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

CENTERS FOR MEDICARE & MEDICAID SERVICES

**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

March 2, 2015

Trevor Higby, Administrator
Horizon Home Health and Hospice
63 W. Willowbrook Drive
Meridian, Idaho 83646

**CMS Certification Number: 13-7065**

**Re: Recertification survey 12/08/2014 found Five (5) Conditions of Participation Not Met**
**Suspension of payments for new admissions if not back in compliance effective 02/08/2015**
**Revisit on 02/06/2015 found One (1) Condition of Participation still Not Met**
**Termination if not back in compliance by 06/08/2015**

Dear Mr. Higby:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Horizon Home health and Hospice 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.

## I. 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 Horizon Home Health and Hospice no longer meets the Conditions of Participation.

On **December 8, 2014**, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at your facility and found five deficiencies. CMS agrees with the State survey agency that the following conditions were not met:

42 CFR 484.14 Organization, Services, and Administration

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| 42 CFR 484.18 | Acceptance of Patients, Plan of Care and Medical Supervision |
| 42 CFR 484.30 | Skilled Nursing Services |
| 42 CFR 484.52 | Evaluation of the Agency's Program |
| 42 CFR 484.55 | Comprehensive Assessment of Patients |

The identified deficiencies have been determined to be of such serious nature as to substantially limit your agency's ability to provide adequate and safe care.

On **February 6, 2015**, a follow up survey was conducted by the Idaho Bureau of Facility Standards (State survey agency) to determine compliance. The survey found that four (4) out of five (5) Conditions of Participation were met. However, 42 CFR 484.18 Acceptance of Patients, Plan of Care, Medical Supervision remains not met which placed your agency still in non-compliance status.

## I. ALTERNATIVE SANCTIONS

Because Horizon Home Health and Hospice is not in compliance with the Conditions of Participation with the Medicare Program, CMS is imposing the following alternative sanction:

**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 8, 2015.** This denial of payment for new admissions also applies to Medicare patients who are members of managed care plans.

If Horizon Home Health and Hospice does not meet all the home health agency Conditions of Participation, its Medicare provider agreement will be terminated no later than **June 8, 2015**. We will publish a legal notice in the local newspaper at least **fifteen days** prior to the termination date.

## III. APPEAL RIGHTS

Horizon Home Health and Hospice 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:

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| **Chief, Civil Remedies Division**<br>**Departmental Appeals Board MS 6132**<br>**Cohen Building, Room 637-D**<br>**330 Independence Avenue, SW**<br>**Washington, D.C. 20201** | **Please also send a copy to:** | **Chief Counsel DHHS**<br>**Office of General Counsel**<br>**701 Fifth Avenue, Suite 1620**<br>**MS RX -10**<br>**Seattle, WA 98104** |

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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 20, 2015

Trevor Higby, Administrator
Horizon Home Health and Hospice
63 West Willowbrook Drive
Meridian, Idaho 83646-1656

Provider: Horizon Home Health and Hospice, CCN 13-7065

Dear Mr. Higby:

On February 5, 2015, an on-site follow-up revisit was conducted to verify that Horizon Home Health and Hospice was in compliance with all Conditions of Participation. The agency's allegation of compliance indicated your agency was in substantial compliance as of January 22, 2015. However, based on our on-site follow-up revisit conducted February 5, 2015, your agency remains out of compliance with the following Condition of Participation:

**G156 42 CFR § 484.18 Acceptance of Patients, Plan of Care, Medical Supervision**

To participate as a provider of services in the Medicare Program, a home health agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused the condition to be unmet, substantially limit the capacity of Horizon Home Health and Hospice to furnish services of sufficient level and 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. Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing corrected deficiencies, is also enclosed.

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 **March 2, 2015.** It is strongly recommended that the agency's Credible Allegation/Plan of Correction for the Condition of Participation and related standard level deficiencies show compliance no later than **March 22, 2015** (45 days from the survey exit date). 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 were recommended to the Centers for Medicare/Medicaid (CMS) Region X Office, following the December 8, 2014, recertification survey of your agency:

- Termination [42 CFR 488.865]
- Suspension of payment for all new Medicare admissions [42 CFR 488.820(b)]

You were notified of these recommendation in our December 24, 2014, letter, sent following the December 8, 2014, recertification survey.

**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.

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/

Enclosures

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

Horizon Home Health & Hospice
Trevor Higby, Administrator
63 W. Willowbrook Dr.
Meridian, ID 83646
208-334-6500



March 2, 2015

Bureau of Facility Standards
Attn: Sylvia Creswell
3232 Elder Street
PO Box 83720
Boise, ID 83720-0009

**Re: CREDIBLE ALLEGATION OF COMPLIANCE/PLAN OF CORRECTION**

Dear Ms. Creswell,

Pursuant to the survey completed at Horizon Home Health on February 5, 2015, please find attached the completed Statement of Deficiencies/Plan of Correction (CMS2567) along with attachments that give further evidence that Horizon Home Health complies with the Conditions of Participation.

Please note: In the Plan of Correction there is reference to "QAPI". We recognize that, presently, this is a Hospice requirement. However, we used the term here to more accurately describe the Quality Assurance Performance Improvement process that we will utilize.

As evidenced in the Plan of Correction and the enclosures, we have and will continue to conduct staff education in each of the deficiencies cited and will continue to maintain evidence of compliance through chart audits and supervisory visits. The enclosures will speak to our compliance with the Conditions of Participation and include:

- Policies and Procedures:
    - Policy 2-008.1 Parameters Indicating Physician Notification
    - Policy 2-012.1 Pain Assessment
    - Policy 2-018.I Care Planning Process
    - Policy 5-006.1 Entries to the Clinical Record
- Attachments:
    - Master Attendance Record (Example)
    - PowerPoint Presentation of Training Conducted in Branches Wk of 2/15/15

In the event that you need additional information, please do not hesitate to contact me at 888-7877 or by email at thigby@horizonhh.com..

Please express our appreciation for the professionalism and helpfulness demonstrated by Susan Costa, RN and Laura Thompson RN, during the conduction of our survey.

Sincerely,

Trevor Higby
Administrator
Horizon Home Health and Hospice

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {G 000} | INITIAL COMMENTS<br><br>The following deficiencies were cited during the follow up survey of your home health agency on 2/02/15 through 2/05/15.<br><br>Surveyors conducting the follow up were:<br><br>Susan Costa, RN, HFS - Team Leader<br>Laura Thompson, RN, HFS<br><br>Acronyms used in this report include:<br><br>CHF - Congestive Heart Failure<br>CKD - Chronic Kidney Disease<br>CPAP - Continuous Positive Airway Pressure<br>D/C - Discontinue<br>DM - Diabetes Mellitus<br>DME - Durable Medical Equipment<br>DON - Director of Nursing<br>ER - Emergency Room<br>HHA - Home Health Aide<br>HTN - Hypertension<br>LPN - Licensed Practical Nurse<br>OT - Occupational Therapy<br>PICC - Percutaneously Inserted Central Catheter<br>POC - Plan of Care<br>PT - Physical Therapy<br>PT/INR = Prothrombin Time/International Normalized Ratio<br>ROC - Resumption of Care<br>RN - Registered Nurse<br>SN - Skilled Nursing<br>SOC - Start of Care<br>UTI - Urinary Tract Infection<br>V.A.C. - Vacuum Assisted Closure | {G 000} | | |
| G 134 | 484.14(c) ADMINISTRATOR | G 134 | **G134 484.14(c) ADMINISTRATOR**<br>**PLAN:**<br>The Administrator or designee will ensure mandatory training (PowerPoint presentation attached) is completed for licensed field staff the week of 2/15/15 to ensure that documentation is complete, and that patients' plans of care are developed and are appropriate and pertinent. Licensed staff who could not attend the training, will be required to view the Webex presentation of this same training.<br>**REVIEW:**<br>The Administrator or designee will oversee the development of a Master Attendance Record (Attachment) for the agency. Each branch will forward a copy of attendance records for agency mandated education, provided in the branches, to the central HR office within 48 hours of the education. A copy of the signed attendance record will also be retained in the branch. The education subject and each attendee will be entered in the Master Attendance Record. The Administrator will also ensure that field staff who were unable to attend the training, in person, have access to a Webex presentation of the training presented in the branches. Licensed clinicians who view the Webex must report to their respective branch offices to sign an attendance record by way of certifying that they have done so by March7, 2015. Inactive, part- time, licensed clinicians will not be re-activated | |

FACILITY STANDARDS
RECEIVED
MAR - 2 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 3/2/15

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 134 | Continued From page 1<br>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of agency training documents and staff interview, it was determined the Administrator failed to ensure mandatory training was completed for 18 of 69 staff members (Staff A - R) who were employed by the agency. This had the potential to result in a failure to obtain informed consent for services, improper documentation and resolution of grievances and complaints, and lack of development of an appropriate and pertinent patient POCs. Findings include:<br><br>Based on a survey completed on 12/08/14, the agency submitted a plan of correction on 1/09/15. The plan of correction included detailed mandatory staff training to be completed by 1/22/15. The training included topics of developing the plan of care, OASIS-C documentation, obtaining consent for services, and reporting and investigating complaints and grievances.<br><br>During an interview on 2/02/15 at 3:00 PM, the DON described her process for ensuring staff education was provided to all staff, including staff at the agency's six branch locations. She stated she delegated the training of branch staff to each branch director. The DON indicated an email was sent to each branch director which outlined the required training. She stated she assumed the branch directors would ensure all staff | G 134 | until they have viewed this Webex. The Webex will also be part of the orientation process with a post-test and attestation for new, licensed clinicians. The Administrator or designee will review the Master Attendance Record to ensure 100% attendance of active licensed personnel, full time and part time. Results will be reported quarterly to the Quality Assurance Performance Committee and recorded in the QAPI meeting minutes.<br>**RESPONSIBLE:**<br>The Administrator has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION DATE:** March 15, 2015 and ongoing | |

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| G 134 | Continued From page 2<br>received the mandated training.<br><br>During the same interview, the DON provided a copy of the email she sent to each branch director describing the content of the required staff training. In the email the DON requested the branch directors to send attendance sheets for proof of the education provided, and they had done so. However, the attendance sheets did not identify which staff had not completed the training. During the interview, the DON was unable to determine if all staff had been trained and stated she did not have a method to determine this. Additionally, she stated she had not requested a list of those staff who missed the training or made further investigations on the basis of the information she received from the branch directors.<br><br>On 2/05/15, the last day of the survey, the DON provided a list of employee names which identified staff that completed the mandatory training and those who did not. The list showed 18 (26%) of the 69 staff (Staff A - R) had not completed all required training.<br><br>The Administrator failed to ensure mandatory training was provided to all staff by 1/22/15, as stated in the plan of correction. | G 134 | **G156 484.18 ACCEPTANCE OF PATIENTS, POC, MEDICAL SUPERVISION**<br>**PLAN:**<br>Director of Nursing provided training to licensed staff, including the case managers for patients #1, #10 and #15, the week of 2/15/15 on the establishment of the patient's plan of care, following the plan of care, notifying the physician when changes to the plan of care are required, obtaining supplemental/verbal orders – timeliness of transmission of orders, timeliness of implementing orders, and reviewing and implementing all orders contained within the referral orders and subsequent orders. Plans of Care will be followed as developed with the patient and attending physician. Upon SOC, the admitting clinician will call the attending physician to obtain verbal orders for frequencies and goals/interventions. This will be documented in the "Narrative" with the physician or physician representative's name, date, and comments related to the verbal order. The 485/POC will then be sent to the physician for signature. The Case Manager will be notified to review the signed 485 for any additional orders or changes to the POC.<br><br>Staff were instructed that all parameters written within the plan of care must be | |
| {G 156} | 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER<br><br>This CONDITION is not met as evidenced by:<br>Based on home visit observations, staff and patient interview, and review of patients' records | {G 156} | | |

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| {G 156} | Continued From page 3<br>and agency policies, it was determined the agency failed to ensure systems to plan for care, and supervise the medical care of patients, were implemented. This failure resulted in a lack of care direction to agency personnel. Findings include:<br><br>1. Refer to G158 as it relates to the agency's failure to ensure the care of patients followed written POCs.<br><br>2. Refer to G159 as it relates to the agency's failure to ensure POCs included all pertinent information.<br><br>3. Refer to G163 as it relates to the agency's failure to ensure the POCs were reviewed by the attending physicians and agency staff at least every 60 days.<br><br>4. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs.<br><br>The cumulative effect of these negative systemic practices impeded the ability of the agency to provide care of sufficient scope and quality. | {G 156} | followed at each visit, unless vital signs or O2 sats are deferred by the patient. If deferred by the patient, MD will be notified. Parameters will also be implemented on the initial and comprehensive visits and all subsequent visits and the physician will be contacted for any readings that are outside of the agency established or physician established parameters.<br>Instruction was provided to staff to adhere to the frequencies of visits established in the plan of care and/or supplemental orders. No deviation will be permitted without consent from the attending physician. Any change in the visit frequency will be documented in the patient's medical record via a physician's order, including services that are on "hold". "Missed Visit" coordination notes will be completed for any visits not made in the Medicare week with physician notification . Team Leads or designee will review the Client No Visit Report weekly, follow up with Case Mangers for patients on the report and compare the list to Missed Visit Notes and MD notification/order entries. | |
| {G 158} | 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER<br><br>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.<br><br>This STANDARD is not met as evidenced by: | {G 158} | Initial referral orders will be reviewed by the admitting clinician and the Case Manager to ensure all ordered treatment and medications are implemented.<br>**REVIEW:**<br>Director of Nursing or designee will review 100% of the SOC/ROC for compliance to the plan of care until 90% compliance is achieved. Indicators below | |

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| {G 158} | Continued From page 4<br>Based on record review, review of agency policies, and patient and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 3 of 15 patients (#1, #10, and #15) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include:<br><br>1. Patient #1 was an 81 year old female admitted to the agency on 1/03/15 for SN and PT services related to pneumonia. Additional diagnoses included lymphedema and CHF. Her records and POC for the certification period 1/03/15 to 3/03/15, were reviewed.<br><br>At SOC on 1/03/15, Patient #1 was living with family members, as she had a PICC line and was receiving IV antibiotics. Her family assisted with administration of the IV antibiotics.<br><br>SN visits were ordered at a frequency of once a week for the first week, twice a week for 2 weeks, and then once a week for four weeks. Based on this frequency, home health nursing visits would continue until the week of 2/09/16.<br><br>In a SN visit note, dated 1/20/15, the RN documented Patient #1's antibiotics were discontinued and the PICC line was removed. The RN documented Patient #1 was moving back to her own home at that time. There were no further nursing visits noted in her record after 1/20/15.<br><br>Patient #1's record included a form titled "Client Calendar Report," that documented completed nursing and therapy visits, as well as, scheduled future visits. The report was printed on 2/02/15 at | {G 158} | 90% will require and action plan for correction with ongoing auditing until 90% or greater compliance is achieved. Compliance results will be reported on a quarterly basis to the QAPI Committee and recorded in the QAPI minutes.<br>**RESPONSIBLE:**<br>Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION: March 15, 2015 and ongoing**<br><br>**G158 484.18 ACCEPTANCE OF PATIENTS, POC, MEDICAL SUPERVISION**<br>Director of Nursing provided training to licensed staff, including the case managers for patients #1, #10 and #15, the week of 2/15/15 on the establishment of the patient's plan of care, following the plan of care, notifying the physician when changes to the plan of care are required, obtaining supplemental/verbal orders – timeliness of transmission of orders, timeliness of implementing orders, and reviewing and implementing all orders contained within the referral orders and subsequent orders. Plans of Care will be followed as developed with the patient and attending physician. Upon SOC, the admitting clinician will call the attending physician to obtain verbal orders for frequencies and goals/interventions. This | |

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| {G 158} | Continued From page 5<br>12:14 PM. The report showed 1/20/15 as the last SN visit. The report showed nursing visits scheduled for 1/29/15, 2/03/15, and 2/10/15, were not completed.<br><br>A phone interview was conducted on 2/04/15 at 1:30 PM, with the RN who completed the SOC assessment for Patient #1 and managed her nursing care. She stated her last nursing visit was on 1/20/15. She stated after Patient #1 moved back to her home, another nurse was assigned to her case.<br><br>The DON was present in the room with the surveyor during the phone interview with the RN. After the call, additional nursing visit notes were requested. However, the DON stated no further nursing visit notes were available. The DON reviewed the "Client Calendar Report," and confirmed SN visits should have occurred on 1/29/15 and 2/03/15. She stated Patient #1 should have received her Advance Beneficiary Notice on 2/03/15, in preparation for her last nursing visit and discharge from the agency on 2/10/15. The DON was unable to locate documentation of missed visit notification to Patient #1's physician, or other communication to determine the reason further nursing visits did not occur.<br><br>Patient #1 did not receive ordered nursing visits.<br><br>2. Patient #15 was a 61 year old female admitted to the agency on 12/03/14 for SN and PT services related to wound care and ambulation. Additional diagnoses included diabetes, use of anticoagulants, muscle weakness, and abnormal gait. Patient #15's record and POC for the certification period 12/03/13 to 1/31/15 were | {G 158} | will be documented in the "Narrative" with the physician or physician representative's name, date, and comments related to the verbal order. The 485/POC will then be sent to the physician for signature. The Case Manager will be notified to review the signed 485 for any additional orders or changes to the POC.<br>Staff were instructed that all parameters written within the plan of care must be followed at each visit, unless vital signs or O2 sats are deferred by the patient. If deferred by the patient, MD will be notified in writing. Parameters will also be implemented on the initial and comprehensive visits and all subsequent visits and the physician will be contacted for any readings that are outside of the agency established or physician established parameters.<br>Instruction was provided to staff to adhere to the frequencies of visits established in the plan of care and/or supplemental orders. No deviation will be permitted without consent from the attending physician. Any change in the visit frequency will be documented in the patient's medical record via a physician's order, including services that are on "hold". "Missed Visit" coordination notes will be completed for any visits not made in the Medicare week with physician notification . Team Leads or designee will review the **Client No Visit Report** weekly, follow up with Case Mangers for patients on the report and compare the list to | |

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| {G 158} | Continued From page 6<br>reviewed.<br><br>a. Patient #15's POC included SN visits for wound care 3 times weekly. Additionally, the POC included orders for SN to instruct and reinforce diabetic care, including diet, skin care, administration of insulin, blood glucose testing, and diabetic foot care.<br><br>Patient #15's record included a form titled "Client Coordination Note Report," dated 1/21/15. The form included documentation of the decision to recertify Patient #15 for continued wound care. The end of Patient #1's first certification period was 1/31/15.<br><br>A SN visit note, dated 1/23/15, documented Patient #15's wound VAC was discontinued. The narrative section indicated the plan for the next nursing visit was to follow up with new wound orders. The visit note also documented a PT/INR lab test was performed.<br><br>The next nursing visit was documented on 1/29/15 at 1:18 PM, as a 3 minute visit in which an unspecified lab test was completed. No other care or communication was documented. Wound care and instruction related to diabetic care, as ordered on the POC, were not documented as completed during the 1/29/15 visit.<br><br>No further visits were provided after the lab test visit on 1/29/15. Patient #15 received only one nursing visit (1/29/15) the week of 1/25/15 - 1/31/15, instead of 3 visits as ordered on her POC.<br><br>Patient #15's record did not include documentation of missed visits or communication | {G 158} | Missed Visit Notes and MD notification/order entries.<br>Initial referral orders will be reviewed by the admitting clinician and the Case Manager to ensure all ordered treatment and medications are implemented.<br>**REVIEW:**<br>Director of Nursing or designee will review 100% of the SOC/ROC for compliance to the plan of care until 90% compliance is achieved. Indicators below 90% will require and action plan for correction with ongoing auditing until 90% or greater compliance is achieved. Compliance results will be reported on a quarterly basis to the QAPI Committee and recorded in the QAPI minutes.<br>**RESPONSIBLE:**<br>Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION: March 15, 2015 and ongoing** | |

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| {G 158} | Continued From page 7<br>with the physician regarding the missed visits and lack of care provided.<br><br>During a phone interview on 2/04/15 at 2:30 PM, the RN Case Manager confirmed she did not provide further nursing visits for wound care after discontinuing the wound VAC on 1/23/15. The RN Case Manager stated Patient #15 had private insurance and would have a large co-pay, so she decided not to continue with home health services.<br><br>b. Patient #15's POC included PT orders for 1 week for 2 weeks, 1 visit every other week for 2 weeks, and then 1 visit a week for 3 weeks. A PT evaluation was performed on 12/08/14. The evaluation documented the physician was not contacted by phone at that time. Instead, the evaluation included the statement "Preferred communication method is via fax. Coordination physician communication note filled out and faxed to Dr."<br><br>A form titled "Physician Verbal Order," dated 12/08/14 at 1:59 PM, included a write up of therapy goals and orders communicated to the physician. The form included PT visits once a week for 1 week, 1 visit every 2 weeks for 2 weeks, and then once a week for 3 weeks. The form was sent to a different physician than the physician who signed the POC.<br><br>There were no further PT visit notes in the record until 1/27/15, which was identified as "Visit #2." A "Physician Verbal Order" form, dated 1/27/15, noted "Updating calendar to continue physical therapy. Order changes effective 1/25/15 for PT twice a week for 1 week." During the week of 1/25/15 - 1/31/15, one PT visit was completed (on | {G 158} | | |

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| {G 158} | Continued From page 8<br>1/27/15) instead of 2 as ordered on Patient #15's POC.<br><br>Additionally, Patient #15's record did not include documentation to explain why there was a break in PT services for the 7 week period of 12/08/14 - 1/27/15.<br><br>Patient #15's record did not include evidence Patient #15's physician was notified of the above missed visits.<br><br>During a phone interview on 2/04/15 at 3:30 PM, Patient #15's Physical Therapist confirmed the first visit occurred on 12/08/15 and the second visit did not occur until 1/27/15. He stated during that time period, Patient #15 had a wound VAC on her foot and was non-weight bearing. He had explained to her that she would not receive PT services due to those factors. The Physical Therapist stated he was unsure if that information was communicated to the physician.<br><br>The Physical Therapist confirmed 1 visit was missed the week of 1/25/15. He stated Patient #15 refused that visit. He stated she told him that she had private insurance, and as it was a new calendar year, she would have to pay a co pay, and did not want to do so. The Physical Therapist confirmed he did not alert the physician of the missed visit.<br><br>Patient #15 did not receive Physical Therapy visits consistent with her POC.<br><br>3. Patient #10 was a 72 year old male admitted on 8/11/14 for SN and HHA services. Diagnoses | {G 158} | | |

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| {G 158} | Continued From page 9<br>included venous insufficiency, stasis ulcers to lower limbs, muscle weakness, diabetes, obesity, neuropathy, HTN, atrial fibrillation, bed confinement, and long term use of insulin and blood thinners. Patient #10's record, including the POC for the certification period 12/09/14 to 2/06/15, was reviewed.<br><br>a. Patient #10's POC included orders for SN to instruct and reinforce diabetic care which included diet, skin care, administration of insulin, blood glucose testing, and diabetic foot care. Patient #10 did not receive education and instruction regarding diabetic care as stated on his POC. Examples include:<br><br>-A SN visit note, dated 1/26/15, and signed by the RN Case Manager, did not include documentation of diabetic teaching or education.<br><br>-A SN visit note, dated 1/28/15, and signed by the RN Case Manager, documented Patient #10 was not monitoring his blood sugar levels. The note did not include assessment of Patient #10's blood sugar level by the RN Case Manager. There was no documentation the RN Case Manager provided education to Patient #10 regarding the need to monitor his blood sugar levels or administer the correct dose of insulin.<br><br>-A SN visit note, dated 1/30/15, signed by the LPN, documented Patient #10 checked his blood sugar levels as needed. The LPN documented Patient #10's blood sugar level was not checked during the visit. There was no documentation the LPN provided reinforcement or education to Patient #10 regarding monitoring of blood sugar levels or administration of insulin. | {G 158} | | |

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| {G 158} | Continued From page 10<br>-A SN visit note, dated 2/02/15, signed by the RN Case Manager, documented Patient #10 was not monitoring his blood sugar levels. The RN Case Manager documented Patient #10 was not compliant with his dietary orders. There was no documentation the RN provided reinforcement or education to Patient #10 regarding monitoring of blood sugar levels or administration of insulin.<br><br>During a home observation, on 2/04/15 beginning at 10:00 AM, the RN Case Manager asked Patient #10 if he was monitoring his blood sugar levels. Patient #10 stated he was not checking regularly. He stated the last time he checked his blood sugar level was "A couple of weeks ago." The RN Case Manager did not check his blood sugar level during the visit.<br><br>During an interview, on 2/04/15 at 10:45 AM, the RN Case Manager confirmed there was no documentation of blood sugar levels for Patient #10. She also confirmed she did not provide education and instruction regarding monitoring of his blood sugar levels. The RN Case Manager stated Patient #10's physician was aware he was not checking his blood sugar. She confirmed the record did not include documentation of physician notification.<br><br>Patient #10's POC was not followed for diabetic education and instruction.<br><br>b. Patient #10's POC included a goal which stated "Patient/Caregiver will verbalize/demonstrate ability to perform wound care. Wound status will improve as evidenced by a decrease in size, drainage, absence of infection, and decreased pain." | {G 158} | | |

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| {G 158} | Continued From page 11<br>An agency policy Wound Assessment Addendum, revised 12/04/14, stated "Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week). Note: when the ordered frequency is less than weekly, the wound is measured on each visit."<br><br>A wound assessment tool was included in Patient #10's record. According to the tool, Patient #10's bilateral lower extremity stasis wounds had not been measured since 11/10/14.<br><br>During an interview on 2/04/15 at 10:45 AM, the RN Case Manager reviewed the record and confirmed Patient #10 had bilateral lower extremity stasis ulcers. She confirmed the wounds were not measured since 11/10/15. She said the measurements were not completed because it was too difficult and they covered a large area of his legs.<br><br>Patient #10's wounds were not measured to assess improvement and progress toward goals specified in his POC. | {G 158} | | |
| {G 159} | 484.18(a) PLAN OF CARE<br><br>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. | {G 159} | **G159 484.18 (A) PLAN OF CARE**<br>Director of Nursing provided training to licensed staff including the Case Manager for patient #10, the week of 2/15/15 , regarding the establishment of the patient's plan of care, following the plan of care, ensuring that the plan of care includes all pertinent information, notifying the physician when changes to the plan of care are required, obtaining supplemental/verbal orders – timeliness of transmission of orders, timeliness of implementing orders, reviewing/implementing all orders contained within the referral orders and subsequent orders, on the completion of the 485 plan of care for physician approval and signature, including but not limited to; all diagnoses pertinent to the care of the patient, DME equipment; i.e. wheelchairs, walkers, hospital beds, CPAP, types of services ordered, medications, | |

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| {G 159} | Continued From page 12<br>This STANDARD is not met as evidenced by:<br>Based on review of patient records and staff interview, it was determined the agency failed to ensure patients' POCs included all pertinent information for 1 of 15 patients (#10) whose records were reviewed. This failure had the potential to interfere with continuity and completeness of patient care. Findings include:<br><br>1. Patient #10 was a 72 year old male admitted on 8/11/14, for SN and HHA services. Diagnoses included venous insufficiency, stasis ulcers to lower limbs, muscle weakness, diabetes, obesity, neuropathy, HTN, atrial fibrillation, bed confinement, and long term use of insulin and blood thinners. Patient #10's record, including the POC, for the certification period 12/09/14 to 2/06/15, was reviewed.<br><br>A SN narrative note, dated 2/02/15, signed by the LPN, stated it was late documentation of a visit completed on 1/30/15. The note documented Patient #10's oxygen saturation level was 86% on room air and the oxygen level increased when he put on his CPAP machine during the visit.<br><br>The National Institutes of Health website, accessed 2/09/15, stated CPAP (continuous positive airway pressure) is a treatment that uses mild air pressure to keep the airways open during sleep. CPAP is used by people who have breathing problems, such as sleep apnea. Sleep apnea is a condition where the airway becomes obstructed when lying down and causes shallow breathing or pauses in breathing.<br><br>During a home visit observation, on 2/04/15 beginning at 10:00 AM, a CPAP machine was observed on a table next to Patient #10's bed. | {G 159} | treatments, safety measures, frequencies, diabetes management, and wound care.<br>**REVIEW:**<br>Director of Nursing or designee will review 100% of the SOC/ROC for compliance to inclusion of all components of the plan of care. Indicators below 90% will require an action plan for correction with ongoing auditing until greater than 90% compliance is achieved. Compliance results will be reported on a quarterly basis to the Quality Assurance Performance Improvement Committee and recorded in the QAPI minutes.<br>**RESPONSIBLE:**<br>Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION: March 15, 2015 and ongoing** | |

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| {G 159} | Continued From page 13<br>Patient #10 confirmed he used the machine each night.<br><br>Patient #10's POC did not include a CPAP machine under locater #14, "DME supplies." His POC did not include instruction or education for using a CPAP machine. Patient #10's record did not include physician orders for the use of a CPAP machine.<br><br>During a phone interview on 2/05/15 at 8:00 AM, the LPN who completed the visit on 1/30/15, reviewed the record and confirmed Patient #10 used a CPAP machine. She also confirmed it was not listed as DME. The LPN confirmed Patient #10 used his CPAP machine during the visit on 1/30/15, while he was awake.<br><br>Patient #10's POC did not include use of a CPAP machine. | {G 159} | | |
| G 163 | 484.18(b) PERIODIC REVIEW OF PLAN OF CARE<br><br>The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode. | G 163 | **G163 484.18 (b) PERIODIC REVIEW OF PLAN OF CARE**<br>Director of Nursing provided training to licensed staff including the Case Manager for patient #15, the week of 2/15/15 regarding the total plan of care is reviewed by the attending physician and home health personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a condition that suggests a need to alter the plan of care, requirements to promptly notify the physician, of any decline or significant change in condition and the requirement to document such notification within the patient's clinical record in a coordination note. Instruction will include agency identified vital sign parameters and that the discipline is required to notify the physician when any readings fall outside of the agency identified parameters or the physician ordered parameters.<br>**REVIEW:** | |

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| G 163 | Continued From page 14<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the agency failed to ensure the POC for 1 of 15 patients (Patient #15) whose records were reviewed, was reviewed by the attending physician and agency staff at least every 60 days. This resulted in a lack of clarity as to Patient 15's current status and needs.<br>Findings include:<br><br>Patient #15 was a 61 year old female admitted to the agency on 12/03/14 for SN and PT services related to wound care and ambulation. Additional diagnoses included diabetes, use of anticoagulants, muscle weakness, and abnormal gait. Patient #15's record, and POC, for the certification period 12/03/13 to 1/31/15, were reviewed.<br><br>Patient #15's record included a form titled "Client Coordination Note Report," dated 1/21/15. The form included documentation of the decision to recertify Patient #15 for continued wound care. The end of Patient #15's first certification period was 1/31/15. However, Patient #15's record was reviewed and did not include a recertification assessment and POC for the next certification period.<br><br>During a phone interview on 2/04/15 at 2:30 PM, the RN Case Manager responsible for Patient #15's care, confirmed the end of Patient #15's certification period was 1/31/15. She stated she just realized on 2/03/15, that she missed the recertification.<br><br>Patient #15's POC was not reviewed at least every 60 days. | G 163 | Director of Nursing distributed to attendees, **Policy 2-008.A "Parameters Indicating Physician Notification, 2-018 "Care Planning Process" , and 2-012.1 "Pain Assessment", Policy 5-006.1 "Entries Into the Clinical Record"** (Attachments) and provided instruction on following the Plan of care orders, reporting on the specific parameters established within the plan of care to the MD and documenting the communication to the patient's MD. Staff were instructed on the requirement to have a specific order to perform a oxygen saturation and at what parameter the discipline is to report to the MD. Nursing is to write their own Oxygen saturation orders and therapy is to write theirs as the use is different for the disciplines. Oxygen is to be included within the orders of the plan of care and Medication profile when used by the patient. Changes in parameters may only be accomplished with an MD order.<br>The Team Leads or designee will conduct case conference every week (or every other week, depending on the size of the of branch) and will utilize the Recertification by Case Manger Report (filtering for 2 weeks in advance of case conference date) and the Admissions Report Non-Duplicated (filtering for all patients admitted within the past 6 days). Case Mangers will submit a case conference report no later than 24 hours prior to case conference outlining the care that has been provided by agency staff | |

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| {G 164} {G 164} | Continued From page 15<br>484.18(b) PERIODIC REVIEW OF PLAN OF CARE<br><br>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview, home visit observation, 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 15 patients (#10 and #14) whose records were reviewed. This resulted in the potential for patients to experience adverse outcomes due to delayed medical interventions. Findings include:<br><br>1. Patient #14 was a 71 year old female admitted to the agency on 4/05/14 for SN and HHA services related to CHF and obesity. Patient #14's record, and POCs for the certification periods 11/30/14 to 1/29/15 and 1/30/15 to 3/30/15, were reviewed.<br><br>A SN visit note, dated 1/27/15, documented Patient #14 went to the ER "the other day," because of vomiting. She was told she had a UTI and was started on antibiotics. There was no documentation agency staff notified her physician of the ER visit, change in her condition, and initiation of antibiotics.<br><br>An RN completed Patient #14's recertification assessment on 1/29/15. The assessment stated Patient #14 had observable and non-observable stasis ulcers. The RN noted they were fully | {G 164} {G 164} | during current episode of care. This report is then attached to an Episode Detail Report (if patient is to be recertified) or an Episode Summary Report (if patient is to be discharged). These reports are then sent to the physician for his/her review and approval.<br>**REVIEW:**<br>Director of Nursing or designee will review 100% of the SOC and plans for Recertification/Discharge for 90% compliance of periodic, timely review of the plan of care. Non-compliance will be addressed with the Case Manager in the form of counseling by Team Lead, Branch Director or DON. Indicators below 90% will require an action plan for correction with ongoing auditing until greater than 90% compliance is achieved. Compliance results will be reported on a quarterly basis to the Quality Assurance Performance Improvement Committee and recorded in the QAPI minutes.<br>**RESPONSIBLE:**<br>Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION: March 15, 2015 and ongoing**<br><br>**G164 484.18 (b) PERIODIC REVIEW OF PLAN OF CARE**<br>**PLAN:** | |

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| HORIZON HOME HEALTH & HOSPICE | 63 WEST WILLOWBROOK DRIVE MERIDIAN, ID 83646 |

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| {G 164} | Continued From page 16<br>granulating, and that Patient #14 also had a few small ulcers on her bilateral lower legs. There was no evidence her physician was contacted to recertify Patient #14 for continued wound care.<br><br>During a phone interview on 2/04/15 at 12:30 PM, the Branch Manager reviewed Patient #14's record and confirmed the RN did not notify the physician about Patient #14's ER visit, UTI, and initiation of antibiotics. The Branch Manager also confirmed the RN did not contact the physician regarding Patient #14's need for ongoing wound care and to obtain approval for an additional recertification period.<br><br>Patient #14's physician was not informed of her changes in her condition, and need for continued services.<br><br>2. Patient #10 was a 72 year old male admitted on 8/11/14 for SN and HHA services. Diagnoses included venous insufficiency, stasis ulcers to lower limbs, muscle weakness, diabetes, obesity, neuropathy, HTN, atrial fibrillation, bed confinement, and long term use of insulin and blood thinners. Patient #10's record, including the POC, for the certification period 12/09/14 to 2/06/15, was reviewed.<br><br>Patient #10 was admitted to a hospital on 1/26/15 for congestive heart failure. Congestive heart failure is a condition in which the heart does not pump blood as well as it should. Symptoms for congestive heart failure, according to the Mayo Clinic website accessed 2/06/15, may include shortness of breath when lying down, wheezing, cough, and chest pain. The website further | {G 164} | Director of Nursing provided training to licensed staff including the Case Manager for patient #15, the week of 2/15/15 regarding the total plan of care is reviewed by the attending physician and home health personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a condition that suggests a need to alter the plan of care, requirements to promptly notify the physician, of any decline or significant change in condition and the requirement to document such notification within the patient's clinical record in a coordination note. Instruction will include agency identified vital sign parameters and that the discipline is required to notify the physician when any readings fall outside of the agency identified parameters or the physician ordered parameters.<br>**REVIEW:**<br>Director of Nursing distributed to attendees, **Policy 2-008.A "Parameters Indicating Physician Notification, 2-018 "Care Planning Process" , and 2-012.1 "Pain Assessment", Policy 5-006.1 "Entries Into the Clinical Record"** (Attachments) and provided instruction on following the Plan of care orders, reporting on the specific parameters established within the plan of care to the MD and documenting the communication to the patient's MD. Staff were instructed on the requirement to have a specific order to perform a oxygen saturation and | |

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| {G 164} | Continued From page 17<br>stated normal oxygen saturation levels range from 95 to 100 percent, and values under 90 percent are considered low.<br><br>A resumption of care assessment was completed by the RN Case Manager on 1/28/15, and the agency resumed care on that date. Patient #10's POC and physician's 1/28/15 verbal orders for resumption of care, did not include orders for oxygen. Therefore, his oxygen saturation levels were assessed on room air.<br><br>A SN visit note, completed by the LPN on 1/30/15, noted Patient #10's oxygen saturation level was 86% on room air. The LPN also documented Patient #10 had abnormal breath sounds, wheezing, and orthopnea (shortness of breath when lying down). The LPN documented she communicated the assessment findings to the RN Case Manager. However, there was no documentation the physician was notified.<br><br>An addendum to the 1/30/15 visit note was documented and signed by the LPN on 2/02/15. The addendum stated Patient #10's physician was not in his office and she was unable to obtain orders on 1/30/15.<br><br>A SN visit note documented by the RN Case Manager on 2/02/15, noted Patient #10 had abnormal breath sounds and was wheezing. A visit was made to Patient #10's home on 2/04/15 beginning at 10:00 AM. During the visit Patient #10's oxygen saturation level was 87% on room air. Patient #10 could easily be heard wheezing, without the use of a stethoscope.<br><br>Patient #10's record included three documented attempts by the RN Case Manager to contact | {G 164} | at what parameter the discipline is to report to the MD. Nursing is to write their own Oxygen saturation orders and therapy is to write theirs as the use is different for the disciplines. Oxygen is to be included within the orders of the plan of care and Medication profile when used by the patient. Changes in parameters may only be accomplished with an MD order.<br>The Team Leads or designee will conduct case conference every week (or every other week, depending on the size of the of branch) and will utilize the Recertification by Case Manger Report (filtering for 2 weeks in advance of case conference date) and the Admissions Report Non-Duplicated (filtering for all patients admitted within the past 6 days). Case Mangers will submit a case conference report no later than 24 hours prior to case conference outlining the care that has been provided by agency staff during current episode of care. This report is then attached to an Episode Detail Report (if patient is to be recertified) or an Episode Summary Report (if patient is to be discharged). These reports are then sent to the physician for his/her review and approval.<br>**REVIEW:**<br>Director of Nursing or designee will review 100% of the SOC and plans for Recertification/Discharge for 90% compliance of periodic, timely review of the plan of care. Non-compliance will be addressed with the Case Manager in the | |

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| {G 164} | Continued From page 18<br>Patient #10's physician. A communication note was sent on 2/02/15 and two voicemail messages were left; one on 2/02/15 and one on 2/04/15. There was no documentation the physician contacted the RN Case Manager.<br><br>During an interview on 2/04/15 at 10:15 AM, the RN Case Manager stated the LPN had communicated with her about the low oxygen saturation level for Patient #10. The RN Case Manager confirmed she had not documented the communication in the record. She stated both her and the LPN had left messages on the voicemail at the physician's office. The RN Case Manager stated the physician had not called her back regarding Patient #10 as of the date of the interview.<br><br>During a phone interview on 2/05/15 at 8:00 AM, the LPN reviewed the record and confirmed Patient #10's oxygen saturation level was 86%. She stated his physician's office was not open on Fridays and the physician did not have an after-hours service. The LPN stated she spoke with a nurse in the physician's office on 2/04/15 regarding Patient #10. She stated she discussed Patient #10's possible need for hospice care, but did not discuss his low oxygen saturation levels. The LPN stated she did not notify the RN Case Manager about the phone call with the physician's office.<br><br>Patient #10's physician was not notified of his low oxygen saturation levels. | {G 164} | form of counseling by Team Lead, Branch Director or DON. Indicators below 90% will require an action plan for correction with ongoing auditing until greater than 90% compliance is achieved. Compliance results will be reported on a quarterly basis to the Quality Assurance Performance Improvement Committee and recorded in the QAPI minutes.<br>**RESPONSIBLE:**<br>Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION: March 15, 2015 and ongoing** | |
| {G 236} | 484.48 CLINICAL RECORDS<br><br>A clinical record containing pertinent past and current findings in accordance with accepted | {G 236} | **G236 484.48 CLINICAL RECORDS**<br>**PLAN:**<br>Director of Nursing provided training to licensed staff including the Case Managers for patients #10 and #13, the week of 2/15/15, regarding the accuracy and consistency of clinical information contained in the patients' records and | |

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| {G 236} | Continued From page 19<br>professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of medical records, agency policies, and staff interview, it was determined the agency failed to ensure medical records contained timely, complete, and accurate documentation for 2 of 15 patients (#10 and #13) whose records were reviewed. This resulted in a lack of clarity regarding patients' care and health status. Findings include:<br><br>1. A policy "Entries Into The Clinical Record," revised March 2014, stated "Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or services provided." This policy was not consistently followed. Examples include:<br><br>a. Patient #10 was a 72 year old male admitted on 8/11/14 for SN and HHA services. Diagnoses included venous insufficiency, stasis ulcers to lower limbs, muscle weakness, diabetes, obesity, neuropathy, HTN, atrial fibrillation, bed confinement, and long term use of insulin and blood thinners. Patient #10's record, including the POC, for the certification period 12/09/14 to 2/06/15, was reviewed.<br><br>- A ROC visit note dated 1/28/15, and signed by | {G 236} | requirement that documentation be completed and synced to the clinical record within 48 hours of the visit. Instruction also included use of the correct forms within the electronic medical record, which includes the use of the wound care documentation forms, documentation of physician notification and communications, and which form to use in the electronic documentation system.<br>All late entries and amendments will have a documented reason as to why the entry is late or being amended.<br>**REVIEW:**<br>Director of Nursing or designee will, by way of workflow in computer system, review 100% of active client's records for accuracy and consistency of information contained in the clinical records. Team Lead or designee will run the Agent Summary Report 3 times a week to check for visits not completed within 48 hours. Compliance below 90% will require an action plan for correction with ongoing auditing until greater than 90% compliance is achieved and non-compliance will be addressed with the Case Manager in the form of counseling by Team Lead, Branch Director or DON. Compliance results will be reported on a quarterly basis to the Quality Assurance Performance Improvement Committee and recorded in the QAPI minutes.<br>**RESPONSIBLE:** | |

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| {G 236} | Continued From page 20<br>the RN Case Manager, documented Patient #10 had no stasis ulcers. She documented, in the same visit note, he had bilateral lower extremity stasis ulcers.<br><br>- A SN visit note dated 2/02/15, and signed by the RN Case Manager, documented Patient #10 had no skin or wound issues identified.<br><br>- A SN visit note dated 1/23/15, signed by the RN Case Manager, documented Patient #10 was not taking insulin or anticoagulant medication. Both medications were listed on his POC.<br><br>During an interview on 2/04/15 at 10:45 AM, the RN Case Manager reviewed the record and confirmed Patient #10 had bilateral lower extremity stasis ulcers. The RN Case Manager confirmed she had mistakenly documented at the ROC visit that Patient #10 did not have stasis wounds. She also confirmed she had mistakenly documented he was not taking insulin or anticoagulant medication.<br><br>Patient #10's medical record did not contain accurate clinical and medication documentation.<br><br>b. Patient #13 was an 80 year old female admitted on 8/18/14 for SN services. Diagnoses included diabetes (juvenile), ulcer of heel and foot, peripheral vascular disease, atrial fibrillation, CKD, muscle weakness, and difficulty walking. Patient #13's record and POC, for the certification period 12/16/14 to 2/13/15, were reviewed.<br><br>- Patient #13 had a diagnosis of heel and foot ulcers. However, SN visit notes dated 1/23/15, 1/26/15, and 1/30/15, and signed by the LPN, documented Patient #13 had no skin problems | {G 236} | Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION: March 15, 2015 and ongoing** | |

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| {G 236} | Continued From page 21<br>identified.<br><br>- Additionally, a SN visit note, dated 1/28/15, completed by the RN Case Manager, documented Patient #13 had no skin problems identified.<br><br>- A SN visit note, dated 1/30/15, completed by the LPN, documented Patient #13 was taking an anticoagulant medication. There were no anticoagulant medications listed on her POC or medication list.<br><br>During a phone interview, on 2/04/15 at 4:20 PM, the RN Case Manager reviewed the record. She confirmed Patient #13 had wounds to both heels. The RN Case Manager stated she had answered the question incorrectly.<br><br>During a phone interview, on 2/05/15 at 8:20 AM, the LPN reviewed the record and confirmed Patient #13 did have bilateral heel wounds. She stated she answered the question incorrectly. The LPN confirmed Patient #13 was not on anticoagulant medication and the documentation was incorrect.<br><br>Patient #13's medical record did not contain accurate clinical and medication documentation. | {G 236} | | |
| G 338 | 484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT<br><br>The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. | G 338 | **G338 484.55(d) UPDATE OF THE COMPREHENSIVE A55ESSMENT**<br>**PLAN:**<br>Director of Nursing provided training to licensed staff including the Case Manager for patient #10, the week of 2/15/15, regarding the accuracy and consistency of clinical information contained in the patients' records including, but not limited to, wound measurement protocols.<br>**REVIEW:**<br>Director of Nursing or designee, as part of daily workflow in computer system, will review 100% of clinical records for accuracy and consistency of information contained in the clinical records and | |

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| G 338 | Continued From page 22<br>This STANDARD is not met as evidenced by:<br>Based on medical record review and staff interview, it was determined the agency failed to ensure patients' ROC assessments were thoroughly updated for 1 of 15 patients (Patient #10) whose records were reviewed. This resulted in a lack of wound documentation and measurement, and had the potential to negatively affect patient care and treatment. Findings include:<br><br>Patient #10 was a 72 year old male admitted on 8/11/14 for SN and HHA services. Diagnoses included venous insufficiency, stasis ulcers to lower limbs, muscle weakness, diabetes, obesity, neuropathy, HTN, atrial fibrillation, bed confinement, and long term use of insulin and blood thinners. Patient #10's record, including the POC, for the certification period 12/09/14 to 2/06/15, was reviewed.<br><br>A SN visit note, dated 1/26/15, signed by the RN Case Manager, documented Patient #10 was admitted to the hospital for one night due to congestive heart failure.<br><br>An ROC assessment visit note dated 1/28/15, and signed by the RN Case Manager, documented Patient #10 had no stasis ulcers. However, in the same visit note, it was noted he had bilateral lower extremity stasis ulcers. Additionally, there was no documentation the stasis ulcers were measured.<br><br>During an interview on 2/04/15 at 10:45 AM, the RN Case Manager reviewed the record and confirmed Patient #10 had bilateral lower extremity stasis ulcers and she had mistakenly documented Patient #10 did not have stasis | G 338 | compliance to wound measurement protocols. Compliance below 90% will require an action plan for correction with ongoing auditing until greater than 90% compliance is achieved. Compliance results will be reported on a quarterly basis to the Quality Assurance Performance Improvement Committee and recorded in the QAPI minutes.<br>**RESPONSIBLE:**<br>Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.<br>**COMPLETION: March 15, 2015 and ongoing** | |

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| G 338 | Continued From page 23<br>wounds. She, also, confirmed she was not measuring the wounds because it is too difficult and they covered a large area of Patient #10's legs.<br><br>Patient #10's ROC assessment included conflicting information and did not include measurements of his wounds. | G 338 | | |

Bureau of Facility Standards

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| {N 000} | 16.03.07 INITIAL COMMENTS<br><br>The following deficiencies were cited during the follow up survey of your home health agency completed 2/02/15 through 2/05/15. Surveyors conducting the review were:<br><br>Susan Costa, RN, HFS, Team Lead<br>Laura Thompson, RN, HFS | {N 000} | **N 152 03.07030.01 PLAN OF CARE**<br><br>**See G158: ACCEPTANCE OF PATIENTS, POC, MEDICAL SUPERVISION** | |
| {N 152} | 03.07030.01.PLAN OF CARE<br><br>N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:<br><br>This Rule is not met as evidenced by:<br>Refer to G158 as it relates to the failure of the agency to ensure care followed a written plan of care. | {N 152} | RECEIVED<br>MAR - 2 2015<br>FACILITY STANDARDS<br><br>**N153 03.07030.01 PLAN OF CARE**<br><br>**SEE G159: PLAN OF CARE** | |
| {N 153} | 03.07030.PLAN OF CARE<br><br>N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:<br><br>a. All pertinent diagnoses;<br><br>This Rule is not met as evidenced by:<br>Refer to G159 as it relates to the failure of the agency to ensure the plan of care covered all | {N 153} | | |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 3/2/15

Bureau of Facility Standards

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| {N 153} | Continued From page 1<br>pertinent diagnoses. | {N 153} | **N172 03.07030.06 PLAN OF CARE**<br><br>**SEE: G164 PERIODIC REVIEW OF PLAN OF CARE** | |
| {N 172} | 03.07030.06.PLAN OF CARE<br><br>N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.<br><br>This Rule is not met as evidenced by:<br>Refer to G164 as it relates to the failure of the agency to ensure professional staff promptly alerted the physician to any changes that suggested a need to alter the plan of care. | {N 172} | | |
| {N 174} | 03.07031.01 CLINICAL RECORDS<br><br>N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services.<br><br>This Rule is not met as evidenced by:<br>Refer to G236 as it relates to the failure of the agency to ensure a clinical record was maintained in accordance with accepted professional standards for all patients. | {N 174} | **N174 03.07031.01 CLINICAL RECORDS**<br><br>**SEE: G236 CLINICAL RECORDS** | |