For Training Purposes Only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00000	A. BUILDING 00 B. WING	11/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HOME HEALTH	123 Main Street Anywhere, US 77000

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G 0574	Plan of care must include the following CFR(s): 484.60(a)(2) (i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and (iv) equipment required; (v) The frequency and duration of visits to be made; (vi) Prognosis; (vii) Rehabilitation potential; Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include.		Survey results revealed our agency failed to include pertinent Patient data to the Plan of Care to include allergies, medications, equipment, interventions, and goals for 4 of 13 Patient's reviewed. The exclusion of the pertinent data put the Patient's safety/wellbeing at risk. A complete medication/allergy review is to be completed at SOC and discussed with Patient on each subsequent visit so the Plan of Care can be updated for changes as they occur. All pertinent clinical interventions and goals are to be care planned to meet the patient’s needs, and according to care planned diagnosis. The admitting clinician does a walkthrough of home and documents all DME that the patient is utilizing to be included on the Plan of Care and the POC are appropriate for the services provided.	

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	This ELEMENT is not met as evidenced by: Based on review of medical records, observation, and patient and staff interview, it was determined the agency failed to ensure the POC was accurate and included all pertinent allergies, medications, equipment, interventions, and goals for 4 of 13 patients (#1, #8, #11, and #12) whose records were reviewed. This failure resulted in incomplete POCs and had the potential to result in unmet patient needs. Findings include: 1. Patient #1 was a 70-year-old female admitted to the agency on 10/07/18, with a primary diagnosis of breast cancer. Additional diagnoses included atrial fibrillation, insulin dependent DM, morbid obesity, and HTN. She received SN and aide services. Her record, including the POC, for the certification period 10/07/18 to 12/05/18, was reviewed. Patient #1's record included a handwritten "SKILLED NURSING EVALUATION," dated 10/07/18. It was not signed by a clinician. The form stated Patient #1 had allergies to Enoxaparin Sodium, Warfarin, Diltiazem, Codeine, Cephalexin, Metoprolol, Monohydrate, and peanuts. Patient #1's POC included allergies to Enoxaparin, Warfarin, Diltiazem, Codeine, and Cephalexin. It did not include her allergies to Metoprolol, Monohydrate, and peanuts.		**Plan of Correction:** The admitting clinicians have been in-serviced, and will complete an admission review sheet as well as a care plan review to ensure all pertinent data is included on The Plan of Care at SOC. The visiting clinicians, case managers have been in-service to review meds/allergies, and any other change that may occur at each subsequent visit, and then will enter a shared communication note as to services. The medication/allergies to be reconciled with the Physician on an ongoing basis. This will be the responsibility of each clinician visiting the Patient. This will be added to the existing SOC chart audit done at admission and performed by the Administrator (or designee) to ensure that POC information is accurate and documented appropriately. 100% of charts will be audited for 2 months or until 90% compliance is achieved (whichever comes first). There after the Administrator (or designee) will ensure ongoing compliance by performing a global chart audit in Feb, June and Oct on 10 charts or 10% from the previous four months (whichever is less). The Administrator will review the audit results to determine if there are areas of continued non-compliance and educate accordingly.	12/10/2018

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	During an interview on 11/01/18 at 3:15 PM, the Administrator stated the handwritten evaluation was a worksheet used by clinicians during the SOC assessment. She stated the information from the worksheet was entered into the agency's EMR after the assessment was completed. The Administrator confirmed 3 of the allergies on the worksheet were not entered the EMR. She confirmed Patient #1's POC did not include all her allergies. Patient #1's POC did not include all her allergies. 2. Patient #12 was a 77-year-old female admitted to the agency on 9/27/18, with a primary diagnosis of CHF. Additional diagnoses included UTI, unsteadiness on feet, Alzheimer's Disease, COPD, and muscle weakness. She received PT services. Her record, including the POC, for the certification period 9/27/18 to 11/25/18, was reviewed. Patient #12's POC included a primary diagnosis of CHF. Her record included an SOC comprehensive assessment, dated 9/27/18, signed by the Physical Therapist. The assessment included her CHF diagnoses with a severity level of 2, meaning her CHF symptoms were controlled with difficulty, affected her daily functioning, and needed ongoing monitoring. However, her POC did not include interventions to monitor her status related to CHF. It did not include goals related to CHF.			

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During an interview on 11/01/18 at 3:35 PM, the Physical Therapist confirmed Patient #12 received physical therapy services only. He stated his primary focus was gait training, strengthening, and safety. When asked why Patient #12's primary diagnosis was CHF, he stated diagnoses were determined by office staff and he was not involved in that process. Additionally, he stated he did not determine the severity codes on the SOC assessment.

Patient #12's POC did not include interventions or goals related to her primary diagnosis of CHF.

3. Patient #11 was a 57-year-old female admitted to the agency on 1/25/18, with a primary diagnosis of UTI. Additional diagnoses included multiple pressure ulcers, HTN, and morbid obesity. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period of 1/25/18 to 3/25/18, was reviewed.

Patient #11's medical record included a "COMMUNICATION NOTE," dated 1/25/18,

signed by the RNCM, which stated "[Patient #11] states she can walk around the house with a 4 prong [sic] walker...".

Patient #11's medical record included a POC, dated 1/25/18, signed by her physician. The POC included a section titled "DME," however, this section was blank. Patient #11's 4-prong walker was not included in her POC.

The Administrator was interviewed on 11/01/18, beginning at 11:25 PM, and Patient #11's medical record was reviewed in her presence. She confirmed Patient #11's POC did not include her DME.

Patient #11's POC was not individualized to include her DME.

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4. Patient #8 was a 77-year-old female admitted to the agency on 10/07/18, with a primary diagnosis of HTN and CKD. Additional diagnoses included CHF, encounter for surgical aftercare following surgery on the circulatory system, presence of cardiac pacemaker, ataxic gait, and dependence on supplemental oxygen. She received SN, PT, and OT services. Her record, including the POC, for the certification period 10/07/18 to 12/05/18, was reviewed. Findings include:

a. Patient #B's record included an SOC assessment, dated 10/07/18, signed by the SOC RN. The assessment documented Patient #8 had HTN, CKD, CHF, and atrial fibrillation. The assessment documented Patient #8 had symptoms controlled with difficulty, affecting daily functioning, and needed ongoing monitoring related to the above diseases.

Patient #B's POC, dated 10/15/18, signed by the SOC RN, included the SN cardiac interventions, "Assess/instruct Pl/Peg: Measures to detect and alleviate fluid retention." There was no goal related to fluid retention.

During an interview on 11/01/18 at 11:50 AM, the RNCM confirmed that Patient #B's POC did not include goals related to fluid retention.

Patient #B's POC was not comprehensive to address her risk for developing fluid retention.

b. Patient #B's POC listed her allergies as Erythromycin and Ceclor. However, Patient #B's records included a "Clinical Summary," dated 10/05/18, signed by the physician, which listed her allergies as Erythromycin, Ceclor, and Keflex."

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	A visit was made to Patient #B's home on 10/31/18, at 11:30 AM, to observe a COTA visit. Patient #8 was interviewed on 10/31/18, beginning at 12:15 PM. She stated she had drug allergies to Erythromycin, Ceclor, and Keflex. The RNCM was interviewed on 11/01/18, beginning at 11:50 AM, and Patient #B's medical record was reviewed in his presence. The RNCM confirmed Patient #B's POC did not include her allergy to Keflex. Patient #B's POC was not comprehensive to include her current drug allergies.			

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