CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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Findings: NOT MET

Review ID: 13237

Region: 02 New York

Contract Number / Name: H3331 INDEPENDENT LIVING FOR SENIORS, INC.

Auditing Guide Version: PACE Audit Guide, Version 1

Auditing Element: DTY01

Review Type: Focused

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Requirement:

(a) Meal requirements. (1) Except as specified in paragraphs (a)(2) or (a)(3) of this section, the PACE organization must ensure, through the assessment and care planning process, that each participant receives nourishing, palatable, well-balanced meals that meet the participant"s daily nutritional and special dietary needs. Each meal must meet the following requirements: (i) Be prepared by methods that conserve nutritive value, flavor, and appearance. (ii) Be prepared in a form designed to meet individual needs. (iii) Be prepared and served at the proper temperature. (2) The PACE organization must provide substitute foods or nutritional supplements that meet the daily nutritional and special dietary needs of any participant who has any of the following problems: (i) Refuses the food served. (ii) Cannot tolerate the food served. (iii) Does not eat adequately. (3) The PACE organization must provide nutrition support to meet the daily nutritional needs of a participant, if indicated by his or her medical condition or diagnosis. Nutrition support consists of tube feedings, total parenteral nutrition, or peripheral parenteral nutrition. (b) Sanitary conditions. The PACE organization must do the following: (1) Procure foods (including nutritional supplements and nutrition support items) from sources approved, or considered satisfactory, by Federal, State, Tribal, or local authorities with jurisdiction over the service area of the organization. (2) Store, prepare, distribute, and serve foods (including nutritional supplements and nutrition support items) under sanitary conditions.(3) Dispose of garbage and refuse properly.

Deficiencies:

Based on the direct observations made in the dining, or common, area between the hours of 11:00 AM and 1:00 PM on June 24, 2008 and interviews with staff, Independent Living for Seniors, Inc. (ILS) failed to provide oversight of the dining area to ensure that the PACE organization provided nutrition support to meet the daily nutritional needs of a participant, if indicated by his or her medical condition or diagnosis. Cross reference to SDY01, SDY03, and SDY04. Observational finding include but are not limited to those noted below. 1. One participant,observed at table zone 1 was positioned slumped over the table and sleeping. The main course was not delivered to the participant until approximately 1:00 PM. The participant was left unattended during the meal service and never prompted to eat the beef barley soup or drink the sprite offered to the other participants before the main course was served. She was also not prompted to take part in the large group activity during the beginning of the meal service. 2. One participant with an edematous tremoring right hand at table zone 8 was observed trying to feed herself apple pie from a Styrofoam desert bowl with a regular fork. The food fell from the fork to her protective clothes barrier. In addition, a family member who was supposed to be assisting the participant was eating her main course of lasagna and green beans. The staff was interviewed and stated the male family member came to see her at the facility frequently but no one had noticed this behavior in the past. 3. The Nutritional Review of the medical record of another participant who was observed feeding herself a pureed meal with thickened to nectar fluid revealed the significant changes noted below had taken place in October 2007. a. Physical or functional changes (Decrease in level of functioning) b. Gastroenterological/respiratory symptoms (Aspiration) c. Gustatory symptoms (Choking on regular diet food) d. Dietary intake (Decrease in oral fluid and food intake) The participant was observed with a divided sectional plate and a regular fork. Her impaired fine motor control of the right hand forced her to hold the fork between her thumb and second digit. The participant had difficulty feeding herself using the regular fork and sectional plate, resulting in frequent spills. The assessment and the care plan did not document these issues on her chart. In addition there had not been any restorative therapy evaluation of her fine motor control and how it affected her ability to feed herself with a regular fork. As a result, no adaptive equipment was recommended and discussed during the IDT meetings. 4. The comfort zone room, or Occupational Therapy Room, had 6 cognitively impaired participants assessed as requiring special attention for prompting and assistance with feeding. There was only one English speaking attendant in the room during the observation made between 12:00PM and 12:20PM. Three of the participants among the group could only communicate in Spanish. At approximately 12:20 PM, a Spanish speaking attendant came into the room to assist and prompt the ladies who had eaten very small amounts until this time. In addition, the one vegetarian in the room only received pureed potatoes and green beans without a protein for the meal. An interview with the dietician revealed that the participant should have received cottage cheese with her meal for her protein intake. 5. During the dining observation, the reviewer noted that the vendor delivered the noon at 11:30 AM. The food was delivered on large trays and was not placed in hot water or other heat source to maintain temperatures within required ranges. One staff member was observed plating the meal while 8 to 10 staff distributed the meal. Food was still being plated at 1:00 PM. Having only one person plate the meal resulted in a delay in participants receiving their meal and can result in food being served at unsafe temperatures.

Corrective Action Required:

The Center must facilitate the assessment process between the dietician and restorative rehabilitative staff for the integration of dietary care needs into the care plan. These include but not limited to Nutritional Review, Physical or functional changes, Gastroenterological symptoms, Gustatory symptoms, Dietary intake and Laboratory values. Refer to CAR under SDY04. The Center will have a dietician in the common area supervising the process with every meal. Provide an implementation timeline to CMS and the New York State Department of Health. The Center will obtain resources to adequately serve and plate the food received from the contractor within a reasonable timeframe to maintain temperatures as well as serve all participants in the following areas: Kitchen, Common/Dining Area, Comfort Zone and Rehabilitative Area. ILS needs to indicate how they will ensure that participants needing assistance with feeding will receive this assistance in a timely manner, including non-English speaking participants. Provide a plan as to how ILS will address these issues, including a timeline for implementation and the personnel responsible for implementation, to CMS and the New York State Department of Health. ILS needs to indicate how they will ensure that participants with special dietary needs will receive a nutritionally balanced meal and indicate how they will ensure that participants and not family or other participants are not consuming all or part of a participant meal. ILS needs to submit its plan to CMS and the New York State Department of Health.

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Auditing Guide Version: PACE Audit Guide, Version 1

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Requirement:

The entire text is very lengthy and is not listed here in its entirety. See Regulation for entire text.(a) Space and equipment" (1) Safe design. A PACE center must meet the several requirements relating to safety of design and construction. (2) Primary care clinic. The PACE center must include sufficient suitable space and equipment to provide primary medical care and suitable space for team meetings, treatment, therapeutic recreation, restorative therapies, socialization, personal care, and dining. (3) Equipment maintenance. There must be a written plan and that recommended maintenence is completed (b) Fire safety" (1) General rule. Except as otherwise provided in this section-- (i) A PACE center must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association that apply to the type of setting in which the center is located. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to PACE centers. (2) Exceptions. (i) The Life Safety Code provisions do not apply in a State in which CMS determines that a fire and safety code imposed by State law adequately protects participants and staff. (ii) CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the center, but only if the waiver does not adversely affect the health and safety of the participants and staff. (5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a PACE center may install alcohol-based hand rub dispensers in its facility if-- (i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; (ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and (iv) The dispensers are installed in accordance code. (c) Emergency and disaster preparedness" (1) Procedures. The PACE organization must establish, implement, and maintain documented procedures to manage medical and nonmedical emergencies and disasters that are likely to threaten the health or safety of the participants, staff, or the public. (2) Emergencies defined. Emergencies include, but are not limited, to the following: (i) Fire. (ii) Equipment, water, or power failure. (iii) Care-related emergencies. (iv) Natural disasters likely to occur in the organization's geographic area. (An organization is not required to develop emergency plans for natural disasters that typically do not affect its geographic location.) (3) Emergency training. A PACE organization must provide appropriate training and periodic orientation to all staff (employees and contractors)... (4) Availability of emergency equipment. Emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs, along with staff who know how to use the equipment, must be on the premises of every center at all times and be immediately available. (5) Annual test of emergency and disaster plan. At least annually, a PACE organization must actually test, evaluate and document the effectiveness of its emergency and disaster plans.

Deficiencies:

Based on the direct observations made in the dining room/common area between the hours of 11:00 AM and 1:00 PM on June 24, 2008 and interviews with staff, Independent Living for Seniors, Inc. (ILS) failed to maintain a facility that provides for the physical safety of participants, personnel, and visitors. The following findings include but are not limited to those noted below. 1. In the common room area, also used for dining, seating was arranged in table zones. There were a total of 10 table zones that seated approximately 85 participants. The spacing between the tables and chairs did not allow for the egress of wheelchairs and walkers safely for seating. This was confirmed by an interview with the staff. There was evidence of inadequate space for medical treatment and care, therapeutic recreation, restorative therapies, socialization, personal care, dining, and potential emergency evacuation. Observational finding include but are not limited to two cognitively and physically-impaired participants seated in motorized wheelchairs were positioned in areas near walls and surrounded by chairs and tables so close together that accessibility in case of an emergency would be difficult. As a result, these high risk participants were long distances from egress points for evacuation and/or not within close proximity of emergency equipment during an emergency. This could lead to a life threatening situations. Staff, serving the meals with large trays, was forced to maneuver through close spaces between chairs and tables that presented a potential safety hazard for staff and participants. 2. During an observation of the restorative therapies room, it was noted that staff assisting participants in wheelchairs or walkers had to wait until other participants could be shifted to other spaces in order to position newly arriving participants for passive therapies such as Hydrocollator therapy or TENS unit therapy. Of the nine participants in the therapy room during this observation, only one participant was engaged in active muscle strengthening activity and the other eight were receiving passive therapies or waiting for therapy. Three aides were present and actively involved in participant care. 3. During the tour of the clinic area and interview with clinical staff, the following findings included but not limited to: Emergency equipment (suction, chemical emergency drugs, and electrocardiogram equipment) was stored in two separate storage areas within the clinic. In addition, there was no basic life support equipment found near the common room/dining area where dining and large group activities were held. As a result, staff access would delay availability of the needed equipment and potentially be a hazard in emergency situations. 4. During an observation of the medical clinic, it was noted that the layout of the clinic was not conducive to free movement through the exam room area or easy access to medical records. For example, the observers had to step into empty exam rooms to avoid blocking the passageway for clinicians and newly arriving patients in wheelchairs or walkers. The narrow passageway raised concerns about the potential for impaired flow of traffic in the clinic in the event of a medical emergency. The number of exam rooms appeared adequate if the daily census remains at its present level of approximately 80-90, but the passageways and access to records should be redesigned.

Corrective Action Required:

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Contract Number / Name: H3331 INDEPENDENT LIVING FOR SENIORS, INC.

Auditing Guide Version: PACE Audit Guide, Version 1

Auditing Element: SDY01

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Requirement:

(a) Plan. A PACE organization must establish and implement a written plan to furnish care that meets the needs of each participant in all care settings 24 hours a day, every day of the year. (b) Provision of services. (1) The PACE organization must furnish comprehensive medical, health, and social services that integrate acute and long-term care. (2) These services must be furnished in at least the PACE center, the home, and inpatient facilities. (3) The PACE organization may not discriminate against any participant in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, or source of payment. (c) Minimum services furnished at each PACE center. At a minimum, the following services must be furnished at each PACE center: (1) Primary care, including physician and nursing services. (2) Social services. (3) Restorative therapies, including physical therapy and occupational therapy. (4) Personal care and supportive services. (5) Nutritional counseling. (6) Recreational therapy. (7) Meals. (d) Center operation. (1) A PACE organization must operate at least one PACE center either in, or contiguous to, its defined service area with sufficient capacity to allow routine attendance by participants. (2) A PACE organization must ensure accessible and adequate services to meet the needs of its participants. If necessary, a PACE organization must increase the number of PACE centers, staff, or other PACE services. (3) If a PACE organization operates more than one center, each center must offer the full range of services and have sufficient staff to meet the needs of participants. (e) Center attendance. The frequency of a participant's attendance at a center is determined by the interdisciplinary team, based on the needs and preferences of each participant.

Deficiencies:

1. Based on the medical record review, and interviews with staff, ILS failed to effectively establish and implement a written plan to furnish care that meets the needs of the participants in all care settings, 24 hours, 7days, every day of the year. Findings include but are not limited to the examples outlined below. Cross reference to DTY01 and SDY04. The medical record review for Participant No. 4 who is diagnosed with Parkinson¿s disease and Reactive Airway Disease revealed that on March 8, 2008, a restorative progress note stated that the participant was evaluated for dysphasia. The new guidelines for safest diet consistencies noted stipulated for a dental soft diet, nectar thick diet. In addition, the speech therapist noted difficulty with family members not adhering to the diet restrictions. The form used for the care plan was the Home Health Certification and Plan of Care Form 485 (certification period 02/06/2008-04/05/2008) which did not document any of these issues from the progress notes. Interviews with the director of nutritional department and QAPI programs reveals that this information was not communicated to the IDT team. As a potential result of the lack of communication, there are progress notes recently dated June 5 & June 17, 2008 that reveals the family members are still feeding the participant solid food which caused the participant to verbalize she was sick, coughing, and scared because she could not clear her airway. The therapist attempted to have a conference call on June 17, 2008 with family and team without results and there was no documentation of a follow up attempt as of the audit date. No documentation was noted on any the 485 care plan forms used by ILS, or the OASIS Reassessments dated June 2, 2008, April 20, 2008, or the May 10, 2008 Semi Annual Assessment of Members, a.k.a. SAAM, of these social issues. As a result, the safety of the participant was compromised in the home environment without documentation of any interventions acted upon and placed on the participant care plan of the recommendations from the speech therapist. In addition, the participant¿s days in the center had been reduced without clinical evaluations or documentation for the decision on the care plans. 2. In nine of the nine medical records reviewed, the number of days for participant attendance at the center was not reduced based on resolution of medical or psychosocial issues or achievement of care plan goals. In one record, the IDT notes contradicted the reduction in days at the center, and in other records, no explanation for reduction in days at the center was documented. Most of the criteria used to assess participant¿s day care needs were based primarily on the need for clinic and rehabilitative services. An inappropriate criterion was frequency of senior center attendance since the PACE should be meeting participant social needs. Participant preference was into consideration as required by regulations. In several appeal denial letters, the PACE organization used standardized language, i.e., not meeting a medical need, as the reason for denial of the appeal to reinstate reduced days of attendance at the center. The IDT members did not document the specific reassessment results that would support achievement of medical, restorative therapy, or psychosocial goals underlying the IDT decision to reduce days of attendance at the center.

Corrective Action Required:

ILS needs to revise the criteria for day care attendance that meets the physical, medical, psychological and social needs of participants and submit the revised criteria to CMS and the New York State Department of Health for review and approval. ILS must develop a plan to reassess all participants to assure that needed services are provided, such as adaptive equipment. Participants whose day care attendance has been reduced are also to be reassesed based on the amended criteria once it has been approved, to determine whether the reduction of day center services is warranted based on participant needs. In addition, ILS needs to develop criteria for triaging the assessments based on risk and condition. Provide CMS and the New York State Department of Health with a timeline indicating when these assessments will be accomplished for review and approval.

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Requirement:

(a) Basic requirement. A PACE organization must meet the following requirements: (1) Establish an interdisciplinary team at each center to comprehensively assess and meet the individual needs of each participant. (2) Assign each participant to an interdisciplinary team functioning at the PACE center that the participant attends. (b) Composition of interdisciplinary team. The interdisciplinary team must be composed of at least the following members: (1) Primary care physician. (2) Registered nurse. (3) Master"s-level social worker. (4) Physical therapist. (5) Occupational therapist. (6) Recreational therapist or activity coordinator. (7) Dietitian. (8) PACE center manager. (9) Home care coordinator. (10) Personal care attendant or his or her representative. (11) Driver or his or her representative. (c) Primary care physician. (1) Primary medical care must be furnished to a participant by a PACE primary care physician. (2) Each primary care physician is responsible for the following: (i) Managing a participant's medical situations. (ii) Overseeing a participant's use of medical specialists and inpatient care. (d) Responsibilities of interdisciplinary team. (1) The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24 hour care delivery. (2) Each team member is responsible for the following: (i) Regularly informing the interdisciplinary team of the medical, functional, and psychosocial condition of each participant. (ii) Remaining alert to pertinent input from other team members, participants, and caregivers. (iii) Documenting changes of a participant's condition in the participant's medical record consistent with documentation policies established by the medical director. (3) The members of the interdisciplinary team must serve primarily PACE participants. (e) Exchange of information between team members. The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and participants and their caregivers consistent with the requirements for confidentiality in Sec.460.200(e).

Deficiencies:

1. Based on the McCauley Center IDT deliberation observation on June 24, 2008 between 9:00 AM ¿ 10:00 AM EST, Independent Living for Seniors, Inc. (ILS) failed to effectively maintain the regulated responsibilities noted below. - Regularly informing the interdisciplinary team of the medical, functional, and psychosocial condition of each participant. - Remaining alert to pertinent input from other team members, participants, and caregivers. - Documenting changes of a participant's condition in the participant's medical record consistent with documentation policies established by the medical director. Findings include but not limited to the findings found in SDY 01, item 1for participant No.4. Participant No. 4 had significant changes noted in diet consistencies and failure of the family to adhere to the guidelines as commented by the speech therapist which resulted in an unsafe environment for the participant in the home environment which was never noted on the care plans. The physician was not present during the morning meeting with the McAuley IDT team until the last five minutes. 2. The physician was not present at the Hudson IDT meeting held on June 24, 2008 between 9:00 AM ¿ 9:30 AM EST. Physician interview reveals this is the time hospitals rounds are conducted and he also attends care plan meetings when he is able. Otherwise he is represented by the nurse practitioner. The nurse practitioner is not a mandated IDT member. 3. Observation at the Hudson team Care Plan meeting on 24, 2008 between 10:00 AM ¿ 10:45 AM, the McAuley team Care Plan meeting on 25, 2008 between 10:15 AM ¿ 10:45 AM and staff interviews revealed that the physicians were not in attendance. ILS physicians were represented by the nurse practitioner teamed with the physician and community based physicians send in a report that is presented to the team by the Home Care Liaison. The terms of the waiver for community based physicians required that the physician participate in IDT meetings. Cross reference to SDY 04.

Corrective Action Required:

ILS needs to develop a plan by which required compliment of IDT members attend Care Plan meetings and other IDT functions and a timeline for implementation. Submit a copy of the plan and timeline to CMS and the New York State Department of Health for Review ands approval.

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Requirement:

The entire text is very lengthy and is not listed here in its entirety. See Regulation for entire text. (a) Initial comprehensive assessment" (1) Basic requirement. The interdisciplinary team must conduct an initial comprehensive assessment on each participant promptly following enrollment. (2) As part of the initial comprehensive assessment, each discipline of the IDT must evaluate the participant in person, at appropriate intervals, and develop a discipline-specific assessment of the participant's health and social status: (3) At the recommendation of team members, other professional disciplines (for example, dentistry, or audiology) may be included in the comprehensive assessment process. (4) The comprehensive assessment must include several areas such as physical and cognitive function and ability and medication use. (b) Development of plan of care. The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each participant through discussion in team meetings and consensus of the entire IDT. (c) Periodic reassessment" (1) Semiannual reassessment. On at least a semiannual basis, the following members of the IDT must conduct an in-person reassessment: Primary care physician, Registered nurse, Master"s-level social worker, Recreational therapist or activity coordinator. (2) Annual reassessment. On at least an annual basis, the following members of the interdisciplinary team must conduct an in-person reassessment: Physical therapist, Occupational therapist, Dietitian, Home care coordinator. (d) Unscheduled reassessments. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following: (1) A change in participant status... (2) At the request of the participant or designated representative... (i) The PACE organization must have explicit procedures for timely resolution of requests by a participant or his or her designated representative to initiate, eliminate or continue a particular service... (iv) The PACE organization must explain any denial of a request to the participant or the participant's designated representative orally and in writing. The PACE organization must provide the specific reasons for the denial in understandable language. The PACE organization is responsible for the following: (A) Informing the participant or designated representative of his or her right to appeal the decision as specified in Sec.460.122. (B) Describing both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services as specified in Sec.460.122. (C) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in Sec. 460.122(e). (v) If the IDT fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised care plan, this failure constitutes an adverse decision, and the participant's request must be automatically processed by the PACE organization as an appeal in accordance with Sec.460.122. (d) Changes to plan of care. Team members who conduct a reassessment must meet the following requirements: (1) Reevaluate the participant's plan of care. (2) Discuss any changes in the plan with the IDT. (3) Obtain approval of the revised plan from the IDT and the participant (or designated representative). (4) Furnish any services included in the revised plan of care as a result of a reassessment to the participant as expeditiously as the participant's health condition requires. (e) Documentation. Interdisciplinary team members must document all assessment and reassessment information in the participant's medical record.

Deficiencies:

Based on the medical record reviews conducted on June 24- 25, 2008, ILS records did not contain documentation of all the information shared by the IDT to include restorative assessments concerning service recommendations, psychosocial observations, and other assessments that give an impression of a sense of the participant¿s physical and cognitive function and ability, medication use, preferences for care, socialization and availability of family support, current health status and treatment needs, nutritional status, home environment, including home access and egress, behavior, psychosocial status, and medical concerns. As a result, the potential safety of participants may be at risk. Findings include but are not limited to those listed below. 1. Please reference findings in SDY0, Item 1 for Participant. In addition, no significant change assessment had been completed when the functional decline in aspiration due to the Parkinson Disease was initiated in October of 2007. 2. In eight of nine medical records reviewed, there was no evidence that an IDT reassessment identified resolution of ongoing medical or restorative therapy issues, or the respective participant requested a reduction in services, that would justify the reduction in days attending the center or restorative therapy services evidenced by the ILS Care Needs Roster submitted prior to the focus visit. 3. Notification to participants of ILS¿ denial of their request to have day center attendance reinstated (to levels prior to the McAuley Center closure) lacked significant explanation of the reason for denial. Although medical necessity was stated as the reason for the reduction in days, the notification letters provided no detailed explanation and the care plans lacked evidence that assessments had been conducted prior to the medical necessity determination.

Corrective Action Required:

ILS needs to revise the criteria for day care attendance and reassess participants whose day care attendance has been reduced based on the revised criteria to determine whether the reduction of day center services is warranted based on participant needs. Include a timeline for completion. ILS must develop a process to ensure that any decision to reduce services is based on an assessment and that full explanation of the reason for the reduction is provided in easily understood language to the participant and/or his/her representative.

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Contract Number / Name: H3331 INDEPENDENT LIVING FOR SENIORS, INC.

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Requirement:

(a) Basic requirement. The interdisciplinary team must promptly develop a comprehensive plan of care for each participant. (b)Content of plan of care. The plan of care must meet the following requirements: (1) Specify the care needed to meet the participant"s medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment. (2)Identifiy measurable outcomes to be achieved. (c) Implementation of the plan of care. (1) The team must implement, coordinate, and monitor the plan of care whether the services are furnished by PACE employees or contractors. (2) The team must continuously monitor the participant"s health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from participants or caregivers, and communications among members of the interdisciplinary team and other providers. (d)Evaluation of plan of care. On at least a semi-annual basis, the inter-disciplinary team must revaluate the plan of care, including defined out-comes, and make changes as necessary.(e) Participant and caregiver involvement in plan of care. The team must develop, review, and reevaluate the plan of care in collaboration with the participant or caregiver, or both, to ensure that there is agreement with the pan of care and that the participant"s concerns are addressed.(f) Documentation. The team must document the plan of care, and any changes made to it, in the participant"s medical record.

Deficiencies:

Based on the medical record reviews conducted on June 24 and 25, 2008, ILS care plans did not contain all the required information as outlined in Section 460.106 in regards to content, implementation, evaluation, and participant and caregiver involvement. Findings include but are not limited to the following. 1. Cross reference SDY01, Finding number 1. 2. In two of nine medical records reviewed, a single plan of care was developed after the initial assessments by each IDT member. However, the initial plan of care did not contain measurable outcomes which would reflect achievement of the participant¿s goals. 3. Although the IDT members developed a single comprehensive plan of care after their initial assessments, they did not use this comprehensive plan of care to coordinate care or monitor participant status. Subsequent assessments were documented on multiple disciple-specific forms and, each quarter, a designated recorder would transcribe highlights from each discipline¿s forms to the HCFA 485 Form to comply with state home health certification requirements. No changes in status or achievement of goals were noted on the comprehensive plan of care. 4. During an observation of an IDT care planning meeting, the comprehensive plan of care was not used to coordinate care for the participants whose cases were discussed. Each discipline reported on their recent encounters with the participant, but there was no subsequent interactive discussion about whether the current plan of care was effective or how participant or caregiver input changed the plan of care. It appeared that the IDT care planning meeting was merely a reporting mechanism rather than a collaborative evaluation of the plan¿s effectiveness. 5. Nine of nine medical records reviewed contained the initial plan of care. However, this document was used as a historical document, not a perpetual record of continuous care rendered by all members of the IDT team. The IDT team did not update the plan of care when participants made progress, achieved goals, or suffered functional or clinical changes or declines in health status. 6. Observation at the Hudson team Care Plan meeting on June 24, 2008 between 10:00 and 10:45 AM revealed that while there is a discussion and exchange of information about how the participant is doing, it is limited to just that. There is no discussion of changes to the care plan based on current status. During an Annual Reassessment of an 89 year old participant with diagnoses of COPD, CHF and frequent falls, the team noted that the participant wants to socialize and likes the day center, yet his time was reduced from two days to one. There was never a discussion about how the participant feels about the reduction in service or discussion about the effect the reduction may have had on the participant. In addition, it was noted the participant was a full code, but there was never any discussion about discussing or updating advanced directives with the participant. 7. There was no evidence that the participant or caregiver reviewed the plan of care or had ongoing opportunities to influence the development of new goals or evaluate the plan¿s effectiveness. Findings continued under ZZ01

Corrective Action Required:

ILS must develop a comprehensive care plan that that incorporates all of the required PACE elements and identifies care needs and problems specific to each discipline involved in the care of the participant, the care to be provided, objective, obtainable goals, the individual responsible and outcomes. Care plans need to reflect changes in status, care needs and goals. There needs to be documentation of participant or caregiver input into the plan of care. A copy of the care plan needs to be provided to CMS and to the New York State Department of Health for review and approval prior to implementation. Once the revised Care Plan has been reviewed and approved, provide a timeline and the personnel responsible for implementation. ILS must develop a plan that will ensure that all nursing staff administers medications in a safe and effective manner. The plan needs to include staff education as well as a medication assistance record that is accurate and complete to specific route, time and dosage and a method of monitoring to ensure that all nursing staff are supervised on a regular basis to ensure compliance. Provide a timeline and the personnel responsible for implemntation. Submit a copy of the plan, including the training module and staff attendance rosters to CMS and the New York State Department of Health.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 13237

Region: 02 New York

Contract Number / Name: H3331 INDEPENDENT LIVING FOR SENIORS, INC.

Auditing Guide Version: PACE Audit Guide, Version 1
Auditing Element: ZZ01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/24/2008
Exit Conference Date: 06/25/2008
Date Report Issued: 08/01/2008
Date Report Due: 07/25/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 08/31/2008

Requirement:

Ad Hoc Compliance Event

Deficiencies:

Continued from SDY05. 8. Based on observation of a medication pass on 6/24/08 from 11:30 AM through 1:15 PM, as well as interview of the nurse providing the medication profile, the ILS failed to implement the plan of care in a safe and effective manner. Five patients received medications and treatments incorrectly. As evidenced by the following: - One participant received Metropromide via peg tube. The nurse then proceeded to flush the peg tube with tap water. Review of the Medication Administration Record (MAR) at the time of the administration confirmed that there was no physician order for a water flush. When questioned, the nurse stated that there was no order but that she understood that all medications were flushed to prevent any remaining in the tubing. - One participant received a half of a tablet of Sinemet. The nurse did not score the medication but proceeded to break the tablet with her gloved fingers. This method allowed for the medication to be delivered in an uneven dosage. - One participant was seated in the comfort room. Anagrelide capsule was ordered for the noon time. The nurse opened the capsule, placed the granules on a spoon and mixed the medication with the participant¿s soup and administered the medication. The MAR at the time of the drug administration did not contain directions to remove the granules from the capsule. There is a potential adverse effect from this medication as the medication is directly absorbed without the benefits of the capsule. - One participant was ordered to have Haldol .5 milligrams at 1 PM. It was observed that the participant was given this antianxiety medication at 11:45 AM prior to receipt of lunch. It was observed that this participant had significant difficulty eating her lunch and appeared lethargic, possibly from the effects of the medication. - The MAR noted for one participant noted the participant forgot to bring her medications to the day care center on June 24, 2008. The MAR also noted that the medications were not brought to the center on June 5, 2008 and on June 12, 2008. There was no plan in place, based on interview of the nurse, to assist the resident to bring the required medications to the day care center daily.

Corrective Action Required:

Refer to SDY05, Plan of Care.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 13237

Region: 02 New York

Contract Number / Name: H3331 INDEPENDENT LIVING FOR SENIORS, INC.

Auditing Guide Version: PACE Audit Guide, Version 1

Auditing Element: ZZ02A

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/24/2008

Exit Conference Date: 06/25/2008

Date Report Issued: 08/01/2008

Date Report Due: 07/25/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 08/31/2008

Requirement:

Ad Hoc Compliance Event

Deficiencies:

The governing body of ILS has fiduciary responsibility for oversight of the PACE, yet board meeting minutes and an interview with a board member lacked evidence that significant notice regarding the closure of the McAuley PACE center was given to the ILS board or that the board retains appropriate oversight of ongoing issues effecting the PACE. The board minutes, which are generic to several ViaHealth subsidiaries, lacked documentation of any discussion of the impending closure and included minimal, if any, discussion of other issues pertinent to the PACE.

Corrective Action Required:

ILS must document how its governing body will take a more active role in the oversight of the PACE. A statement co-signed by the Chairman of ViaHealth and the President of ILS must be submitted, attesting to their agreement that the ILS board will retain oversight of the PACE and such oversight shall be reflected in the board minutes. Submit the minutes of the next two Board of Directors meetings.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 13237

Region: 02 New York

Contract Number / Name: H3331 INDEPENDENT LIVING FOR SENIORS, INC.

Auditing Guide Version: PACE Audit Guide, Version 1

Auditing Element: ZZ95

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/24/2008

Exit Conference Date: 06/25/2008

Date Report Issued: 08/01/2008

Date Report Due: 07/25/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 08/31/2008

Requirement:

Ad Hoc Compliance Event

Deficiencies:

During an observation of a Medication Pass on June 24, 2008 from 11:30 AM through 1:15 PM in the common area, the reviewer watched a blood glucose monitoring performed on a participant before lunch. The participant was seated in a wheelchair at a table in the middle of one of the dining rooms. The nurse conducted the monitoring, inclusive of the finger prick at the table with other participants present. The participant was not afforded any privacy. When the nurse was questioned, she stated that moving the participant with her wheelchair was an issue due to the confined area.

Corrective Action Required:

ILS needs to develop a plan to ensure that participants are afforded privacy and confidentiality in their care and treatment, including a plan to train all staff.