IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 23, 2009

RECEIVED
FEB 04 2009
FACILITY STANDARDS

Greg Lake
Idahealth Home Care
2867 East Copperpoint Drive
Meridian, Idaho 83642

RE: Idahealth Home Care, provider #137091

Dear Mr. Lake:

This is to advise you of the findings of the Medicare/Licensure survey at Idahealth Home Care which was concluded on January 8, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 5, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosures

PRINTED: 01/22/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137091	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER IDAHEALTH HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2867 E COPPERPOINT DR MERIDIAN, ID 83642	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Home Health agency. The following surveyors conducted the Medicare recertification survey: Patrick Hendrickson RN, HFS Team Leader Patricia O'Hara RN, HFS Acronyms used in this report include: Acronyms used in this report include: ADL's - Activities of Daily Living ALF- Assisted Living Facility CVA- Cerebral Vascular Accident HHA - Home Health Aide IV- Intravenous DNS- Director of Nursing Services OT - Occupational Therapy PT - Physical Therapy POC - Plan of Care RN - Registered Nurse ROM- Range of Motion SOC - Start of Care	G 000	"This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to Home Health. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the agency that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the severity of the deficiencies cited is correctly applied." RECEIVED FEB 04 2009 FACILITY STANDARDS	
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by:	G 141	**G 141** **Systemic Changes** Written personnel policies have been developed for P.T. and O.T. and have been reviewed with the current employees.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Greg B. Lake — TITLE: Administrator — (X6) DATE: 2/3/09

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 141	Continued From page 1 Based on staff and administrator interview and review of job descriptions, it was determined that the facility failed to provide written personnel policies for PT and OT, specifically defining the job description, scope and expectation. Lack of this written direction had the potential to result in patients not receiving complete or appropriate treatment. Findings include: Three staff interviews were conducted. One Physical Therapist, who was contracted with the agency, stated on 1/7/09 at 10:30 AM, that the patient's home safety assessment was the responsibility of the Occupational Therapist. A second Physical Therapist, who was employed directly by the agency, stated on 1/7/09 at 11:00 AM, that the patient's home safety assessment was the responsibility of the Physical Therapist. Both therapists interviewed had previous home health experience. One Occupational Therapist was observed on 1/7/09 at 1:00 PM, doing an initial assessment. The therapist explained to the patient that physical therapy dealt with issues "from the waist down" and occupational therapy dealt with issues "from the waist up." The facility Administrator was asked for job descriptions for physical therapists and occupational therapists. Provided was a policy titled "Therapy Services." This fourteen line printed policy did not differentiate between physical therapists and occupational therapists. The policy included eight responsibilities for all therapists collectively, one of which stated, "evaluate the home environment and make recommendations." It did not provide specific delineation for areas of expertise.	G 141	**Monitors** The Administrator will perform random monthly audits of personnel files to ensure that job descriptions are present. He will report his findings at the Q.A. meetings and make changes to the above plan of correction as needed. **Date of Compliance** 2/3/2009	

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G 141	Continued From page 2 The facility did not provide appropriate direction to staff members for providing complete and appropriate patient care.	G 141		
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 staff interview, review of clinical records and agency policies, it was determined the agency failed to ensure care was effectively coordinated with ALF's and other personnel who also provided care to 4 of 15 patients (#2, #5,#13, and #14) whose records were reviewed. This deficient practice prevented the agency's staff, physicians and ALF staff from working together to improve the health of patients. Findings include: 1. Patient #2 was an 86 year-old male with a SOC of 6/25/08 and was discharged from the agency on 7/17/08. The patient lived in an ALF. The patient's record contained a PT POC, dated 6/27/08. The POC stated the Physical Therapist would see the patient one to two times a week for six weeks. The Physical Therapist was to help the patient ambulate 500 feet on uneven surfaces, increase his dynamic balance, and increase his strength in both lower extremities. Patient #2's clinical record and case conference notes did not contain any documented evidence the HHA's Physical Therapist had coordinated the patient's care with the ALF. The patient's Physical Therapist was interviewed on 1/7/09	G 143	**G 143** **Systemic Changes** Staff have been inserviced in regards to interdisciplinary communication and communication with Assisted Living Facility Staff if appropriate. Weekly meetings are held to discuss patient care issues with the interdisciplinary team present. **Monitors** The Director of Nursing will perform random weekly audits of 10% of current patients' records to ensure that issues identified during the weekly meetings are addressed and followed through on. The Director of Nursing will also perform random calls to ALF's where patients reside to ensure that care coordination is in place. She will report her findings at the Q.A. meetings. **Date of Compliance** 2/3/2009	

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G 143	Continued From page 3 starting at 10:04 AM. She stated she did not have contact with ALF staff and she would "go in, work with the patient, write a note and leave it." The Agency's undated "Communication" policy, found on page 36 in the policy manual, stated "Care must be coordinated to ensure that the treatment plan is followed, to communicate change in the patient's condition, and to coordinate appropriate interventions...All caregivers providing care in the patient's home will meet regularly at least once per month per patient to discuss the patient's progress and problems." The Physical Therapist failed to maintain liaison with the ALF staff to ensure that their efforts were coordinated effectively. 2. Patient #5 was an 86 year-old female with a SOC of 9/4/08, was a current patient at the time of the survey. The patient lived in an ALF. The patient's record contained a PT POC, dated 12/10/08, that stated the Physical Therapist would see the patient one to three times a week for six weeks. The Physical Therapist was to help the patient with transfer training, therapeutic exercises and balance training. Patient #5's clinical record and case conference notes did not contain any documented evidence that the HHA's Physical Therapist had coordinated the patient's care with the ALF. The patient's Physical Therapist was interviewed on 1/7/09 starting at 10:04 AM. She stated she did not coordinate with the ALF staff and did not know who the ALF's nurse was. Additionally, Patient #5 had received OT services one to three times a week for four weeks beginning on 12/7/08. The Occupational Therapist was to help the patient increase her functional endurance to complete her ADL's,	G 143		

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G 143	Continued From page 4 maximize safe mobility and teach the patient safe bed and toilet transferring techniques. Patient #5's clinical record and case conference notes did not contain any documented evidence the Occupational Therapist had coordinated the patient's care with the ALF. The patient's Occupational Therapist was interviewed on 1/7/09 starting at 11:50 AM. She stated she had not, as of 1/7/09, talked to ALF staff. She stated she intended to teach staff to do basic transfers and use the patient's assistive devises. She said she had not done this yet because the patient was waiting for a bed rail. She did not know who the facility's nurse was. The Occupational Therapist and Physical Therapist failed to maintain liaison with the ALF staff to ensure their efforts were coordinated effectively to support the objectives outlined in the patient's plan of care. 3. Patient #13 was a 58 year old male admitted on 1/2/09. His diagnoses included CVA and hypertension. An OT visit note, dated 1/5/09, documented the patient's blood pressure to be 166/103, an abnormal value that put the patient at increased risk for another CVA. There was no documentation that this finding had been reported to the RN case manager. In an interview, on 1/5/09 at 2:00 PM, the case manager confirmed the OT's findings and stated that she had not been notified. The agency failed to ensure that communication between disciplines providing care to the patient was maintained. 4. Patient #14 was a 74 year old female admitted on 12/12/08. Her diagnoses included pressure ulcer on the left hip. Skilled nursing was providing wound vacuum dressing changes three	G 143		

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G 143	Continued From page 5 times a week. The patient was also being seen by an outside wound clinic. During an interview with the patient, in her home on 1/6/09, the patient stated that she had blood cultures taken at the wound clinic approximately two weeks prior. She was subsequently placed on an antibiotic, for treatment of wound infection, and had been experiencing side effects of nausea and diarrhea. Two OT visit notes, dated 12/29/08 and 1/1/09, documented the nausea but the information was not relayed to the RN case manager. Skilled nursing notes from 12/18/08 through 1/6/09 did not document any new medications or any new symptoms or side effects. The RN case manager, in an interview on 1/8/09 at 1:00 PM, confirmed that she was not made aware of this change in the patient's condition. She also stated that this information was provided to her by another RN at Care Conference the morning of 1/8/09. The agency failed to ensure that communication between disciplines was maintained.	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 record review and interview, the agency failed to ensure the clinical record reflected effective coordination of patient care in 3 of 4 patients (#2, #3 and #5), whose records were reviewed that lived in an ALF. This could have	G 144	**G 144** **Systemic Changes** Staff have been inserviced in regards to communication with Assisted Living Facilities and proper documentation.	

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G 144	Continued From page 6 resulted in a lack of clarity as to whether the agency communicated potentially significant clinical information to/or from the ALF and allowing the HHA and ALFs to update patients' POCs. Findings include: 1. Patient #2 was an 86 year-old male with a SOC of 6/25/08 and was discharged from the agency on 7/17/08. The patient lived in an ALF. The patient's POC dated 6/25/08, stated the HHA's nurse was to see the patient twice a week for two weeks, then once a week for two weeks and then every other week for six weeks. The POC also stated the nurse had two as needed visits for fall with injury, impaired skin integrity or signs of infection, blood collection or specimen collection and wound care as needed. The POC stated the nurse would assess the following; vitals, medication compliance and efficiency, breath sounds, pulse oximeter, cardiovascular status, appetite, nutrition, hydration, cough, sputum, pain, use of nebulizer, peripheral pulses, change in bowel habits/stool, bowel incontinence, strength/ROM, balance/coordination, bed mobility, transfer ability, gait, character of urine, signs and symptoms of urinary track infection and incision infection with dressing changes every day. The POC further stated the nurse would provide education to the patient's caregiver. Patient #2's clinical record and case conference notes did not contain any documented evidence that the agency's nurse had coordinated the nursing care with the ALF's nurse. During an interview with the DNS on 1/8/09, starting at 1:20 PM, she stated that nursing staff did coordinate with staff in ALF's but it had not been a practice to document those interactions. 2. Patient #3 was an 89 year-old female with a	G 144	**Monitors** The Director of Nursing will perform random weekly audits of 10% of patients charts who reside in ALF's and will contact the associated ALF's to ensure that not only is communication about the patients care and condition is happening and documented. She will report her findings at the Q.A. meetings and make changes to the above plan of correction as needed. **Date of Compliance** 2/3/2009	

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G 144	Continued From page 7 SOC of 6/13/08. The patient was admitted after a right hip fracture that required surgical repair. The patient lived in an ALF. The patient was discharged from the agency after falling on 7/1/08 and re-fracturing her hip. The patient's POC dated 6/13/08, stated skilled nursing was to see the patient once a week for three weeks and also have three as needed visits for fall with injury, impaired skin integrity or signs of infection, blood collection or specimen collection and wound care as needed. The POC stated the nurse would assess the following; vitals, medication compliance and efficiency, appetite, nutrition, hydration, breath sounds, pulse oximeter, cardiovascular status, pain, change in bowel habits/stool, bowel incontinence, strength/ROM, balance/coordination, bed mobility, transfer ability, gait, character of urine, signs and symptoms of urinary track infection, safety, emotional/mental status, behavior, orientation. The POC further stated the nurse would provide education to the patient's caregiver. Patient #3's record contained a "CARE COORDINATION NOTE", dated 6/17/08, that stated the ALF had called and reported the patient had fallen and had developed a skin tear. An order dated 6/19/08 and signed by a physician on 6/20/08 stated, the patient had a fall and requested "INCREASED SKILLED NURSE VISITS DUE TO FALL RESULTING IN SKIN TEARS." A nursing note, dated 6/18/08 at 12:45 PM, stated "PT (Patient) states hit elbow on something and tore it a couple days ago. Dressing removed large amount bloody drainage. 2 skin tears above R (right) elbow, painful to touch, both with peeled back skin and beefy red base. New Polymer, times two placed. PT (Patient) taught to keep arm and dressing dry, not	G 144		

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G 144	Continued From page 8 to shower until healed." Patient #3's clinical record and case conference notes did not contain any documented evidence that the HHA's nurse had coordinated the nursing care with the ALF's nurse or other staff. Additionally, Patient #3 had received OT services two times a week for three weeks beginning on 6/16/08. The Occupational Therapist was to help the patient be independent with showers, dressing and transferring using a walker. Patient #3's clinical record and case conference notes did not contain any documented evidence the Occupational Therapist had coordinated the patient's care with the ALF. The HHA's Occupational Therapist was not available for interview during the time of the survey. 3. Patient #5, an 86 year-old female with a SOC of 9/4/08, was a current patient at the time of the survey. The patient lived in an ALF. The patient's POC, dated 11/3/08, stated the HHA's nurse was to see the patient three times a week for eight weeks and then twice during week nine of the certification period. The POC also stated the nurse had two as needed visits for fall with injury, impaired skin integrity or signs of infection, blood collection or specimen collection and wound care as needed. The POC stated the nurse would assess the following; Vitals, medication compliance and efficiency, breath sounds, pulse oximeter, cardiovascular status, appetite, nutrition, hydration, cough, sputum, pain, use of nebulizer, peripheral pulses, change in bowel habits/stool, bowel incontinence, strength/ROM, balance/coordination, bed mobility, transfer ability, gait, character of urine, signs and symptoms of urinary track infection and incision infection with dressing changes. Patient	G 144		

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G 144	Continued From page 9 #5's clinical record and case conference notes did not contain any documented evidence that the nurse had coordinated the nursing care with the ALF's nurse. During an interview with the DNS on 1/8/09, starting at 1:20 PM, she stated that nursing staff did coordinate with staff in ALF's but it had not been a practice to document those interactions.	G 144		
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, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, staff interview and review of agency policies, it was determined that the agency failed to ensure staff provided care that followed a written POC. This affected 6 of 15 patients (#2, # 9, # 11, #12, #14 and #15) whose records were reviewed. Failure to provide care according to the POC could have potentially led to the negative outcome of patients not meeting goals in a timely manner as expected by the physician. Findings include: 1. Patient #11 was an 82 year old male admitted on 12/18/09. His diagnoses included fractured pelvis and diabetes for which insulin had recently been prescribed. The patient's POC, which was undated, noted the patient's nutritional requirements as "no concentrated sweets." A skilled nursing note, dated 12/23/08, documented the nurse instructing the patient in the use of "power pudding" for the treatment of constipation. This consisted of bran, prune juice and apple sauce, a concentrated sweet. A skilled nursing	G 158	**G 158** **Systemic Changes** Staff have been inserviced in regards to the following: 1. Following the plan of care and documentation of care provided. 2. Missed Visit forms and the associated policy and procedures. 3. Obtaining orders for additional visits if needed. **Monitors** The Director of nursing will perform random weekly audits of 10% of the current patients medical records to ensure that staff is; 1. Following the plan of care and performing supporting documentation of such care.	

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G 158	Continued From page 10 note, dated 12/30/08, instructed the patient to ingest an unlimited amount of the blend until he had a bowel movement. The same skilled nursing note documented the patient complained of upper respiratory infection symptoms. The nurse instructed the patient to drink tea with lemon and honey, a concentrated sweet, for sore throat relief. The nurse failed to follow the patient's POC that stated "no concentrated sweets." The POC for Patient #11 further listed skilled nursing treatments to include blood glucose monitoring, teaching the patient and caregiver medication actions/uses/side effects and teaching patient and caregiver the signs and symptoms of disease recurrence/complications. There was no documentation in the patient's record that the skilled nurse had done teaching related to the newly prescribed insulin or diabetes. There was no documentation that skilled nursing had monitored the patient's blood glucose levels. During an interview, on 1/8/09 at 1:00 PM, the case manager confirmed the skilled nursing documentation, dated 12/30/08. The care given to the patient by skilled nursing did not follow the written POC that called for teaching of medication and disease process and monitoring blood glucose levels. 2. Patient #9 was a 45 year old male admitted 10/27/08. His diagnoses included bilateral fractured ankles and seizure disorder. His discharge order, dated 10/25/08, from a local hospital called for services from a home health aide, physical therapy and skilled nursing for medication management. The patient's POC, dated 10/27/08, showed skilled nursing treatments to include teaching the patient medication actions/uses/side effects and teaching the patient pain management with medications.	G 158	2. Completing missed visit forms (if appropriate). 3. Orders have been obtained for additional visits if needed. She will report her findings at the Q.A. meetings and make changes to the above plan of correction as needed. **Date of Compliance** 2/3/2009	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137091		01/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHEALTH HOME CARE	2867 E COPPERPOINT DR MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 11 The patient's initial assessment, dated 10/27/08, documented that he did not have all of his ordered medications in the home. It also stated that the patient's mental health case manager, who was not employed by the agency, would obtain medications for the patient. There was no documentation in subsequent skilled nursing notes indicating the patient had obtained all of his necessary medications. Further, there was no documentation that skilled nursing had done medication teaching. The facility failed to ensure that the skilled nurse provided medication management and teaching according to the written POC. The record was reviewed by the DNS on 1/8/09 at 1:30 PM. She confirmed that the record did not contain documented evidence that medication teaching was done. 3. Patient #14 was a 74 year old female admitted on 12/12/08. Her diagnoses included pressure ulcer on the left hip. Skilled nursing was providing wound vacuum dressing changes three times a week. The patient was also being seen by an outside wound clinic. The patient's POC, dated 12/12/08, listed skilled nursing treatments to include, "measure wound weekly." The patient was seen by skilled nursing three times a week from 12/12/08 through 1/6/09. Wound measurements were documented only on 12/12/08, at the time of the patient's initial assessment, and once again on 1/2/09. There was no documentation that the wound had been measured every week, as ordered on the POC. During an interview, on 1/8/09 at 1:00 PM, the RN case manager confirmed that the patient's wound had not been measured weekly as ordered. She stated the wound clinic "must be measuring it." Skilled nursing did not provide care according to the patient's POC.	G 158		

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G 158	Continued From page 12 4. Patient #2 was an 86 year-old male with a SOC of 6/25/08 and was discharged from the agency on 7/17/08. The patient's admitting diagnosis was for surgery aftercare. The patient's record contained a PT POC, dated 6/27/08. The POC stated the Physical Therapist would see the patient one to two times a week for six weeks. During week two of the patient's certification the patient was admitted into the hospital. The patient resumed service the second day of week three. There was no documented evidence the patient was seen during that week by PT nor was there documented evidence the physician was notified of the missed visit. The agency's undated "MISSED VISIT" policy, located on page 66 in the agencies policies, stated "If a visit is missed, the employee will fill out a missed visit form and the form will then be faxed to the physician." This policy was not followed for the missed visits during the second and third week of the patient's certification period. On 1/8/08 during an interview that started at 1:20 PM, the DNS confirmed the missed visit. 5. Patient #12 was an 82 year-old female with a SOC on 12/5/08. The patient's admitting diagnosis was cellulitis. The record contained a physician's order dated 12/22/08 that stated nursing was to see the patient two times a week for one week, then five times a week for one week and then three times a week for one week. Nursing notes starting 12/21/08 to 1/08/09, documented that nursing staff was seeing the patient seven days a week to administer IV antibiotics. The record did not contain orders for additional visits. On 1/8/09, during an interview that started at 1:20 PM, the DNS stated she thought she had orders for the additional visits to	G 158		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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G 158	Continued From page 13 administer the IV antibiotics. She reviewed the record and could not find an order. 6. Patient #15 was a 90 year-old male with a SOC of 11/17/08. The patient's admitting diagnosis was abnormality of gait. Patient #9's POC, dated 11/17/08, stated the aide would see the patient two times a week for eight weeks. The patient was seen only once on 12/2/08, by the HHA during the third week of the certification period. The record did contain a "MISSED VISIT FORM", dated 12/2/08 that was not faxed to the physician. On 1/8/08 during an interview that started at 1:20 PM, the DNS confirmed the missed visit form was not faxed.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure for 6 of 15 patients whose records were reviewed (#2, #3, #5, #6, #12, and #13) POC'S delineated duties and roles and included all health care treatments and health status monitoring needs. The failure to fully develop patient's POC's lead to inconsistent nursing interventions and lack of guidance to nursing staff. Findings include:	G 159	**G 159** **Systemic Changes** Staff have been inserviced in regards to completing an accurate plan of care and following the plan of care as written. They have also been inserviced on coordination of care with ALF's as appropriate. **Monitors** The Director of Nursing will perform random weekly audits of 10% of current patients charts to ensure that an appropriate plan of care is in place, it is being followed and that coordination of care is in place with ALF's if appropriate. She will report her findings at the Q.A. meetings and make changes in the above plan of correction as needed. **Date of Compliance** 02/03/2009	

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G 159	Continued From page 14 1. Patient #2, an 86 year-old male with a SOC of 6/25/08, was discharged from the agency on 7/17/08. The patient lived in an ALF. The patient's POC dated 6/25/08, stated skilled nursing was to see the patient twice a week for 2 weeks, then once a week for two weeks, then every other week for 6 weeks. The POC also stated the nurse had two, as needed visits, for fall with injury, impaired skin integrity or signs of infection, blood collection or specimen collection and wound care as needed. The POC stated the nurse would assess the following; vitals, medication compliance and efficiency, breath sounds, pulse oximeter, cardiovascular status, appetite, nutrition, hydration, cough, sputum, pain, use of nebulizer, peripheral pulses, change in bowel habits/stool, bowel incontinence, strength/ROM, balance/coordination, bed mobility, transfer ability, gait, character of urine, signs and symptoms of urinary track infection and incision infection with dressing changes every day. The POC further stated the nurse would provide education to the patient's caregiver. The POC did not delineate and coordinate duties and roles between the ALF nurse and the agency's nurse. The patient's record also contained a PT POC, dated 6/27/08, which stated the Physical Therapist would see the patient one to two times a week for six weeks. The Physical Therapist was to help the patient ambulate 500 feet on uneven surfaces, increase his dynamic balance, and increase his strength in both lower extremities. The patient's Physical Therapist was interviewed on 1/7/09 starting at 10:04 AM. She stated she did not include the ALF staff in the development of the POC nor did the POC	G 159		

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G 159	Continued From page 15 delineate and coordinate services and roles between the ALF staff and the HHA. The DNS was interviewed on 1/8/09 starting at 1:20 PM. She stated that it was not a practice of the HHA to delineate duties and roles between the ALF staff and the HHA on the POC's. Further she stated the HHA did not coordinate with the ALF in the development of the overall plan of care. The agency failed to ensure that Patient #2's POC's delineated and coordinated duties and roles between the ALF staff and the HHA. Further more, the HHA did not include the ALF in the development of the overall plan of care. 2. Patient #3 was an 89 year-old female with a SOC on 6/13/08. The patient was admitted after a right hip fracture that required surgical repair. The patient lived in an ALF. The patient was discharged after falling on 7/1/08 and re-fracturing her hip. The patient's POC dated 6/13/08, stated skilled nursing was to see the patient once a week for three weeks and also had three as needed visits for fall with injury, impaired skin integrity or signs of infection, blood collection or specimen collection and wound care as needed. The POC stated skilled nursing would assess the following; vitals, medication compliance and efficiency, appetite, nutrition, hydration, breath sounds, pulse oximeter, cardiovascular status, pain, change in bowel habits/stool, bowel incontinence, strength/ROM, balance/coordination, bed mobility, transfer ability, gait, character of urine, signs and symptoms of urinary track infection, safety, emotional/mental status, behavior, orientation. The POC further stated the nurse would provide education to the patient's caregiver. The POC did not delineate and coordinate duties and roles between the ALF	G 159		

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G 159	Continued From page 16 nurse and the agency nurse. The patient's record also contained a PT POC, dated 6/16/08, which stated the Physical Therapist would see the patient one to three times a week for four weeks. The Physical Therapist was to help the patient improve her standing balance, ambulate with a walker safely and demonstrate safe mobility. The patient's Physical Therapist was interviewed on 1/7/09 starting at 10:30 AM. He stated she did not include the ALF staff in the development of the POC nor did the POC delineate and coordinate services and roles between the ALF staff and the agency. Additionally, the patient's record also contained an OT POC, dated 6/16/08, that stated the Patient #3 had received OT services two times a week for three weeks. The Occupational Therapist was to help the patient be independent with showers, dressing and transferring using a walker. The POC did not delineate or coordinate duties and roles between the ALF nurse and the OT. The Occupational Therapist was not available for interview during the time of the survey. 3. Patient #5 was an 86 year-old female with a SOC of 9/4/08 and was a current patient at the time of the survey. The patient lived in an ALF. The patient's POC, dated 11/3/08, stated skilled nursing was to see the patient three times a week for eight weeks and then twice during week nine of the certification period. The POC also stated the nurse had two as needed visits for fall with injury, impaired skin integrity or signs of infection, blood collection or specimen collection and wound care as needed. The POC stated the	G 159		

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G 159	Continued From page 17 nurse would assess the following; vitals, medication compliance and efficiency, breath sounds, pulse oximeter, cardiovascular status, appetite, nutrition, hydration, cough, sputum, pain, use of nebulizer, peripheral pulses, change in bowel habits/stool, bowel incontinence, strength/ROM, balance/coordination, bed mobility, transfer ability, gait, character of urine, signs and symptoms of urinary track infection and incision infection with dressing changes. The POC further stated the nurse would provide education to the patient's caregiver. The POC did not delineated and coordinate duties and roles between the ALF nurse and the agency's nurse. The patient's record also contained a PT POC, dated 12/10/08, that stated the Physical Therapist would see the patient one to three times a week for six weeks. The Physical Therapist was to help the patient with transfer training, therapeutic exercises and balance training. The patient's Physical Therapist was interviewed on 1/7/09 starting at 10:04 AM. She stated she did not coordinate with the ALF staff and did not know who the ALF's nurse was. She stated she did not include the ALF staff in the development of the POC nor did the POC delineate or coordinate services and define roles between the ALF staff and herself. The patient's record also contained an OT POC, dated 12/12/08, that stated the Patient #5 had received OT services one to three times a week for four weeks. The Occupational Therapist was to help the patient increase her functional endurance to complete her ADL's, maximize safe mobility and teach the patient safe bed and toilet transferring techniques. The POC did not delineate or coordinate duties and roles between	G 159		

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G 159	Continued From page 18 the ALF nurse and the OT. The patient's Occupational Therapist was interviewed on 1/7/09 starting at 11:50 AM. She stated she had not, as of 1/7/09, talked to ALF staff. She stated she intended to teach staff to do basic transfers and use the patient's assistive devises. She said she had not done this yet because the patient was waiting for a bed rail. She did not know who the facility's nurse was. She stated she did not include the ALF staff in the development of the POC nor did the POC delineate or coordinate services and define roles between the ALF staff and herself. 4. Patient #6 was an 85 year-old female with a SOC of 1/9/09, and was a current patient at the time of the survey. The patient lived in an ALF. The patient's POC, dated 1/1/08, stated skilled nursing was to see the patient once a week for three weeks. The POC also stated the nurse also had two as needed visits for fall with injury, impaired skin integrity or signs of infection, blood collection or specimen collection and wound care as needed. The POC stated the nurse would assess the following; vitals, medication compliance and efficiency, breath sounds, pulse oximeter, cardiovascular status, appetite, nutrition and hydration. The POC further stated the nurse would provide education to the patient's caregiver. The POC did not delineate and coordinate duties and roles between the ALF nurse and the HHA's nurse. The patient's record also contained a PT POC, dated 1/5/09, that stated the Physical Therapist would see the patient one to three times a week for nine weeks. The Physical Therapist was to help the patient with sitting and standing balances, transfer training for safety and improve	G 159		

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G 159	Continued From page 19 endurance. The POC did not delineate and coordinate duties and roles between the ALF nurse and the Physical Therapist. This was confirmed on 1/8/08 with the DNS during an interview that started at 1:20 PM. 5. Patient #12 was an 82 year-old female with a SOC on 12/5/08. The patient's admitting diagnosis was cellulitis. The record contained a physician's order dated 12/18/08, that stated the patient was to get IV antibiotic through her IV. The patient had a saline lock for the use of the ordered IV antibiotics. Nursing notes dated 12/21, 12/20, 12/19 and 12/25/08 stated the nurse was flushing the IV with normal saline and heparin. However, the patient's POC was not developed to state how nursing staff was to maintain the patency of the IV and the record did not contain a physician's order for the heparin flush. This was confirmed with the DNS during an interview on 1/8/09, which started at 1:20 PM. 6. Patient #13 was a 58 year old male admitted on 1/2/09. His diagnoses included CVA and hypertension. An initial assessment was done on 1/2/09 by the RN case manager. The agency provided a tool for use during the initial assessment titled, "Aspen Home Care Plan of Treatment." On this tool, under, "General Goals", was a goal that read, "Vital signs within normal limits of Aspen Home Care values: B/P: 90/60 - 160/90, P: 60 - 100, R: 12 - 28, T: 94 - 100. This goal was not checked for Patient #13 to provide parameters for an appropriate blood pressure. Subsequently, appropriate parameters for staff and the patient to follow were not included in the development of the patient's POC. In an interview, on 1/6/09 at 11:00 AM, the RN case manager confirmed that the goal was not filled	G 159		

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G 159	Continued From page 20 out on the tool used for Patient #13, therefore, the acceptable parameters for blood pressure were not included on the patient's POC. On 1/5/09, the patient's blood pressure reading of 166/103 went unreported by the OT. This was also confirmed by the RN case manager. Incomplete care planning resulted in negative patient outcome manifested by un-addressed elevated blood pressure, leading to the patient being at risk for another stroke.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review, interview and home visits it was determined that the agency failed to ensure physicians were made aware of significant changes in patients' conditions. This affected 3 of 15 patients, (#12, #13 and #15) whose records were reviewed. This failure could have potentially led to negative patient outcome if the physician was not aware that a condition existed that warranted a change in the POC. The findings included: 1. Patient #13 was a 58 year old male admitted on 1/2/09. His diagnoses included CVA and hypertension. An OT visit, dated 1/5/09, documented the patient's blood pressure to be 166/103, an abnormal value that put the patient at increased risk for another CVA. There was no documentation that this finding had been reported to the physician. The agency's undated "Communication Policy" stated, "Each caregiver	G 164	**G 164** **Systemic Changes** Staff have been inserviced in regards to notification of physicians of significant changes in condition and updating plans of care. **Monitors** The Director of Nursing will perform random weekly audits of 10% of the current patients to ensure that physician's have been notified of significant changes in condition (if any) and that the P.O.C. has been updated (if needed). She will report her findings at the Q.A. meetings and make changes to the above plan of correction as needed. **Date of Compliance** 02/03/2009	

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G 164	Continued From page 21 is also to report any specific conditions indicated by the Case Manager or physician. The case manager is assigned to supervise and coordinate care for a patient. He/she shall have the primary responsibility to notify the attending physician and other agency staff of any significant changes in the patient' status...The Nurse should also promptly report any significant changes in the patient's condition". In an interview, on 1/5/09 at 2:00 PM, the case manager confirmed that she had not notified the physician about the patient's elevated blood pressure. Lack of physician notification of changes in the patient's condition could potentially result in negative patient outcome manifested by another CVA. 2. Patient #15 was a 90 year-old male with a SOC on 11/17/08. The patient's admitting diagnosis was abnormality of gait. The record contained a "PT Intervention" note, dated 12/2/08 at 2:35 PM. The note stated the patient had fallen out of his wheelchair trying to pet a dog on 12/1/08. There was no documented evidence that the physician was notified about the fall to maybe care plan an increase of services or a possible change of the patient's POC. During an interview on 1/8/09, that started at 1:20 PM, the DNS stated the physician was not alerted to the fall because the patient did not get injured. 3. Patient #12 was an 82 year-old female with a SOC on 12/5/08. The patient's admitting diagnosis was cellulitis. The record contained a "Nursing Intervention" note, dated 12/26/08 4:25 PM. The note stated the patient had fallen in the bathroom on 12/25/08. The record contained a second "Nursing Intervention" note dated 12/29/08 3:45 PM. The note stated the patient had fallen in the "bathroom" that day. There was	G 164		

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G 164	Continued From page 22 no documented evidence that the HHA had notified the physician about the fall. During an interview on 1/8/09, that started at 1:20 PM, the DNS stated she had called the physician after the second fall but did not document the phone call.	G 164		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, review of policies and staff interview, it was determined the agency failed to ensure verbal orders were dated and timed for 15 of 15 patient records (#1 - #15) reviewed. Additionally, the agency failed to ensure that 1 of 15 records (#12), contained all verbal orders for treatment. Without physicians orders, staff are practicing medicine without written physician's guidance or passably without the knowledge of the physician. Findings include: 1. The agency's undated "Verbal Orders' Policy, was found on page 31 in the agency's policy manual. The policy stated, "Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable State and Federal Law..." A-166 states, "Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse". Patients #1 through #15's POC's, under #23 of the "Nurse's Signature and Date of Verbal SOC", only contained the DNS's signature for the SOC verbal	G 166	**G 166** **Systemic Changes** Staff have been inserviced in regards to verbal orders are dated and timed and proper completion of verbal orders. **Monitors** The Director of Nursing will perform random weekly audits of 10% of the current patients' charts to ensure that verbal orders are written, dated and timed. She will report her findings at the Q.A. meetings and make changes to the above plan of correction as needed. **Date of Compliance** 02/03/2009	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137091	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER IDAHEALTH HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2867 E COPPERPOINT DR MERIDIAN, ID 83642	

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G 166	Continued From page 23 order, it did not include a date or time of the verbal orders. On 12/8/08, the DNS was interviewed starting at 1:20 PM. The DNS stated she had taken SOC verbal orders for Patients #1 through #15 from the physician. She stated she did not know that she needed to include the date and time of the verbal orders. 2. Patient #12 was an 82 year-old female with a SOC of 12/5/08. The patient's admitting diagnosis was cellulitis. The record contained a physician's order dated 12/23/08. The order requested nursing staff to clean the left fifth toe wound using normal saline or wound cleanser, apply Iodosorb, cover with Optifoam and COPA and secure the dressing with Hypafit three times a week. "Nursing Intervention" notes from 12/23/08 to 12/28/08 did not document the nurse had followed the physicians orders. The nurse was dressing the wound with a wet to dry, gauze dressing. On 1/5/09 during a home visit that started at 2:00 PM, the nurse was interviewed. She said the patient's pharmacy was unable to fill the physician's request for the dressing because the dressings were on back order. She said she called the physician and obtained orders for a gauze dressing until the other dressing arrived. She stated she did not write the verbal order down. The agency's un-dated "Verbal Orders" Policy, found on page 31 in the agency's policy manual stated that a copy of all verbal orders was to remain in the patient's record. Additionally, the patient had a saline lock for the use of IV antibiotics. Nursing notes dated 12/19, 12/20, 12/21 and 12/25/08 stated the nurse was flushing the IV with normal saline and heparin. The agency's "General IV Policies", that was not dated but found at 4.5 of the policy manual, stated "Heparin loc (lock) flush will be ordered by the	G 166		

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G 166	Continued From page 24 physician." The record did not contain a physician's order for the heparin flush. This was confirmed with the DNS during an interview on 12/8/09, which started at 1:20 PM.	G 166		
G 186	484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure the Occupational Therapist thoroughly evaluated and developed a POC for 1 of 4 patients (#12) who received OT services. This may have contributed to the patient falling in her bathroom multiple times. Findings include: Patient #12 was an 82 year-old female with a SOC on 12/5/08. The patient's admitting diagnosis was cellulites. The patient's POC, dated 12/05/08, stated that OT was to see the patient 1-3 times a week for nine weeks. The Occupational Therapist was to help the patient with her ADL's. An "OT Intervention" note dated 12/8/08, stated the patient was moderately independent with toileting and needed minimum assistance with bathing. She documented the patient needed no environmental changes or equipment. On 12/11/08, nursing staff had noticed the patient was developing a sore on the left fifth toe and by 12/17/08, the patient was placed in a specialty boot to keep the wound from friction. The record contained a "Nursing Intervention" note, dated 12/26/08 at 4:25 PM. The note stated the patient had fallen in the	G 186	**G 186** **Systemic Changes** Staff has been inserviced in regards to proper evaluation and documentation of a Plan of Care for patients with changes in condition. **Monitors** The Administrator and Director of Nursing will perform random weekly audits of 10% of the current patients charts to ensure that proper evaluations and associated documentation is being performed on patients with changes in condition. They will report their findings at the Q.A. meetings and will make changes to the above plan of correction as needed. **Date of Compliance** 02/03/2009	

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NAME OF PROVIDER OR SUPPLIER: IDAHEALTH HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 2867 E COPPERPOINT DR, MERIDIAN, ID 83642

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G 186	Continued From page 25 bathroom on 12/25/08. The record contained a second "Nursing Intervention" note dated 12/29/08 at 3:45 PM. The note stated the patient had fallen in the bathroom that day and had broken a towel rack and broke apart the shower curtain. An "OT Intervention" note dated 12/26/08, that was un-timed, stated the patient reported to the Occupational Therapist that she had fallen "yesterday". The Occupational Therapist documented that she saw the patient for "ADL's". A second "OT Intervention" note, dated 12/31/08, that was also un-timed, stated the patient reported to the Occupational Therapist that she had fallen "again". The Occupational Therapist documented that she saw the patient for "ADL's". On 1/5/08, during a home visit that started at 2:00 PM, the patient was observed and interviewed. The patient reported that she had multiple falls in the bathroom. She stated that since she had to wear the "boot" she was off balance. She stated she was using a towel holder to help her get off the toilet and it broke. The patient reported she had no grab bars in the bathroom to assist her in safe transferring. The patient's boot was observed. The boot sole was 2 to 3 inches high. The patient was wearing a slipper on the other foot. This made the patient's gait uneven. The patient's record did not contain a re-evaluation from the Occupational Therapist. The "OT Intervention" notes, dated 12/17, 12/24, 12/26 and 12/31/08 stated the OT POC needed no changes. During an interview on 1/7/09, which started at 11:15 PM, the Occupational Therapist stated she was working with the patient with showering and bathing safety. She stated the	G 186		

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G 186	Continued From page 26 patient had a difficult time with sitting, standing, balance and safety. She said the patient had a toilet riser with hand rails she was to use to transfer in and out of the shower and on and off the toilet. She stated that she had done a safety evaluation of the patient's home at the beginning of services. She stated there was no further equipment needed at that time. She stated that after the patient had her falls she talked to the patient. She found out then the patient was leaving her walker outside of the bathroom and ambulating in the bathroom without it and that was the reason for the falls. She stated during the evaluation she did talk to the patient about bathroom hand rails but the patient refused. Review of the record did not disclose a home safety evaluation by the Occupational Therapist. The Occupational Therapist confirmed that the home safety evaluation was not documented in the patient's record nor did the POC include home safety measures to prevent falls at home. The Occupational Therapist did not realize the patient's gait was off balance due to the elevated boot. The Occupational Therapist confirmed she did not document a re-evaluation of the patient's needs after her falls in the bathroom.	G 186		
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, staff interview and agency policies, it was determined the agency failed to ensure the registered nurse conducted	G 229	G 229 **Systemic Changes** Staff have been inserviced that a Registered Nurse must make an on-site visit to the patients' homes no less frequently than every two weeks.	

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G 229	Continued From page 27 onsite supervisory visits of the home health aide every 14 days for 1 of 2 sampled patients (#15), whose records reviewed had home health aide services. The failure to perform home health aide supervisory visits had the potential for patients' needs not to be met. Findings include: 1. Patient #15 was a 90 year-old male with a SOC on 11/17/08. The patient's admitting diagnosis was abnormality of gait. Patient #9's POC, dated 11/17/08, stated the home health aide would see the patient two times a week for eight weeks. The patient also had PT services. Review of Patient #15's record documented three "Aide Supervision Sheets", dated 11/26, 12/10, and 12/24/08. These sheets were filled out by the RN. However, the information on the form was obtained over the phone rather than during a home visit. On 1/6/08 at 10:00 AM the DNS stated that "sometimes" the nurse would do a supervisory visit in the patient's home rather then over the phone. She said this was not done for Patient #15. She said she should have gone to the patient's home to do the visit. The agency's "Registered Nurse" policy, that was not dated but found on page 18 in the policy manual stated the RN would "Make supervisory visits with or without the aide's presence every two weeks (every 14 days)..." The agency did not follow this policy.	G 229	**Monitors** The Director of Nursing will perform random weekly audits of 10% of the current patients' charts to ensure that a Registered Nurse has performed on-site visits to the patients' homes at least every two weeks. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. **Date of Compliance** 02/03/2009	

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Home Health agency. The following surveyors conducted the Medicare recertification survey: Patrick Hendrickson RN, HFS Team Leader Patricia O'Hara RN, HFS Acronyms used in this report include: ADL's - Activities of Daily Living ALF- Assisted Living Facility CVA- Cerebral Vascular Accident HHA - Home Health Aide IV- Intravenous DNS- Director of Nursing Services OT - Occupational Therapy PT - Physical Therapy POC - Plan of Care RN - Registered Nurse ROM- Range of Motion SOC - Start of Care	N 000	RECEIVED FEB 04 2009 FACILITY STANDARDS	
N 050	03.07021. ADMINISTRATOR N050 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: d. Insuring that personnel employed shall be qualified to perform their assigned duties and that agency practices are supported by written personnel policies. This Rule is not met as evidenced by: Refer to G141.	N 050	**N 050** Please see G 141	

Bureau of Facility Standards

Greg B. Lake

TITLE Administrator (X6) DATE 2/3/09

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

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N 050	Continued From page 1	N 050		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G144.	N 062	**N 062** Please see G 144	
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G 229.	N 119	**N 119** Please see G 229	
N 124	03.07025.01.THERAPY SERV.	N 124		

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N 124	Continued From page 2 N124 01. Qualified Therapist. A qualified therapist duties include the following: a. Assists in developing the plan of care and revising it when necessary; This Rule is not met as evidenced by: Refer to G186.	N 124	**N 124** Please see G 186	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158.	N 152	**N 152** Please see G 158	
N 167	03.07030.PLAN OF CARE N167 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: o. Other appropriate items. This Rule is not met as evidenced by: Refer to G159.	N 167	**N 167** Please see G 159	

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N 167	Continued From page 3	N 167		
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refre to G164.	N 172	N 172 Please see G 164	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G173.	N 173	N 173 Please see G 173	