as needed].</p> <p>A. The patient diagnoses on the plan of care, included but not limited to, non pressure chronic ulcer, falls, localized edema, arthropathy, and hypertension. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations, as well as measurable goals.</p> <p>B. Review of a skilled nursing visit note dated 6/6/16, the narrative note indicated the patient had five small open areas on the left lower extremity near the ankle.</p>		<p>educational session that took place on 07/19/2016. Nursing staff received re-education on plan of care containing patient specific information and be updated to reflect patient current status containing but not limited to include diagnosis and parameters for oxygen saturation, location of wounds to be treated, size and maintenance of foley catheters, amount/frequency/type of fluid for irrigation of foley catheters, route of how to obtain lab specimens and measurable goals. Updated agency policy for vital sign was distributed at this staff re-education session included blood pressure, pulse, respiration, temperature and oxygen saturation by nursing, physical therapy and occupational therapy with every patient visit. Orders obtained to implement agency policy for vital signs upon admission was stressed. Full set of vital sign to include oxygen saturation with every visit is now included on the plan of care for each patient. This initiative was added to the agency focus weekly review with a 100% threshold for compliance. Each visit documentation has on-going weekly reviews by the DCS or designee to evaluate if the clinician is adhering to the practice expectations related to assessment/care evaluation techniques, Foley catheters including associated</p>				

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	<p>1. Review of a physician's order dated 6/6/16, indicated a treatment order to the "new small open areas" on the left lower extremity. The order failed to include a location of the new wounds to the left lower extremity.</p> <p>C. Review of a physician's order from the assisted living facility dated 06/16/16, indicated for a foley catheter to be placed and changed monthly.</p> <p>1. Review of a physician's order dated 06/16/16, indicated an extra skilled nurse visit to anchor a foley catheter. The order failed to include size of foley catheter, amount to instill sterile water for bulb inflation, frequency to change the foley catheter, and measurable goals.</p> <p>2. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The patient's diagnoses on the plan of care, included but not limited to, pressure ulcer, type 2 diabetes with diabetic peripheral neuropathy, and peripheral vascular disease. The plan of care failed to be updated and revised to include a diagnosis and description of the</p>		<p>anchoring fluid type/amount, labs specimen site, wound care orders, the taking of vital signs per orders and following all other physician ordered care instructions. Staff signed an attestation that he/she shall follow ordered care instructions, concentrate on documenting best practice initiatives and to be cognizant of progressive discipline procedures up to and including termination. Administrator will be responsible for continued compliance with N524 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>3. Clinical record number 5, SOC 05/04/16, included a plan of care established by the physician for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The OASIS start of care comprehensive assessment dated 05/04/16, M1400 asked when was the patient dyspneic or noticeably short of breath. The answer provided was "0 - Patient is not short of breath".</p> <p>1. The patient's diagnoses on the plan of care, included but not limited to, muscle weakness, other abnormalities of gait and mobility, cognitive communication deficit, cerebrovascular disease, therapeutic drug level monitoring, and chronic atrial fib. The plan of care failed to be updated and revised to include a description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>B. Review of the physician orders dated 05/09, 05/18, 05/25, 06/01, 06/08,</p>			

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	<p>and 06/15/16, the order indicated for the skilled nurse to obtain an INR lab specimens from the patient. The order failed to include if the lab specimens were to be obtained by fingerstick and / or by venipuncture.</p> <p>4. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing to assess oxygen saturation on room air as needed and to change the patient's catheter every month using an 18 French catheter.</p> <p>A. The patient's diagnoses on the plan of care, included but not limited to, attention to cystostomy, enlarged prostate with lower urinary tract symptoms, and diabetes mellitus. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>B. Review of the OASIS recertification dated 05/10/16, indicated the patient has an 18 Fr 10 cc suprapubic catheter. The note indicated the patient's spouse had been flushing the patient's catheter every other day.</p>			

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	<p>C. A skilled nursing visit note dated 05/24/16, indicated the patient's spouse flushes the patient's suprapubic catheter 4 to 5 times a week.</p> <p>The plan of care failed to include the patient's catheter was a suprapubic catheter and the bulb needs to be inflated with 10 cc of sterile water. The plan of care failed to include the patient's suprapubic catheter flushes, with amount of flush, the type of fluid to flush the catheter, and frequency of flushes to be provided.</p> <p>5. Clinical record number 10, SOC 06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The patient diagnoses on the plan of care included repeated falls, unsteady with feet, end stage renal disease / dialysis, type 2 diabetes, depression, polyneuropathy, chronic pain, and rheumatoid arthritis. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p>			

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N 0527 Bldg. 00	<p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on record review and interview, the agency failed to ensure that the physician was notified of a new wound for 1 of 2 records of patient's with wounds (#2) in a sample of 12, failed to ensure that the physician was informed of missed visits in 4 of 10 records reviewed of active patients (#3, 4, 5, and 6) in a sample of 12, and failed to ensure that the physician was notified in a timely manner of a patient in need of additional services in 2 of 10 records reviewed of active patients (#4 and 6) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 02/17/16, included a plan of care established by a physician for the certification periods of 02/17/16 to 04/17/16, with orders for skilled nursing to provide wound treatments to the right</p>	N 0527	<p>The DCS shall assume responsibility for re-educating therapy staff on the need to follow physician orders for visit frequency and duration with notification to the prescribing physician of any missed visits. Physician notification must include recommendations by skilled staff for additional services, such as OT and SLP evaluations. In these events,an order must be obtained from the prescribing physician to agree with the recommendation and order same day. This survey finding shall be shared with all therapy staff prior to 07/20/2016. This initiative shall be monitored by the DCS or designee for 3 consecutive months with a 100%threshold. After the 3 months, the daily review shall move to quarterly if the</p>	07/20/2016

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	<p>2nd toe, left 2nd toe and to the left 3rd toe, two times a week for nine weeks.</p> <p>The patient has a past medical history of diabetic peripheral neuropathy, amputation of toes, and peripheral vascular disease.</p> <p>A. Review of a skilled nursing visit note dated 03/22/16, indicated the patient developed a new wound to the left great toe. The clinical note failed to evidence that the physician had been notified of the wound.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a plan of care established by a physician for the certification periods of 03/22/16 to 05/20/16 with orders for physical and occupational therapy.</p> <p>A. Review of the physical therapy visit notes, a missed visit form dated 04/29/16, indicated the patient declined a visit on 04/27/16 due to having an increase in pain and wanted to rest his / her hip. The note also indicated the patient declined a visit for 04/29/16, and physical therapy would see the patient on the next scheduled visit on 05/02/16. The note indicated the physician's office was not notified. The physical therapist failed to notify the physician of the missed visits due to the increase in pain.</p>		<p>threshold has been consistently met. The DCS will be responsible for ensuring ongoing compliance with N527.</p>	

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	<p>B. Review of the occupational therapy visit notes, a missed visit form dated 04/06/16, indicated the patient was not available and the occupational therapist planned to see the patient again on 04/12/16. The note indicated the physician's office was not notified. The occupational therapist failed to notify the physician of the missed visit.</p> <p>3. Clinical record number 4, SOC 12/09/15, included a plan of care established by the physician for the certification period of 04/22/16 to 06/20/16, with orders skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of a physical therapy evaluation dated 04/20/16, the physical therapist indicated a recommendation for occupational therapy to assess the patient. The physical therapist failed to evidence in the evaluation that the physician had been notified and agreed with the plan of treatment / recommendation and failed to evidence coordination with the case manager.</p> <p>1. Review of the physician orders, the occupational therapy evaluation was written on 05/06/16, by an skilled nurse. The agency failed to ensure a clinician notified the physician</p>			

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	<p>and obtain an order for the occupational therapy evaluation in a timely manner.</p> <p>B. Review of the physical therapy visit notes, a missed visit form dated 06/17/16, indicated the patient declined a visit due to a friend visiting from out of town and asked to wait to be seen until the next visit scheduled on 06/20/16. The note indicated the physician's office was not notified. The physical therapist failed to notify the physician of the missed visit.</p> <p>4. Clinical record number 5, SOC 05/04/16, included a plan of care established by a physician for the certification periods of 05/04/16 to 07/02/16 with orders for occupational therapy.</p> <p>A. Review of the occupational therapy visit notes, a missed visit form dated 05/10/16, indicated the patient had a missed visit due to the therapist being ill. The note indicated the physician's office was not notified. The occupational therapist failed to notify the physician of the missed visit.</p> <p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders skilled nursing, home health aide, and physical therapy.</p>			

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N 0529	<p>A. Review of a physical therapy evaluation dated 04/29/16, the physical therapist indicated a recommendation for speech therapy to assess the patient. The physical therapist failed to evidence in the evaluation that the physician had been notified and agreed with the plan of treatment / recommendation and failed to evidence coordination with the case manager.</p> <p>1. Review of the physician orders, the agency failed to ensure a clinician notified the physician and obtain an order for the speech therapy evaluation in a timely manner.</p> <p>2. Review of a physical therapy visit notes, a missed visit form dated 05/16/16, indicated the patient did not feel well and asked to skip physical therapy. The note indicated the physician was not notified. The physical therapist failed to notify the physician of the missed visit.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>410 IAC 17-13-1(a)(2)</p>			

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Bldg. 00	<p>Patient Care</p> <p>Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the:</p> <p>(A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on record review and interview, the agency failed to ensure that a written summary report had been sent to the attending physician at least every 60 days in 4 of 4 records reviewed of patient's on service for longer than 60 days in a sample of 12. (#2, 3, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16 and 04/17/16 to 06/15/16, with orders for skilled nursing to provide treatments to the right and left toe wounds. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been sent to the attending physician.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16 and 05/21/16 to 07/19/16, with orders for skilled nursing, home health</p>	N 0529	<p>The DCS has assumed responsibility for educating staff about corrective clinical behaviors and the monitoring of documentation related to this deficiency. The staff education session is scheduled to occur prior to 07/20/2016 with a focus on completing and forwarding the 60 day summary to the prescribing physician. Review monitoring shall occur daily by the DCS with 100% threshold for compliance. This review shall continue for 3 consecutive months and move to quarterly reviews if the threshold is consistently met. Staff shall be subjected to progressive discipline for failure to adhere to the improved practice principles. The DCS will be responsible for ensuring ongoing compliance with N529.</p>	07/20/2016	

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N 0537 Bldg. 00	<p>aide, physical and occupational therapy. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been sent to the attending physician.</p> <p>3. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech therapy. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been sent to the attending physician.</p> <p>4. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing. The electronic medical record and the paper clinical record failed to evidenced that a 60 day written summary had been sent to the attending physician.</p> <p>5. The Director of Clinical Services was interviewed on 06/22/16 at 9:40 AM and was unable to provide any further documentation upon request.</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</p>			

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	<p>nurse in accordance with the medical plan of care as follows: Based on record review and interview, the Registered Nurse failed to assess patients as ordered per the plan of care in 3 of 10 active records reviewed (#1, 2, and 9) in a sample of 12, failed to provide wound treatment as ordered per the plan of care for 1 of 2 records reviewed of patients with wounds (# 2) in a sample of 12, and failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing visits in 3 of 10 active records reviewed (#2, 3, and 6) in a sample of 12, failed to ensure treatments were provided as ordered by a physician in 2 of 2 records reviewed of patient's with wounds (#1 and 2, failed to ensure that lab specimen obtained were ordered by the physician in 1 of 1 record reviewed of patient's with labs (#5) in a sample of 12, and failed to ensure orders were obtained prior to recommending treatments to caregivers for 1 of 2 patients with catheters (#9) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 05/30/16, included a written plan of care for the certification period of 05/30/16 to 07/28/16, with orders for</p>	N 0537	<p>The DCS met with all professional staff to reinforce the teachings on the Comprehensive Assessment, accurate completion of the OASIS Data-Set and interim skilled nurse visits in accordance with policy, best practices and physician orders. Nursing staff received re-education on 07/19/2016 on providing services according to plan of care and following physician orders. A focus was stressed that relates to wound assessment, the taking of all vitals inclusive of temperatures, medication review/reconciliation, OASIS accuracy completion, inconsistent OASIS responses, full health system checks, and accuracy of all documented responses. This meeting took place on 07/19/2016. Updated agency policy for vital signs will include blood pressure, pulse, respiration, temperature and oxygen saturation by nursing, physical therapy and occupational therapy with every patient visit. Orders will be obtained to implement agency policy for vital signs on admission. Full set of vital sign's to include oxygen saturation with every visit to be included on plan of care for each patient. DCS or designee initiated weekly review of admission/readmission assessments on 7/20/2016 to determine if</p>	07/20/2016

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	<p>skilled nursing three times a week for 9 weeks, to provide treatments to the left lower extremity wounds. The skilled nurse was to cleanse the left leg ulcer with wound cleanser or normal saline, apply manuka to large wound bed, pack adjacent two wounds with prisma, drape around wound, cut foam to fit each wound and bridge together, drape over foam, apply drain and initiate wound vac suction at 125 mmHg continuous. The skilled nurse was to assess wounds for signs and symptoms of infection, healing status, wound deterioration, and complications.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/30/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p> <p>B. Review of the skilled nursing visit note dated 06/03/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs.</p> <p>C. Review of the skilled nursing visit note dated 06/10/16, the note failed to evidence a temperature and skin assessment.</p> <p>D. During a home visit with</p>		<p>the teachings were effective. A threshold of 100% compliance is set for 3 months then move to quarterly. Data collected from weekly reviews will be the focus at each quarterly quality meeting and results shared with the governing body. Governing body will be updated weekly on compliance with nursing staff providing care according to plan of care and physician orders being followed. Staff failing to adhere to the new expectations of documentation improvement shall be subjected to progressive discipline up to and including termination. Administrator will be responsible for continued compliance with N537 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>Employee B, a Registered Nurse, on 06/17/16 at 10:00 AM, Employee B failed to obtain a temperature while obtaining the patient's vital signs.</p> <p>E. Review of the skilled nursing visits dated 06/03/16, 06/06/16, 06/13/16, and 06/15/16, the notes indicated skin prep was applied to the peri wound.</p> <p>F. Review of the physician orders dated 06/03/16, 06/06/16, 06/08/16, 06/10/16, and 06/15/16, failed to evidence an order for the application of skin prep.</p> <p>2. Clinical record number 2, SOC 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing two times a week for nine weeks, to cleanse the right 2nd toe and left 3rd toe with wound cleanser, apply calcium alginate AG, cover with gauze and secure with tape and to cleanse the left 2nd toe with wound cleanser and apply polymem with adhesive border. The skilled nurse was also to assess skin for breakdown every visit and signs / symptoms of infection, healing status, wound deterioration, and complications.</p> <p>A. Review of a physician's order dated 02/16/16, was faxed to the agency</p>			

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	<p>on 02/16/16. The order indicated to cleanse the left lateral 3rd toe and right distal 2nd toe with normal saline or wound cleanser, apply silver alginate to both wounds. Cover right 2nd toe wound with 2 x 2 gauze.</p> <ol style="list-style-type: none"> Review of the OASIS start of care comprehensive assessment dated 02/17/16, failed to evidence coordination with the physician. Review of section 23 of the plan of care, (Nurse's signature and date of verbal start of care), the plan of care failed to evidence a verbal start of care date. The admitting nurse failed to notify and obtain approval for the new treatment orders. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to evidence that care coordination had been provided with the physician. The physician signed the plan of care and returned to the agency on 03/25/16. The skilled nurse provided services on 02/17, 02/19, 02/25, 03/01, 03/07, 03/15, and 03/22/16, without a physicians order. The vital sign section failed to 			

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	<p>evidence that a temperature had been obtained with the remaining vital signs. The assessment also failed to provide an assessment of the patient's blood sugars.</p> <p>B. Review of the skilled nursing visit note dated 03/1/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's blood sugars.</p> <p>C. Review of the skilled nursing visit note dated 03/07/16, the vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's blood sugars.</p> <p>D. Review of the skilled nursing visit note dated 03/15/16, the vital sign section failed to evidence that a temperature, blood pressure, and pulse had been obtained. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>E. Review of the skilled nursing visit note dated 03/22/16, the vital sign section failed to evidence that a temperature and blood pressure had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p>			

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	<p>F. Review of the skilled nursing visit note dated 03/29/16, the note indicated the patient had 3+ pitting edema to the right lower extremity and was started on antibiotics. The vital sign section failed to evidence that a temperature had been obtained with the remaining vital signs. The note also failed to evidence an assessment of the patient's skin and blood sugars.</p> <p>G. Review of the skilled nursing visit note dated 04/01/16, the vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's skin, cardiovascular, nutrition, and blood sugars.</p> <p>H. Review of the skilled nursing visit note dated 04/08/16, the note indicated the patient had developed red tiny bumps to the bilateral lower extremities continued to have 2+ pitting edema to the right lower extremity with warmth and redness, and continued on antibiotics for the right lower extremity. The vital sign section failed to evidence that a temperature had been obtained and failed to evidence an assessment of the patient's blood sugars.</p> <p>3. Clinical record number 3, SOC</p>			

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	<p>03/22/16, included a plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing one time a week for three weeks then every other week.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The physician signed the plan of care and returned to the agency on 04/21/16. The skilled nurse provided services on 03/22, 03/29, 04/05, and 04/19/16, without a physicians order.</p> <p>4. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to educate patient / caregiver and to check INR's per orders.</p> <p>A. Review of the OASIS comprehensive start of care dated 05/04/16, the registered nurse obtained a blood sample via fingerstick to obtain an INR specimen. The electronic medical record and the paper clinical record failed</p>			

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	<p>to evidence orders for an INR lab specimen via finger stick to be done upon admission.</p> <p>B. Review of a skilled nursing visit note dated 05/09/16, the registered nurse obtained a blood sample via fingerstick to obtain an INR. The electronic medical record and the paper clinical record failed to evidence orders for an INR lab specimen via finger stick to be done upon admission.</p> <p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing one time a month for 3 months.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The plan of care was signed by the physician on 05/31/16 and received by the agency on 06/01/16. The skilled nurse provided services on 04/27/16 and 05/25/16, without a physicians order.</p>			

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	<p>5. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing to assess the patient's general systems status every visit.</p> <p>A. A skilled nursing visit note dated 05/24/16, indicated the patient's spouse flushes the patient's suprapubic catheter 4 to 5 times a week. The note indicated the skilled nurse was encouraging the spouse to flush the patient's suprapubic catheter daily. The skilled nurse was recommending treatments without a physician's order.</p> <p>B Review of the skilled nursing visit note dated 06/11/16, the note failed to include an assessment of the patient's vital signs, respiratory, cardiovascular, and gastrointestinal systems.</p> <p>C. B. A skilled nursing visit note dated 06/20/16, indicated the skilled nurse was encouraging the spouse to flush the patient's suprapubic catheter twice a day. The skilled nurse was recommending treatments without a physician's order.</p> <p>D. Review of a skilled nursing visit note dated 06/21/16, the note failed to include an assessment of the patient's</p>			

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N 0541 Bldg. 00	<p>vital signs, respiratory, cardiovascular, gastrointestinal systems, and diabetes.</p> <p>6. The Director of Clinical Services was interviewed on 06/20/16 at 9:10 AM. The Director of Clinical Services indicated that the company did not have the funds to purchase temporal thermometers. The Director of Clinical Services had an infection control concern with oral thermometers.</p> <p>7. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM. The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p> <p>8. A policy titled "Vital Sign Parameters" dated 02/09/16, indicated "Vital signs are to be completed during any visit requiring an OASIS. Vital will be performed on a weekly basis and with any change in condition "</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview,</p>	N 0541	The DCS will re-educate	07/20/2016

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	<p>the Registered Nurse failed to re-evaluate the patient's nursing needs for 1 of 10 active records reviewed (#8) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing every other week for three weeks then one time a month for two months.</p> <p>A. Review of a skilled nursing visit note dated 04/27/16, the note indicated the visit was a prn (as needed) visit due to the patient's left eye was red and draining.</p> <p>B. Review of a skilled nursing visit note dated 05/03/16, the note indicated the visit was a prn visit due to a significant change in condition. The patient was sent to the ER.</p> <p>C. Review of a skilled nursing visit note dated 05/05/16, the note indicated the visit was a prn visit due to the patient returned from the ER the previous day. The note indicated the patient was provided with IV fluids for dehydration. The note also indicated a neurologist at the hospital was recommending IV fluids</p>		<p>clinical staff on the need to adjust the Plan of Care in the event of utilizing PRN visits at a frequency that dictate the need to request physician orders for a visit frequency and duration change. The DCS shall review all daily documentation to research if this initiative has been corrected. "As needed" visits will be evaluated to determine by the DCS if the skilled nurse needs to converse with the physician for a potential need to increase the current visit frequency. This review is set for 3 consecutive months with a 100% threshold. The DCS will be responsible for ensuring ongoing compliance with N541.</p>	

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N 0542 Bldg. 00	<p>to be done in the home weekly but the daughter was trying to increase oral fluid intake during the day.</p> <p>D. Review of a skilled nursing visit note dated 05/13/16, the note indicated the visit was a prn visit due to the patient complaining of burning, inability to urinate and very strong odor with urination. A urinalysis with a culture and sensitivity was obtained.</p> <p>The skilled nurse failed to re-evaluate the patient's nursing needs and adjust the skilled nursing frequency due to the frequent prn visits related to the patient's constant change in conditions.</p> <p>2. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the Registered Nurse failed to update and</p>	N 0542	The DCS shall include in the professional staff teaching	07/20/2016

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	<p>revise the plan of care to include diagnosis and parameters for oxygen saturations, location of wounds to be treated, size and maintenance of foley catheters, the amount / frequency / type of fluid for irrigation of foley catheters, route of how to obtain lab specimens, and measurable goals, for 5 of 10 active records reviewed in a sample of 12. (# 1, 2, 5, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 5/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing to provide treatments to three wounds to the left lower extremity and orders for skilled nursing to assess oxygen saturation on room air "prn" [as needed].</p> <p>A. The patient diagnoses on the plan of care, included but not limited to, non pressure chronic ulcer, falls, localized edema, arthropathy, and hypertension. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations, as well as measurable goals.</p>		<p>session scheduled for 07/20/2016, the need for the clinician to improve review and documentation for evaluating/documenting O2 saturation levels and other skilled care monitoring, inclusive of wound status, ulcers (present or potential risk), catheters, blood sugar ranges for establishing a baseline for diabetic patients, pain parameters with medication usage for same, and vital signs per orders. Daily review of all submitted documentation shall be reviewed by the DCS or designee with a 100% threshold for adherence to expected documentation. Staff must adhere to improvement in documentation or be subjected to progressive discipline up to and including termination. This admission documentation review has no end date. The DCS will be responsible for ensuring ongoing compliance with N542.</p>	

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	<p>B. Review of a skilled nursing visit note dated 6/6/16, the narrative note indicated the patient had five small open areas on the left lower extremity near the ankle.</p> <p>1. Review of a physician's order dated 6/6/16, indicated a treatment order to the "new small open areas" on the left lower extremity. The order failed to include a location of the new wounds to the left lower extremity.</p> <p>C. Review of a physician's order from the assisted living facility dated 06/16/16, indicated for a foley catheter to be placed and changed monthly.</p> <p>1. Review of a physician's order dated 06/16/16, indicated an extra skilled nurse visit to anchor a foley catheter. The order failed to include size of foley catheter, amount to instill sterile water for bulb inflation, frequency to change the foley catheter, and measurable goals.</p> <p>2. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan of care for the certification period of 02/17/16 to 04/16/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The patient's diagnoses on the</p>			

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	<p>plan of care, included but not limited to, pressure ulcer, type 2 diabetes with diabetic peripheral neuropathy, and peripheral vascular disease. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>3. Clinical record number 5, SOC 05/04/16, included a plan of care established by the physician for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The OASIS start of care comprehensive assessment dated 05/04/16, M1400 asked when was the patient dyspneic or noticeably short of breath. The answer provided was "0 - Patient is not short of breath".</p> <p>1. The patient's diagnoses on the plan of care, included but not limited to, muscle weakness, other abnormalities of gait and mobility, cognitive communication deficit, cerebrovascular disease, therapeutic drug level monitoring, and chronic atrial fib. The plan of care failed to be updated and revised to include a description of the</p>			

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	<p>patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>B. Review of the physician orders dated 05/09, 05/18, 05/25, 06/01, 06/08, and 06/15/16, the order indicated for the skilled nurse to obtain an INR lab specimens from the patient. The order failed to include if the lab specimens were to be obtained by fingerstick and / or by venipuncture.</p> <p>4. Clinical record number 9, SOC 09/24/13, included a written plan of care for the certification period of 05/11/16 to 07/09/16, with orders for skilled nursing to assess oxygen saturation on room air as needed and to change the patient's catheter every month using an 18 French catheter.</p> <p>A. The patient's diagnoses on the plan of care, included but not limited to, attention to cystostomy, enlarged prostate with lower urinary tract symptoms, and diabetes mellitus. The plan of care failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>B. Review of the OASIS</p>			

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	<p>recertification dated 05/10/16, indicated the patient has an 18 Fr 10 cc suprapubic catheter. The note indicated the patient's spouse had been flushing the patient's catheter every other day.</p> <p>C. A skilled nursing visit note dated 05/24/16, indicated the patient's spouse flushes the patient's suprapubic catheter 4 to 5 times a week.</p> <p>The plan of care failed to include the patient's catheter was a suprapubic catheter and the bulb needs to be inflated with 10 cc of sterile water. The plan of care failed to include the patient's suprapubic catheter flushes, with amount of flush, the type of fluid to flush the catheter, and frequency of flushes to be provided.</p> <p>5. Clinical record number 10, SOC 06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing to assess oxygen saturation on room air as needed.</p> <p>A. The patient diagnoses on the plan of care included repeated falls, unsteady with feet, end stage renal disease / dialysis, type 2 diabetes, depression, polyneuropathy, chronic pain, and rheumatoid arthritis. The plan of care</p>			

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N 0543 Bldg. 00	<p>failed to be updated and revised to include a diagnosis and description of the patient's medical signs and symptoms that would warrant a measurement of oxygen saturations.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review and interview, the Registered Nurse failed to include an assessment of wounds being treated with each nursing visit for 2 of 2 records reviewed of patients with wounds in a sample of 12. (#1 and 2)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 05/30/16, included a written plan of care for the certification period of 5/30/16 to 7/28/16, with orders for skilled nursing three times a week for 9 weeks, to provide treatments to the left lower</p>	N 0543	The DCS met with all nursing staff for the survey finding results on 07/19/2016 with a focus on the need to perform wound assessments in accordance with best practice principles with inclusion of reports to the prescribing physician. Nurses received re-education to provide description of wound bed, surrounding tissue, drainage and odor noted with each visit, measurements weekly and to report any changes to physician. When wound patient's are seen by two different nurses, the nurses will compare documentation and technique. Discrepancies in documentation	07/20/2016

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	<p>extremity wounds.</p> <p>A. Review of the skilled nursing visit note dated 06/01/16, the note failed to evidence a description of the wound bed to wound #1, failed to provide a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3.</p> <p>B. Review of the skilled nursing visit note dated 06/06/16, the note failed to evidence a description of the wound bed to wound #1, failed to provide a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3.</p> <p>C. Review of the skilled nursing visit note dated 06/08/16, the note failed to evidence a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3. The clinical note also failed to evidence if treatment had been provided to the new wounds near the patient left ankle as well as the description of the wounds.</p> <p>D. Review of the skilled nursing visit note dated 06/10/16, the note failed to evidence a description of the wound bed to wounds #1, #2, and #3.</p> <p>E. Review of the skilled nursing visit</p>		<p>or technique will be shared with DCS and Administrator. Clinical records with wound care will be reviewed weekly for 3 consecutive months with 100%threshold with focus on wound assessments, description and measurements. The record review will move to quarterly once threshold is met for 3 months. Data collected from weekly review will be focus at quarterly quality meeting and results shared with the governing body. Governing body will be updated weekly on compliance with nursing staff wound assessment. Once review is moved to quarterly, nursing staff wound assessments will be a focus at the quality meeting. Results will be shared with the governing body and professional advisory board. Administrator will be responsible for continued compliance with N543 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>note dated 06/13/16, the note failed to evidence a description of the wound bed, surrounding tissue, drainage, and odor to wounds #2 and #3.</p> <p>F. Review of the skilled nursing visit note dated 06/15/16, the note failed to evidence a description of the wound bed, surrounding tissue, drainage, and odor to wounds #1, #2, and #3. The narrative note indicated a new wound to the right lower extremity. The note failed to evidence a description of the wound bed.</p> <p>2. Clinical record number 2, SOC 2/17/16, included a written plan of care for the certification period of 2/17/16 to 4/16/16, with orders for skilled nursing to provide wound care. The treatment orders on the plan of care instructed to cleanse the right 2nd toe and left 3rd toe with wound cleanser, apply calcium alginate AG, cover with gauze and secure with tape and to cleanse the left 2nd toe with wound cleanser and apply polymem with adhesive border.</p> <p>A. Review of the OASIS comprehensive start of care assessment dated 02/17/16, the assessment identified wound #1 as the left 2nd toe, wound #2 as the left third toe, and wound #3 as the right 2nd toe.</p>			

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	<p>1. Review of the skilled nursing visit note dated 02/19/16, the note identified wound #1 as the left 3rd toe and wound #2 as the right 2nd toe. The visit note also failed to correctly identify the wounds, failed to evidenced a description of the wound bed, surrounding tissue, drainage, and odor to the reported wounds #1 and #2, and failed to identify and evidenced if treatment had been provided to the left 2nd toe.</p> <p>2. Review of the skilled nursing visit note dated 02/25/16, the visit note failed to evidenced a description of the wound bed, surrounding tissue, drainage, and odor to wounds #1, #2, and #3.</p> <p>3. Review of the skilled nursing visit note dated 03/01/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 2nd toe, and wound #3 as the left 3rd toe. The visit note failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wounds #1, #2, and #3.</p> <p>4. Review of the skilled nursing visit note dated 03/07/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 3rd toe, and wound #3 as the left 2nd toe. The visit note</p>			

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	<p>failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wounds #1, #2, and #3.</p> <p>5. Review of the skilled nursing visit note dated 03/15/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 2nd toe, and wound #3 as the left 3rd toe. The visit note failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wound #2. The note indicated wounds #1 and #3 were closed.</p> <p>6. Review of the skilled nursing visit note dated 03/22/16, the note identified wound #1 as the right 2nd toes, wound #2 as the left 2nd toe, wound #3 as the left 3rd toe, and a new wound #4 as the left great toe. The visit note failed to correctly identify the wounds and failed to evidenced a description of the wound bed to the reported wound #1, #2, #3, and #4.</p> <p>7. Review of the skilled nursing visit note dated 03/29/16, the note identified wound #1 as the left 2nd toe, wound #2 as the left 3rd toe, and wound #3 as the right 2nd toe. The visit note failed to evidenced a description of the wound bed to the reported wound #1, #2,</p>			

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	<p>and #3. The visit note also failed to identify and evidenced an assessment to wound #4.</p> <p>8. Review of the skilled nursing visit note dated 04/01/16, the note identified wound #1 as the left 2nd toe and wound #2 as the left 3rd toe. The registered nurse applied calcium alginate to the left 2nd toe. The visit note failed to provide the correct treatment to the left 2nd toe, and failed to evidence a description of the wound bed, surrounding tissue, drainage, and odor to wound #1 and #2. The visit note also failed to identify and evidenced an assessment and treatment to the right 2nd toe wound and failed to identify and evidenced an assessment to the left great toe (wound #4).</p> <p>9. Review of the skilled nursing visit note dated 04/08/16, the note identified wound #1 as the right 2nd toe, wound #2 as the left 3rd toe, and wound #3 as the left 2nd toe. The visit note also failed to correctly identify the wounds and failed to evidenced a description of the wound bed, surrounding tissue, drainage, and odor to the reported wounds #1, #2, and #3. The visit note also failed to identify and evidenced an assessment of the left great toe (wound #4).</p>			

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N 0545 Bldg. 00	<p>3. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</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.</p> <p>Based on interview and record review, the Registered Nurses failed to ensure their efforts were coordinated effectively with the dialysis centers that was furnishing services in 1 of 1 records reviewed (# 10), failed to ensure coordination of services in 1 of 2 records reviewed of patients receiving services from an outside home health agency (# 8), failed to ensure disciplines providing service to patients coordinated effectively in 7 of 10 active records (#2, 3, 4, 5, 6, 8, and 10), and failed to ensure that the physician was notified of a new wound for 1 of 2 records of patient's with wounds (#2) in a sample of 12.</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 02/17/16, included a written plan</p>	N 0545	The agency Director of Clinical Services assumes responsibility for staff re-education, documentation monitoring, and strategies required to assure a sustained resolution of this deficiency. The clinical staff re-education initiatives include reinforcing agency related policies and to remind all clinical staff of their individual role and responsibilities. Wound care, missed visits, recommending additional care and services, failure to notify the physician of missed visits and lack of care coordination with such external care providers as wound care center staff and other visiting home care agency staff, among other topics, are talking points. This re-education session is scheduled to occur no later	07/20/2016

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	<p>of care for the certification period of 02/17/16 to 04/16/16.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care.</p> <p>B. Review of the OASIS start of care comprehensive assessment dated 02/17/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>C. Review of a skilled nursing visit note dated 03/22/16, indicated the patient developed a new wound to the left great toe. The clinical note failed to evidence that the physician had been notified of the wound.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing, home health aide, physical and occupational therapy.</p> <p>A. The plan of care failed to indicate that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 03/22/16, the assessment failed to evidence that care coordination had been</p>		<p>than 07/20/2016. The DCS shall assure daily monitoring of all clinical documentation to assist in identifying deviations from acceptable practices. The threshold is set at 100% with the monitoring continuation for 3 consecutive months. At the end of the 3 month study and IF the threshold has been met for the 3 previous months, the study will be moved to every other month. Results shall be shared with the agency PAC and Governing Body Committee members. This study initiative shall be added to the agency Quality Assurance/Performance Improvement Plan with results documented in the agency Annual Report. Deviations from expected staff documentation shall result in progressive discipline up to and including termination. The DCS will be responsible for ensuring ongoing compliance with N545.</p>	

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	<p>provided with the physician, home health aide, physical therapist and occupational therapist.</p> <p>3. Clinical record number 4, SOC 04/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. The plan of care failed to indicate that verbal orders had been obtained at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/19/16, the re-assessment failed to evidence that care coordination had been provided with the physician, home health aide, and physical therapist.</p> <p>4. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing, home health aide, physical, occupational, and speech therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/04/16, the assessment failed to evidence that care coordination had been provided with the home health aide, physical, occupational, and speech therapist.</p>			

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	<p>5. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been provided with the physician, home health aide and the physical therapist.</p> <p>6. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech therapy.</p> <p>A. On 06/16/16, the Director of Clinical services provided a list of patient's who was receiving services from outside agencies. Patient number 8 was listed and was receiving outside services from two separate agencies.</p> <p>B. Review of the case communication / coordination notes, the clinical record failed to evidence coordination of services with one of the two agencies.</p> <p>7. Clinical record number 10, SOC</p>			

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	<p>06/14/16, included a written plan of care for the certification period of 06/14/16 to 08/12/16, with orders for skilled nursing and physical therapy.</p> <p>A. Review of the case communication / coordination note dated 06/14/16, the agency had contacted a dialysis center to inform them of the agency services to the patient. The communication note failed to evidence if the agency inquired about the patient's diet restrictions, fluid restrictions, and the medications / flushes that the patient would receive during dialysis.</p> <p>8. Employee A, a Registered Nurse, was interviewed on 06/21/16 at 2:30 PM. Employee A indicated he / she did not notify the physician upon the start of care and did not always converse with therapy after the start of care, and therapy did not converse with him / her after their evaluation.</p> <p>9. A policy titled "Staff Communication Process" dated 10/2004, indicated " ... The Agency is committed to ensuring that all communication regarding patient care and concerns is accurate, efficient and prompt ... The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the</p>			

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N 0547 Bldg. 00	<p>patient's care ... All communication with other staff, patient, patient representative and professional and public community is documented in the patient's clinical record."</p> <p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview, the Registered Nurse failed to ensure that verbal orders were put into writing, signed and dated with the date of receipt by the accepting clinician in 2 of 12 records reviewed. (#2 and 5)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC 2/17/16, included a plan of care established by a physician for the certification periods of 02/17/16 to 04/17/16, with orders for skilled nursing to provide wound treatments two times a week for nine weeks.</p> <p>A. Review of the skilled nursing visit note dated 03/15/16, the note indicated new orders had been received by the</p>	N 0547	The DCS met with nursing staff to reinforce the teachings on accepting and carrying out physician orders. The meeting focused on accepting verbal orders, updating medication profile, explaining how new medication information is obtained, and writing orders. This meeting took place on 07/19/2016. DCS or designee initiated weekly review of physician orders and visit notes to determine if the teachings were effective. A threshold of 100% compliance is set for 3 months then moved to quarterly. Data collected from weekly review will be focus at each quarterly quality meeting and results shared with the governing body. Governing body will be updated weekly on compliance with nursing staff accepting and carrying out physician orders. Staff failing to	07/20/2016	

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	<p>physician. The electronic clinical record and the paper clinical record failed to evidence the written verbal order that was obtained by the registered nurse.</p> <p>B. Review of the skilled nursing visit note dated 03/29/16, the note indicated the skilled nurse had notified the physician of changes to the patient's right lower extremity and that the physician had ordered new antibiotics for the patient.</p> <p>1. Review of the medication profile, indicated that Keflex 500 milligrams, to be taken orally twice a day for ten days, had been prescribed to the patient on 3/29/16. The electronic medical record and the patient's paper clinical record failed to evidence the written verbal order that was obtained by the registered nurse.</p> <p>C. Review of the skilled nursing visit note dated 04/01/16, the note indicated the physician was made aware of the patient's right lower extremity and antibiotics had been started.</p> <p>1. The medication profile indicated that the patient started on Bactrim DS 800 milligrams - 160 milligrams, to be taken orally twice a day and hydrocortisone 0.5% topical cream to</p>		<p>adhere to the new expectations of documentation improvement shall be subjected to progressive discipline up to and including termination. Administrator will be responsible for continued compliance with N547 to ensure deficiency is corrected and will not reoccur.</p>	

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	<p>be applied to the bilateral lower extremities as needed on 04/01/16. The electronic medical record and the patient's paper clinical record failed to evidence if the new order was obtained verbally by the physician and / or failed to evidence in a nursing visit note that the new medication orders were from labels of the filled prescriptions.</p> <p>2. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing to educate patient / caregiver and to check INR's per orders.</p> <p>A. Review of the OASIS start of care comprehensive assessment dated 05/04/16, the registered nurse documented that he / she received verbal orders for the patient to hold the coumadin on 05/04/16, start coumadin 2.5 milligrams on Monday and Thursday, 5 milligrams on all other days, and to recheck the patient's INR on 05/09/16. The electronic medical record and the patient's paper clinical record failed to evidence the written verbal order that was obtained by the registered nurse.</p> <p>B. Review of the skilled nursing visit note dated 05/09/16, the skilled nurse indicated "I made the changes with the</p>			

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N 0560 Bldg. 00	<p>metoprolol in med box."</p> <p>1. Review of the medication profile, a new entry dated 05/09/16, indicated the patient had a new order for metoprolol 50 mg to be taken by mouth twice a day. The electronic medical record and the patient's paper clinical record failed to evidence the written order for the new dose of medication. The skilled nursing visit note failed to evidence if the new doseage was obtained from a filled prescription bottle.</p> <p>3. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p> <p>410 IAC 17-14-1(b) Scope of Services Rule 14 Sec. 1(b) Any therapy services furnished by the home health agency shall be provided by: (1) a physical therapist or physical therapist assistant supervised by a licensed physical therapist in accordance with IC 25-27-1; or (2) an occupational therapist or occupational therapist assistant supervised by an occupational therapist in accordance with IC 25-23.5. (3) a speech-language pathologist or audiologist in accordance with IC 25-35.6.</p>			

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	<p>Based on record review and interview, the Physical, Occupational, and Speech Therapist failed to ensure visits were made as ordered for 3 of 10 active records reviewed in a sample of 12. (# 5, 6 and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for occupational therapy one to three times a week for eight weeks.</p> <p>A. Review of the occupational therapy visit notes, a missed visit form dated 05/10/16, indicated the patient had a missed visit due to the therapist being ill. The agency failed to ensure that another occupational therapist provided the therapy visit versus having a missed visit.</p> <p>2. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for physical therapy one to three times a week for nine weeks.</p> <p>A. Review of the physical therapy notes, the physical therapist failed to make a visit between 05/29/16 to</p>	N 0560	<p>The DCS shall assume responsibility for re-educating therapy staff on the need to follow physician orders for visit frequency and duration with notification to the prescribing physician of any missed visits. In event of missed visits, an notification must be sent to the prescribing physician. This survey finding shall be shared with all therapy staff prior to 07/20/2016. This initiative shall be monitored by the DCS for 3 consecutive months with a 100%threshold. After the 3 months, the daily review shall move to quarterly if the threshold has been consistently met. The DCS will be responsible for ensuring ongoing compliance with N560.</p>	07/20/2016

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	<p>06/04/16.</p> <p>3. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for occupational, and speech therapy one to three times a week for eight weeks.</p> <p>A. Review of a physician order dated 04/05/16, the order indicated for speech therapy to evaluate and treat as indicated. Review of the speech therapy visit notes, the speech evaluation was not completed until 04/12/16, and recommended speech therapy visits one time a week for nine weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs. The speech therapist failed to evaluate the patient within a timely manner.</p> <p>B. Review of the speech therapy visit notes, the speech therapist failed to make a visit between 05/01/16 to 05/07/16 and 05/08/16 to 05/14/16.</p> <p>C. Review of occupational therapy notes, the occupational therapy evaluation was not completed until 04/12/16. The plan of care was developed prior to the occupational therapy evaluation and failed to be specific to the patient needs. The</p>			

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N 0565 Bldg. 00	<p>occupational therapist failed to evaluate the patient within a timely manner.</p> <p>D. An occupational therapy missed visit form was written on 05/10/16 due to the occupational therapist was ill. The agency failed to ensure that another therapist was available to see the patient as planned and ordered.</p> <p>4. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM. The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on record review and interview, the Physical, Occupational, and Speech Therapist failed to ensure the attending physician was in agreement with the plan of care / treatment and verbal orders were obtained prior to making ongoing visits in 5 of 8 records reviewed of patients having therapy services in a sample of 12. (# 3, 4, 5, 6, and 8)</p> <p>Findings include:</p>	N 0565	The DCS assumed responsibility for re-educating therapy staff on the need to obtain physician orders prior to the delivery of therapy services in addition to any recommendations by therapy staff for additional services, such as OT and SLP evaluations. Education session took place on 07/19/2016. In these events, an order must be obtained from the prescribing physician prior to the delivery of therapy services. All results of this survey finding	07/20/2016

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	<p>1. Clinical record number 3, SOC 03/22/16, included a plan of care for the certification period of 03/22/16 to 05/20/16, with orders for physical and occupational therapy one to three times a week for nine weeks. Physical and Occupational therapy were to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of a physical therapy evaluation dated 03/23/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 03/22, 03/25, 03/28, 04/01, 04/04, 04/06, 04/11, 04/13, 04/18, 04/22,</p>		<p>was shared with all therapy staff on 07/19/2016. DCS or designee will monitor weekly for orders being obtained by therapy prior to delivery of services in addition to any recommendations by therapy staff for additional services. Weekly monitoring will continue for 3 consecutive months with a 100% threshold. After the 3 months, the weekly review shall move to quarterly if the threshold has been consistently met. Data collected from weekly review will be focus at quarterly quality meeting and results shared with the governing body. Governing body will be updated weekly on compliance with therapy staff having order prior to delivery of service. Once review is moved to quarterly therapy orders received prior to providing care will be a focus of the quality meeting. Results will be shared with the governing body and professional advisory board. Administrator will be responsible for continued compliance with N565 to ensure deficiency is corrected and will not reoccur.</p>		

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	<p>04/25, 05/02, 05/09, 05/11, and 05/16/16, without a physician's approval for the plan of treatment.</p> <p>2. Clinical record number 4, SOC 04/19/15, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for physical therapy one to three times a week. Physical therapy was to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of a physical therapy evaluation dated 04/20/16, the physical therapist indicated on the evaluation, that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals. The plan of care failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/20, 04/22, 04/25, 05/11,</p>			

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	<p>05/16, 05/20, 05/23, 05/25, 05/30, 06/01, 06/06, 06/08, 06/15, and 06/20/16, without a physician's approval for the plan of treatment.</p> <p>3. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for speech therapy one to three times a week for eight weeks. Speech therapy was to evaluate and submit a plan of treatment to the attending physician.</p> <p>A. Review of the speech therapy evaluation and plan of treatment dated 05/11/16, the speech therapist indicated that visits would be two times a week for eight weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record indicated the plan of treatment was sent to the physician on 06/01/16. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been returned and</p>			

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	<p>signed by the physician.</p> <p>3. Review of the speech therapy visit notes, speech therapy had provided services on 05/11, 05/12, 05/18, 05/19, 05/23, 05/26, 06/01, 06/02, 06/08, 06/09, 06/13, 06/16 and 06/20/16, without a physician's approval for the plan of treatment.</p> <p>4. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for physical therapy one to three times a week for nine weeks.</p> <p>A. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, both forms failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>B. The plan of treatment was signed by the physician on 05/24/16 and received by the agency on 05/25/16. The physical therapist provided services on 04/29, 05/02, 05/04, 05/11, 05/13, 05/18, and 05/23/16, without a physicians order.</p> <p>5. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for physical therapy</p>			

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	<p>one to three times a week for eight weeks.</p> <p>A. Review of a physical therapy evaluation dated 04/07/16, the physical therapist indicated on the evaluation that visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician immediately after the evaluation. The fax was sent to the physician on 04/27/16 and returned signed by the physician on 04/28/16.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/07, 04/14, 04/19, 04/21, and 04/26/16, without a physician's approval for the plan of treatment.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM.</p>			

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N 0567 Bldg. 00	<p>The Director of Clinical Services was unable to provide any further documentation in reference to the above findings.</p> <p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on record review and interview, the Physical, Occupational and Speech therapist failed to ensure to coordinate with other therapists and case managers and document their efforts in 5 of 8 records reviewed of patients with multiple disciplines providing services in a sample of 12. (# 3, 4, 5, 6, and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 3, SOC 03/22/16, included a written plan of care for the certification period of 03/22/16 to 05/20/16, with orders for skilled nursing, home health aide, physical and occupational therapy.</p> <p>A. Review of the physical therapy evaluation dated 03/23/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide</p>	N 0567	<p>The DCS shall assume responsibility for therapy staff re-education on care coordination efforts both with other agency team members and the prescribing physician. The DCS shall review all therapy documentation daily for 3 consecutive months with a 100% threshold for compliance with care coordination among other therapy team members and the prescribing physician. This study shall be extended if the threshold is not met. The therapy education session shall occur prior to 7/20/2016. The DCS will be responsible for ensuring ongoing compliance with N567.</p>	07/20/2016

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	<p>and the occupational therapist.</p> <p>B. Review of the occupational therapy evaluation dated 03/25/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, home health aide, and the physical therapist.</p> <p>C. Review of the physical therapy visit notes, a missed visit form dated 04/27/16, indicated the patient declined a visit due to having an increase in pain and wanted to rest his / her hip. The note also indicated the patient declined a visit for 04/29/16, and physical therapy would see the patient on the next scheduled visit on 05/02/16. The note indicated the physician's office was not notified. The physical therapist failed to notify and coordinate with the skilled nurse in regards to the patients missed visit due to pain.</p> <p>2. Clinical record number 4, SOC 04/19/16, included a written plan of care for the certification period of 04/19/16 to 06/17/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of a physical therapy evaluation note dated 04/20/16, the note indicated a recommendation for occupational therapy to assess the patient.</p>				

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	<p>The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide and the occupational therapist.</p> <p>B. Review of a occupational therapy evaluation note dated 05/06/16, the visit failed to evidence care coordination with the skilled nurse, home health aide, and physical therapist.</p> <p>C. Review of a physical therapy visit note dated 05/23/16, the physical therapist indicated that the patient was newly diagnosed with Parkinson's disease and was started on a new medication. The visit note failed to evidence that the skilled nurse, home health aide, and the occupational therapist had been informed of the patient's new diagnosis and medication.</p> <p>3. Clinical record number 5, SOC 05/04/16, included a written plan of care for the certification period of 05/04/16 to 07/02/16, with orders for skilled nursing, home health aide, physical, occupational, and speech therapy.</p> <p>A. Review of the physical therapy evaluation dated 05/05/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health</p>			

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	<p>aide, speech and occupational therapist.</p> <p>B. Review of the occupational therapy evaluation dated 05/05/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, home health aide, physical and speech therapist.</p> <p>C. Review of the speech therapy evaluation dated 05/11/16, the assessment failed to evidence that care coordination had been provided with the physician, the skilled nurse, home health aide, physical and occupational therapist.</p> <p>4. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing, home health aide, and physical therapy.</p> <p>A. Review of the physical therapy evaluation and plan of treatment dated 04/29/16, indicated the physical therapist had a recommendation for speech therapy to assess the patient. The assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, home health aide, and speech therapy.</p> <p>5. Clinical record number 8, SOC 04/05/16, included a written plan of care</p>			

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	<p>for the certification period of 04/05/16 to 06/03/16, with orders for skilled nursing, physical, occupational, and speech therapy.</p> <p>A. Review of the physical therapy evaluation and plan of treatment dated 04/07/16, the assessment failed to evidence that care coordination had been provided with the physician, skilled nurse, occupational, and speech therapist.</p> <p>B. Review of the occupational therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and speech therapy.</p> <p>C. Review of the speech therapy evaluation and plan of treatment dated 04/12/16, the assessment failed to evidence that care coordination had been provided with the skilled nurse, physical, and occupational therapy.</p> <p>6. Employee A, a Registered Nurse, was interviewed on 06/21/16 at 2:30 PM. Employee A indicated he / she did not notify the physician upon the start of care and did not always converse with therapy after the start of care, and therapy did not converse with him / her after their evaluation.</p>			

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N 0608 Bldg. 00	<p>7. A policy titled "Staff Communication Process" dated 10/2004, indicated " ... The Agency is committed to ensuring that all communication regarding patient care and concerns is accurate, efficient and prompt ... The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care ... All communication with other staff, patient, patient representative and professional and public community is documented in the patient's clinical record."</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p>				

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	<p>Based on record review and interview, the agency failed to ensure that care was coordinated with the physician, verbal orders obtained, and written orders faxed to the physician in a timely manner in 5 of 10 active records reviewed in a sample of 12. (#2, 3, 4, 6, and 8)</p> <p>1. Clinical record number 2, SOC (start of care) 2/17/16, included a written plan of care for the certification period of 2/17/16 to 4/16/16, with orders for skilled nursing to provide wound care.</p> <p>A. The treatment orders on the plan of care instructed to cleanse the right 2nd toe and left 3rd toe with wound cleanser, apply calcium alginate AG, cover with gauze and secure with tape and to cleanse the left 2nd toe with wound cleanser and apply polymem with adhesive border.</p> <p>1. Review of a physician's order dated 02/16/16, was faxed to the agency on 02/16/16. The order indicated to cleanse the left lateral 3rd toe and right distal 2nd toe with normal saline or wound cleanser, apply silver alginate to both wounds. Cover right 2nd toe wound with 2 x 2 gauze.</p> <p>2. Review of the OASIS start of care comprehensive assessment dated 02/17/16, failed to evidence coordination</p>	N 0608	<p>The agency Director of Clinical Services assumes responsibility for staff re-education, documentation monitoring, and strategies required to assure a sustained resolution of this deficiency. The clinical staff re-education initiatives include reinforcing agency related policies and to remind all clinical staff of their individual role responsibilities. Wound care, missed visits, care coordination, recommending additional care and services, failure to notify the physician of missed visits, timely orders and lack of care coordination, among other topics, are talking points. This re-education session is scheduled to occur no later than 07/20/2016. The DCS shall assure daily monitoring of all clinical documentation to assist in identifying deviations from acceptable practices. The threshold is set at 100% with the monitoring continuation for 3 consecutive months. At the end of the 3 month study and IF the threshold has been met for the 3 previous months, the study will be moved to every other month. Results shall be shared with the agency PAC and Governing Body Committee members. This study initiative shall be added</p>	07/20/2016			

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	<p>with the physician.</p> <p>3. Review of section 23 of the plan of care, (Nurse's signature and date of verbal start of care), the plan of care failed to evidence a verbal start of care date. The clinical record failed to evidence clear and accurate treatment orders for patient #2 wounds.</p> <p>2. Clinical record number 3, SOC 03/22/16, included a plan of care established by the physician for the certification period of 03/22/16 to 05/20/16, with orders for physical and occupational therapy 1 - 3 times a week for 9 weeks, evaluate and submit a plan of treatment.</p> <p>A. Review of a physical therapy evaluation dated 03/23/16, the physical therapist indicated that visits would be 2 times a week for 9 weeks. The evaluation provided the treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had</p>		<p>to the agency Quality Assurance/Performance Improvement Plan with results documented in the agency Annual Report. Deviation from expected staff documentation shall result in progressive discipline up to and including termination. The DCS will be responsible for ensuring ongoing compliance with N608. Agency ensures compliance with receipt of clinical documents, physician orders and care coordination.</p>	

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	<p>been submitted / faxed to the physician for signature.</p> <p>B. Review of the occupational therapy evaluation dated 03/25/16, the occupational therapist indicated that visits would be 1 to 3 times per week for 9 weeks and that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>1. Review of the electrical medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician for signature.</p> <p>3. Clinical record number 4, SOC 04/19/15, included a plan of care established by the physician for the certification period of 04/19/16 to 06/17/16.</p> <p>A. Review of an Occupational therapy evaluation and plan of treatment dated 05/06/16, the occupational therapist indicated that visits would be 1 to 3 times per week for 9 weeks and that the physician was notified and agreed with the plan of care, frequency, and duration.</p> <p>1. Review of the electrical medical record and the paper clinical record failed to evidence that the plan of</p>			

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	<p>treatment had been submitted / faxed to the physician for signature.</p> <p>4. Clinical record number 6, SOC 04/27/16, included a written plan of care for the certification period of 04/27/16 to 06/25/16, with orders for skilled nursing one time a month for 3 months and physical therapy one to three times a week for nine weeks.</p> <p>A. Section 23 of the plan of care failed to evidence that the admitting nurse obtained start of care orders at the start of care. Review of the OASIS start of care comprehensive assessment dated 04/27/16, the assessment failed to evidence that care coordination had been provided with the physician.</p> <p>1. The plan of care was signed by the physician on 05/31/16 and received by the agency on 06/01/16.</p> <p>2. Review of the electronic medication record, the plan of treatment dated 04/29/16, was sent to the physician on 05/24/16. The plan of treatment was signed by the physician on 05/24/16 and received by the agency on 05/25/16. The agency failed to ensure verbal orders were obtained and the written orders were faxed to the physician for signature in a timely manner.</p>			

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	<p>5. Clinical record number 8, SOC 04/05/16, included a written plan of care for the certification period of 04/05/16 to 06/03/16, with orders for physical, occupational, and speech therapy one to three times a week for eight weeks.</p> <p>A. Review of a physician order dated 04/05/16, the order indicated for speech therapy to evaluate and treat as indicated. Review of the speech therapy visit notes, the speech evaluation was not completed until 04/12/16, and recommended speech therapy visits one time a week for nine weeks. The plan of care was developed prior to the speech therapy evaluation and failed to be specific to the patient needs. The speech therapist failed to evaluate the patient within a timely manner.</p> <p>B. Review of occupational therapy notes, the occupational therapy evaluation was not completed until 04/12/16. The plan of care was developed prior to the occupational therapy evaluation and failed to be specific to the patient needs. The occupational therapist failed to evaluate the patient within a timely manner.</p> <p>C. Review of a physical therapy evaluation dated 04/07/16, the physical therapist indicated on the evaluation that</p>			

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	<p>visits would be two times a week for nine weeks. The evaluation provided treatment plan and goals.</p> <p>1. The evaluation failed to indicate that the physician was notified and agreed with the plan of care, frequency, and duration. The frequency on the plan of care failed to be specific to the patient needs.</p> <p>2. The electronic medical record and the paper clinical record failed to evidence that the plan of treatment had been submitted / faxed to the physician immediately after the evaluation. The fax was sent to the physician on 04/27/16 and returned signed by the physician on 04/28/16.</p> <p>3. Review of the physical therapy visit notes, physical therapy had provided services on 04/07, 04/14, 04/19, 04/21, and 04/26/16, without a physician's approval for the plan of treatment.</p> <p>6. The Director of Clinical Services was interviewed on 06/21/16 at 4:15 PM and was unable to provide any further documentation in reference to the above findings.</p>			