



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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CERTIFIED MAIL: 7000 1670 0011 3315 1637

January 26, 2015

Chad Mangum, Administrator
Access Home Care
74 West 100 North
Logan, UT 84321

RE: Access Home Care, Provider #137110

Dear Mr. Mangum:

Based on the survey completed at Access Home Care, on January 9, 2015, by our staff, we have determined Access Home Care is out of compliance with the Medicare Home Health Agency (HHA) Condition of Participation of Acceptance of Patients, POC, Med Super (42 CFR 484.18). To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Access Home Care, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

- The administrator's signature and the date signed, on page 1 of both the state and federal 2567 forms.

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **February 8, 2015**. The Credible Allegation of Correction for each Condition of Participation and related standard level deficiencies must show compliance no later than **February 23, 2015**, 45 days from survey exit. We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

Please note, all references to regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Consistent with the provisions of 42 CFR 488, Alternative Sanctions for Home Health Agencies, the following remedies will be recommended to the Centers for Medicare/Medicaid (CMS) Region X Office:

- Termination [42 CFR 488.865]

Please be aware, this notice does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal written notice of that determination.

If the revisit survey of the agency finds one or more of same Conditions of Participation out of compliance, CMS may choose to revise sanctions imposed.

In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal dispute resolution (IDR) process. To be given such an opportunity, you are required to send your written request and all required information as directed in the attached document. This request must be received by **February 8, 2015**. If your request for IDR is received after **February 8, 2015**, the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting (Refer to page 6 of the attached IDR Guidelines).

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt

Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Fe Yamada, CMS Region X Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600
Seattle, WA 98104



IMPORTANT NOTICE – PLEASE READ CAREFULLY

January 30, 2015

Chad Mangum, Administrator
Access Home Care
74 West 100 North
Longan, Utah 84321

CMS Certification Number: 13-7110

**Re: Recertification survey found Condition of Participation Not Met
Suspension of payments for new admissions if not back in compliance by 02/23/2015
Mandatory Termination if not back in compliance by 04/09/2015**

Dear Mr. Mangum:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Access Home Care no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act.

BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a home health agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a home health agency is found to be out of compliance with the home health agency Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program. The Social Security Act Section 1866(b) authorizes the Secretary to terminate a home health agency's Medicare provider agreement if the provider no longer meets the requirements for a home health agency. Regulations at 42 Code of Federal Regulations (CFR) § 489.53 authorize the Centers for Medicare and Medicaid Services (CMS) to terminate Medicare provider agreements when a provider, such as Access home Care no longer meets the Conditions of Participation.

On January 9, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at your facility and found that the Condition of Participation below was not met.

42 CFR 484.18 Acceptance of Patients, Plan of care, and Medical Supervision

CMS agrees with the State survey agency that the identified deficiency was determined to be of such serious nature as to substantially limit your agency's ability to provide adequate and safe care.

Because Access Home Care is not in compliance with the Conditions of Participation with the Medicare Program, CMS is imposing the following action:

Suspension of payment for all new Medicare admissions, as authorized by the Social Security Act, Sections 1891(e) through (f) and implemented at 42 CFR 488.840.

This is effective for new Medicare admissions made on or after **February 23, 2015**, if not back in substantial compliance. This denial of payment for new admissions also applies to Medicare patients who are members of managed care plans. If Access Home Care does not meet all the home health agency Conditions of Participation, its Medicare provider agreement will be terminated no later than **April 9, 2015**. CMS will publish a legal notice in the local newspaper at least **fifteen days** prior to the termination date.

APPEAL RIGHTS

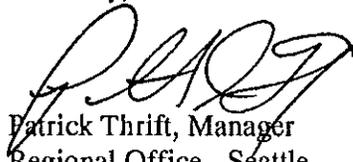
Access Home Care has the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR § 498.40 et seq. A written request for a hearing must be filed not later than **60 days** after the date you receive this letter. Such a request may be made to:

Chief, Civil Remedies Division Departmental Appeals Board MS 6132 Cohen Building, Room 637-D 330 Independence Avenue, SW Washington, D.C. 20201	Please also send a copy to:	Chief Counsel DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 MS RX -10 Seattle, WA 98104
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A request for a hearing must identify the specific issues, and findings of fact and conclusions of law with which you disagree. Additionally, you must specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense.

If you have further questions, please contact Fe Yamada of my staff at (206) 615-2381 or by email at marie.yamada@cms.hhs.gov.

Sincerely,



Patrick Thrift, Manager
Regional Office - Seattle
Division of Survey, Certification and Enforcement

cc: Idaho Bureau of Facility Standards



240 W. Burnside Ste. B
Chubbuck, Idaho 83202
Tel. (208) 637-2273 Fax (208) 637-8867
www.accesshomecareandhospice.com

February 5, 2015

Sylvia Creswell
Co-Supervisor, Non-Long Term Care
Bureau of Facility Standards
P.O. Box 83720
3232 Elder Street
Boise, ID 83720-0009

RECEIVED

FEB - 6 2015

FACILITY STANDARDS

RE: Allegation of Compliance/Plan of Correction

Dear. Ms. Creswell,

Please see the attached Plan of Correction from the survey completed on January 9, 2015. Access Home Care has started the initial steps to correct the deficiencies which led to non-compliance. It is our hope that the Plan of Correction can be accepted as soon as possible. We look forward to your prompt response.

Cordially,

A handwritten signature in cursive script that reads "Brett Cooper".

Brett Cooper
Administrator

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

PRINTED: 01/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2015
NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare Recertification survey of your agency from 1/05/15 to 1/09/15. The surveyors conducting the survey were:</p> <p>Susan Costa, RN, HFS, Team Leader Don Sylvester, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>BID - Twice a day BP - Blood Pressure CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease D/C - discharge DM - Diabetes Mellitus DME - Durable Medical Equipment DON - Director of Nursing EMS - Emergency Medical Service ESRD - End Stage Renal Disease HCL - Hydrochloric Acid HHA - Home Health Aide HTN - Hypertension LPN - Licensed Practical Nurse mg - milligrams ml - milliliters NS - Normal Saline OT - Occupational Therapist P - pulse PICC - peripherally inserted central catheter POC - Plan of Care PRN - as needed PT - Physical Therapy QD - every day RN - Registered Nurse SASH - Saline, Administer Therapy, Saline,</p>	G 000	<p>Initial Comments:</p> <p>The Plan of Correction has been reviewed by the Administrator, Director of Patient Care Services, and the Governing Body. Full compliance to the following deficiencies will be in effect February 23rd.</p>	

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FEB - 6 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Brett Cooper* TITLE Administrator (X6) DATE 2/5/15

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 000	Continued From page 1 Heparin (method for flushing ports) SN - Skilled Nurse ST - Speech Therapy SOC - Start of Care	G 000			
G 114	484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. This STANDARD is not met as evidenced by: Based on review of records and interviews with staff and patients, it was determined the agency failed to ensure patients were informed in writing of home health charges they might have to pay for 4 of 16 patients (#4, #5, #14, #15) whose records were reviewed. This resulted in patients not being fully informed of financial liability that could have impacted decision-making regarding accepting or refusing home health services. Findings include: A form titled "Consent and Notification," was included in each patient record. The form included a section titled "Financial Responsibilities Terms and Conditions." The section included boxes to be checked if the patient had Medicare, Private Insurance, or was Private Pay. The form included information for the patient such as the cost of the various	G 114	G114 An inservice will be given to all staff by February 13, 2015 by the Administrator and Director of Patient Care Services in order to present an updated patient consent form that addresses accurate financial information, i.e., the correct payor source and the patient's financial liability. The form will be included in all admission packets (see Addendum 7) and will be used on all new admissions starting 2/9/15. Full compliance to this deficiency will be February 23, 2015.		

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G 114	<p>Continued From page 2 .</p> <p>disciplines, the patient deductible, out of pocket expense, and co-pay, if any. The form was incomplete or did not provide accurate financial information in the following examples:</p> <p>1. Patient #4 was a 3 year old female with a SOC of 12/05/14. She received nursing and therapy services related to Cerebral Palsy, Speech and Language impairment. Patient #4's record included a consent form that indicated she would be receiving services from nursing, PT, OT, and ST. The form did not include information regarding the payor source and if there was any financial liability.</p> <p>During an interview on 1/09/15 beginning at 8:00 AM, the DON reviewed Patient #4's record and confirmed the consent did not include payor and financial liability.</p> <p>The agency did not provide financial liability information to Patient #4 before services were initiated.</p> <p>2. Patient #5 was a 21 year old female with a SOC of 10/14/14. She received nursing and therapy services related to ESRD and generalized weakness. Patient #5's record included a consent form that indicated she would be receiving services from nursing, PT, OT, and ST. The consent form was unclear as to who the payor source would be and if she had any financial liability.</p> <p>a. The form was checked to indicate Patient #5 had Medicare insurance as well as Private Insurance.</p> <p>b. The box beside the word Private insurance</p>	G 114		

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G 114	<p>Continued From page 3</p> <p>was checked, however the word Medicaid was written in next to that.</p> <p>c. The section of the consent for Medicare indicated 100% of the cost for homecare services would be covered by Medicare.</p> <p>d. The section of the consent for Private Insurance did not indicate if there was any financial liability.</p> <p>Patient #5's RN Case Manager was interviewed on 1/08/15 beginning at 2:30 PM. He reviewed the record and stated he was not the admitting nurse for Patient #5, and had not reviewed the signed consents. He stated the RN who completed the consent and admission paperwork no longer worked for the agency. He confirmed the consent included multiple payor sources, and lacked clarity as to patient financial liability.</p> <p>The agency did not provide clear and accurate information to Patient #5 regarding her financial obligation if any, before home health services were provided.</p> <p>3. Patient #15 was a 44 year old male admitted to the agency on 11/20/14. He received nursing and therapy services for care related to paraplegia and wound care. The consent form did not include information regarding payor and financial liability.</p> <p>A visit to Patient #15's home was conducted on 1/07/15 at 9:30 AM. During the visit, Patient #15 and his mother were interviewed, and confirmed the consent did not identify what his financial responsibility would be. Patient #15's mother stated he initially had private insurance, but then</p>	G 114		

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G 114	Continued From page 4 recently had applied for Medicaid. She stated she was unsure what his bill would be for home health services. The agency did not provide clear and accurate information to Patient #15 regarding his financial obligation before services were provided. 4. Patient #14 was a 54 year old female with a SOC of 12/16/14. She received nursing and therapy services related to a hip replacement. Patient #14's record included a consent form that indicated she would be receiving services from SN, PT, and OT. The consent form was unclear as if she had any financial liability. a. The form was checked to indicate Patient #14 had private insurance. b. The section of the consent for private insurance did not specify if there was any financial liability. The DON was interviewed on 1/08/15 beginning at 1:12 PM. She confirmed the consent included the private insurance payor source, and did not include patient financial liability. The agency did not provide clear and accurate information to Patient #14 regarding her financial obligation if any, before home health services were provided.	G 114			
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	G 143	G143 An inservice will be given to all staff by February 13, 2015 by the Administrator and Director of Patient Care Services in order to ensure the health care team effectively coordinates care between		

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G 143	<p>Continued From page 5 the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care coordination between disciplines was documented for 1 of 12 patients (#1) who received services from more than one discipline and whose records were reviewed. This interfered with quality and continuity of patient care. Findings include:</p> <p>1. Patient #1 was a 92 year old male admitted to the agency on 12/24/14 for nursing services related to septicemia. His visit notes, current medication list, and POC for the certification period 12/24/14 to 2/21/15, were reviewed.</p> <p>A SN visit note, dated 12/31/14 at 8:00 AM, completed by an RN, documented Patient #1's PICC line was a double lumen; red port and a purple port. The purple port would not flush due to pressure. His physician was notified. The physician indicated using only one port was satisfactory. However, if both ports occluded further actions would be necessary.</p> <p>Lippincott Williams & Wilkins sixth edition pages 564-571, "Nursing Procedures" states the following PICC procedure for preparing an infusion: perform hand hygiene and don gloves, clean injection surface with alcohol, clamp extension tubing and connect saline-filled syringe to the tubing, release the clamp and aspirate slowly to verify blood return, then flush with 5 ml of normal saline solution to clear the blood from the catheter. NURSING ALERT, "don't force the flush solution into the tubing because the catheter</p>	G 143	<p>disciplines and that the patient chart reflects such coordination. This inservice will contain references to policy 2019 (Care Planning and Coordination – Addendum 1), 2030 (Coordination of Services – Addendum 2).</p> <p>Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>		

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G 143	Continued From page 6 may be occluded." A SN visit note, dated 1/01/15 at 9:00 AM, completed by the LPN, documented Patient #1's PICC line "Purple port was difficult to flush but was able to flush with saline then heparin." The RN Case Manager did not ensure the LPN was aware of the occluded port and not to flush it. The RN Case Manager was interviewed by telephone on 1/09/14 beginning at 8:25 AM. She confirmed the RN who had made a SN visit on 12/31/14 reported Patient #1's PICC purple port occlusion. She confirmed she needed to ensure communication between members. Communication between members of Patient #1's health care team did not ensure effective coordination of care.	G 143			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care coordination between disciplines was documented for 1 of 12 patients (#5) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with the quality and continuity of care provided to all patients who received	G 144	G144 An inservice will be given to all staff by February 13, 2015 by the Administrator and Director of Patient Care Services regarding the need to adequately communicate/coordinate between the team and the physician the patient's BP and pain if it is outside of the parameters (as indicated in the POC), and that any changes of condition are communicated/coordinated between the team and the physician. This inservice will contain references to policy 2019 (Care Planning and Coordination – Addendum 1), 2030 (Coordination of Services – Addendum 2).		

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G 144	<p>Continued From page 7 agency services. Findings include:</p> <p>1. Patient #5 was a 21 year old female who was admitted to the agency on 10/14/14 for nursing and therapy services related to ESRD and weakness. Her records for the certification period 12/13/14 to 2/10/15 were reviewed.</p> <p>Patient #5's POC included orders to report any vital signs outside the established agency parameters to her physician. The blood pressure parameters listed were Systolic >160 or < 90, and Diastolic >90 or <50. Patient #5's recertification assessment dated 12/13/14, included her acceptable level of pain as 5 or 6 on a scale of 1-10.</p> <p>Patient #5's record indicated frequent notations of elevated blood pressure readings, complaints of severe levels of pain, and changes in her condition without communication of her status to her physician and other members of her home health team as follows:</p> <p>a. The recertification assessment dated 12/13/14 at 12:00 PM, included her blood pressure of 156/102, which was out of the agency parameters. The RN did not contact the physician to report the elevated diastolic reading or to establish patient specific blood pressure parameters for Patient #5. Additionally, there was no documentation of communication with other members of the home health team related to her acceptable levels of pain or blood pressure.</p> <p>b. A PT evaluation dated 12/18/14 at 1:05 PM, included Patient #5's pain intensity score of 9/10. The evaluation included a section "Care Coordination." The therapist noted he</p>	G 144	<p>Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>		

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G 144	<p>Continued From page 8</p> <p>conferenced with the SN and PTA, but did not include details of what he communicated. The therapist documented he notified Patient #5's physician regarding the therapy POC, goals, frequency, duration, and direction, however, there was no indication he alerted the physician of the severity of Patient #5's pain.</p> <p>c. A nursing note dated 12/20/14 at 1:10 AM, documented the on-call nurse came to Patient #5's home for complaints of nausea and vomiting. Her blood pressure was noted to be 182/120, and her pain was described as a level 10 on a scale of 1-10. The RN documented Patient #5 wanted to go to the hospital to be checked, and EMS was contacted for transport. After calling 911, the RN documented Patient #5 told her that she fell the day before and was taken by ambulance to the hospital for x-rays. The RN noted that after placing Patient #5 in the ambulance, the paramedics informed her that over the last week the patient contacted EMS on 9 consecutive shifts. They told her they realized how sick she was, but something needed to be done, and they could not realistically keep coming everyday.</p> <p>The RN wrote in the nursing note under the section "Coordination Plan," that she conferenced with the SN and with the DON regarding the number of EMS visits to the patient home in the last week. Additionally, she documented "Need for SW intervention, and probable need for placement to meet needs." However, her record did not include documentation of communication with the DON or RN Case Manager Patient #5's recent fall and Emergency Room visit, the severity of her pain, or her elevated blood pressure.</p>	G 144			

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G 144	<p>Continued From page 9</p> <p>d. A nursing note dated 12/22/14 at 11:00 AM, included documentation of Patient #5's blood pressure of 148/110, which was outside the parameters noted on her POC. Additionally, her pain intensity was described as 8/10. The RN documented Patient #5 stated her pain was in her abdomen, and she was told by the staff at the hospital that it was due to extra fluid in her abdomen.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's RN Case Manager or physician were notified regarding the outcome of the recent Emergency Room visit, her elevated blood pressure, or severity of her pain.</p> <p>e. In a nursing note, dated 12/23/14 at 11:05 PM, the on-call RN documented Patient #5's blood pressure of 182/124. She documented Patient #5 complained of chest pain with a severity of 10/10. The RN documented she contacted EMS and Patient #5 was transported to the hospital.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's physician was notified regarding her need to go to the hospital, her elevated blood pressure, or severity of pain. There was no documentation the RN Case Manager was informed of the on-call visit.</p> <p>f. A PTA visit note dated 12/26/14 at 2:00 PM, included documentation Patient #5's blood pressure was 138/90. Her pain intensity was described as 8/10.</p> <p>The section in the PTA visit note "Care Coordination," included documentation that the</p>	G 144			

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G 144	<p>Continued From page 10</p> <p>PTA conferenced with her therapy supervisor regarding patient progress. There was no documentation that the elevated pain and blood pressure was communicated with her supervisor, the RN Case Manager, or Patient #5's physician.</p> <p>g. A nursing note, dated 12/26/14 at 2:40 PM, documented Patient #5's blood pressure was 168/110. Her record did not include documentation the RN notified Patient #5's physician regarding the elevated blood pressure. The record did not include case conference notes or modifications to her POC.</p> <p>h. In a nursing note, dated 12/26/14 at 8:30 PM, the on-call RN documented Patient #5's blood pressure was 146/108. The RN noted he was called to evaluate Patient #5's fistula site in her left arm. He noted Patient #5 had been to her dialysis appointment earlier in the day, and there was bleeding for several hours that did not stop. The RN documented he removed the dressing from the site and blood spurted out about 2 feet. He noted EMS was notified and Patient #5 was transported to the hospital for evaluation.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's physician or her RN Case Manager were notified regarding the fistula site bleeding, transport to the hospital, or elevated blood pressure.</p> <p>i. A nursing note dated 12/28/14 at 1:00 PM, documented the on-call nurse was requested by Patient #5 to assess the fistula site. Her blood pressure was noted to be 140/100. The RN noted "B/P is within normal range for patient and pt (patient) states it is actually lower than normal."</p>	G 144		

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G 144	<p>Continued From page 11</p> <p>There was no documentation Patient #5's physician or the RN Case Manager were notified of the elevated blood pressure.</p> <p>j. A PTA visit note dated 12/29/14 at 2:00 PM, documented Patient #5's blood pressure as 179/96. She noted her pain as 8/10. There was no documentation the PTA communicated the elevated blood pressure or level of pain to her therapy supervisor, the RN Case Manager, or Patient #5's physician.</p> <p>k. A nursing note dated 12/29/14 at 2:45 PM, documented Patient #5's blood pressure of 156/104. The record did not indicate Patient #5's physician was notified of the elevated blood pressure. The RN documented Patient #5's pain at 4/10. There was no indication the RN acknowledged the notes from the therapy visit earlier that afternoon that referenced severe pain and elevated blood pressure.</p> <p>l. A nursing note dated 12/30/14 at 11:00 AM, documented the RN made a prn visit to assess Patient #5's fistula site. Her blood pressure was noted to be 148/98, there was no documentation of communicating Patient #5's elevated blood pressure to her physician.</p> <p>m. A PTA visit note dated 12/30/14 at 2:15 PM, documented Patient #5's blood pressure as 140/94. Her pain was noted at 8/10. There was no documentation the therapy supervisor, the RN Case Manager, or Patient #5's physician was notified of the elevated blood pressure or the severity of her pain.</p> <p>During an interview on 1/08/15 beginning at 11:45 AM, the Physical Therapist for Patient #5, who</p>	G 144			

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G 144	<p>Continued From page 12</p> <p>also performed supervisory oversight for the PTA, reviewed the record. He confirmed the PTA entries described the high levels of pain, as well as, the elevated blood pressures. The Physical Therapist looked in his notes, his phone, and his tablet at the patient record. He stated he had no record of communication with the PTA and did not recall direct conversations with the PTA regarding blood pressure or pain concerns. The Physical Therapist stated if he was notified of vital signs out of the parameters, he would refer the PTA to contact the clinical staff. The Physical Therapist confirmed there was no documentation to indicate Patient #5's physician was alerted to the severity of her pain and the elevated blood pressure readings. Additionally, the Physical Therapist confirmed he documented care coordination with Patient #5's physician, and described his process. He stated after the evaluation was performed, the paperwork was completed, and sent to the physician for a signature. The Physical Therapist stated he did not routinely contact the physician directly, and rarely called a physician for orders.</p> <p>During an interview on 1/08/15 beginning at 2:30 PM, the RN Case Manager reviewed Patient #5's record and confirmed the documentation of severe pain and elevated blood pressures. He stated he was aware that Patient #5 had gone to the hospital on multiple occasions, and had received communication from the on call RN. He stated the record did not include documentation of all the communication that occurred regarding Patient #5. He stated he spoke with the dialysis center frequently without including notes of the communication in Patient #5's record. Additionally, the RN stated when he attempted to contact Patient #5's physician at his office, he</p>	G 144		
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G 144	Continued From page 13 was told to contact the dialysis center. He stated he stopped trying to contact the physician, and would relay information through the dialysis center only. The RN confirmed Patient #5's POC included agency vital sign parameters that required physician notification. He confirmed the lack of physician notification.	G 144		
G 156	<p>The agency did not ensure coordination of care, 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>This CONDITION is not met as evidenced by: Based on staff and patient interview, review of medical records and agency policies, and observation, it was determined the agency failed to ensure systems to plan for care and supervise the medical care of patients were implemented. These failures resulted in unmet patient needs and negatively impacted the continuity, safety, and quality of patient care. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with POCs. 2. Refer to G159 as it relates to the failure of the agency to ensure the POC included all pertinent diagnoses, types of services and equipment required. 3. Refer to G160 as it relates to the failure of the agency to consult physicians to approve POCs. 4. Refer to G164 as it relates to the agency's 	G 156	<p>G156 For this plan of correction, refer to G158, G159, G160, G164</p>	

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G 156	Continued From page 14 failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs.	G 156			
G 158	The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs. 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, patient interview, agency policies, and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 4 of 16 patients (#1, #8, #11, and #15) whose records were reviewed. This resulted in unauthorized treatments as well as omissions of care and had the potential to result in unmet patient needs. Findings include: 1. Patient #15 was a 44 year old male who was admitted to the agency on 11/20/14 with diagnosis of non-healing surgical wound. a. The physician responsible for Patient #15's care and orders on the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/20/14 to 1/18/14, was licensed and practiced in another state. According to the 42 CFR 42.484.4, a physician is	G 158	G158 An inservice will be given to all pertinent staff by February 13, 2015 by the Administrator and/or Director of Patient Care Services regarding the regulation and agency's policies 2019 (Care Planning and Coordination – Addendum 1), 2030 (Coordination of Services – Addendum 2), and 2001 (Acceptance/Admission of Patients – Addendum 6) which include information stating that a written plan of care is established and reviewed by a physician practicing and licensed in the state of Idaho, that all disciplines follow the POC as approved by the physician, and that each discipline includes notification to patient's physician when vital signs are outside of parameters. Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart		

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G 158	<p>Continued From page 15</p> <p>defined as "A doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed."</p> <p>Patient #15's physician did not have an Idaho license, and he did not practice medicine or surgery in the state of Idaho. Therefore, he was not able to order Home Health services in the state of Idaho.</p> <p>An agency policy titled "Physician Licensure Verification," dated 1/01/09, stated the agency verified and documented that each physician providing orders and/or prescriptions for patient care, treatment and/or services had a current and valid license in good standing to practice in the state.</p> <p>During an interview on 1/08/15 at 1:40 PM, the RN Case Manager confirmed Patient #4's physician was not licensed in the state of Idaho. She stated she was unaware of the requirement for physician licensure.</p> <p>b. The RN's "Start of Care Assessment," dated 11/20/14, indicated Patient #15 had recently been discharged from a hospital following an automobile accident that resulted in paralysis. During the hospitalization, he developed a sacral pressure ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/20/14 to 1/18/15, included orders for PT, ST, and OT evaluations as well as RN visits and a MSW evaluation.</p> <p>The MSW conducted an evaluation on 11/21/14. The evaluation included a plan for the MSW to visit Patient #15 1-2 times for the first month.</p>	G 158	<p>audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>		

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G 158	<p>Continued From page 16</p> <p>The evaluation was signed by the out of state physician on 12/02/14. However, review of Patient #15's record did not include further MSW visits, which would indicate there were 1-2 missed MSW visits.</p> <p>The MSW POC was not followed.</p> <p>During an interview on 1/08/15 at 1:40 PM, the RN Case Manager confirmed Patient #15 was under the care of the out of state physician, as he was hospitalized in the other state and received care by that physician. She stated the out of state physician ordered home health services, and she did not know Patient #15 needed a physician who was licensed in the state of Idaho to manage his care. The RN Case Manager confirmed the MSW evaluation and POC included additional visits planned, but was unable to explain why they did not occur.</p> <p>The agency did not ensure Patient #15's physician was licensed in the state of Idaho, and orders for therapy visits were received before the visits occurred.</p> <p>2. Patient #11 was a 45 year old female admitted to the agency on 1/07/14, for nursing services related to wound care and DM type II. Her medical record and POC for the certification period 1/07/14 to 3/07/14 were reviewed.</p> <p>Patient #11's POC included orders for vital signs to be performed on every visit, and to report any vital signs outside agency parameters to the physician. However, the RN Case Manager did not ensure Patient #11's physician was informed of vital signs were outside of agency parameters</p>	G 158			

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G 158	<p>Continued From page 17 as follows:</p> <ul style="list-style-type: none"> - 1/27/14 (BP 154/104), - 1/29/14 (BP 194/96), - 1/31/14 (BP 176/118), - 2/03/14 (BP 163/88), - 2/07/14 (P 102, BP 178/102), - 2/10/14 (P 101), - 2/12/14 (BP 162/90), - 2/14/14 (P 103, BP 166/92), - 2/17/14 (BP 174/90), - 2/19/14 (BP 184/104), - 2/21/14 (BP 204/116), - 2/24/14 (P 103, BP 192/118), - 2/26/14 (P 105, BP 174/106), - 3/03/14 (BP 166/96), - 3/05/14 (P 102, BP 168/94). <p>The DON was interviewed on 1/09/15 beginning at 8:30 AM. She confirmed 15 SN visit notes were outside vital sign parameters and the physician was not notified.</p> <p>Patient #11's SN notes did not include notification of her physician as ordered on her POC.</p> <p>3. Patient #8's medical record documented an 84 year old male who was admitted to the agency on 12/19/14, for SN related to a pressure ulcer wound care and DM II.</p> <p>Patient #8's POC for the certification period of 12/19/14 to 2/17/15, included orders for SN to check blood glucose on every visit. However, the following SN visit notes did not include documentation of blood glucose checks: 12/20/14, 12/22/14, 12/31/14, and 1/02/14.</p> <p>The DON was interviewed on 1/09/15 beginning</p>	G 158		
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G 158	<p>Continued From page 18 at 8:45 AM. She confirmed blood glucose checks were not documented.</p> <p>Patient #8's glucose was not assessed each nursing visit as ordered on his POC.</p> <p>4. Patient #1 was a 92 year old male admitted to the agency on 12/24/14 for nursing services related to septicemia. His visit notes, current medication list, and POC for the certification period 12/24/14 to 2/21/15 were reviewed.</p> <p>Patient #1's POC included SN orders to use "SASH" (Saline, Administer Therapy, Saline, Heparin) procedure for PICC line care daily.</p> <p>SN visit note dated 12/26/14 stated, "Port 1: SN flushed with 10 ml NS, administered antibiotics, flushed with 10 ml of heparin, flushed with 10 ml of NS. Port 2: SN flushed with 10 ml NS then 10 ml heparin, flushed with 10 ml of NS."</p> <p>The nurse did not follow the POC, as she documented that for Port 1, she followed the antibiotic dose with heparin flush, and not the NS, which was contrary to the "SASH" protocol. For Port 2, as no antibiotic was administered, it was flushed with NS then heparin, but she followed the heparin flush with an additional flush of NS, which was not within the agency protocol.</p> <p>The RN Case Manager was interviewed by telephone on 1/09/14 beginning at 8:25 AM, and confirmed the nursing note documentation of PICC line care was not consistent with the "SASH" protocol.</p> <p>Patient #1's PICC line was not cared for as per agency policy.</p>	G 158		

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G 159	<p>484.18(a) PLAN OF CARE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure the plan of care included all pertinent information for 2 of 16 patients (#5, and #15) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include:</p> <p>1. Patient #5 was a 21 year old female who was admitted to the agency on 10/14/14 for nursing and therapy services related to ESRD and weakness. Her records for the certification period 12/13/14 to 2/10/15 were reviewed. Additionally; Patient #5 had a tracheostomy as a result of respiratory arrest in 2011, and received outpatient renal dialysis three times weekly.</p> <p>The recertification comprehensive assessment dated 12/13/14 included additional diagnoses of CHF and depressive disorder, with a severity level of "2" which indicated "symptoms were controlled with difficulty, affecting daily functioning, and patient needs ongoing monitoring."</p>	G 159	<p>G159</p> <p>An inservice will be given to all staff by February 13, 2015 by the Administrator and Director of Patient Care Services regarding the need to include interventions and goals that address all pertinent diagnoses, that the POC must be individualized to the patient's need, and that all providers involved in the patient's care are included in the POC. This inservice will contain references to policy 2019 (Care Planning and Coordination – Addendum 1), 2030 (Coordination of Services – Addendum 2).</p> <p>Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>		

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G 159	<p>Continued From page 20</p> <p>Patient #5's POC for the certification period 12/13/14 to 2/10/15, did not include interventions and goals which addressed CHF, depression, high blood pressure, and pain. The following examples clearly demonstrate the need for additional interventions as follows:</p> <p>a. A nursing visit note dated 12/17/14 at 1:25 PM included documentation that Patient #5 had diminished breath sounds in her lower lobes and she was on oxygen at 5 liters. The RN noted Patient #5 had a depressed mood, and demonstrated impaired decision making. Her POC and nursing visit notes did not include interventions related to her depression, and diminished breath sounds.</p> <p>b. A nursing visit note dated 12/20/14 at 1:10 AM, documented the on-call RN was summoned to assess Patient #5 for complaints of nausea and dizziness. The RN noted her blood pressure was 182/120, and she was dizzy when standing. The nurse did not complete the visit note to include respiratory assessment and cardiac assessment. Patient #5 requested assistance to go to the hospital for evaluation, and the RN contacted EMS, who transported her.</p> <p>c. A nursing visit note dated 12/22/14 at 11:00 AM, included documentation that Patient #5's blood pressure was 148/110, her pain was stated at 6/10, she had diminished breath sounds in her lower lobes with a productive cough, and was on oxygen at 5 liters. The RN noted Patient #5 had a depressed mood and demonstrated impaired decision making. The "Skilled Intervention" section of the nursing visit note included interventions of "SN to teach and assess skin care including turning and positioning. SN to</p>	G 159			

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G 159	Continued From page 21 teach /assess trach care and site. SN to teach assess cardiac disease process including management. SN to instruct patient to use prescribed assistive device when ambulating. SN to teach/assess home safety including use of AD as needed. SN to complete PT/INR via fingerstick as directed by MD." The RN did not include interventions related to Patient #5's pain, impaired respiratory status, elevated blood pressure, depressed mood or dizziness. d. A nursing visit note dated 12/26/14 at 2:40 PM, included documentation that Patient #5's blood pressure was 168/110, her breath sounds were diminished in the bases, she had a productive cough, and complained of shortness of breath. The RN noted Patient #5 as having a depressed mood and impaired decision making. The "Skilled Intervention" section of the nursing visit note included the exact same verbiage as in the nursing note on 12/22/14 at 11:00 AM. There were no interventions related to Patient #5's impaired respiratory status, elevated blood pressure, or depressed mood. e. A nursing visit note dated 12/29/14 at 2:45 PM, included documentation that Patient #5's blood pressure was 156/104, her breath sounds were diminished in the bases, she had a productive cough, and complained of shortness of breath. The RN noted Patient #5 as having a depressed mood and impaired decision making. The "Skilled Intervention" section of the nursing visit note included the exact same verbiage as in the nursing note on 12/22/14 at 11:00 AM, and 12/26/14 at 2:40 PM. There were no interventions related to Patient #5's impaired respiratory status, elevated blood pressure, or depressed mood.	G 159			

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G 159	Continued From page 22 During an interview on 1/08/15 beginning at 2:30 PM, the RN Case Manager reviewed Patient #5's record. He confirmed the documentation of interventions did not address additional findings that were noted during the assessments. The RN admitted that he should have updated the POC to reflect the changing needs of Patient #5. The RN confirmed he did not address the depression and impaired decision making that he had documented on each nursing note. Patient #5's POC was not individualized to meet her needs as identified on her comprehensive assessment and updated as her needs changed. 2. Patient #15 was a 44 year old male who was admitted to the agency on 11/20/14 with diagnosis of non-healing surgical wound. Patient #15's plan of care for the certification period 11/20/14 to 1/18/15, did not include all providers who were involved with his medical care. Patient #15's record indicated he was being treated by a wound care physician, general practitioner, and a psychiatrist. Patient #15's POC did not include all the medical providers involved in his care. During an interview on 1/08/15 at 1:40 PM, the RN Case Manager confirmed she did not include the other physicians on the POC. Patient #15's POC was not comprehensive.	G 159			
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation	G 160	G160 An inservice will be given to all staff, both employed and contractual, by February 13, 2015 by the Administrator		

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G 160	<p>Continued From page 23</p> <p>visit, the physician is consulted to approve additions or modification to the original plan.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records, and staff interview, it was determined the agency failed to ensure a physician was consulted to approve changes or additions to the plan of care for 3 of 16 patients (#4, #8, and #15) whose records were reviewed. This resulted in POCs that were developed without therapy input and physician approval. Findings include:</p> <p>During the entrance interview with the Administrator and DON on 1/05/15 beginning at 2:00 PM, the DON described the process for developing the POC for each patient. The DON stated it was the practice of the agency that all SOC and Recertification assessments would be performed by an RN. She stated that after the SOC assessment, the nurse called the physician, often from the patients' homes. She stated the RN obtained orders from the physician or representative, and generated what she called "Gap" orders. The Gap orders included initial patient orders until the POC was signed by the physician. Additionally, the DON stated after therapy evaluations were performed and sent to the physician for signature, the signed therapy evaluation was considered signed therapy orders. She stated the therapists did not routinely contact the physician by phone unless a problem was noted.</p> <p>1. Patient #4's medical record documented a 3 year old female who was admitted to the agency on 12/05/14, for SN and therapy services related to cerebral palsy and speech disorder.</p>	G 160	<p>and Director of Patient Care Services regarding the need to ensure that the POC is developed in coordination with all disciplines and approved by a physician prior to the initiation of nursing and therapy services. This inservice will contain references to policy 2019 (Care Planning and Coordination – Addendum 1), 2030 (Coordination of Services – Addendum 2).</p> <p>Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>		

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G 160	Continued From page 24 The SOC comprehensive assessment was performed by an RN on 12/15/14, and documented Patient #4's physician's representative was notified of her admission to home care on 12/08/14. The RN did not indicate if "Gap" orders were received at that time. The faxed copy of the POC for the certification period 12/05/14 to 2/02/15, indicated it was sent to the physician for approval 12/12/14, which was 7 days after her SOC. The signed POC did not include ST, PT, or OT treatment goals or frequencies. A PT evaluation was performed on 12/09/14, the evaluation was signed by Patient #4's physician on 12/15/14 and returned by fax on 12/17/14. PT visits were conducted on 12/09/14 and 12/12/14, before the signed PT evaluation was returned to the agency. PT services were performed without physician's orders. The ST evaluation was conducted on 11/21/14. The evaluation included a plan for ST visits once weekly for 6 weeks. The section of the evaluation titled "Care Coordination," included a box next to "Physician," which remained unchecked. There was no documentation of communication with Patient #15's physician to indicate orders were obtained. The evaluation was signed by the out of state physician on 12/02/14. Two ST visits were performed, one on 11/25/14, and one on 12/06/14, when he was discharged from ST services. The visit on 11/25/14 occurred before the evaluation was signed by Patient #15's physician. An OT evaluation was performed on 12/08/14, the evaluation was signed by Patient #4's	G 160			

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G 160	<p>Continued From page 25 physician on 12/30/14.</p> <p>During an interview on 1/09/15 at 8:30 AM, the DON reviewed Patient #4's record and confirmed the physician was not contacted after the SOC assessment.</p> <p>Patient #4's POC was not developed by all disciplines involved in her care and approved by her physician prior to the initiation of nursing and therapy services.</p> <p>2. Patient #15 was a 44 year old male admitted to the agency on 11/20/14 for nursing and therapy services related to paraplegia and wound care.</p> <p>A PT evaluation was conducted on 11/20/14. The evaluation included a plan for PT visits twice weekly for five weeks. The section of the evaluation titled "Care Coordination," included a box next to "Physician," which was checked. However, there was no further documentation of communication with Patient #15's physician to indicate what was discussed, what orders were obtained, and when the physician was contacted. The evaluation was signed by the out of state physician on 12/02/14. Two PT visits were conducted, one on 11/25/14 and 11/28/14, before the physician signed the evaluation.</p> <p>A ST evaluation was performed on 11/21/14, the evaluation was signed by Patient #15's physician on 12/02/14. A ST visit was conducted on 11/25/14, before the signed ST evaluation was returned to the agency, indicating ST services were performed without physician's orders.</p> <p>During an interview on 1/08/15 at 1:40 PM, the RN Case Manager confirmed Patient #15 was</p>	G 160			

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G 160	<p>Continued From page 26</p> <p>under the care of the out of state physician, as he was hospitalized in the other state and received care by that physician. She stated the out of state physician ordered home health services. Additionally, the Case Manager stated therapists generally did not contact the physician after evaluating a patient, and the therapy evaluations served as communication with the physician. When the evaluation was faxed to the physician and returned with a signature, the signed evaluation would be considered orders.</p> <p>Patient #15's PT and ST services were initiated prior to physician authorization.</p> <p>3. Patient #8's medical record documented an 84 year old male who was admitted to the agency on 12/19/14, for nursing services related to pressure ulcer wound care and DM II.</p> <p>A PT evaluation, which included a POC for the frequency, duration and type of services to be provided, was performed on 12/23/14, and unsigned by the physician as of 1/09/15. The evaluation did not include physician communication for PT orders. PT visits were conducted on 12/29/14, 12/31/14, 1/01/15, and 1/05/14. PT services were performed without physician orders.</p> <p>During a telephone interview on 1/09/15 at 9:40 AM, the RN Case Manager confirmed Patient #8's PT evaluation was not signed and returned by the physician. She confirmed therapy visits were made before the physician signed the evaluations.</p>	G 160			

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G 160	Continued From page 27	G 160			
G 164	<p>Patient #8 received PT services prior to physician approval.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of patient records, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 2 of 16 patients (#5 & #11) whose records were reviewed. This resulted in 1) wound care provided without orders, 2) lack of physician notification of blood pressure and blood sugar readings beyond parameters identified in patients' POCs, and 3) a patient's intense pain not reported to the physician. Findings include:</p> <p>1. Patient #5 was a 21 year old female who was admitted to the agency on 10/14/14 for nursing and therapy services related to ESRD and weakness. Her records, including the POC for the certification period 12/13/14 to 2/10/15 were reviewed.</p> <p>Patient #5's POC included orders to report any vital signs outside the established agency parameters to her physician. The blood pressure parameters listed were Systolic >160 or < 90, and Diastolic >90 or <50. Patient #5's recertification assessment dated 12/13/14,</p>	G 164	<p>G164</p> <p>An inservice will be given to all staff by February 13, 2015 by the Administrator and Director of Patient Care Services in order to ensure that field staff promptly alert the physician to any significant changes in the patient's condition, including and not limited to changes with a patient's wound, vital signs and pain outside of designated parameters, and changes in blood sugar readings. This inservice will contain references to policy 2019 (Care Planning and Coordination – Addendum 1), 2030 (Coordination of Services – Addendum 2).</p> <p>Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>		

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G 164	<p>Continued From page 28</p> <p>included her acceptable level of pain as 5 or 6 on a scale of 1-10.</p> <p>Patient #5's record indicated frequent notations of elevated blood pressure readings, complaints of severe levels of pain, and changes in her condition without notifications to her physician, or modifications to her POC, as follows:</p> <p>a. The recertification assessment dated 12/13/14 at 12:00 PM, included her blood pressure of 156/102, which was out of the parameters stated on her POC. There was no documentation in her record that Patient #5's physician was alerted to the elevated blood pressure or of adjustment of the POC to individualize her parameters.</p> <p>b. A PT evaluation dated 12/18/14 at 1:05 PM, included a blood pressure of 122/84. Her pain intensity was noted at 9/10. There was no documentation the therapist alerted Patient #5's physician of the elevated blood pressure or level of severe pain.</p> <p>c. A nursing note dated 12/20/14 at 1:10 AM, documented the on-call nurse came to Patient #5's home for complaints of nausea and vomiting. Her blood pressure was noted to be 182/120, and her pain was described as a level 10 on a scale of 1-10. The RN documented Patient #5 wanted to go to the hospital to be checked, and EMS was contacted for transport. After calling 911, the RN documented Patient #5 told her that she fell the day before and was taken by ambulance to the hospital for x-rays. The RN noted that after placing Patient #5 in the ambulance, the paramedics informed her that over the last week the patient contacted EMS on 9 consecutive shifts. They told her they realized how sick she</p>	G 164			

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G 164	<p>Continued From page 29</p> <p>was, but something needed to be done, and they could not realistically keep coming every day.</p> <p>Patient #5's record did not include documentation her physician was notified of the elevated blood pressure, of the severity of her pain, her recent fall, or of the multiple visits to the hospital. Patient #5's record did not include case conference notes that addressed the same issues and there were no changes to the POC.</p> <p>d. A nursing note dated 12/22/14 at 11:00 AM, included documentation of Patient #5's blood pressure of 148/110, which was outside the agency parameters. Additionally, her pain intensity was described as 6/10. The RN documented Patient #5 stated her pain was in her abdomen, and the hospital told her it was due to extra fluid in her abdomen.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's physician was notified regarding the recent Emergency Room visit, the recent fall, her elevated blood pressure, or severity of pain.</p> <p>e. A nursing note dated 12/23/14 at 11:05 PM, by the on-call RN, documented Patient #5's blood pressure of 182/124. She documented Patient #5 complained of chest pain with a severity of 10/10. The RN documented she contacted EMS and Patient #5 was transported to the hospital.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank, there was no documentation Patient #5's physician was notified regarding her need to go to the hospital, her elevated blood pressure, or severity of pain.</p>	G 164			

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G 164	<p>Continued From page 30</p> <p>There was no documentation the RN Case Manager was informed of the on-call visit.</p> <p>f. A PTA visit note dated 12/26/14 at 2:00 PM, included documentation Patient #5's blood pressure was 138/90. Her pain intensity was described as 8/10. There was no documentation in her record that Patient #5's physician was notified of the elevated blood pressure or severe pain.</p> <p>g. A nursing note dated 12/26/14 at 2:40 PM, documented Patient #5's blood pressure was 168/110. Her record did not include documentation the RN notified Patient #5's physician regarding the elevated blood pressure. The RN did not document the outcome of Patient #5's recent trip to the hospital for elevated blood pressure, severe chest pain, or note if there were any changes to her POC or medications.</p> <p>h. A nursing note dated 12/26/14 at 8:30 PM, by the on-call RN, documented Patient #5's blood pressure was 146/108. The RN noted he was called to evaluate Patient #5's fistula site in her left arm. He noted Patient #5 had been to her dialysis appointment earlier in the day, and there was bleeding for several hours that did not stop. The RN documented he removed the dressing from the site and blood spurted out about 2 feet. He noted EMS was notified and Patient #5 was transported to the hospital for evaluation.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's physician or her RN Case Manager was notified regarding the fistula site bleeding, transport to the hospital, or elevated blood pressure.</p>	G 164			

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G 164	Continued From page 31 i. A nursing note dated 12/28/14 at 1:00 PM, documented the on-call nurse was requested by Patient #5 to assess the fistula site. Her blood pressure was noted to be 140/100. The RN noted "B/P is within normal range for patient and pt (patient) states it is actually lower than normal." There was no documentation Patient #5's physician or the RN Case Manager were notified of the elevated blood pressure. j. A PTA visit note dated 12/29/14 at 2:00 PM, documented Patient #5's blood pressure as 179/96. She noted her pain as 8/10. There was no documentation Patient #5's physician was notified of the elevated blood pressure or the severity of her pain. k. A nursing note dated 12/29/14 at 2:45 PM, documented Patient #5's blood pressure of 156/104. The record did not indicate Patient #5's physician was notified of the elevated blood pressure. l. A nursing note dated 12/30/14 at 11:00 AM, documented the RN made a prn visit to assess Patient #5's fistula site. The record noted there was blood on the dressing, and the site was cleansed and a compression dressing was placed. Her blood pressure was noted to be 148/98. There was no documentation Patient #5's physician was notified of the elevated blood pressure. Additionally, Patient #5's POC did not include orders for the fistula site dressing change. There was no documentation Patient #5's physician was contacted to obtain dressing change orders. m. A PTA visit note dated 12/30/14 at 2:15 PM,	G 164			

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G 164	<p>Continued From page 32</p> <p>documented Patient #5's blood pressure as 140/94. Her pain was noted at 8/10. There was no documentation Patient #5's physician was notified of the elevated blood pressure or the severity of her pain.</p> <p>During an interview on 1/08/15 beginning at 11:45 AM, the Physical Therapist for Patient #5, who also performed supervisory oversight for the PTA, reviewed her record. He confirmed the PTA entries described the high levels of pain, as well as, the elevated blood pressures. The Physical Therapist looked in his notes, his phone, and his tablet at the patient record. He stated he had no record of communication with the PTA and did not recall direct conversations with the PTA regarding blood pressure or pain concerns. The Physical Therapist stated if he was notified, he would refer the PTA to contact the clinical staff. The Physical Therapist confirmed there was no documentation to indicate Patient #5's physician was alerted to the severity of her pain and the elevated blood pressure readings.</p> <p>During an interview on 1/08/15 beginning at 2:30 PM, the RN Case Manager reviewed Patient #5's record and confirmed the elevated blood pressures. He stated the record did not include documentation of all the communication that occurred regarding Patient #5. He stated he spoke with the dialysis center frequently without including notes of the communication in Patient #5's record. Additionally, the RN stated when he attempted to contact Patient #5's physician at his office, he was told to contact the dialysis center. He stated he stopped trying to contact the physician, and would relay information through the dialysis center only. The RN confirmed Patient #5's POC included agency vital sign</p>	G 164			

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G 164	<p>Continued From page 33</p> <p>parameters that required physician notification. He confirmed the lack of physician notification.</p> <p>Patient #5's physician was not notified of changes in her condition.</p> <p>2. Patient #11 was a 45 year old female admitted to the agency on 1/07/14, for nursing services related to wound care and DM type II. Her medical record and POC for the certification period 1/07/14 to 3/07/14 were reviewed.</p> <p>Patient #11's POC included orders to report any vital signs outside the established agency parameter to her physician. The blood pressure parameters listed were Systolic >160 or <90, and Diastolic >90 or <50. Pulse parameters were <66 or >100.</p> <p>Patient #11's POC included orders for vital signs to be performed on every visit, and to report any vital signs outside agency parameters to the physician. The following SN visit notes documented vital signs outside the parameters noted on Patient #11's POC, without evidence of physician notification:</p> <p>1/27/14 (BP 154/104) 1/29/14 (BP 194/96) 1/31/14 (BP 176/118) 2/03/14 (BP 163/88) 2/07/14 (P 102, BP 178/102) 2/10/14 (P 101) 2/12/14 (BP 162/90) 2/14/14 (P 103, BP 166/92) 2/17/14 (BP 174/90) 2/19/14 (BP 184/104) 2/21/14 (BP 204/116) 2/24/14 (P 103, BP 192/118)</p>	G 164		

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G 164	Continued From page 34 2/26/14 (P 105, BP 174/106) 3/03/14 (BP 166/96) 3/05/14 (P 102, BP 168/94). The DON was interviewed on 1/09/15 beginning at 8:30 AM. She confirmed the 15 SN visit notes documented vital signs outside of the parameters established on Patient #11's POC and the physician was not notified.	G 164		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure nursing services were provided in accordance with the POC for 1 of 16 patients (#1) whose records were reviewed. Failure to follow the established POC had the potential to result in negative patient outcomes. Findings include: Patient #1 was a 92 year old male admitted to the agency on 12/24/14 for nursing services related to septicemia. His visit notes, current medication list, and POC for the certification period 12/24/14 to 2/21/15 were reviewed. Patient #1's POC included SN orders to use "SASH" (Saline, Administer Therapy, Saline, Heparin) procedure for PICC line care daily. SN visit note dated 12/26/14 stated, "Port 1: SN	G 170	G170 An inservice will be given to all nursing staff by February 13, 2015 by the Administrator and Director of Patient Care Services regarding policy 2007 (Skilled Nursing Duties – Addendum 3) specifically to ensure that skilled nursing services are provided in accordance with the POC. Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.	

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G 170	Continued From page 35 flushed with 10 ml NS, administered antibiotics, flushed with 10 ml of heparin, flushed with 10 ml of NS. Port 2: SN flushed with 10 ml NS then 10 ml heparin, flushed with 10 ml of NS." The nurse did not follow the POC, as she documented for Port 1, she followed the antibiotic dose with heparin flush, and not the NS, which was contrary to the "SASH" protocol. For Port 2, as no antibiotic was administered, it was flushed with NS then heparin, but she followed the heparin flush with an additional flush of NS, which was not within the agency protocol. The RN Case Manager was interviewed by telephone on 1/09/14 beginning at 8:25 AM, and confirmed the nursing note documentation of PICC line care was not consistent with the "SASH" protocol.	G 170	Full compliance to this deficiency will be February 23, 2015.		
G 176	Patient #1's PICC line care was not followed as ordered on his POC. 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on patient record review and staff interview, it was determined the RN failed to ensure coordinated services and informed the physician of changes in patients' condition for 2 of 16 patients (#5 and #11) whose records were reviewed. This had the potential to result in	G 176	G176 An inservice will be given to all nursing staff by February 13, 2015 by the Administrator and Director of Patient Care Services regarding policy 2007 (Skilled Nursing Duties – Addendum 3) specifically to ensure that the RN coordinates services with the team and physician and informs the team and physician of changes in the patient's condition. This inservice will contain references to policy 2019 (Care Planning and Coordination – Addendum 1), 2030 (Coordination of Services – Addendum 2).		

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G 176	<p>Continued From page 36</p> <p>unmet patient needs and negatively impact continuity and quality of patient care. Findings include:</p> <p>1. Patient #5 was a 21 year old female who was admitted to the agency on 10/14/14 for nursing and therapy services related to ESRD and weakness. Her record, including the POC, for the certification period 12/13/14 to 2/10/15 were reviewed.</p> <p>Patient #5's POC included orders to report any vital signs outside the established agency parameters to her physician. The blood pressure parameters listed were Systolic >160 or < 90, and Diastolic >90 or <50. Patient #5's recertification assessment dated 12/13/14, included her acceptable level of pain as 5 or 6 on a scale of 1-10.</p> <p>a. The recertification assessment dated 12/13/14 at 12:00 PM, included a blood pressure of 156/102, which was out of the parameters on her POC. The RN did not contact the physician regarding the out of range diastolic reading.</p> <p>b. A nursing note dated 12/20/14 at 1:10 AM, documented the on-call nurse came to Patient #5's home for complaints of nausea and vomiting. Her blood pressure was noted to be 182/120, and her pain was described as a level 10 on a scale of 1-10. The RN documented Patient #5 wanted to go to the hospital to be checked, and EMS was contacted for transport. After calling 911, the RN documented Patient #5 told her that she fell the day before and was taken by ambulance to the hospital for x-rays. The RN noted that after placing Patient #5 in the ambulance, the paramedics informed her that over the last week</p>	G 176	<p>Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>	

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G 176	<p>Continued From page 37</p> <p>the patient contacted EMS on 9 consecutive shifts. They told her they realized how sick she was, but something needed to be done, and they could not realistically keep coming everyday.</p> <p>The RN wrote in the nursing note under the section "Coordination Plan," that she conferenced with the SN and with the DON regarding the number of EMS visits to the patient's home in the last week. Additionally, she documented "Need for SW intervention, and probable need for placement to meet needs." However, her record did not include documentation of communication with the DON or the RN Case Manager regarding Patient #5's recent fall and Emergency Room visit, the severity of her pain, or her elevated blood pressure.</p> <p>c. A nursing note dated 12/22/14 at 11:00 AM, included documentation of Patient #5's blood pressure of 148/110, which was outside the diastolic parameter noted on her POC. Additionally, her pain intensity was described as 6/10. The RN documented Patient #5 stated her pain was in her abdomen, and she was told by the staff at the hospital that it was due to extra fluid in her abdomen.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's RN Case Manager or physician were notified regarding the outcome of the recent Emergency Room visit, her elevated blood pressure, or severity of her pain.</p> <p>d. In a nursing note, dated 12/23/14 at 11:05 PM, the on-call RN documented Patient #5's blood pressure of 182/124. She documented Patient #5 complained of chest pain with a severity of 10/10.</p>	G 176			

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G 176	<p>Continued From page 38</p> <p>The RN documented she contacted EMS and Patient #5 was transported to the hospital.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's physician was notified regarding her need to go to the hospital, her elevated blood pressure, or severity of pain. There was no documentation the RN Case Manager was informed of the on-call visit.</p> <p>e. A nursing note, dated 12/26/14 at 2:40 PM, documented Patient #5's blood pressure was 168/110. Her record did not include documentation the RN notified Patient #5's physician regarding the elevated blood pressure. The record did not include case conference notes or modifications to her POC.</p> <p>f. In a nursing note, dated 12/26/14 at 8:30 PM, the on-call RN documented Patient #5's blood pressure was 146/108. The RN noted he was called to evaluate Patient #5's fistula site in her left arm. He noted Patient #5 had been to her dialysis appointment earlier in the day, and there was bleeding for several hours that did not stop. The RN documented he removed the dressing from the site and blood spurted out about 2 feet. He noted EMS was notified and Patient #5 was transported to the hospital for evaluation.</p> <p>The section in the nursing note titled "Coordination Plan," remained blank. There was no documentation Patient #5's physician or her RN Case Manager were notified regarding the fistula site bleeding, transport to the hospital, or elevated blood pressure.</p> <p>g. A nursing note dated 12/28/14 at 1:00 PM,</p>	G 176			

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G 176	<p>Continued From page 39</p> <p>documented the on-call nurse was requested by Patient #5 to assess the fistula site. Her blood pressure was noted to be 140/100. The RN noted "B/P is within normal range for patient and pt (patient) states it is actually lower than normal." There was no documentation Patient #5's physician or the RN Case Manager were notified of the elevated diastolic reading.</p> <p>h. A nursing note dated 12/29/14 at 2:45 PM, documented Patient #5's blood pressure of 156/104. The record did not indicate Patient #5's physician was notified of the elevated diastolic reading. The RN documented Patient #5's pain at 4/10. There was no indication the RN acknowledged the notes from the therapy visit earlier that afternoon that referenced severe pain and elevated blood pressure.</p> <p>i. A nursing note dated 12/30/14 at 11:00 AM, documented the RN made a prn visit to assess Patient #5's fistula site. Her blood pressure was noted to be 148/98, there was no documentation of communicating Patient #5's elevated diastolic reading to her physician.</p> <p>During an interview on 1/08/15 beginning at 2:30 PM, the RN Case Manager reviewed Patient #5's record and confirmed the documentation of severe pain and elevated blood pressures. He stated he was aware that Patient #5 had gone to the hospital on multiple occasions, and had received communication from the on-call RN. He stated the record did not include documentation of all the communication that occurred regarding Patient #5. He stated he spoke with the dialysis center frequently without including notes of the communication in Patient #5's record. Additionally, the RN stated when he attempted to</p>	G 176			

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G 176	<p>Continued From page 40</p> <p>contact Patient #5's physician at his office, he was told to contact the dialysis center. He stated he would relay information through the dialysis center only. The RN confirmed Patient #5's POC included agency vital sign parameters that required physician notification. He confirmed the lack of physician notification.</p> <p>The agency did not ensure Patient #5's RN Case Manager coordinated care between disciplines and her physician.</p> <p>2. Patient #11 was a 45 year old female admitted to the agency on 1/07/14, for nursing services related to wound care and DM type II. Her medical record and POC for the certification period 1/07/14 to 3/07/14 were reviewed.</p> <p>Patient #11's POC included orders to report any vital signs outside the established agency parameter to her physician. The blood pressure parameters listed were Systolic >160 or <90, and Diastolic >90 or <50. Pulse <66 or >100.</p> <p>Patient #11's POC included orders for vital signs to be performed on every visit, and to report any vital signs outside agency parameters to the physician. However, the RN Case Manager did not ensure Patient #11's physician was informed of vital signs were outside of agency parameters as follows:</p> <ul style="list-style-type: none"> - 1/27/14 (BP 154/104), - 1/29/14 (BP 194/96), - 1/31/14 (BP 176/118), - 2/03/14 (BP 163/88), - 2/07/14 (P 102, BP 178/102), 	G 176		

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G 176	Continued From page 41 - 2/10/14 (P 101), - 2/12/14 (BP 162/90), - 2/14/14 (P 103, BP 166/92), - 2/17/14 (BP 174/90), - 2/19/14 (BP 184/104), - 2/21/14 (BP 204/116), - 2/24/14 (P 103, BP 192/118), - 2/26/14 (P 105, BP 174/106), - 3/03/14 (BP 166/96), - 3/05/14 (P 102, BP 168/94). The DON was interviewed on 1/09/15 beginning at 8:30 AM. She confirmed 15 SN visit notes were outside vital sign parameters and the physician was not notified. The RN Case Manager failed to ensure Patient #11's physician was notified of abnormal vital signs.	G 176			
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on review of medical records and agency policies, observations during home visits, and staff and patient interviews, it was determined the agency failed to ensure the comprehensive assessment included all medications the patient was taking, as well as a medication review to evaluate for drug interactions, identify significant side effects, and identify duplicative therapy for 7	G 337	G337 An inservice will be given to all nursing staff by February 13, 2015 by the Administrator and Director of Patient Care Services regarding policy 3001 (Medication Management – Addendum 4) and policy 3005 (Medication Orders and Administration – Addendum 5) specifically to ensure that the each discipline updates the medication list as needed and to ensure the medication reconciliation occurs and MD is notified of any major drug interactions. This inservice will contain references to policy 2030 (Coordination of Services – Addendum 2).		

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G 337	<p>Continued From page 42 of 16 patients, (#1, #2, #5, #10, #12, #15, and #16) whose records were reviewed. Failure to complete a medication review had the potential to place patients at risk for adverse events and potential drug reactions. Findings include:</p> <p>During an interview with the DON and Administrator on 1/05/15 beginning at 1:30 PM, the DON stated a comprehensive drug review was conducted for each patient during the SOC assessment. She stated that during each nursing or therapy visit the staff would also ask the patient if any medication changes had occurred.</p> <p>An agency policy titled "Medication Management-Patient Information," dated 1/01/2009, stated that during the initial assessment visit the admitting RN would review patient medications, including prescription, over the counter, and herbal remedies. The policy also stated the RN would perform an assessment of the medications to determine whether actual or potential interactions exists between the medications. It stated any questions or concerns about the patient's current medications and herbal remedies would be directed to the ordering physician.</p> <p>An additional policy titled "Medication orders and Administration," dated 1/01/2009, stated unresolved, or significant concerns about the medication would be discussed with the nurse and the prescribing physician. It further stated that patient medications and changes would be documented in the initial assessment, recertification assessment, and in the clinical visit notes. These policies were not followed. Examples include:</p>	G 337	<p>Along with all-staff inservices, the associated deficiencies will also be addressed in proceeding IDT Case Conferences. The Quality Assurance team will also conduct 10-12 chart audits weekly and the results of those audits will be given to the Director of Patient Care Services or delegated personnel in order to track trends and show improvement. These reports will be discipline specific and show compliance to the POC.</p> <p>Full compliance to this deficiency will be February 23, 2015.</p>	

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G 337	<p>Continued From page 43</p> <p>1. Patient #5 was a 21 year old female admitted to the agency on 12/13/14 for nursing and therapy services related to ESRD and weakness. Her visit notes, current medication list, and POC for the certification period 12/13/14 to 1/18/15 were reviewed.</p> <p>In a Skilled Nurse Visit note dated 12/23/14 at 11:40 PM, the RN documented she completed an on-call visit to Patient #5's home. The RN noted Patient #5 was complaining of chest pain, nausea, and diarrhea. The RN noted she was hypertensive, with a blood pressure of 182/124. The RN noted Patient #5 told her she was "out of nitro" (Nitroglycerin is a medication used for chest pain, as it dilates the coronary vessels) and needed a refill. Nitroglycerin was not on the medication list on Patient #5's POC.</p> <p>During an interview on 1/08/15 at 2:30 PM, the RN Case Manager reviewed Patient #5's record. He confirmed the notation of Patient #5 statement that she needed a refill of Nitroglycerin, and that it was not listed on her POC. The RN stated he did not question Patient #5 or her physician if she renewed the prescription, or confirmed that she was to take it.</p> <p>Patient #5's medications were not updated and discrepancies clarified with her physician.</p> <p>2. Patient #15 was a 44 year old male who was admitted to the agency on 11/20/14 for nursing and therapy services related to paraplegia and wound care.</p> <p>a. A visit was made to Patient #15's home on 1/07/15 at 9:30 AM, to observe nursing care. At the end of the home visit Patient #15's</p>	G 337		

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G 337	<p>Continued From page 44</p> <p>medications were reviewed with his mother who was his primary caregiver. Immediately prior to the home visit the agency provided a list of Patient #15's current medications. The following medications were identified as being at a dose different than what was provided on his current list, with the discrepancy identified during the in-home medication review:</p> <ul style="list-style-type: none"> - Albuterol Sulfate Inhaler (2 puffs twice daily), Patient #15's mother stated he stopped the medication in early December as it caused an elevated heart rate. - Mometasone Furo-Formoterol Inhaler (2 puffs twice daily), Patient #15's mother stated he stopped the medication in early December as it caused an elevated heart rate. - Bisacodyl Rectal suppository (1 daily), Patient #15's mother stated he stopped taking the medication in early December as it caused nausea. - Fluticasone Propionate Nasal spray (once daily), Patient #15's mother stated he never filled the prescription, and did not have the medication. - Zolpidem Tartarate 5 mg (1 every night), Patient #15's mother stated the medication had been increased to 10 mg. - Gabapentin 400 mg, (1 at 6:00 AM, 1 at 2:00 PM, and 2 at 10:00 PM), the medication container instructed Patient #15 to take 1 capsule three times daily. Patient #15's mother read the container and stated she was surprised to see he was to take only one capsule at night, and stated she wondered why he ran out of the medication 	G 337		

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G 337	<p>Continued From page 45 early.</p> <ul style="list-style-type: none"> - Testosterone Transdermal patch. Patient #15's mother stated he no longer had the medication in patch form, and the nurses were administering the medication by injection every 2 weeks. - Lorazepam 0.5 mg (1 tablet every 8 hours as needed), Patient #15's mother stated the dosage had been increased in mid-December to 1 mg three times daily. - Oxycodone 10/325 mg, (1 tablet every 4 hours for pain), Patient #15's mother stated he took 1.5 tablets every 4 hours around the clock for a total of 9 pills daily. <p>During an interview on 1/08/15 beginning at 1:40 PM, the RN Case Manager reviewed Patient #15's record, and stated she had not updated the medication list to reflect the new changes. She stated she returned to Patient #16's home 1/07/15 in the afternoon, and reviewed the medications with his mother. The RN stated she completed a medication reconciliation and was going to send it to Patient #15's physician for review.</p> <p>b. The SOC Comprehensive Assessment, performed on 11/20/14, included under locator M2000, (Drug Regimen Review) noted "Problems found during review." Additionally, locator M202, (Medication Follow-up) documented Patient #15's physician was not contacted within 1 calendar day to resolve significant medication issues and/or reconciliation.</p> <p>Patient #15's record included a form titled "Medication Interactions," dated 11/20/14. The</p>	G 337			

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G 337	<p>Continued From page 46</p> <p>form listed one drug to drug interaction with "Intervention Required." The medications were Cerovite and Tolterodine Tartarate ER Capsule.</p> <p>Additionally, during a home visit on 1/07/15 beginning at 11:00 AM, Patient #15's mother provided all his medications to be reviewed. It was noted that he was taking Oxycodone 10/325 (1.5 tabs every 4 hours), as well as, acetaminophen extra strength 650 mg every 4 hours. The Oxycodone, taken as described by his mother resulted in a dose of 2,925 mg acetaminophen daily, and combined with the acetaminophen extra strength provided an additional 3,900 mg for a total of 6,825 mg daily.</p> <p>According to "Nursing 2014 Drug Handbook" acetaminophen has a black box warning as follows: "Acetaminophen can cause acute liver failure, which may require a liver transplant or cause death. Most cases of liver injury are associated with drug doses exceeding 4,000 mg/day and often involve more than one acetaminophen-containing product."</p> <p>According to an article in May 2014, by fda.gov, "Inadvertant overdoses with prescription drugs that contain acetaminophen and a narcotic have been responsible for a significant proportion of all the cases of acetaminophen-related liver failure in the United States."</p> <p>During an interview on 1/08/15 beginning at 1:40 PM, the RN Case Manager reviewed Patient #15's record and confirmed the interaction of Cerovite and Tolterodine Tartarate ER. She confirmed she did not communicate directly with Patient #15's physician regarding the interaction. The RN stated she was not aware that Patient</p>	G 337			

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G 337	<p>Continued From page 47</p> <p>#15 was receiving such a high amount of acetaminophen each day. She stated she was aware he took the extra strength acetaminophen, but did not know the Oxycodone contained acetaminophen.</p> <p>Patient #15's medication list was not current and accurate.</p> <p>3. Patient #16 was a 92 year old male admitted to the agency on 10/25/14, for nursing services related to wound care. His visit notes, current medication list, and POC for the certification periods 10/25/14 to 12/23/14 and 12/24/14 to 2/21/15 were reviewed.</p> <p>A visit was made to Patient #16's home on 1/07/15 at 11:00 AM, to observe nursing care. At the end of the home visit Patient #16 brought out his medications to review. The following medications were not on his POC, however he stated he had been taking the medications regularly:</p> <ul style="list-style-type: none"> - Iron tablets 325 mg (once daily), - Meclizine 12.5 mg (daily as needed for dizziness), - Ambien 10 mg (at bedtime). <p>The RN Case Manager was present during the medication review, and stated she did not know Patient #16 was taking the above medications in addition to the medications listed on his POC. She stated she usually reviewed his medications with Patient #16's daughter, rather than with Patient #16.</p>	G 337			

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G 337	<p>Continued From page 48</p> <p>Patient #16's medication list was not accurate and current.</p> <p>4. Patient #10 was a 35 year old male admitted to the agency on 8/16/14 for nursing and therapy services related to wound care and paraplegia.</p> <p>The SOC Comprehensive Assessment, performed on 8/16/14, included under locator M2000, (Drug Regimen Review) noted "Problems found during review." Additionally, locator M202, (Medication Follow-up) documented Patient #10's physician was not contacted within 1 calendar day to resolve significant medication issues and/or reconciliation.</p> <p>Patient #10's record included a form titled "Drug Interaction Report." The report included the medications on the POC for the certification period 8/16/14 to 10/14/14. Additionally, the 52 page report included interactions between his medications, with the classification of minor, moderate, or major. The report listed major interactions with the following medication combinations:</p> <ul style="list-style-type: none"> - Cyclobenzaprine HCL 10 mg with Fluvoxamine Maleate 100 mg, - Cyclobenzaprine HCL 10 mg with Duloxetine HCL 60 mg, - Fluvoxamine 100 mg and Seroquel 50 mg, - Coumadin 2 mg and Doxycycline Hyclate 100 mg, - Coumadin 2 mg and Rifampin 300 mg, 	G 337			

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G 337	<p>Continued From page 49</p> <p>During an interview on 1/09/15 beginning at 8:00 AM, the DON reviewed Patient #10's record and confirmed the report identified major interactions. She stated a major interaction on the report would require physician notification, and confirmed the SOC assessment included the notation of "Problems found during review." She confirmed the record did not document communication with Patient #10's physician regarding the drug interactions.</p> <p>5. Patient #12 was a 71 year old female admitted to the agency on 7/30/14 for nursing care related to wound care.</p> <p>The SOC Comprehensive Assessment, performed on 7/30/14, included under locator M2000, (Drug Regimen Review) noted "Problems found during review." Additionally, locator M202, (Medication Follow-up) documented Patient #12's physician was not contacted within 1 calendar day to resolve significant medication issues and/or reconciliation.</p> <p>Patient #12's record included a form titled "Drug Interaction Report." The report included the medications on the POC for the certification period 7/30/14 to 9/27/14. Additionally, the 30 page report included interactions between her medications, with the classification of minor, moderate, or major. The report listed major interactions with the following medication combinations:</p> <ul style="list-style-type: none"> - Ibuprofen 200 mg and Aspirin 81 mg, - Ibuprofen 200 mg and Anacin Max Strength 500-32 mg, 	G 337			

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G 337	<p>Continued From page 50</p> <p>- Fluconazole 150 mg and Levofloxacin 750 mg,</p> <p>During an interview on 1/09/15 beginning at 8:40 AM, the DON reviewed Patient #12's record and confirmed the report identified major interactions. She stated a major interaction on the report would require physician notification, and confirmed the SOC assessment included the notation of "Problems found during review." She confirmed the record did not document communication with Patient #12's physician regarding the drug interactions.</p> <p>The agency did not ensure Patient #15's medication records were accurate, and notified his physician of interactions, and/or discrepancies.</p> <p>6. Patient #1 was a 92 year old male admitted to the agency on 12/24/14 for nursing services related to septicemia. His visit notes, current medication list, and POC for the certification period 12/24/14 to 2/21/15 were reviewed.</p> <p>A visit was made to Patient #1's home on 1/06/15 at 8:00 AM, to observe nursing care. At the end of the home visit, Patient #1's medications were reviewed with his wife who was his primary caregiver. Prior to the home visit, the agency provided a list of Patient #1's current medications. Additional medications were noted at the time of the home visit that Patient #1's wife confirmed he was taking. The following medications were not included on the agency medication list or the POC:</p> <p>-Melatonin 5 mg, over the counter for sleep.</p>	G 337			

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G 337	<p>Continued From page 51</p> <p>-Probiotic, over the counter for digestive health.</p> <p>-Losartan Potassium 50 mg 1 daily, for hypertension.</p> <p>-Multivitamin one tablet daily, over the counter supplement.</p> <p>During a phone interview on 1/09/15 at 8:25 AM, the RN Case Manager reviewed the medication list and stated she asked about Patient #1's medications, but did not update the list.</p> <p>Patient #1's medication list was not current and accurate.</p> <p>7. Patient #2 was a 32 year old male admitted to the agency on 12/09/14 for nursing and physical therapy services related to DM II and muscle weakness-general.</p> <p>The SOC Comprehensive Assessment, performed on 12/09/14, included under locator M2000, (Drug Regimen Review) "No problems found during review."</p> <p>Patient #2's record included a form titled "Medication Interactions." The form included the medications on the POC for the certification period 12/09/14 to 2/06/15. Additionally, the 3-page form included interactions between his medications, with the classification of review suggested, potential interaction risk, or intervention required. The form-listed intervention required with the following medication combinations:</p> <p>-Metoclopramide HCL oral solution 10 mg/ml with Promethazine HCL oral tablet 12.5 mg. The</p>	G 337			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2015
NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202		
(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 337	<p>Continued From page 52</p> <p>warning stated, may increase the risk of extrapyramidal reactions, and is contraindicated according to official package labeling.</p> <p>During an interview on 1/06/15 beginning at 9:40 AM, the Quality Assurance Director reviewed Patient #2's record and confirmed the form identified interactions that required interventions. She stated this type of contraindication required physician notification, and confirmed the SOC assessment should have included the notation of "Problems found during review." She confirmed the record did not document communication with Patient #2's physician regarding the drug interactions.</p> <p>Patient #2's SOC medication reconciliation was not complete and accurate.</p>	G 337			