STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	297078		01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL CARE HOME HEALTH	2575 MONTESSOURI STREET, #100 LAS VEGAS, NV 89117

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G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare Recertification Survey conducted at your agency on January 26, 2009 through January 27, 2009. A separate Statement of Deficiencies was generated as a result of the State Licensure Survey conducted during the same time period. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The census at the time of the survey was 38. Fifteen clinical records were reviewed. Six home visits were conducted. The agency failed to maintain condition level compliance with the following Condition of Participation: 42 CFR 484.55 - Comprehensive Assessment of Patients The following regulatory deficiencies were identified:	G 000		
G 104	484.10(b)(1)&(2) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.	G 104		

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 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on clinical record review and policy review, the agency failed to ensure patients exercised their rights as patients by signing service agreements for 4 of 15 patients (#4, #5, #7 and #1). Findings include: Patient #4 was admitted to the agency on 1/8/09 with diagnoses of gait abnormality, cerebral-vascular accident, hypertension, depression, angina, and psychosis. Skilled nursing was ordered for evaluation only. Physical therapy was ordered for gait abnormality. During review of the clinical record, it was noted that the service agreement document was unsigned as of 1/26/09. Patient #5 was admitted to the agency on 1/8/09 with diagnoses of gait abnormality, decubitus ulcer of the buttocks, cerebral-vascular accident, diabetes mellitus II, and hypertension. Skilled nursing was ordered for weekly observation, assessment, and wound care. Physical therapy was ordered for gait abnormality. During review of the clinical record, it was noted that the service agreement document was unsigned as of 1/26/09. Patient #7 was admitted to the agency on 1/8/09 with diagnoses of walking difficulty, Alzheimer's disease, seizures, gastroesophageal reflux disease, and hypertension. Skilled nursing was ordered for an evaluation only. Physical therapy was ordered for walking difficulty.	G 104		

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G 104	Continued From page 2 During review of the clinical record, it was noted that the service agreement document was unsigned as of 1/26/09. Patient #1 was admitted to the agency on 7/28/08 with diagnoses of difficulty walking and unspecified falls. Skilled nursing was ordered for evaluation only. MSW (medical social worker) was to evaluate and treat for community resources. Physical therapy evaluation for gait, balance, strength and endurance. During review of the clinical record, it was noted that the start of care documents were signed by the patient's son. The patient's son was not the patient power of attorney for healthcare. The patient's daughter was the patient's power of attorney for healthcare. The agency policy #1000.03, titled Advance Directives: Living wills, DNR orders, durable power of attorney for health care, last revised 4/01/99, was located in the administrative policy and procedure manual. On page four of the policy, under number 3 revealed the following: 3. Guardian of the person: If a guardian has been appointed for the patient, the clinical supervisor should review the appointment to make sure it is a GUARDIANSHIP OF THE PERSON, which gives the guardian the right to make medical decisions for the patient. Any appointment of a guardian should be noted in the patient's chart. Consent for the DNR order should then be sought from guardian. The consent should be in writing in the patient's chart.	G 104		
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a	G 107		

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G 107	Continued From page 3 patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on policy review, staff interview and document review, it was determined that the agency failed to ensure that patient complaints regarding care and its resolution were documented in accordance with the agency policy and procedure. Findings include: On 1/26/09 at 2:30 PM, an interview with the Director of Professional Services was conducted. When asked about a separate grievance/complaint log, she stated that she did not keep one. She stated that she was not keeping it separate from the clinical record and when asked if she could find one in a clinical record, she was unable to find a complaint documented. The agency policy Number 1000.01, titled Patient Rights, with effective date of 12/29/00, was located in the administrative policy and procedure manual. On page one, under number eight, revealed the following: The HHA (home health agency) will investigate complaints made by the patient or the patient's family or guardian regarding the care that is (or fails to be) furnished, or regarding the lack of	G 107		

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G 107	Continued From page 4 respect for the patient's property by anyone furnishing services on behalf of the HHA, and will document both the existence of the complaint and the resolution of the complaint. The patient/family will not be subject to discrimination or reprisal for filing a complaint.	G 107		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to insure the accuracy of the home health hotline in the information given to the patients at the start of care. Findings include: During review of documentation that was given to patient's at the start of care, the section of the patient handbook titled patient's bill of rights, revealed the following: 13. To be advised of the availability of the toll-free HHA hotline in the State of Nevada. The	G 116		

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G 116	Continued From page 5 HHA must advise the patient in writing of the HHA hotline number of 1-900-xxx-xxxx, 24 hours a day, the hours of operation 8am-5pm Monday through Friday; recording after 5pm, weekends and holidays. The correct phone number was 1-800-xxx-xxxx. When brought to the attention of the Director of Professional Services, on the afternoon of 1/26/09, she agreed that the information was incorrect and that the number must have been changed during the revision of the forms for the patient.	G 116		
G 131	484.14(b) GOVERNING BODY The governing body adopts and periodically reviews written bylaws or an acceptable equivalent. This STANDARD is not met as evidenced by: Based on staff interview and review of the governing body meeting minutes, it was determined that the agency failed to provide documented evidence that the governing body periodically reviewed the bylaws or an acceptable equivalent. Findings include: On the afternoon of 1/27/09, the governing body minutes were requested from the agency staff. They were unable to locate minutes for the governing body that were more recent than the meeting in 2006. The Director of Professional Services was unable to determine the location of the minutes after contacting the Administrator for assistance.	G 131		
G 132	484.14(b) GOVERNING BODY	G 132		

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G 132	Continued From page 6 The governing body oversees the management and fiscal affairs of the agency. This STANDARD is not met as evidenced by: Based on documentation provided by administrative staff, it was determined the governing body failed to oversee the fiscal affairs of the agency. Findings include: On the afternoon of 1/27/09, the governing body minutes were requested from the agency staff. They were unable to locate minutes for the governing body that were more recent than the meeting in 2006. The Director of Professional Services was unable to determine the location of the minutes after contacting the Administrator for assistance. The agency staff was then asked for the budget committee meeting minutes, or a copy of the current budget. They were unable to locate the items requested.	G 132		
G 136	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, implements an effective budgeting and accounting system. This STANDARD is not met as evidenced by: Based on review of documentation provided by the agency staff, the agency failed to maintain a budget and ensure an effective budgeting and accounting system was implemented.	G 136		

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G 136	Continued From page 7 Findings include: On the afternoon of 1/27/09, the governing body minutes were requested from the agency staff. They were unable to locate minutes for the governing body that were more recent than the meeting in 2006. The Director of Professional Services was unable to determine the location of the minutes after contacting the Administrator for assistance. The agency staff was then asked for the budget committee meeting minutes, or a copy of the current budget. They were unable to locate the items requested.	G 136		
G 143	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. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to coordinate its care efforts effectively for 1 of 15 patients (#6). Findings include: Patient #6 was admitted to the agency on 11/9/08 and recertified on 1/8/09 with diagnoses of walking difficulty, venous embolism, hypertension, congestive heart failure, depression, and gastritis. Skilled nursing was ordered for evaluation only. Physical therapy was ordered for gait abnormality.	G 143		

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G 143	Continued From page 8 On 11/15/08, physical therapy discharged Patient #6 and indicated "skilled service no longer necessary". Physical therapy continued to see Patient #6 on 11/16/08, 11/18/08, and 11/22/08. The clinical record lacked new orders for these three additional visits. On 1/27/09 at 1:55 PM, the Director of Professional Services lacked an explanation for these three physical therapy visits. On 12/26/08, occupational therapy discharged Patient #6. Occupational therapy was the last discipline to see Patient #6 during the care episode of 11/9/08 to 1/7/09. The skilled nurse recertified Patient #6 for another care episode on 1/8/09. On 1/27/09, the clinical record lacked documented evidence of care coordination between physical therapy, occupational therapy, and the skilled nurse. On 1/27/09 at 3:30 PM, the Director of Professional Services indicated the agency failed to realize occupational therapy discharged Patient #6 from services as the last discipline, so the skilled nurse recertified (and did not readmit) Patient #6. The agency failed to discharge Patient #6 and readmit Patient #6 with a new start of care date.	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the agency failed to establish effective care coordination for 1 of 15 patients (#9).	G 144		

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G 144	Continued From page 9 Findings include: Patient #9 was admitted to the agency on 1/6/09 with diagnoses of walking difficulty, hypertension, diabetes mellitus II, depression, and anemia. Skilled nursing was ordered for weekly observation, assessment, and teaching. On 1/6/09, the plan of care indicated weekly skilled nursing visits for three weeks. On 1/27/09, the clinical record lacked documented evidence of a skilled nursing visit for the week of 1/17/09 to 1/23/09. On 1/27/09 at 2:40 PM, the Director of Professional Services indicated the agency lacked a skilled nursing visit for this week because it decided to discharge Patient #9, but the clinical record lacked a discharge summary. The Director of Professional Services indicated Patient #9's discharge was pending.	G 144		
G 147	484.14(i) INSTITUTIONAL PLANNING The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan. (1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense. (2) Capital expenditure plan. (i) There is a capital expenditure plan for at	G 147		

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G 147	Continued From page 10 least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds. (ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following: (A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental	G 147		

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G 147	Continued From page 11 Health Centers Construction Act of 1963. (B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations. (C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency. This STANDARD is not met as evidenced by: Based on review of documentation and staff interview, the agency failed to prepare an overall plan and budget that included an annual operating and capital budget for at least a three year period. Findings include: On the afternoon of 1/27/09, the governing body minutes were requested from the agency staff. They were unable to locate minutes for the governing body that were more recent than the meeting in 2006. The Director of Professional Services was unable to determine the location of the minutes after contacting the Administrator for assistance. The agency staff was then asked for the budget committee meeting minutes, or a copy of the current budget. They were unable to locate the items requested.	G 147		
G 148	484.14(i) INSTITUTIONAL PLANNING The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the	G 148		

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G 148	Continued From page 12 governing body, the administrative staff, and the medical staff (if any) of the HHA. This STANDARD is not met as evidenced by: Based on review of the information presented by the agency staff, it was determined the agency failed to prepare the budget under the direction of the governing body. Findings include: On the afternoon of 1/27/09, the governing body minutes were requested from the agency staff. They were unable to locate minutes for the governing body that were more recent than the meeting in 2006. The Director of Professional Services was unable to determine the location of the minutes after contacting the Administrator for assistance. The agency staff was then asked for the budget committee meeting minutes, or a copy of the current budget. They were unable to locate the items requested.	G 148		
G 149	484.14(i) INSTITUTIONAL PLANNING The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA. This STANDARD is not met as evidenced by:	G 149		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 157		

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G 157	Continued From page 13 Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the agency failed to meet a reasonable expectation providing for patients' needs for 6 of 15 patients (#3, #6, #8, #9, #12 and #1). Findings include: Patient #3 was admitted to the agency on 1/12/09 with diagnoses of walking difficulty, chronic pain, diabetes mellitus II, right above the knee amputation, weakness, and left lower extremity discomfort. Skilled nursing was ordered for observation, assessment, and evaluation of pain status twice weekly. Physical therapy was ordered to evaluate and treat. Occupational therapy was ordered to evaluate and treat. Patient #3 was seen by skilled nursing on 1/12/09 for the start of care evaluation and OASIS data collection. On 1/27/09 in the afternoon, the Director of Professional Services indicated the agency's secondary disciplines were expected to see patients within 72 hours of the start of care. The patient was seen by physical and occupational therapy on 1/16/09 for the evaluations. These visits occurred four days after the start of care date of 1/12/09. Patient #6 was admitted to the agency on 11/9/08 and recertified on 1/8/09 with diagnoses of	G 157		

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G 157	Continued From page 14 walking difficulty, venous embolism, hypertension, congestive heart failure, depression, and gastritis. On 1/7/09, a physician's verbal order indicated a physical therapy evaluation. The agency completed a physical therapy evaluation on 1/14/09. On 1/27/09 in the afternoon, the Director of Professional Services indicated the agency's secondary disciplines were expected to see patients within 72 hours of the start of care. The physical therapy evaluation visit occurred six days after the start of care date of 1/8/09. Patient #8 was admitted to the agency on 1/15/09 with diagnoses of walking difficulty, diabetes mellitus II, gastroesophageal reflux disease, depression, congestive heart failure, and dementia. Occupational therapy was ordered to evaluate and treat. On 1/15/09, a physician's verbal order indicated an occupational therapy evaluation. The agency completed an occupational therapy evaluation on 1/22/09. On 1/27/09 in the afternoon, the Director of Professional Services indicated the agency's secondary disciplines were expected to see patients within 72 hours of the start of care. The occupational therapy evaluation visit occurred a week after the start of care date of 1/15/09. Patient #9 was admitted to the agency on 1/6/09 with diagnoses of walking difficulty, hypertension, diabetes mellitus II, depression, and anemia. Physical therapy was ordered to evaluate and treat. The agency completed a physical therapy evaluation on 1/20/09. On 1/27/09 in the	G 157		

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G 157	Continued From page 15 afternoon, the Director of Professional Services indicated the agency's secondary disciplines were expected to see patients within 72 hours of the start of care. The physical therapy evaluation visit occurred two weeks after the start of care date of 1/6/09. Patient #12 was admitted to the agency on 12/31/08 with diagnoses of abnormality of gait, late effects of cerebrovascular accident, essential hypertension, abnormal heart sounds and multiple infarct dementia. Skilled nursing was ordered for evaluation. Physical therapy and occupational therapy to evaluate and treat. Occupational therapy evaluated the patient on 1/09/09, 9 days after the start of care. Patient #1 was admitted to the agency on 7/28/08 with diagnoses of difficulty walking and unspecified falls. Skilled nursing was ordered for evaluation only. MSW (medical social worker) was to evaluate and treat for community resources. Physical therapy evaluation for gait, balance, strength and endurance. The patient was seen by the medical social worker five days after the beginning of care. The patient was seen by the physical therapist seven days after the beginning of care. During an interview on 1/26/09 at 2:30 PM with the Director of Professional Services, she stated that secondary disciplines were to see the patient with in 72 hours from the physician's order.	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine,	G 158		

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G 158	Continued From page 16 osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the agency failed to follow the plan of care for 4 of 15 patients (#2, #3, #5, and #15). Findings include: Patient #2 was admitted to the agency on 1/16/09 with diagnoses of liver failure, diabetes mellitus, hypertension, bilateral lower extremity edema, and weakness. On 1/27/09, Patient #2's plan of care, which the agency initiated on 1/16/09, indicated an order for an occupational therapy evaluation the agency never completed. After discussion, the Director of Professional Services wrote a physician's verbal order cancelling the evaluation on the afternoon of 1/27/09. Patient #3 was admitted to the agency on 1/12/09 with diagnoses of walking difficulty, chronic pain, diabetes mellitus II, right above the knee amputation, weakness, and left lower extremity discomfort. Physical therapy was ordered to evaluate and treat. On 1/16/09, the physical therapy evaluation and physician's order form indicated three weekly physical therapy visits for three weeks. On 1/27/09, the clinical record revealed two physical therapy visits for the week of 1/17/09 to 1/23/09: 1/19/09 and 1/21/09. Patient #5 was admitted to the agency on 1/8/09 with diagnoses of gait abnormality, decubitus	G 158		

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G 158	Continued From page 17 ulcer of the buttocks, cerebral-vascular accident, diabetes mellitus II, and hypertension. Skilled nursing was ordered for weekly observation, assessment, and wound care. On 1/8/09, Patient #5's plan of care ordered the skilled nurse to perform wound measurements weekly. On 1/12/09 at 9:45 AM, the skilled nurse note lacked wound measurements. Patient #15 was admitted to the agency on 9/2/08 with diagnoses of walking difficulty, diabetes mellitus II, and hypertension. Physical therapy was ordered to evaluate and treat. On 9/4/08, Patient #15's physical therapy evaluation and physician's order form indicated three visits weekly starting with the second care week. Patient #15's second care week occurred between 9/7/08 and 9/13/08. Patient #15 received two physical therapy visits during this week on 9/9/08 and 9/11/08. The clinical record lacked an order and plan of care change accounting for the reduction in visits.	G 158		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on observation, staff interview and clinical record review, the agency failed to administer drugs and treatments only as ordered by the physician for 3 of 15 patients (#5, #6, and #15). Findings include:	G 165		

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G 165	Continued From page 18 Patient #5 was admitted to the agency on 1/8/09 with diagnoses of gait abnormality, decubitus ulcer of the buttocks, cerebral-vascular accident, diabetes mellitus II, and hypertension. Skilled nursing was ordered for weekly observation, assessment, and wound care. Physical therapy was ordered for gait abnormality. On 1/22/09, the agency conducted an occupational therapy evaluation. On 1/26/09, Patient #5's plan of care lacked an order for occupational therapy, and a physician's verbal order indicated this order was omitted from the plan of care on 1/27/09. Patient #6 was admitted to the agency on 11/9/08 with diagnoses of walking difficulty, venous embolism, hypertension, congestive heart failure, depression, and gastritis. Physical therapy was ordered for gait abnormality. On 11/15/08, physical therapy discharged Patient #6 and indicated "skilled service no longer necessary". Physical therapy continued to see Patient #6 on 11/16/08, 11/18/08, and 11/22/08. The clinical record lacked new orders for these three additional visits. On 1/27/09 at 1:55 PM, the Director of Professional Services lacked an explanation for these three additional physical therapy visits. On 11/20/08, the agency conducted an occupational therapy evaluation. On 1/26/09, the clinical record lacked a physician order to conduct this occupational therapy evaluation. Patient #15 was admitted to the agency on 9/2/08 with diagnoses of walking difficulty, diabetes mellitus II, and hypertension. Physical therapy	G 165		

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G 165	Continued From page 19 was ordered to evaluate and treat. On 9/4/08, Patient #15's physical therapy evaluation and physician's order form indicated one visit for the first care week. Patient #15's first care week occurred between 8/30/08 and 9/6/08. Patient #15 received two physical therapy visits during this week on 9/4/08 and 9/6/08. On 1/27/09 at 1:40 PM, the Director of Professional Services indicated the physical therapy evaluation counted as the first visit in terms of visit frequency in a care week. The clinical record lacked an order and plan of care change accounting for the additional visit.	G 165		
G 176	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. This STANDARD is not met as evidenced by: Based on record review, the agency failed to coordinate services regarding changes in the patient's condition and needs for 1 of 15 patients (#14). Findings include: Patient #14 was admitted to the agency on 9/8/08 with diagnoses of walking difficulty, bronchial neoplasm, pleural effusion, shortness of breath, malaise/fatigue, and chronic airway obstruction. Skilled nursing was ordered for weekly observation, assessment, and teaching. Home health aide assistance was ordered weekly for personal care. Physical therapy was ordered to	G 176		

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G 176	Continued From page 20 evaluate and treat. The agency conducted home health aide visits for Patient #14 on 9/9/08, 9/11/08, 9/16/08, 9/19/08, and 9/23/08. According to the clinical record, Patient #14's respirations exceeded 24 on each of the aforementioned visits. On 9/8/08, the certified nurse aid care plan indicated required notification of the case manager when Patient #14's respirations exceeded 24. On 1/27/09, the clinical record lacked documented evidence required notification occurred for any of the aforementioned visits.	G 176		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review, the agency failed to conduct supervisory visits for its home health aides no less frequently than every 2 weeks for 1 of 15 patients (#14). Findings include: Patient #14 was admitted to the agency on 9/8/08 with diagnoses of walking difficulty, bronchial neoplasm, pleural effusion, shortness of breath, malaise/fatigue, and chronic airway obstruction. Skilled nursing was ordered for weekly observation, assessment, and teaching. Home health aide assistance was ordered weekly for personal care.	G 229		

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G 229	Continued From page 21 The agency completed Patient #14's first home health aide visit on 9/9/08. The agency completed Patient #14's last home health aide visit on 9/23/08. The clinical record lacked documented evidence of a skilled nurse conducting a supervisory visit for the home health aide between 9/9/08 and 9/23/08.	G 229		
G 246	484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the agency failed to report the results of the evaluation to those responsible for the operation of the agency. Findings include: On the afternoon of 1/27/09, the governing body minutes were requested from the agency staff. They were unable to locate minutes for the governing body that were more recent than the meeting in 2006. The Director of Professional Services was unable to determine the location of the minutes after contacting the Administrator for assistance. The agency evaluation was present in the 2008 professional advisory group minutes.	G 246		
G 250	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	G 250		

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G 250	Continued From page 22 closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the agency failed to provide at least quarterly, a review of clinical records by appropriate health professionals, to determine whether established policies were followed in furnishing care to patients. Findings include: During review of the professional advisory group minutes for 2008, the record lacked documented evidence of quarterly review of clinical records for the year 2008. There were reports for the review of clinical records for 2007 only. During an interview with the Director of Professional Services on the afternoon of 1/26/09, she stated that she had not yet done any of the record reviews for 2008.	G 250		
G 303	484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to demonstrate that discharge summaries were available to the	G 303		

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G 303	Continued From page 23 physician that contained pertinent information on the care of the patient in 1 of 15 patient records reviewed. (#1) Findings include: Patient #1 was admitted to the agency on 7/28/08 with diagnoses of difficulty walking and unspecified falls. Skilled nursing was ordered for evaluation only. MSW (medical social worker) was to evaluate and treat for community resources. Physical therapy evaluation for gait, balance, strength and endurance. The patient was transferred to the hospital on 8/06/08. A transfer OASIS was completed for the transfer date. The patient was later discharged from service, but no discharge summary was completed. The Director of Professional Services was interviewed on 1/26/09 in the afternoon about the missing discharge summary. She stated that it must not have been done.	G 303		
G 323	484.20(c)(1) TRANSMITTAL OF OASIS DATA The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the agency failed to electronically transmit OASIS data for each patient the agency provided service to at least monthly. Findings include:	G 323		

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G 323	Continued From page 24 Prior to the survey date, a report titled submission statistics by Agency was generated as part of the pre-survey data collection. The report listed the OASIS submission dates generated over the time span of 7/01/08 and 12/31/08. There were only three months in that time period in which the agency submitted data, 07/08, 09/08 and 11/08. The submission dates were more than 31 days apart.	G 323		
G 324	484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on reports obtained prior to the survey date, the agency failed to submit collected patient assessments within the CMS timing guidelines. The submission date of the records is more than 30 days from the completion date. Findings include: Prior to the survey date, a report titled error summary report by HHA (Home Health Agency) was generated as part of the pre-survey data collection. The report listed the number of errors generated over the time span of 7/01/08 and 12/31/08. There were 219 errors recorded on this report, 83 of which dealt with error #286 - Inconsistent MO090/submission date: The submitted assessment was not submitted within CMS timing guidelines. The submission date is more than 30 days from the MO090 (completion date). The percentage of assessments with the error was 28.33%.	G 324		

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G 330	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary This CONDITION is not met as evidenced by: This CONDITION is not met as evidenced by: Based on clinical record review, policy review, staff interview and patient interview, the agency failed to adequately assess the needs of their patients. The agency failed to ensure each patient received, patient specific, comprehensive assessment that accurately, reflected the patient's current health status and met the patients medical and nursing needs; and failed to ensure the comprehensive assessment included a review of all medications the patient was using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant during	G 330		

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G 330	Continued From page 26 interactions, duplicate drug therapy, and noncompliance with drug therapy (G337). The cumulative effect of these systemic practices resulted in the failure of the agency to adequately assess the needs of their patients.	G 330		
G 334	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. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to complete the comprehensive assessment no later than 5 calendar days after the start of care for 9 of 15 patients (#4, #6, #7, #8, #15, #12, #1, #10 and #11). Findings include: Patient #4 was admitted to the agency on 1/8/09 with diagnoses of gait abnormality, cerebral-vascular accident, hypertension, depression, angina, and psychosis. Skilled nursing was ordered for evaluation only. Physical therapy was ordered for gait abnormality. Patient #4 was seen by skilled nursing on 1/8/09 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 1/10/09 for its evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment and OASIS document were	G 334		

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G 334	Continued From page 27 completed within the 5 day window following the actual start of care date. Patient #6 was admitted to the agency on 11/9/08 with diagnoses of walking difficulty, venous embolism, hypertension, congestive heart failure, depression, and gastritis. Skilled nursing was ordered for evaluation only. Physical therapy was ordered for gait abnormality. Patient #6 was seen by skilled nursing on 11/9/08 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 11/11/08 for its evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment and OASIS document were completed within the 5 day window following the actual start of care date. Patient #7 was admitted to the agency on 1/8/09 with diagnoses of walking difficulty, Alzheimer ' s disease, seizures, gastroesophageal reflux disease, and hypertension. Skilled nursing completed an evaluation only on 1/8/09. Physical therapy was ordered for walking difficulty. Patient #7 was seen by skilled nursing on 1/8/09 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 1/10/09 for its evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment and OASIS document were completed within the 5 day window following the	G 334		

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G 334	Continued From page 28 actual start of care date. Patient #8 was admitted to the agency on 1/15/09 with diagnoses of walking difficulty, diabetes mellitus II, gastroesophageal reflux disease, depression, congestive heart failure, and dementia. Skilled nursing was ordered for an evaluation only. Physical and occupational therapy were ordered to evaluate and treat and by skilled nursing on 1/15/09 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 1/17/09 for its evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment and OASIS document were completed within the 5 day window following the actual start of care date. Patient #15 was admitted to the agency on 9/2/08 with diagnoses of walking difficulty, diabetes mellitus II, and hypertension. Skilled nursing was ordered for evaluation only. Physical therapy was ordered to evaluate and treat. Patient #15 was seen by skilled nursing on 9/2/08 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 9/4/08 for its evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment and OASIS document were completed within the 5 day window following the actual start of care date. Patient #12 was admitted to the agency on 12/31/08 with diagnoses of abnormality of gait,	G 334		

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G 334	Continued From page 29 late effects of cerebrovascular accident, essential hypertension, abnormal heart sounds and multiple infarct dementia. Skilled nursing was ordered for evaluation. Physical therapy and occupational therapy to evaluate and treat. Patient #12 was seen by skilled nursing on 12/31/08 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 1/02/09 for the evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment with OASIS document were completed within the 5 day window following the actual start of care date. Patient #1 was admitted to the agency on 7/28/08 with diagnoses of difficulty walking and unspecified falls. Skilled nursing was ordered for evaluation only. MSW (medical social worker) was to evaluate and treat for community resources. Physical therapy evaluation for gait, balance, strength and endurance. Patient #1 was seen by skilled nursing on 7/28/08 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 8/04/08 for the evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment with OASIS document were completed within the 5 day window following the actual start of care date. Patient #10 was admitted to agency on 12/11/08	G 334		

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G 334	Continued From page 30 with diagnoses of difficulty in walking, arthritis - many sites, diabetes, essential hypertension and senile dementia. Patient #10 was seen by skilled nursing on 12/11/08 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 12/13/08 for the evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment with OASIS document were completed within the 5 day window following the actual start of care date. Patient #11 was admitted to the agency on 12/31/08 with diagnoses of difficulty in walking, chronic back pain, essential hypertension, diabetes, depression and senile dementia. Skilled nursing was ordered for evaluation only. Physical therapy was ordered to evaluate and treat. Patient #11 was seen by skilled nursing on 12/31/08 for the start of care evaluation and OASIS data collection. Skilled nursing provided no skilled service during the evaluation. The patient was seen by physical therapy on 1/02/09 for the evaluation which was the actual start of care date for the episode. The clinical record lacked documented evidence that a comprehensive assessment with OASIS document were completed within the 5 day window following the actual start of care date.	G 334		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently	G 337		

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G 337	Continued From page 31 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. This STANDARD is not met as evidenced by: Based on observation, interview and clinical record review, the agency failed to review and update current medications for 6 of 15 patients (#2, #8, #7, #5, #6 and #4). Findings include: Patient #2 was admitted to the agency on 1/16/09 with diagnoses of liver failure, diabetes mellitus, hypertension, bilateral lower extremity edema, and weakness. Skilled nursing was ordered for observation, assessment, and teaching. On 1/27/09 at 8:30 AM, observation of Patient #2's medication revealed a container with the following label: Lasix 40 milligrams daily. At 9:10 AM the skilled nurse failed to indicate a reason for why Patient #2's plan of care lacked the Lasix prescription. The clinical record lacked a physician order for Lasix. The Director of Professional Services wrote a physician's verbal order adding Lasix 40 milligrams daily to Patient #2's plan of care on the afternoon of 1/27/09. During observation of a home visit on the afternoon of 1/27/09, the Director of Nurses at the ICF/MR facility provided copies of the patient's current medications. Patient #8's medication list from the facility was compared to the updated medication list in the clinical record of the agency. The agency's medication profile for the patient lacked documented evidence of the following medications ordered for the patient:	G 337		

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G 337	Continued From page 32 Tylenol 325 mg (milligrams) two tablets orally every four hours as needed for pain or fever Milk of magnesia 30 cc (cubic centimeter) orally as needed everyday Lortab 5/500 mg one tablet orally every four hours as needed for pain Glipizide CR 10 mg orally before breakfast Plavix 75 mg orally everyday Aspirin 81 mg orally every day The agency's medication profile listed the following medications at a different dosage than the facility's records: Facility: Regular insulin, 200-250, 2 units, 251-300, 4 units, 301-350, 6 units, 351-400, 5 units and >400, 10 units, if blood sugar is >400, recheck every two hours and cover accordingly Agency: Regular insulin, 70-150, no units, 151-200, 3 units, 201-250, 6 units, 251-300, 9 units, >300 call MD. Humulin 70/30 insulin 10 units subcutaneously twice a day Facility: Amiodarone (cordarone) 200 mg orally everyday Agency: Amiodarone (cordarone) 300 mg orally everyday Facility: Digoxin 0.125 mg orally everyday Agency: Digoxin 0.25 mg orally daily Facility: Lisinopril 10 mg orally everyday Agency: Lisinopril 10 mg orally twice a day Facility: Duloxetine (Cymbalta) 60 mg orally everyday Agency: Duloxetien (Cymbalta) 90 mg orally everyday	G 337		

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G 337	Continued From page 33 Facility: Carvedilol (Coreg) 3.125 mg orally twice a day Agency: Carvedilol (Coreg) 6.25 mg orally twice a day During observation of a home visit on the afternoon of 1/27/09, the Director of Nurses at the ICF/MR facility provided copies of the patient's current medications. Patient #7's medication list from the facility was compared to the updated medication list in the clinical record of the agency. The agency's medication profile for the patient lacked documented evidence of the following medications ordered for the patient: Tylenol 325 mg (milligrams) two tablets orally every four hours as needed for pain or temperature >100.5 degrees Milk of magnesia 30 cc (cubic centimeter) orally everyday as needed if no bowel movement in two days Dulcolax suppository 10 mg one suppository inserted rectally, if no results from milk of magnesia in 24 hours Fleets enema one rectally every day as needed, if no results from dulcolax in 12 hours and call MD During observation of a home visit on the afternoon of 1/27/09, the Director of Nurses at the ICF/MR facility provided copies of the patient's current medications. Patient #5's medication list from the facility was compared to the updated medication list in the clinical record of the agency. The agency's medication profile for the patient lacked documented evidence of the following medications ordered for the patient: Tylenol 325 mg (milligrams) two tablets orally	G 337		

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G 337	Continued From page 34 every four hours as needed for pain or temperature >100.5 Milk of magnesia 30 cc (cubic centimeter) orally as needed if the patient has no bowel movement in two days Dulcolax suppository 10 mg one suppository inserted rectally as needed if no results from milk of magnesia in 12 hours Fleets enema one rectally as needed if no results from Dulcolax in 12 hours Zinc SO4 one tablet orally every day Vitamin C 500 mg one tablet orally every day Megace liquid 400 mg orally twice a day The agency's medication profile listed the following medications at a different dosage than the facility's records: Facility: Regular insulin, if >400 recheck every two hours and cover accordingly until <300. Agency: Regular insulin, if >400 10 units Facility: Dilantin 300 mg orally at bedtime (changed on 1/16/09) Agency: Dilantin 200 mg orally at bedtime During observation of a home visit on the afternoon of 1/27/09, the Director of Nurses at the ICF/MR facility provided copies of the patient's current medications. Patient #6's medication list from the facility was compared to the updated medication list in the clinical record of the agency. The agency's medication profile for the patient lacked documented evidence of the following medications ordered for the patient: Tylenol 325 mg (milligrams) two tablets orally every four hours as needed for pain or temperature >101 degrees	G 337		

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G 337	Continued From page 35 Milk of magnesia 30 cc (cubic centimeter) orally everyday as needed for constipation Dulcolax suppository 10 mg one suppository inserted rectally as needed for constipation Resource 2.0 60 ml (milliliter) three times a day with medication pass Fleets enema one rectally every three days as needed for constipation Omeperizole 20 mg one orally twice a day The agency's medication profile listed the following medications at a different dosage than the facility's records: Facility: Aricept 10 mg orally everyday (changed on 1/13/09) Agency: Aricept 10 mg orally twice a day During observation of a home visit on the afternoon of 1/27/09, the Director of Nurses at the ICF/MR facility provided copies of the patient's current medications. Patient #4's medication list from the facility was compared to the updated medication list in the clinical record of the agency. The agency's medication profile for the patient lacked documented evidence of the following medications ordered for the patient: Tylenol 325 mg (milligrams) two tablets orally every four hours as needed for pain Milk of magnesia 30 cc (cubic centimeter) orally as needed if the patient has three consecutive days without a bowel movement Dulcolax tabs EC 5 mg as needed if the milk of magnesia is not effective in 12 hours Cough syrup 2 tsp as needed orally every four hours	G 337		
G 342	484.55(e) INCORPORATION OF OASIS DATA ITEMS	G 342		

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G 342	Continued From page 36 The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to incorporate the OASIS(Outcome and assessment information set) data items into the agency's own comprehensive assessment for all patient's currently admitted to service. Findings include: On the morning of 1/26/09, during review of the admission paperwork the agency provides for patients during admission, it was noted that the nursing paperwork for admission, recertification and resumption of care, contained the CMS OASIS document with a nurse's note attached to it. The OASIS data was not incorporated into a comprehensive assessment as required. An interview with the Director of Professional Services revealed that she was not aware of the requirement that the OASIS elements needed to be incorporated into the comprehensive assessment.	G 342		