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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000000	A. BUILDING 00 B. WING	01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HOME HEALTH	1234 MAIN ST Anywhere, US 77000

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G 0574	Based on observation, record review and interview, the Registered Nurse (RN) failed to accurately complete the plan of care to include all pertinent diagnoses for 6 of 8 (#1, 2, 3, 4, 6, 8) active and full records reviewed and 1 of 1 discharged record reviewed, ensure the goals were measurable and present for all identified needs for 7 of 8 active and full records reviewed (#1, 2, 3, 4, 5, 6, 8) and 1 of 1 (#7) discharged record reviewed, to include all patient-specific frequency and duration for 4 of 8 (#1, 5, 6, 8) active and full records reviewed and contained all accurate medications for 1 of 1 (#3) home visit patients with medication set up and 1 of 1 (#6) records reviewed of patients with orders for discontinued medications in a sample of 8 active and full records reviewed. Findings include: 1. The agency policy revised 1/29/17 titled "Physicians plan of treatment," Policy #: 2.18 indicated "... A physician's plan of treatment ... must include a. all diagnoses relevant to Rose home Sent plan of care ... medications ... Specific orders and frequency of visits " 2. The clinical record of patient #1 was reviewed on 01/02/19 and indicated a start of care date of 12/31/12. The record contained a plan of care for the certification period of 11/30/18-1/28/19 that indicated diagnoses of "Incontinent of urine, abnormality of gait, history of falls…Medications: glipizide (diabetes)…lovastatin (hypertension)…Orders: HMK [homemaker] 20 hrs. [hours] per month…Goals: client to be free from falls /injuries while in the home environment. [Patient] will be free from skin breakdown, will be clean, dry, and odor free, meds taken as prescribed, no s/s [signs and symptoms] of infection through infection control "	G 0574	The clinical director will review the plans of care to reflect 16 required elements. All plan of care will be updated to include all 16 elements. Any changes will be sent to physician for MD signature and explanation for needed changes. Clinical Director will Educate on need to individualize plan of care with specific emphasis on specific DX, frequency, duration, patient specific goals based on DX and comprehensive assessments that are measurable. A consultant (Carmel Creek Consulting) will be retained for purpose of training, competence and conforming to agency policy and procedures and all clients" plans of care. Consultant scheduled for 3-5-19 All new admits and recert will be audited by QA within 10 days of last scheduled visit to adhere to compliance for six months then Quarterly The administrator shall be responsible for monitoring these corrective actions with ongoing monthly QAPI review to ensure that this deficiency is corrective and does not recur.	02/25/2019

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	The agency's comprehensive recertification dated 11/26/18 identified the patient had pain. The patient received homemaker services 1 hour per day, 5 days a week from 11/30/18 to 12/21/18. The plan of care failed to evidence pertinent diagnoses of diabetes and hypertension in relation to the medications identified on the medication list, failed to evidence a patient-specific frequency and duration for homemaker services, failed to evidence goals related to pain based on needs of the patient on the comprehensive assessment, and that goals were measurable with attainable dates. 3. The clinical record of patient #2 was reviewed on 01/02/19 and indicated a start of care date of 8/1/18. The record contained a plan of care for the certification period of 11/29/18-1/27/19 that indicated diagnoses of "multiple sclerosis, Incontinence, hx [history] of falls ... Medications: Lexapro (depression) ...Norco (pain) ... Lyrica (Pain) ... Lidocaine 5% patch (pain) ... oxycodone (pain) ... Goals: Client to be observed and environment kept safe to prevent falls / injuries while in home environment. Client will be observed for skin breakdown d/t [due to] incontinence and immobility. Client will remain clean, dry, odor free. Hygiene and personal care needs will be met with HHA assist. Weekly injection site to be free from infection or complications" The agency's comprehensive recertification dated 11/26/18 identified the patient had pain daily. The plan of care failed to evidence pertinent diagnoses of depression and pain in relation to the medications identified on the medication list, goals related to pain based on needs of the patient on the comprehensive assessment, and that goals were measurable with attainable dates.			

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	4. The clinical record of patient #3 was reviewed on 01/02/19 and indicated a start of care date of 10/30/18. The record contained a plan of care for the certification period of 12/4/18-2/1/19 that indicated diagnoses of "Debility, depression, HTN [hypertension], lymph nodes ... Medications: levimir (diabetes) ... Novolog (diabetes) ... Goals: Client to be observed and environment kept safe to prevent falls / injuries while in home environment. Client will be observed for skin breakdown in immobility. Client will remain clean, dry, odor free. Hygiene and personal care needs will be met with HHA assist. Monitor diet and diabetes ... " The agency start of care comprehensive assessment dated 12/4/18 identified the patient had cancer, was undergoing chemotherapy, had weakness and was depressed about the condition. During a home visit observation on 01/03/19 at 12:55 PM, with patient #3, employee E, licensed practical nurse (LPN), was observed providing skilled care. Employee E was observed completing a medication set-up. The medications trazodone 100 mg (milligrams) at bedtime and metformin 1000 mg twice daily were observed in the home. During this time, Employee E stated that these medications were not on the medication list. Patient #3 replied that the medications were not new. Levemir was viewed in the refrigerator with instructions to administer 35 units twice daily. Patient #3 stated that the dose had changed and currently was 60 units in the morning and if blood sugar at 5:00 PM was higher than 200, then an additional 60 units were to be injected at 5:00PM. The plan of care failed to evidence pertinent diagnosis of diabetes in relation to the medications identified on the medication list,			

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	failed to evidence medications viewed in the home that patient reported taking, failed to evidence goals related to cancer treatments, weakness or depression based on the needs of the patient on the comprehensive assessment, and that goals were measurable with attainable dates. During an interview on 1/10/19 at 2:34 PM, the patient's nurse practitioner (NP) was consulted about patient #3's plan of care. The NP stated that she did not understand why diabetes was not on the plan of care because the patient had a need for diabetes and medication management and that was what she thought the agency was providing. The NP reported that she had never spoken with the agency regarding this patient 5. The clinical record of patient #4 was reviewed on 01/02/19 and indicated a start of care date of 7/12/16. The record contained a plan of care for the certification period of 10/30/18 - 12/28/18 that indicated diagnoses of "Encephalomyelitis, Dementia, Bladder incontinent, Seizures ... Medications: Novolog (diabetes) ... Fentanyl patch (Pain) ... ATTC [attendant care] 147 hrs. [hours] a month used for PM [evening] care ... Goals: Client to be observed and environment kept safe to prevent falls / injuries while in home environment. Client will be observed for skin breakdown d/t [due to] Incontinence and immobility. Client will remain clean, dry, odor free. Hygiene and personal care needs will be met with HHA [home health aide] assist " The agency's comprehensive recertification dated 10/25/18 identified the patient had dyspnea with minimal exertion. The patient received attendant services in 15 minutes to 8-hour increments from 10/28/18-12/7/18. The plan of care failed to evidence pertinent diagnoses diabetes and pain in			

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	relation to the medications identified on the medication list, failed to evidence a patient-specific frequency and duration for attendant care services, and failed to evidence goals related to dyspnea and the respiratory status based on needs of the patient on the comprehensive assessment, and that goals were measurable with attainable dates. 6. The clinical record of patient #5 was reviewed on 01/02/19 and indicated a start of care date of 12/8/17. The record contained a plan of care for the certification period of 12/3/18-1/31/19 that indicated "Area 5 respite 30 hrs./mo. [hours per month] ... Goals: Client to be observed and environment kept safe to prevent falls/injuries while in home environment. Client will be observed for skin breakdown d/t incontinence and immobility. Client will remain clean, dry, odor free. Hygiene and personal care needs will be met with the HHA assist" The agency's comprehensive recertification dated 11/29/18 identified the patient had depression and was on medications for this. The plan of care failed to evidence a patient-specific frequency and duration for respite services and what discipline the respite hours were for, failed to evidence goals related to depression based on needs of the patient on the comprehensive assessment, and that goals were measurable with attainable dates. 7. The clinical record of patient #6 was reviewed on 01/07/19 and indicated a start of care date of 1/16/18. The record contained a plan of care for the certification period of 7/15/18-9/12/18 that indicated diagnoses of "Debility, Hx of pelvic fracture, hx of falls, COPD [chronic obstructive pulmonary disease] Medications: venlafaxine (nerve pain and antidepressant) voltaren (pain)			

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	Livestreams 93 hrs. ATTC, 20 hrs. HMK ... Goals: Client to be observed and environment kept safe to prevent falls / injuries while in home environment. Client will be observed for skin breakdown d/t incontinence and immobility. Client will remain clean, dry, odor free. Hygiene and personal care needs will be met with the HHA assist ... " A drug to drug interaction report was sent to the physician on 1/16/18. The physician faxed the interaction form back to the agency on 1/17/18 with written orders to discontinue the diclofenac (Voltaren). The agency medication record signed by employee C, assistant director of nursing (ADON), on 1/16/18, 3/15/18, 5/14/18, and 7/11/18 indicated an order for Voltaren dated 1/16/18 as an active medication. The record failed to evidence that diclofenac (Voltaren) was ever discontinued per physician order. The agency's comprehensive recertification dated 7/11/18 identified the patient had anxiety, agitation, and depression. The plan of care failed to evidence pertinent diagnoses depression and pain in relation to the medications identified on the medication list, failed to evidence a patient-specific frequency and duration for homemaker and attendant care services, failed to evidence goals related to anxiety, agitation or depression based on needs of the patient on the comprehensive assessment, that goals were measurable with attainable dates. During an interview on 1/16/19 at 12:42 PM, the director of nursing stated that the Voltaren should have been discontinued by the nurse.			

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	8. The clinical record of patient #7 was reviewed on 1/7/19 and indicated a start of care date of 6/4/18. The record contained a plan of care for the certification period of 10/2/18-11/30/18 that indicated diagnoses of "debility, pancreatic insufficiency, gastroparesis, incontinent ... Medications: Dulera (respiratory) ... Singulair (respiratory) ... ventolin (respiratory) ... Goals: Client to be observed and environment kept safe to prevent falls / injuries while in home environment. Client will be observed for skin breakdown d/t incontinence and immobility. Client will remain clean, dry, odor free. Hygiene and personal care needs will be met with the HHA assist ... " The agency's comprehensive recertification dated 10/2/18 identified the patient had a GJ (gastrojejunostomy) tube used for enteral feedings. The plan of care failed to evidence pertinent diagnosis related to respiratory issues to the medications identified on the medication list, failed to evidence goals related to the GJ tube and nutrition based on needs of the patient on the comprehensive assessment, and that goals were measurable with attainable dates. 9. The clinical record of patient #8 was reviewed on 1/14/19 and indicated a start of care date of 6/20/16. The record contained a plan of care for the certification period of 8/19/16-10/17/16 that indicated diagnoses of "quadriplegia, tracheotomy, urinary incontinence, bowel incontinence, vent dependent Medications: Clonidine (HTN Spironolactone -HCTZ [hydrochlorothiazide] (HTN) Orders: HMK 8 hrs. / mo., respite 60 hrs. / month. Goals: Client to be observed and environment kept safe to prevent falls / injuries while in home environment. Client will be observed for skin breakdown d/t			

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	incontinence and immobility. Client will remain clean, dry, odor-free with SN assist. Hygiene and personal care needs will be met by caregiver / SN. Home environment will remain clean and safe for power chair mobility. Client will maintain adequate nitration / hydration, elimination patterns with SN assist throughout cert [certification] period. " [sic] The agency's comprehensive recertification dated 8/17/16 identified the patient had a tracheotomy, used a ventilator and used oxygen at night. The plan of care failed to evidence pertinent diagnosis of hypertension in relation to the medications identified on the medication list, failed to evidence a patient-specific frequency and duration for homemaker and respite services, what discipline the respite hours were for, and failed to evidence goals related to the respiratory status based on the needs of the patient on the comprehensive assessment, and that goals were measurable with attainable dates. 10. During an interview on 1/14/19 at 4:52 PM, the director of nursing stated that all plans of care should contain the diagnoses "we're dealing with," an accurate frequency and duration, accurate medications, and measurable goals for everything identified on the comprehensive assessment.			

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