

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

March 26, 2015

Vicki Salerno, Administrator
Care At Home
929 NW 16th Street
Fruitland, Idaho 83619

CMS Certification Number: 13-7068

**Re: Notice of Enforcement Action on Care At Home
Recertification survey completed, Conditions of Participation Not Met
Suspension of payments for new admissions if not back in compliance effective 04/21/2015
Termination if not back in compliance effective 08/19/2015**

Dear Ms. Salerno:

This is to inform you that based on careful review of the findings of the recertification survey conducted at your agency on February 20, 2015 by the Idaho Department of Health and Welfare, Bureau of Facility Standards, the Centers for Medicare and Medicaid Services (CMS) has determined that Care At Home is not in compliance with the applicable Conditions of Participation requirements for a provider of home health services in the Medicare program 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 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 no longer meets the Conditions of Participation.

On February 20, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at your facility and found three deficiencies. CMS agrees with the State survey agency that the following conditions were not met:

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

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.

ALTERNATIVE SANCTIONS

CMS is imposing the following alternative sanctions based on the agency's non-compliance with Medicare Conditions of Participation:

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 **April 21, 2015**. This suspension of payment for new admissions also applies to Medicare patients who are members of managed care plans.

If Care At Home fails to meet all home health agency Conditions of Participation, your Medicare provider agreement will be terminated no later than **August 19, 2015**. CMS will publish a legal notice in the local newspaper at least **fifteen days** prior to the termination date.

APPEAL RIGHTS

Care At Home 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.

Page 3 – Ms. Salerno

If you have further questions, please contact Fe Yamada of my staff at (206) 615-2313.

Sincerely,

A handwritten signature in black ink, appearing to read 'P. Thrift', written over a horizontal line.

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

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
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 7000 1670 0011 3315 1613

March 6, 2015

Vicki Salerno, Administrator
Care At Home
929 Nw 16th Street
Fruitland, ID 83619-2256

RE: Care At Home, Provider #137068

Dear Ms. Salerno:

Based on the survey completed at Care At Home, on February 20, 2015, by our staff, we have determined Care At Home is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Acceptance of Patients, POC, Med Super (42 CFR 484.18), Skilled Nursing Services (42 CFR 484.30) and Evaluation of the Agency's Program (42 CFR 484.52)**. 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 these conditions to be unmet, substantially limit the capacity of Care At Home, 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 **March 19, 2015**. The Credible Allegation of Correction for each Condition of Participation and related standard level deficiencies must show compliance no later than **April 6, 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]
- Suspension of payment for all new Medicare admissions [42 CFR 488.820(b)]

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.

Vicki Salerno, Administrator
March 6, 2015
Page 3 of 3

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 **March 19, 2015**. If your request for IDR is received after **March 19, 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



April 20, 2015

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

RECEIVED
APR 20 2015
FACILITY STANDARDS

Dear Ms. Creswell,

Enclosed please find our revised 2567 Survey Response. We have made some changes following our discussion with Laura Thompson on Friday, April 17, 2015.

If you have any questions please call at any time.

Thank you,

Vicki Salerno

Vicki Salerno
Administrator
vsalerno@careathomehh.com
208-642-1838
208-880-1925 (cell)

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2015
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NAME OF PROVIDER OR SUPPLIER CARE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 16TH STREET FRUITLAND, ID 83619
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(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
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare Recertification survey of your agency from 2/17/15 to 2/20/15. The surveyors conducting the survey were:</p> <p>Laura Thompson, RN, BSN,HFS, Team Leader Nancy Bax, RN, BSN,HFS Susan Costa, RN,HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility BID - Twice a day BP - Blood Pressure BPH - Benign Prostatic Hyperplasia CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease D/C - discharge DM - Diabetes Mellitus DME - Durable Medical Equipment DON - Director of Nursing HCL - Hydrochloric Acid HHA - Home Health Aide HTN - Hypertension IV - Intravenous LPN - Licensed Practical Nurse mg - milligrams mg/dl - milligrams per deciliter ml - milliliters NS - Normal Saline OT - Occupational Therapist POC - Plan of Care PRN - as needed PT - Physical Therapy QD - every day RN- Registered Nurse</p>	G 000	<p>RECEIVED</p> <p>MAR 19 2015</p> <p>FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicki Salerno</i>	TITLE <i>Adm.</i>	(X6) DATE <i>3.18.15</i>
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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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RECEIVED
APR 20 2015
FACILITY STANDARDS

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

TITLE

(X6) DATE

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G 000	Continued From page 1 SN - Skilled Nurse ST - Speech Therapy SOC - Start of Care TIF - Transfer to Inpatient Facility	G 000		
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients were fully informed of their right to appeal a discharge from home health services for 1 of 12 patients (#2) who were Medicare beneficiaries and whose records were reviewed. This had the potential for services to be terminated without the patients' understanding of their ability to appeal the discharge. Findings include: The CMS Manual System, Pub 100-04 includes direction to the provider that they must include the effective date (i.e. the last day of coverage) on the "Notice Of Medicare Non-Coverage" (NOMNC) form. Additionally, it states: "The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily." The NOMNC is to be signed and dated by the patient to indicate receipt of notice of discharge. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14 and again after a brief hospitalization, on 1/29/15. He	G 101		

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NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 16TH STREET FRUITLAND, ID 83619	
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G 101	<p>Continued From page 2</p> <p>received SN and PT services related to CHF, COPD, and HTN. His records, including the POC's for the certification periods 12/31/14 to 2/28/15 and 1/29/15 to 3/29/15 were reviewed.</p> <p>In a "Nursing Intervention" narrative, dated 2/11/15, Patient #2's RN wrote: "Client is stable and will be discharged next week." However, there was no documentation Patient #2 was provided information regarding his rights to appeal the termination of his home health services.</p> <p>Patient #2's record included a discharge assessment dated 2/18/15, and signed by the RN. Additionally, it included a discharge summary dated 2/18/15.</p> <p>Patient #2's record included a form, titled "Notice of Medicare Non-Coverage," (NOMNC.) The section of the form which stated "The Effective Date Coverage of Your Current Home Health Services Will End:____," was completed with the date 2/18/15. The back of the form was signed by Patient #2 to indicate receipt of the notice. Patient #2's signature was dated 2/18/15, the date of his final home health visit.</p> <p>During an interview on 2/20/15 beginning at 8:30 AM, the DON stated the form should have been presented to Patient #2 during his second to last visit, rather than during his last visit. She stated she had educated the nursing staff about the NOMNC form, and the timing of its presentation to the patients. Additionally, she stated she was unsure if Patient #2's RN explained the appeals process to him, as there was no documentation in his record.</p>	G 101	<p>Action: Skilled staff educated as to the purpose of the NOMNC and that it MUST be completed at least 48 hours prior to DC. Education provided as to how to satisfy this requirement in the event that client declines further services.</p> <p>Description: Staff education will assist with the NOMNC being performed within the time frame allowed.</p> <p>Completion date for deficiency: April 20, 2015</p> <p>Monitoring: The Director of Professional Services (Kim Thomas RN) will audit nursing, and Therapy Director (Sheila Jacobs PT) will audit therapy upcoming discharges for completion of the NOMNC prior to DC.</p>	

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G 101	Continued From page 3 Patient #2, a Medicare beneficiary, was not notified prior to his discharge, of his right to appeal discontinuation of home health services.	G 101			
G 113	484.10(e)(1) PATIENT LIABILITY FOR PAYMENT The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure patients were informed in writing of the extent to which payment could be expected, and the charges the individual might have to pay, for 1 of 14 patients (#11) whose records were reviewed. This had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related to the agency's care and treatment. Findings include: Patient #11 was a 19 year old female admitted to the agency on 1/10/15, for SN services. Diagnoses included hyperemesis gravidarum, dehydration, anxiety, vascular catheter, therapeutic drug monitoring, and long term use of medications. Patient #11's record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #11's record included a financial liability form which was signed by her, and dated 1/10/15. The form stated "The undersigned requests that	G 113			

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G 113	Continued From page 4 payment of authorized insurance benefits be made on his/her behalf for services rendered and agrees to individually obligate himself/herself to pay any balance owing above benefits received to Care at Home." The form did not include financial information about how much Patient #11 would be required to pay for services, if services were not covered by her insurance plan benefits. During an interview on 2/20/15 at 12:05 PM, the DON reviewed the record and confirmed Patient #11 was not informed of possible out of pocket expenses for services. She stated Patient #11 had secondary insurance and most likely would not have had to pay anything. The DON confirmed this was not documented on the financial liability form Patient #11 signed. Patient #11 was not informed in writing of potential financial liability before services were provided.	G 113	Action: Care at Home will provide all insurance clients with a notice of liability even if the liability is verified as zero. Description: Providing a notice to all clients even if the liability is verified to be zero will allow all clients to be notified of the possibility of a copay. Completion date: April 20, 2015. Monitoring: Medical records specialist (Heather Thomas) will evaluate client's insurance for a liability. Director of Professional will verify that when the payer source is an insurance that there is a liability letter attached for signature prior to assigning the open.	
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, review of medical records and agency policies and procedures, and staff interview, it was determined the agency failed to ensure staff complied with accepted standards of practice related to infection control and wound care. This impacted 1 of 6 sample patients (#5)	G 121		

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G 121	<p>Continued From page 5</p> <p>whose home visits were observed. This failure had the potential to introduce or facilitate the spread of an infection. Findings include:</p> <p>A policy titled "Central Venous Catheter Maintenance," effective 2/14, stated the dressing change of a central venous catheter is a sterile dressing change and sterile technique will be used when doing the dressing change to reduce the risk of infection.</p> <p>A policy MP-13 "Wound Care and Assessments," effective 10/08, stated "All wounds or areas of potential skin breakdown will be observed at each dressing change. Wound reassessments will be completed weekly or more often if the general health of the patient or the status of the wound changes. For clean (non-sterile) dressing changes: the irrigation solution bottle will be dated when the bottle is opened and the solution is good for 30 days from that date." These policies were not followed during the care provided to Patient #5.</p> <p>Patient #5 was a 67 year old female admitted to the agency on 1/06/15, for SN services related to wound care. Her medical record, including the POC, for the certification period 1/06/15 to 3/06/15, was reviewed.</p> <p>Patient #5's POC included orders for wound VAC care and PICC line dressing changes to be provided 3 times a week by SN services. The wound was being treated with a VAC (Vacuum assisted closure device.) Patient #5 also had a PICC line in her left arm. A PICC (Peripherally inserted central catheter) is used for long term IV therapy treatment.</p>	G 121	<p>Action: Reviewed policy and procedure on the care of a PICC line and dressing change procedure. Reiterated need to educate client in the event they refuse to wear a mask and document education each visit. Additional information added to policy manual on when to notify MD when dealing with a PICC line. Educated on clean and sterile dressing changes, changing of gloves, and use of bottled solutions. Reviewed policy and procedure on wound care and weekly measurements. You tube Video on proper measuring techniques and proper measuring of tunneled wounds was viewed.</p> <p>Description: The above education will assure that every client with wound care will be cared for with proper procedures and aseptic techniques. Reminder check list will be added to the wound care addendum for the Nurse to address weekly.</p> <p>Compliance date: April 20, 2015.</p> <p>Monitoring: Director of Professional Services will review all Nursing Interventions and will observe for wound care clients. The DPS will keep an internal audit tool to log measurements to ensure they are being recieved weekly.</p>	

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G 121	<p>Continued From page 6</p> <p>A home visit was conducted on 2/17/15, beginning at 10:30 AM, to observe skilled nursing services provided to Patient #5.</p> <p>At the beginning of the home visit, Patient #5 stated she was at the wound clinic the previous day. She stated the right hip wound dressing was changed during the visit. Patient #5 did not believe the dressing needed to be changed again. The RN looked at the dressing, which was secure and intact, and the VAC that was functioning without problems, then told Patient #5 she would change the dressing.</p> <p>- The RN changed the PICC line dressing first. Patient #5 was upright on the couch with her left arm extended. A PICC line dressing change required using sterile technique. The APIC (Association for Professionals in Infection Control) website, accessed on 2/25/15, stated "Sterile technique involves strategies used in patient care to reduce and maintain objects and areas as free from microorganisms as possible." The RN put on a mask, and stated Patient #5 did not like to wear a mask, and "would just turn her head the other way." During the dressing change Patient #5 turned her head towards the open and undressed PICC site numerous times. By Patient #5 turning her head towards the undressed catheter site, without wearing a mask, there was the possibility of introducing microorganisms through the PICC line insertion site.</p> <p>- The dressing was removed from the PICC line and the catheter was observed to slide out from the insertion site approximately an inch and a half. The RN cleansed the site with Betadine, then alcohol, then Chlorhexidine.</p>	G 121			

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G 121	<p>Continued From page 7</p> <ul style="list-style-type: none"> - After cleansing the site, the nurse slid the catheter back into the insertion site, up to the hub. The line was secured and a new occlusive dressing was applied. After completing the PICC line dressing change, the RN flushed the line and started the antibiotic infusion. The RN told Patient #5 she decided she would change the wound VAC, even though it was changed the day before. As Patient #5 positioned herself on the couch, the RN washed her hands and organized her supplies for the wound VAC and dressing change. - The RN removed the VAC and occlusive dressing. After cleansing the wound with wound cleanser, she was noted to place her non sterile gloved finger inside the tunneled part of the wound to measure the depth. The RN did not change her gloves after removing the dressing and cleaning the wound, before placing the soiled gloved finger into the deepest part of the wound. - The RN measured the bed of the wound by placing the tape measure directly on top of it, potentially contaminating the wound. - The wound cleansing supplies were stored in a plastic bag. The bag contained a bottle of saline solution, a bottle of wound cleanser, a large syringe, and unwrapped 4 x 4 gauze. The bottle of saline solution was previously opened and was not dated for expiration, as required by agency policy. - The nurse was observed reaching into the bag multiple times to pull out the gauze, wound cleanser, irrigation solution, or syringe. She did not change her gloves before reaching into the 	G 121			

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G 121	<p>Continued From page 8 plastic bag for the supplies.</p> <p>- The RN was observed reaching into her right pocket with her soiled gloves on. She pulled out a pen and wrote the date on the wound VAC dressing, and placed the pen back in her pocket.</p> <p>- After the wound care was finished, the RN placed the wound cleanser, opened bottle of irrigation solution, unwrapped 4 X 4 gauze, and large syringe back into the gallon sized plastic bag. The RN placed the items in the bag without wiping them down or isolating them from each other. She then put the bag in a box with other dressing supplies.</p> <p>The APIC website, accessed on 2/25/15, stated "Clean technique involves meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves, sterile instruments, and prevention of direct contamination of materials and supplies."</p> <p>The DON was interviewed on 2/19/15 at 5:00 PM, and asked about policies and procedures for wound care and IV therapy. She stated the agency had an IV therapy manual and they also have a clinical procedural resource for wound care, wound VAC, and wound dressings. The DON stated she also utilized videos on social media.</p> <p>The agency's wound care clinical procedure resource, undated, stated "All wounds must be measured weekly and dressing changes have to be according to the POC." The procedural resource for wound care, stated "Put on disposable latex gloves and gently take off the old dressing. Remove your gloves and throw away</p>	G 121			

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G 121	Continued From page 9 used dressings and disposable supplies right away. Wash your hands again. Put on a new pair of gloves. Be sure to wash your hands again." Patient #5's RN was interviewed on 2/19/15 at 2:15 PM. She discussed the surveyor's observation of the PICC line and wound VAC dressing changes and wound care that was provided during the home visit. The RN stated she realized the catheter had come out a bit from the insertion site, but then it went back in, so she thought it was acceptable. The RN confirmed the saline irrigation solution and the syringes she used to irrigate the wound were not sterile. She stated as the wound care was a "clean" procedure, she did not have to use sterile supplies. She stated she stored the opened 4 X 4 gauze in the plastic bag with the other supplies, and confirmed she did not wipe the wound cleanser container or other items after handling them with soiled gloves. The RN confirmed she had opened the saline irrigation solution during a previous visit, and did not date the bottle to indicate the date it should be discarded. When asked, the RN stated she decided to change the clean and intact wound VAC dressing because she thought the surveyor would want to see Patient #5's wound. Wound care and PICC line dressing changes were not provided within acceptable practice standards.	G 121			
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison	G 143			

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G 143	<p>Continued From page 10</p> <p>to ensure that their efforts are coordinated effectively and support the objectives outlined in 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 for 5 of 12 patients (#1, #2, #3, #6 and #13) 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 32 year old male admitted to the agency on 10/06/14, for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His medical record, and POC for the certification period 10/06/14 to 12/04/14, were reviewed.</p> <p>Patient #1's POC included goals to keep vital signs within agency established parameters. The parameters listed for blood pressure were systolic 90-140 and diastolic 60-90, and for oxygen saturation levels of greater than 89%. The POC also included an order for SN to assess his cardio/pulmonary status.</p> <p>a. A nursing intervention note, dated 10/13/14, and signed by the RN, documented his blood pressure was 150/100. Additionally, the RN documented Patient #1 went to the emergency room recently and was told he had a "slight heart attack" and may have a cyst on his heart.</p> <p>The intervention note included a section "Care Coordination." There was no documentation the</p>	G 143	<p>G143</p> <p>Action: Care at Home will begin giving Nursing and Therapy access to the 485 POC via Home Solutions so they are aware of the other disciplines plan. Inservices were performed to skilled nursing and therapy to reiterate the need to document care coordination and when to coordinate. Staff reminded that if they mark the care coordination box on the Intervention sheet the info conveyed must be documented.</p> <p>Description: This education will ensure that coordination of care is being performed when needed. This will also ensure that coordination is being documented.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: DPS will monitor all nursing interventions for proper care coordinations and Therapy Director will monitor the therapy intervention sheets.</p>		

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G 143	<p>Continued From page 11</p> <p>RN communicated his trip to the emergency room or elevated blood pressure with the Physical Therapist.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN reviewed the record and confirmed she had not contacted or communicated with the Physical Therapist about his elevated blood pressure or visit to the emergency room.</p> <p>b. Patient #1's record included a PT visit note, dated 10/13/14, and signed by the Physical Therapist. The visit note documented Patient #1 had gone to the emergency room and was told he had a heart attack. Patient #1's blood pressure was documented as 140/100, indicating a diastolic level above agency parameters.</p> <p>A PT visit note, dated 10/15/14, and signed by the physical therapist documented an oxygen saturation level of 88%, below the agency's parameter of greater than 89%. Additionally, the Physical Therapist documented Patient #1 was groggy and difficult to arouse.</p> <p>There was no documentation the Physical Therapist communicated with the RN regarding Patient #1's elevated diastolic blood pressure, trip to the emergency room, heart attack, low oxygen saturation level, or him being difficult to arouse.</p> <p>During a phone interview on 2/19/15 at 4:30 PM, the physical therapist confirmed he had not notified or communicated with the RN about the visit Patient #1 made to the emergency room. He also confirmed he had not notified the RN about the vital signs that were outside of parameters listed on the POC.</p>	G 143		

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G 143	<p>Continued From page 12</p> <p>Patient #1's care was not coordinated between disciplines.</p> <p>2. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His records, including the POCs for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #2's POC, for the certification period 1/29/15 to 3/29/15, included goals to keep vital signs within agency established parameters. The blood pressure parameters listed were systolic 90-140 and diastolic 60-90.</p> <p>a. A nursing intervention note, dated 2/02/15, and signed by the RN, documented Patient #2's blood pressure was 163/80. Additionally, the RN documented he was having interrupted sleep. The intervention note included a section "Care Coordination." There was no documentation the RN communicated Patient #2's loss of sleep or elevated systolic blood pressure to the Physical Therapist.</p> <p>b. A nursing intervention note dated 2/09/15, and signed by the RN, documented Patient #2's blood pressure was 134/95. Additionally, the RN documented he had lost 9 pounds in one week. The intervention note included a section "Care Coordination." There was no documentation the RN communicated Patient #2's weight loss or elevated diastolic blood pressure to the Physical Therapist.</p> <p>c. A nursing intervention note dated 2/12/15, and signed by the RN documented Patient #2's blood</p>	G 143			

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G 143	<p>Continued From page 13</p> <p>pressure was 87/48. Additionally, the RN documented he was depressed and had insomnia with interrupted sleep. The Intervention note included a section "Care Coordination" which was left blank. There was no documentation the RN communicated Patient #2's depression, continued loss of sleep, or low blood pressure with the Physical Therapist.</p> <p>During an interview on 2/19/15 at 1:30 PM, the RN reviewed the record and confirmed she had not called Patient #2's physician about his blood pressure readings that were outside of the agency established parameters. She stated it was dependent on the patient whether the vital sign goals were considered parameters which needed to be reported to the physician. Additionally, the RN confirmed she did not communicate with the Physical Therapist about Patient #2's change in condition or blood pressure.</p> <p>During an interview on 2/19/15 at 1:50 PM, the assistant to the DON stated the vital sign goals listed on patients' POCs are agency established parameters and the patient's physician should be contacted when vital sign measurements fall outside of these parameters. She stated the clinicians are aware they must notify the physician of all vital signs outside of the agency established parameters. The assistant to the DON confirmed notification to the physician is not specified on the POC.</p> <p>The agency failed to ensure Patient #2's care was coordinated between the RN and Physical Therapist.</p> <p>3. Patient #3 was a 67 year old female admitted</p>	G 143			

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G 143	<p>Continued From page 14 to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included physician orders for home health services, dated 4/24/14. The orders included "Social Work for home safety."</p> <p>Patient #3's record included an MSW visit note, dated 4/30/14, and signed by the MSW. The note documented the purpose of the visit was "Safety issues in home." The visit note stated "Patient is now living with her daughter, so safety issues not relevant."</p> <p>Patient #3's record included an SN SOC assessment, completed on 4/28/14, and signed by the RN. The note stated Patient #3 was bathing on her own, but should have help due to weakness.</p> <p>Patient #3's record did not document communication between the MSW and the RN regarding safety concerns or to communicate Patient #3's need for assistance or safety devices while bathing due to her weakness.</p> <p>During an interview on 2/20/15 at 11:30 AM, the MSW stated he did not recall communicating with Patient #3's RN regarding her status or safety needs. He stated if he had communicated with them he would have documented the conversations in his note.</p> <p>The MSW did not communicate with the RN regarding Patient #3's status, or to establish a</p>	G 143		

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G 143	<p>Continued From page 15 plan to ensure her needs were met.</p> <p>4. Patient #6 was an 80 year old male admitted to the agency on 2/04/15, for care related to right shoulder pain. Additional diagnoses included dementia, peripheral neuropathy and diabetes type II. He received SN, PT, OT, HHA and MSW services. His record, including the POC, for the certification period 2/04/15 to 4/04/15, was reviewed.</p> <p>a. Patient #6's POC included an order for a HHA for bathing assistance 1-2 times per week. Patient #6's record included an Aide Care Plan, completed on 2/04/15, and signed by the RN. In addition to personal care tasks, the care plan included the following housekeeping tasks to be completed by the HHA: Clean bathroom twice a week, change linens 1 time a week, and empty trash as needed.</p> <p>Patient #6's record included HHA visit notes dated 2/06/15, 2/09/15 and 2/13/15. The 3 notes documented assistance with personal care, however, they did not document the HHA cleaned the bathroom, changed linens or emptied trash as ordered on the care plan.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN confirmed Patient #6's HHA care plan included orders for the HHA to clean the bathroom twice a week, change linens 1 time a week, and empty trash as needed. She stated she had not communicated with the HHA regarding the care plan and was not aware the housekeeping tasks were not being completed as ordered. The RN stated she would expect the HHA to call her if she was unable to complete the tasks on the care plan for any reason.</p>	G 143			

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G 143	<p>Continued From page 16</p> <p>The RN and the HHA did not communicate to ensure Patient #6 received the services he needed during his HHA visits.</p> <p>b. Patient #6's record included an SN SOC comprehensive assessment, dated 02/04/15, and signed by the RN.</p> <p>Patient #6's record included an MSW visit note, dated 2/05/15, and signed by the MSW. The note documented the purpose of the visit was "patient has many medical problems." However, Patient #6's record did not document the MSW spoke with the RN prior to the MSW visit, to discuss Patient #6's medical issues and needs, as determined during the SN assessment.</p> <p>During an interview on 2/20/15 at 11:40 AM, the MSW stated he did not communicate with the RN regarding Patient #6's status or needs.</p> <p>The MSW did not communicate with the RN regarding Patient #6's status or to determine needs to be addressed by the MSW.</p> <p>5. Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15 were reviewed.</p> <p>Patient #13's record included an order for a HHA for bathing assistance 1-2 times per week. Patient #13's record included an Aide Care Plan, completed on 9/03/14, updated on 11/29/14, and</p>	G 143			

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G 143	Continued From page 17 signed by the RN. In addition to personal care tasks, the care plan directed the HHA to complete prescribed exercises 2 times per week. However, Patient #13's record did not document instruction to the HHA regarding the exercises to be completed. During an interview on 2/19/15 at 2:55 PM, the DON stated the RN who completed the HHA care plan was no longer employed by the agency. The DON reviewed Patient #13's record and confirmed the HHA care plan included an order for prescribed exercises. Additionally, the DON confirmed there was no documentation of instruction to the HHA regarding the exercises to be completed. Patient #13's record did not document communication between the RN and the HHA to ensure his exercises were completed as prescribed.	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 (Patient #1) who received services from more than one discipline and whose records were reviewed. This had the	G 144	See Tag 143		

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G 144	<p>Continued From page 18</p> <p>potential to interfere with the quality and continuity of care provided to all patients who received agency services. Findings include:</p> <p>1. Patient #1 was a 32 year old male admitted to the agency on 10/06/14, for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His record, including the POC, for the certification period 10/06/14 to 12/04/14, was reviewed.</p> <p>Patient #1's POC included goals to keep vital signs within agency established parameters. The blood pressure parameters listed were systolic 90-140 and diastolic 60-90. The POC also included SN visits to assess cardio/pulmonary status and blood glucose levels.</p> <p>A nursing intervention note dated 10/13/14, and signed by the RN documented Patient #1's blood pressure was 150/100. Additionally, the RN documented he did not have a blood glucose monitor to check his blood sugar levels, and to allow him to take his insulin as ordered on the POC.</p> <p>The nursing intervention note, dated 10/13/14, also documented Patient #1 went to the emergency room recently and was told he had a "slight heart attack" and may have a cyst on his heart.</p> <p>The intervention note included a section "Care Coordination." There was no documentation the RN communicated Patient #1's trip to the emergency room, elevated blood pressure, or lack of a blood glucose monitor to his physician or the Physical Therapist.</p>	G 144			

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G 144	Continued From page 19 During an interview on 2/19/15 at 3:35 PM, the RN reviewed the record and confirmed she had not contacted Patient #1's physician about his elevated blood pressure or visit to the emergency room. She stated she sent an interim order for the blood glucose monitor to his physician on 10/10/14, but it was not signed prior to the 10/13/14 visit. The RN confirmed she had not communicated with the Physical Therapist.	G 144		
G 156	The agency failed to ensure Patient #1's care was coordinated. 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER 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 patients needs were met, and POCs were completely developed, followed, and updated. These failures had the potential to result in unmet patient needs and negatively impact the continuity, safety, and quality of patient care. Findings include: 1. Refer to G157 as it relates to the failure of the agency to ensure that patients needs can be adequately met. 2. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with patients' POCs. 3. Refer to G159 as it relates to the failure of the	G 156	Refer to G 157 Refer to G 158 Refer to G 159 Refer to G 160 Refer to G 164	

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G 156	Continued From page 20 agency to ensure patients' POCs included all pertinent information. 4. Refer to G160 as it relates to the failure of the agency to ensure a physician was contacted to approve changes or additions in patients' POCs. 5. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to provide quality care in accordance with established POCs.	G 156			
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on record review, review of agency policies, and staff interview, it was determined the agency failed to ensure patients were accepted for treatment on the basis of a reasonable expectation that the patients' needs could be met and services provided in a timely manner, for 1 of 12 sampled patients (Patient #3) whose records were reviewed for SOC. This resulted in delay of necessary services and unmet patient needs, and had the potential to result in negative outcomes for agency patients. The findings include:	G 157			

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G 157	<p>Continued From page 21</p> <p>An agency policy titled "Acceptance and Assignment," effective 11/93, stated "Patient's eligibility for services by a Care at Home discipline will be evaluated in a timely manner: Skilled nursing within 48 hours of the referral, unless otherwise specified by the referral source." Additionally, the policy stated "Physical therapists, speech pathologists, occupational therapists, medical social workers, and home health aides within 48 hours unless otherwise specified by the referral source."</p> <p>The policy did not include postponement of admissions due to lack of weekend staff.</p> <p>Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included an intake/Referral form. The form stated the order for home health services was received from the hospital on 4/25/14, a Friday. The form also stated Patient #3 was discharged from the hospital on 4/25/14.</p> <p>Patient #3's record included physician orders for home health services, signed by the physician on 4/25/14. The fax date stamp indicated the orders were faxed from the hospital to the agency on 4/25/14. The physician orders stated Patient #3 was to receive education related to insulin injections and a blood draw for a basic metabolic panel to be completed in 2 days. Additionally, the form included orders for PT to evaluate and treat for safety, balance and strength, and social work</p>	G 157	<p>G157</p> <p>Action: Reviewed Care at Home Policy AP-05 to evaluate for accuracy. Policy was adjusted to better meet regulations and to meet the individual needs of each patient. Nursing staff educated to call MD for approval of postponement of open in the event that the client cannot be opened within the 48 hour time frame.</p> <p>Description: Policy AP-05 better reflects the open process of Care at Home. See attached revised policy. Education provided will ensure that coordination of care is being followed through during postponement of opens.</p> <p>Compliance date: April 20, 2015</p> <p>Monitoring: Director of Professional services will monitor that Skilled Nursing Client Admission is performed within 48 hours of referral unless otherwise specified by MD or client/family preference. Will review all opens greater than 48 hours to ensure appropriate orders were obtained.</p>		

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G 157	<p>Continued From page 22 to evaluate home safety.</p> <p>Patient information faxed to the agency with the orders stated Patient #3 had been admitted to the hospital on 4/21/14, due to a blood glucose level of 600 mg/dl. The American Diabetes Association website, accessed on 2/24/15, stated a diabetic's blood glucose level after a meal should be less than 180 mg/dl. The information also stated Patient #3 had not taken insulin injections prior to her hospitalization, and she had not been checking her blood glucose levels as her monitor was not working. Therefore, she required education related to blood glucose monitoring and insulin injections.</p> <p>Patient #3's record included an SOC SN assessment, signed by the RN and dated 4/28/14, 3 days after the order was received. The assessment did not document completion of a blood draw for a basic metabolic panel, ordered to be completed on 4/27/14. Additionally, the assessment documented Patient #3 had not obtained a blood glucose monitor or insulin, therefore she was not checking her blood glucose level or taking her insulin as ordered by the physician upon discharge from the hospital. The note documented Patient #3 was encouraged to obtain her insulin and glucose monitor that day, however, Patient #3's record did not include documentation to indicate she was contacted that day or the next day to ensure she had obtained the insulin and glucose monitor. The next SN visit was documented on 5/02/14, 4 days after the initial assessment.</p> <p>Patient #3's record included an MSW evaluation, signed by the MSW and dated 4/30/14, 5 days after the referral.</p>	G 157			

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G 157	<p>Continued From page 23</p> <p>Patient #3's record did not include an initial PT evaluation prior to 5/04/14.</p> <p>Patient #3's record included a form titled "Transfer to Inpatient Facility," dated 5/04/14, and signed by an RN. The form stated she was admitted to the hospital due to difficulties with blood glucose levels. Patient #3's record included information from the hospital which stated her blood glucose level on arrival to the hospital on 5/04/14, was 600 mg/dl.</p> <p>During the survey entrance conference on 2/17/15, beginning at 8:30 AM, the Administrator stated an initial assessment by an RN was to be completed within 48 hours of receipt of physician orders, unless the physician specified a different start of care date. She stated when additional disciplines were ordered (therapies or social services) their initial evaluations were to be completed within 48 hours of admission. Additionally, the Administrator stated if the agency received a referral, and they were unable to provide the services as ordered, the referring physician would be notified and the referral would not be accepted.</p> <p>During an interview on 2/20/15 at 8:15 AM, the DON confirmed the SOC assessment was completed 3 days after the referral and physician's order were obtained. She stated the agency did not always have an RN to do visits on weekends. Therefore, when a referral was received on a Friday, the agency would have the referral source ask the physician if the SOC could be delayed until Monday. The DON confirmed there was no documentation in Patient #3's record stating the physician had authorized a</p>	G 157			

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G 157	Continued From page 24 delay in the SOC. The DON confirmed the laboratory test was not completed as ordered by the referring physician. Additionally, the DON confirmed the PT and MSW evaluations were not completed within the agency's 48 hour time frame.	G 157			
G 158	The agency failed to meet Patient #3's needs for assessment, education and laboratory tests. 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 and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 4 of 14 patients (#1, #2, #3 and #13) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include: 1. Patient #1 was a 32 year old male admitted to the agency on 10/06/14, for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His medical record, including the POC, for the certification period 10/06/14 to 12/04/14, were reviewed. Patient #1's POC included orders for blood glucose management and education. His POC included Humalog insulin to be given on a sliding scale (dosage based on blood glucose level as measured by a blood glucose monitor.) The	G 158	G158 Action: Nursing to be provided a copy of the completed nursing POC. Educated on the need to follow the plan of care as written and to notify MD of adjustments needed, as well as when to notify immediately. Patient information/teaching sheet will be utilized to give reminders. See also G 143. Description: Education provided will ensure that the POC is followed as written and needed adjustments are performed in a timely manner. See attached Patient Information/ Teaching sheet. Compliance date: April 20, 2015 Monitoring: DPS or ADPS will review 485 for accuracy prior to giving a copy to Case Manager. Director of Professional Services will review nursing intervention for changes to assist with compliance.		

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G 158	<p>Continued From page 25</p> <p>orders stated the sliding scale Insulin was to be taken at meals and bedtime.</p> <p>A nursing intervention note dated 10/13/14, and signed by the RN, documented Patient #1 did not have a blood glucose monitor to check his blood sugar levels. The note did not state whether Patient #1 was taking insulin, or how he would determine how much insulin to take without a monitor to measure his blood glucose level.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN reviewed the record and confirmed Patient #1 did not have a blood glucose monitor in his home. She stated she sent an interim order for the blood glucose monitor to his physician on 10/10/14, but it was not signed prior to the 10/13/14 visit. The RN confirmed she had not contacted Patient #1's physician regarding Patient #1's inability to take his insulin as ordered.</p> <p>Patient #1's POC was not followed related to insulin administration, blood glucose monitoring, and patient education.</p> <p>2. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His records, including the POCs for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed. Patient #2's POC dated 1/29/15 to 3/29/15, included wound care orders for a traumatic wound to his left lower extremity. The wound care orders stated to cleanse the wound, apply Bacitracin to the wound bed, then cover with a band-aid. The POC did not specify how the wound was to be cleansed.</p>	G 158			

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G 158	<p>Continued From page 26</p> <ul style="list-style-type: none"> - A nursing intervention note dated 2/02/15, and signed by the RN, documented the wound was cleansed with Skintegrity wound cleanser. - A nursing intervention note dated 2/04/15, and signed by the RN, documented Patient #2's wound was cleansed with Skintegrity and covered with a Duoderm dressing (a non-breathable wafer dressing.) - A nursing intervention note dated 2/09/15, and signed by the RN documented the wound was cleansed with Skintegrity and left open to air. The RN documented the wound opening had closed. <p>Patient #2's record did not include updated physician orders for wound care.</p> <p>During an interview on 2/19/15 at 1:30 PM, the RN reviewed the record and confirmed she had not followed Patient #2's POC for wound care orders.</p> <p>The agency failed to ensure Patient #2's wound care was provided as ordered on his POC.</p> <p>3. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>a. Patient #3's record included physician orders for home health services, signed by the physician on 4/25/14. The fax date stamp indicated the orders were faxed from the hospital to the agency</p>	G 158			

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G 158	<p>Continued From page 27 on 4/25/14. The physician orders stated Patient #3 was to receive a blood draw for a basic metabolic panel in 2 days. Additionally, the form included orders for PT to evaluate and treat for safety, balance, and strength.</p> <p>Patient #3's record included a SOC SN assessment, signed by the RN and dated 4/28/14, 3 days after the order was received. The assessment did not document completion of a blood draw for a basic metabolic panel, ordered to be completed on 4/27/14.</p> <p>Patient #3's record did not include an initial PT evaluation prior to 5/04/14, when she returned to the hospital.</p> <p>During an interview on 2/20/15 at 8:15 AM, the DON confirmed the laboratory test and the PT evaluation were not completed as ordered by the referring physician.</p> <p>Patient #3's laboratory test and PT evaluation were not completed as ordered by her referring physician.</p> <p>b. Patient #3's record included a POC for the certification period 4/28/14 to 6/26/14, signed by her physician on 7/22/14. The POC included orders for SN visits 1-2 times per week for 5 weeks, with 2 prn visits. However, the POC did not include a description of the medical signs and symptoms for which a prn SN visit would be performed.</p> <p>During an interview on 2/19/15 at 5:10 PM, the DON reviewed Patient #3's POC and confirmed the reasons SN prn visits would be performed were not specified.</p>	G 158			

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G 158	<p>Continued From page 28</p> <p>The agency failed to document the reasons prn SN visits would be performed on Patient #3's POC.</p> <p>4. Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15 were reviewed.</p> <p>a. Patient #13's record included a POC for the certification period 11/30/14 to 1/28/14, signed by his physician on 12/08/14. The POC did not include orders for HHA services.</p> <p>Patient #13's record included a Physician Interim Order that stated "...Could we please have an order for bath aid services 1-2 times per week as directed by the case manager?" The order was dated 1/08/15 and was signed by his physician on 1/12/15.</p> <p>Patient #13's record included 12 HHA visit notes dated between 11/30/14 and 1/11/15, prior to the receipt of a physician's order for HHA services.</p> <p>During an interview on 2/19/15 at 2:55 PM, the DON reviewed Patient #13's record and confirmed the HHA visits between 11/30/14 and 1/11/15, were made without a physician's order.</p> <p>The agency provided HHA services to Patient #13 without a physician's order.</p> <p>b. Patient #13's record included an SN visit note</p>	G 158			

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G 158	Continued From page 29 dated 12/01/14, and signed by the RN. The note documented Triamcinolone (a prescription corticosteroid ointment) was applied to an unspecified area. Patient #13's record included an SN visit note dated 12/05/14, and signed by the RN. The note documented "applied itching cream around dressing." The type of cream was not specified. Patient #13's record included a POC and medication profile for the certification period 11/30/14 to 1/28/14. The POC and medication profile did not include Triamcinolone ointment or a cream to be used for itching. During an interview on 2/19/15 at 2:55 PM, the DON reviewed Patient #13's record and confirmed there was no order for Triamcinolone ointment or a cream to be used for itching. She stated Patient #13 had previously used Triamcinolone ointment for itching, however the order was discontinued and replaced with another topical agent in 9/2014.	G 158			
G 159	The agency failed to ensure Patient #13's wound care was completed per the physician's orders. 484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and	G 159			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2015
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 10TH STREET FRUITLAND, ID 83619		
(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)	(X6) COMPLETION DATE	
G 159	<p>Continued From page 30 any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records and staff and patient interview, it was determined the agency failed to ensure POCs included all pertinent information, including diagnosis and nursing interventions, equipment, wound care instructions and all pertinent treatments for 3 of 14 patients (#3, #6 and #10) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include:</p> <p>1. Patient #10 was a 75 year old female admitted to the agency on 1/20/15, for SN, PT, OT, and HHA services related to cellulitis, malaise and fatigue, and HTN. Her medical record, including the POC, for the certification period 1/20/15 to 3/20/15, was reviewed.</p> <p>A home visit was conducted on 2/19/15 at 10:30 AM, to observe care provided by the HHA. DME was noted to be in use by Patient #10, however it was not included on the POC, including:</p> <ul style="list-style-type: none"> -shower chair -oxygen concentrator and tubing - nebulizer machine for breathing treatments - glucometer and supplies - compression stockings <p>During an interview on 2/19/15 at 1:30 PM, Patient #10's RN reviewed the record and</p>	G 159	<p>G159 Action: Nursing was educated about the need to document all DME equipment the client has in the home for completeness of the 485 POC. Nursing care plan will include the need for MSW to ensure completeness of 485 POC.</p> <p>Description: Documenting the DME and the need for the MSW will ensure the completeness of the 485 POC and that all services are on the 485 POC.</p> <p>Completion Date: April 20, 2015</p> <p>Monitoring: The DPS and Assistant Director of Professional services will review all Start of Care for completenss and question if no DME is listed, and ensure that MSW is added to Nursing Care plan. This will ensure that all services that the patient recieves are included on the 485 plan of Care.</p>		

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G 159	<p>Continued From page 31</p> <p>confirmed the above listed DME was not included on her POC.</p> <p>Patient #10's POC was not comprehensive and complete.</p> <p>2. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included an MSW assessment, dated 4/30/14, and signed by the MSW. However, MSW services were not included on Patient #3's POC.</p> <p>During an interview on 2/19/15 at 5:10 PM, the DON reviewed Patient #3's POC and confirmed it did not include MSW services.</p> <p>Patient #3's POC did not include all services she received from the agency.</p> <p>3. Patient #6 was an 80 year old male admitted to the agency on 2/04/15, for care related to right shoulder pain. Additional diagnoses included dementia, peripheral neuropathy and diabetes type II. He received SN, PT, OT, HHA and MSW services. His record, including the POC, for the certification period 2/04/15 to 4/04/15, was reviewed.</p> <p>Patient #6's record included an MSW assessment, dated 2/05/15, and signed by the MSW. However, MSW services were not included on Patient #6's POC.</p>	G 159			

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G 160	<p>During an interview on 2/19/15 at 11:10 AM, the DON reviewed Patient #6's POC and confirmed it did not include MSW services.</p> <p>Patient #6's POC did not include all services he received from the agency.</p> <p>484.18(a) PLAN OF CARE</p> <p>If a physician refers a patient under a plan of care that cannot be completed until after an evaluation 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, observation, and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 6 of 14 patients (#2, #3, #6, #7, #8, and #10) whose records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include:</p> <p>1. Patient #6 was an 80 year old male admitted to the agency on 2/04/15, for care related to right shoulder pain. Additional diagnoses included dementia, peripheral neuropathy and diabetes type II. He received SN, PT, OT, HHA and MSW services. His record, including the POC, for the certification period 2/04/15 to 4/04/15, was reviewed.</p> <p>A copy of Patient #6's record was presented to surveyors upon request on 2/17/15. A note stated the chart was away for coding, therefore the POC had not yet been created. The POC was</p>	G 160	<p>G160</p> <p>Action: Nursing and therapy educated as to the need to have signed orders before care can be provided. Preliminary care plan form was reviewed and updated to better meet these requirements. Steps generated to ensure that orders are returned signed in a timely manner.</p> <p>Description: Preliminary Care Plan adjusted to include therapy, See attached Preliminary Care Plan form. Skilled nursing will call to get a verbal start of care if client needs seen prior to obtaining signature. Preliminary orders will be faxed to MD and placed into a binder to track for signatures by MD last name. Per MD preference orders will be faxed daily or hand deliver for signature on Tuesdays and Thursday. See attached process</p> <p>Completion Date: April 20, 2015</p> <p>Monitoring: Quality Assurance Specialist services will audit the binder weekly to ensure that orders are being taken for signature and that signatures are being obtained in a timely manner.</p>	

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G 160	<p>Continued From page 33</p> <p>presented to surveyors on 2/18/15. A stamp indicated it was faxed to Patient #6's physician on 2/18/15. It was unsigned by his physician as of 2/20/15.</p> <p>a. Patient #6's record included an RN SOC visit note, dated 2/04/15. The note did not include documentation of contact with Patient #6's physician.</p> <p>Patient #6's record included a Physician Interim Order, dated 2/04/15, and signed by the Assistant to the DON on 2/11/15. It included a summary of Patient #6's status and orders for additional SN visits for assessment and education. A stamp indicated it was faxed to Patient #6's physician on 2/11/15. It was unsigned by his physician as of 2/20/15.</p> <p>Patient #6's record included SN visit notes, dated 2/12/15 and 2/17/15, and signed by the RN. However, his physician was not contacted to approve his POC, and the POC was not signed by his physician as of 2/20/15.</p> <p>b. Patient #6's record included a PT evaluation dated 2/06/15, and signed by the Physical Therapist. Under the communication section of the note there was a slash mark next to "MD notified." However, there was no documentation of physician contact, to indicate what was communicated to the physician, or to document physician approval of the PT POC.</p> <p>Patient #6's record included a Physician Interim Order, dated 2/06/15, and signed by the Therapy Director. The signature was undated. It included orders for PT visits 1 time a week for 1 week, and 2 times a week for 3 weeks, with PT interventions</p>	G 160			

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G 160	<p>Continued From page 34 and goals. There was no indication it was sent to Patient #6's physician and it was unsigned by his physician as of 2/20/15.</p> <p>Patient #6's record included PT visit notes, dated 2/09/15 and 2/11/15, and signed by the Physical Therapist. Additionally, a PT visit was observed on 2/18/15. However, Patient #6's physician was not contacted to approve his POC, and the POC was not signed by his physician as of 2/20/15.</p> <p>c. Patient #6's record included an OT evaluation dated 2/06/15, and signed by the Occupational Therapist. The note did not include documentation of contact with Patient #6's physician.</p> <p>Patient #6's record included a Physician Interim Order, dated 2/06/15, and signed by the Therapy Director. The signature was undated. It included orders for OT visits 1 time a week for 1 week, and 2 times a week for 4 weeks, with OT interventions and goals. There was no indication it was sent to Patient #6's physician and it was unsigned by his physician as of 2/20/15.</p> <p>Patient #6's record included OT visit notes, dated 2/10/15 and 2/12/15, and signed by the Occupational Therapist. However, Patient #6's physician was not contacted to approve his POC, and the POC was not signed by his physician as of 2/20/15.</p> <p>During an interview on 2/19/15 at 11:10 AM, the DON reviewed Patient #6's record and confirmed the orders for PT and OT visits had not been sent to Patient #6's physician, and the order for SN visits had not been signed by the physician. She confirmed the SN, PT and OT visits had been</p>	G 160		

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G 160	<p>Continued From page 35 completed without physician orders.</p> <p>Patient #6's physician was not consulted to approve his POC and additional visits following the SN, PT and OT initial assessments.</p> <p>2. Patient #10 was a 75 year old female admitted to the agency on 1/20/15 for SN, PT, OT, and HHA services related to cellulitis, malaise and fatigue, and HTN. Her medical record, including the POC, for the certification period 1/20/15 to 3/20/15, were reviewed.</p> <p>Patient #10's SOC assessment was completed on 1/20/15, the PT and OT evaluations were completed on 1/21/15, and the POC was developed. Interim orders were initiated and sent to Patient #10's physician. The interim orders were signed by the physician and returned on 1/30/15. However, SN, PT, HHA, and OT visits were conducted before a verbal or written authorization for further visits were obtained.</p> <p>a. Patient #10's record included SN visit notes dated 1/23/15, 1/27/15, and 1/30/15, prior to physician authorization.</p> <p>b. Patient #10's record included PT visit notes dated 1/26/15 and 1/29/15, prior to physician authorization.</p> <p>c. Patient #10's record included OT visit notes dated 1/26/15 and 1/28/15, prior to physician authorization.</p> <p>d. Patient #10's record included HHA visit notes dated 1/22/15, 1/26/15, and 1/29/15, prior to physician authorization.</p>	G 160			

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G 160	<p>Continued From page 36</p> <p>During an interview on 2/19/15 at 1:30 PM, the RN reviewed Patient #10's record and confirmed the SN, PT, OT, and HHA visits were conducted before physician authorization was obtained. She stated she did not routinely contact the physician for orders after a SOC visit. She stated the POC and interim orders were sent to the physician for approval by someone in the office.</p> <p>Patient #10's physician was not consulted to approve the POC before additional visits were made.</p> <p>3. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His records, including the POCs for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #2's SOC assessment was completed on 1/29/15, and signed by the RN. There was no documentation the physician was contacted to obtain an order for additional visits.</p> <p>Patient #2's record included a physician interim order dated 1/30/15, and signed by the Assistant to the DON, for SN assessment, visits and interventions. The interim order was stamped indicating it was faxed to his physician on 2/02/15. The physician interim order was not signed by Patient #2's physician as of 2/20/15.</p> <p>Patient #2's POC included orders for SN visits 1-2 times a week for 4 weeks, and 2 prn visits. The POC was stamped indicating it was faxed to his physician on 2/12/15. The POC was not signed by his physician as of 2/20/15.</p>	G 160			

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G 160	<p>Continued From page 37</p> <p>Patient #2's record included a nursing intervention note, dated 2/02/15, and signed by the RN. However, there was no documentation his physician was contacted to approve his POC prior to 2/02/15, and his POC was not signed by his physician as of 2/20/15.</p> <p>During an interview on 2/19/15 at 1:30 PM, the RN who completed the SOC assessment confirmed she did not contact Patient #2's physician after the SOC visit to obtain orders for additional SN visits. She stated her process was to send an order request to the home health office following an admission visit. She stated the order was sent to the physician by someone in the office.</p> <p>Patient #2's physician was not contacted to approve his POC before additional visits were made.</p> <p>4. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included an RN admission visit note, dated 4/28/14, and signed by the RN. The note did not include documentation of contact with Patient #3's physician.</p> <p>Patient #3's POC included orders for SN visits 1-2 time a week for 4 weeks, and 2 prn visits. The POC contained a date stamp indicating it was faxed to her physician on 5/22/14. The POC</p>	G 160			

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G 160	<p>Continued From page 38 was not signed by her physician as of 2/20/15 .</p> <p>Patient #3's record included an SN visit note, dated 5/02/14, and signed by the RN. However, her physician was not contacted to approve her POC prior to 5/02/14, and the POC was not signed by her physician as of 2/20/15.</p> <p>During an interview on 2/19/15 at 3:10 PM, the RN who completed Patient #3's admission assessment confirmed she did not obtain a verbal order for SN visits prior to the SN visit on 5/02/14. She stated her process was to send an order request to the home health office following an admission visit. She stated the order was sent to the physician by someone in the office, however, she was not notified when the order was signed by the physician. She stated she would be notified by the office if there was a problem obtaining authorization for additional visits. However, that had never happened with her patients.</p> <p>Patient #3's record included a Physician Interim Order, dated 4/29/14. It included a summary of Patient #3's status and and orders for additional SN visits for assessment and education. There was no information on the form to indicate it had been sent to Patient #3's physician, and the lines for clinician and physician signatures were blank.</p> <p>During an interview on 2/19/15 at 5:10 PM, the DON reviewed Patient #3's record and confirmed there was no physician authorization for additional SN visits after the SOC visit.</p> <p>Patient #3's physician was not consulted to approve her POC and additional visits following the SN SOC assessment.</p>	G 160		

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G 160	<p>Continued From page 39</p> <p>5. Patient #7 was an 89 year old female admitted to the agency on 4/18/13, for care related to rheumatoid arthritis. Additional diagnoses included hypertension and glaucoma. She received SN and HHA services. Her record, including the POC, for the certification period 2/07/15 to 4/07/15, was reviewed.</p> <p>Patient #7's record included a Physician Interim Order dated 1/26/15, and signed by the Assistant to the DON. The order stated "May we have a recertification order to continue providing bathing assistance, weekly injections, and med [medication] management...for the next 60 day certification period?" A stamp indicated it was faxed to Patient #7's physician on 1/26/15. However, there was no physician signature on the order request as of 2/20/15.</p> <p>Patient #7's record included a POC for the certification period 2/07/15 to 4/07/15. The POC was not signed by Patient #7's physician as of 2/20/15.</p> <p>Patient #7's record included an SN visit note, completed 2/11/15, and signed by the RN, and HHA visit notes, completed 2/12/15 and 2/14/15, and signed by the HHA. However, her physician was not contacted to approve her POC, and the POC was not signed by her physician as of 2/20/15.</p> <p>During an interview on 2/19/15 at 1:45 PM, the DON reviewed Patient #7's record and confirmed the agency had not obtained a physician's order for services after 2/06/15.</p> <p>Patient #7's physician was not consulted to</p>	G 160			

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G 160	<p>Continued From page 40 approve her POC and visits for the certification period beginning 2/07/15.</p> <p>6. Patient #8 was an 86 year old male admitted to the agency on 2/10/15, for PT and OT services. Diagnoses included care involving rehabilitation services, muscle weakness, Alzheimer's disease, dementia, dysphagia, esophageal reflux, coronary atherosclerosis, myocardial infarction, and anxiety. Patient #8's record, including the POC, for the certification period 2/10/15 to 4/10/15, was reviewed.</p> <p>a. Patient #8's record included a PT evaluation visit note, dated 2/11/15, and signed by the Physical Therapist. The record did not include documentation the Physical Therapist contacted Patient #8's physician for verbal approval of the POC prior to initiation of ongoing services.</p> <p>Patient #8's record included a PT visit note dated 02/17/15, and signed by the Physical Therapist. However, Patient #8's POC was not signed by his physician as of 2/20/15.</p> <p>During an interview on 02/18/15 at 2:20 PM, the Physical Therapist stated after an evaluation visit with a patient he would turn in his evaluation visit note to the Therapy Director. He stated the Therapy Director would fax the therapy POC to the physician. The Physical Therapist stated he rarely called the physician regarding a therapy POC after the initial evaluation. He stated he would call only if there was no need for therapy or if the patient was very ill.</p> <p>PT visits were provided to Patient #8 prior to physician approval of the PT POC.</p>	G 160			

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G 160	Continued From page 41 b. Patient #8's record included an OT evaluation visit note dated 2/10/15, and signed by the Occupational Therapist. The record did not include documentation the Occupational Therapist contacted Patient #8's physician for verbal approval of the POC prior to initiation of ongoing services. Patient #8's record included an OT visit note dated 2/13/15, signed by the Occupational Therapist. Additionally, an OT visit was observed on 2/18/15. During an interview on 02/20/15 at 10:40 AM, the Therapy Director reviewed Patient #8's record and confirmed the OT POC was not approved by his physician prior to the subsequent therapy visits. She stated the evaluation visit notes were given to her by the therapists and she would write and fax an interim POC order to the physician. The Therapy Director confirmed the interim POC orders for OT were not signed by the physician as of 2/20/15.	G 160			
G 164	OT visits were provided to Patient #8 prior to physician approval of the OT POC. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to	G 164			

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G 164	<p>Continued From page 42</p> <p>ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the POC for 7 of 10 patients (#1, #2, #3, #9, #11, #12, and #13) whose conditions indicated a need to alter the POC and whose records were reviewed. As a result, physicians were precluded from making changes in patients' POCs to ensure their needs were met. Findings include:</p> <p>1. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>a. Patient information faxed to the agency with the orders for home health stated Patient #3 had been admitted to the hospital on 4/21/14, due to a blood glucose level of 600 mg/dl. The American Diabetes Association website, accessed on 2/24/15, stated a diabetic's blood glucose level after a meal should be less than 180 mg/dl. The information stated Patient #3 had not taken insulin injections prior to her hospitalization, and she had not been checking her blood glucose levels as her monitor was not working. Therefore, she required education related to blood glucose monitoring and insulin injections.</p> <p>Patient #3's record included an SN SOC assessment, signed by the RN and dated 4/28/14. The assessment documented Patient #3 had not obtained a blood glucose monitor or insulin, therefore she was not checking her blood glucose level or taking her insulin as ordered by the physician upon discharge from the hospital.</p>	G 164	<p>G164</p> <p>Action: Parameters were adjusted to notify MD if client is out of parameters as approved by MD for 2 consecutive visits. In the event that the MD is aware of chronic stable condition the MD will be notified of findings that are out of parameter after 2 visits then only when the client is out of his normal limits. MD will still be contacted with any significant change. Physician interim orders reviewed with staff and form was adjusted to have a carbon copy so orders can be written in the home. Education given on performing a TIF and utilizing the back page to notify MD of DC. MD will be notified of any missing medications that the client needs.</p> <p>Description: Education and direction provided will ensure that MDs are notified of significant changes and medications discrepancies. Carbon copy interim orders will ensure that the staff have access to be able to write verbal orders immediately.</p> <p>Compliance date: April 20, 2015</p> <p>Monitoring: For Nursing the DPS or ADPS will ensure that the parameters for notifying MD of Vitals is being placed on Nursing Care Plans, Therapy manager will ensure that the therapy care plan has the parameters also.</p>	

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G 164	<p>Continued From page 43</p> <p>The assessment did not document Patient #3's physician was notified she had not obtained a blood glucose monitor and was not taking insulin as ordered.</p> <p>Patient #3's record included a form titled "Transfer to Inpatient Facility," dated 5/04/14, and signed by an RN. The form stated she was admitted to the hospital due to difficulties with blood glucose levels. Patient #3's record included information from the hospital which stated her blood glucose level on arrival to the hospital on 5/04/14, was 600 mg/dl.</p> <p>During an interview on 2/19/14 at 3:10 PM, the RN confirmed she did not notify the physician that Patient #3 had not obtained insulin or a blood glucose monitor and was therefore unable to follow her discharge instructions.</p> <p>The agency did not ensure Patient #3's physician was notified she was unable to follow discharge instructions because she did not have the necessary equipment and supplies.</p> <p>b. Patient #3's record included a referral from the hospital to continue home health services after her discharge from the hospital on 5/06/14. A resumption of care assessment completed on 5/07/14, and signed by the RN documented her blood glucose level as 343. There was no documentation stating Patient #3's physician was notified of her elevated blood glucose.</p> <p>Patient #3's POC, updated on 5/07/14, following her hospitalization included a goal of a blood glucose level between 75 and 175.</p> <p>Patient #3's record included a SN visit note, dated</p>	G 164			

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G 164	<p>Continued From page 44</p> <p>5/09/14, and signed by the RN. It documented her blood glucose level as 370. There was no documentation stating Patient #3's physician was notified of her elevated blood glucose.</p> <p>During an interview on 2/19/14 at 3:10 PM, the RN confirmed she did not notify the physician of Patient #3's elevated blood glucose levels on 5/07/14 and 5/09/14.</p> <p>The agency did not ensure Patient #3's physician was notified of her elevated blood glucose levels.</p> <p>2. Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15 were reviewed.</p> <p>During an interview on 2/19/15 at 2:55 PM, the DON stated vital sign parameters are listed as a goal on the POC for all patients. She stated clinicians are expected to report to the physician all vital signs outside of the parameters listed on the patient's POC.</p> <p>Patient #13's record included POCs, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15. Both POCs listed parameters for Patient #13's vital signs. The BP parameters were a systolic (top number) BP of 90 to 130 and a diastolic (bottom number) BP between 60 and 90. The POC also indicated Patient #13's heart rate was to be kept between 60 and 90. Vital signs were documented to be outside of parameters as follows:</p>	G 164			

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G 164	Continued From page 45 - An SN visit note, dated 12/01/14, documented a BP of 89/61, showing a low systolic BP, and low heart rate of 58. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 12/03/14, documented a BP of 82/60, indicating a low systolic BP. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 12/23/14, documented a BP of 126/97, reflecting high diastolic BP. The note also included a high heart rate of 136. The section of the note used to document contact with the physician was blank. -An SN visit note dated 12/26/14, documented a high systolic and low diastolic BP of 132/45. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 12/31/14, documented a BP level of 118/96, reflecting a high diastolic level. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 1/06/15, documented high systolic and diastolic BP levels of 142/98. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 1/14/15, documented BP of 80/56, reflecting low systolic and diastolic levels. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 1/21/15, documented BP of 160/71, reflecting a high systolic level. The	G 164			

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G 164	<p>Continued From page 46</p> <p>section of the note used to document contact with the physician was blank.</p> <p>-An SN visit note dated 2/02/15, documented BP of 93/55, reflecting a low diastolic level. It also noted a high heart rate of 95. The section of the note used to document contact with the physician was blank.</p> <p>-An SN visit note, dated 2/09/15, documented BP of 95/41, reflecting a low diastolic level. The section of the note used to document contact with the physician was blank.</p> <p>During an interview on 2/19/15 at 2:55 PM, the DON reviewed Patient #13's record and confirmed the vitals signs listed above were outside of established parameters for Patient #13 and should have been reported to his physician.</p> <p>The agency failed to notify Patient #13's physician of vital signs outside of established parameters.</p> <p>3. Patient #1 was a 32 year old male admitted to the agency on 10/06/14, for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His medical record, including the POC, for the certification period 10/06/14 to 12/04/14, was reviewed.</p> <p>Patient #1's POC indicated the physician was to be notified of a systolic (top number) BP above 130 or below 90 and a diastolic (bottom number) BP above 90 or below 60. The POC also indicated the physician was to be notified if Patient #1's oxygen saturation level was lower than 89%. Vital signs were documented to be outside of parameters as follows:</p>	G 164			

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G 164	<p>Continued From page 47</p> <p>The Mayo Clinic website, accessed on 2/25/15, stated normal oxygen saturation levels range from 95 to 100 percent, and values under 90 percent are considered low. Additionally, the website stated normal blood pressure levels range between 120-139 systolic (top number) and 80-89 diastolic (low number).</p> <p>a. Patient #1's record included a PT visit note, dated 10/13/14, and signed by the Physical Therapist. The visit note documented Patient #1 had gone to the emergency room and was told he had a heart attack. Patient #1's blood pressure was documented as 140/100 in the visit note.</p> <p>Patient #1's record included a PT visit note, dated 10/15/14, and signed by the Physical Therapist. The visit note documented an oxygen saturation level of 88%. Additionally, the Physical Therapist documented Patient #1 was groggy and difficult to arouse.</p> <p>There was no documentation of communication with Patient #1's physician by the Physical Therapist or other agency staff.</p> <p>During a phone interview on 2/19/15 at 4:30 PM, the Physical Therapist reviewed the record and confirmed he had not notified Patient #1's physician about the emergency room. He also confirmed he had not notified Patient #1's physician of the vital signs that were outside of goals listed on his POC.</p> <p>Patient #1's physician was not informed of changes in his condition that might suggest a need to alter his POC.</p> <p>b. A nursing intervention note, dated 10/13/14,</p>	G 164			

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G 164	<p>Continued From page 48</p> <p>and signed by the RN, documented Patient #1 went to the emergency room over the weekend and was told he had a "slight heart attack." The RN documented Patient #1 was seeing a specialist on 10/23/14. Additionally, during the visit Patient #1's blood pressure was noted to be 150/100.</p> <p>The RN further documented Patient #1's skin color was pale, ashen, and gray and he had slowed speech.</p> <p>There was no documentation the physician was notified of Patient #1's condition during or after the visit.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN reviewed the record. She confirmed she did not notify the physician of Patient #1's emergency room visit, blood pressure, or skin color.</p> <p>Patient #1's physician was not informed of his emergency room visit or changed health status.</p> <p>4. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His records, including the POCs for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #2's POC, for the certification period 1/29/15 to 3/29/15, included goals to keep vital signs within agency established parameters. The blood pressure parameters listed were systolic 90-140 and diastolic 60-90.</p> <p>a. A nursing intervention note, dated 2/02/15, and</p>	G 164		

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G 164	<p>Continued From page 49</p> <p>signed by the RN, documented Patient #2's blood pressure was 163/80. Additionally, the RN documented he was having interrupted sleep. The intervention note included a section "Care Coordination." There was no documentation the RN communicated Patient #2's loss of sleep or elevated systolic blood pressure to his physician.</p> <p>b. A nursing intervention note dated 2/09/15, and signed by the RN, documented Patient #2's blood pressure was 134/95. Additionally, the RN documented he had lost 9 pounds in one week. The intervention note included a section "Care Coordination." There was no documentation the RN communicated Patient #2's weight loss or elevated diastolic blood pressure to his physician.</p> <p>c. A nursing intervention note dated 2/12/15, and signed by the RN documented Patient #2's blood pressure was 87/48. Additionally, the RN documented he was depressed and had insomnia with interrupted sleep. The intervention note included a section "Care Coordination" which was left blank. There was no documentation the RN communicated Patient #2's depression, continued loss of sleep, or low blood pressure with his physician.</p> <p>During an interview on 2/19/15 at 1:30 PM, the RN reviewed the record and confirmed she had not called Patient #2's physician about his blood pressure readings that were outside of the agency established parameters. She stated it was dependent on the patient whether the vital sign goals were considered parameters which needed to be reported to the physician.</p> <p>During an interview on 2/19/15 at 1:50 PM, the assistant to the DON stated the vital sign goals</p>	G 164			

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G 164	<p>Continued From page 50</p> <p>listed on patients' POCs are agency established parameters and the patient's physician should be contacted when vital sign measurements fall outside of these parameters. She stated the clinicians are aware they must notify the physician of all vital signs outside of the agency established parameters. The assistant to the DON confirmed notification to the physician is not specified on the POC.</p> <p>Patient #2's was not notified of his change in health status or labile blood pressure measurements.</p> <p>5. Patient #9 was a 55 year old male admitted to the agency on 2/10/15, for PT and OT services. Diagnoses included care involving rehabilitation, hemiplegia left side, chronic airway obstruction, sleep apnea, hypertension, depression, high cholesterol, tobacco use, and peripheral vascular disease. Patient #9's record, including the POC, for the certification period 2/10/15 to 4/10/15, was reviewed.</p> <p>Patient #9's record included a SOC assessment dated 2/10/15, and signed by the RN. The RN documented there was no palpable pulse in Patient #9's left foot. Additionally, the RN documented Patient #9 had edema (swelling) to the left lower extremity. There was no documentation his physician was notified.</p> <p>During an interview on 2/19/15 at 1:25 PM, the RN who completed the SOC confirmed she was not able to feel a pulse in Patient #9's left foot. She stated the circulation, sensation, and motor function were present. The RN confirmed there was no documentation Patient #9's circulation, sensation, and motor function were intact during</p>	G 164		

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G 164	<p>Continued From page 51</p> <p>the SOC assessment. The RN confirmed the physician was not notified.</p> <p>Patient #9's physician was not informed he did not have a palpable pedal pulse in his left foot.</p> <p>6. Patient #11 was a 19 year old female admitted to the agency on 1/10/15, for SN services. Diagnoses included hyperemesis gravidarum, dehydration, anxiety, vascular catheter, therapeutic drug monitoring, and long term use of medications. Patient #11's record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed.</p> <p>Patient #11's POC included orders for SN visits 1-3 times a week for 6 weeks. The record included a SOC visit note dated 1/10/15, and signed by the RN. There were no other visit notes or missed visit notes by SN services included in the record after 1/10/15.</p> <p>During an interview on 2/19/15 at 3:00 PM, the RN who completed the SOC visit confirmed Patient #11 was not seen after that visit because she went to another home health agency for service. She stated she attempted to contact Patient #11 by phone for 5-7 days to schedule another home visit. Patient #11 returned the RN's phone call after 7 days and stated her insurance had informed her the agency was not covered by her benefits. The RN confirmed Patient #11's physician was not notified of the change in agencies.</p> <p>The agency failed to notify Patient #11's physician she had transferred her care to a new home health agency.</p>	G 164			

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G 164	<p>Continued From page 52</p> <p>7. Patient #12 was a 67 year old male admitted to the agency on 1/02/15, for SN, PT, and OT services. Diagnoses included end stage renal disease, DM Type II, polyneuropathy, myalgia and myositis, anemia, esophageal reflux, BPH, osteoarthritis, and dysphagia. Patient #12's record, including the POC, for the certification period 1/02/15 to 3/02/15, was reviewed.</p> <p>Patient #12's record included a "Transfer to Inpatient Facility" note dated 1/13/15, and signed by the Therapy Director. The note documented Patient #12 was admitted to a hospital on 1/08/15.</p> <p>Patient #12's record included a "Notification of Changes" form dated 1/09/15, and signed by the Medical Records Director. The form documented Patient #12 was hospitalized on 1/08/15 and his therapists were informed with a phone call. There was no documentation Patient #12's physician was notified.</p> <p>During an interview on 2/20/15 at 8:30 AM, the DON reviewed the record and stated since nursing was not continuing with services past the SOC visit, therapy would be responsible for notifying the physician.</p> <p>During an interview on 2/20/15 at 10:50 AM, the Therapy Director reviewed the record and confirmed there was no documentation in the record Patient #12's physician was notified of the hospitalization or discharge from the home health agency.</p> <p>Patient #12's physician was not notified of his hospitalization or discharge.</p>	G 164			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2015
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 16TH STREET FRUITLAND, ID 83619		
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G 168 G 168	Continued From page 53 484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on record review, policy review, observation, and staff interview, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the plan of care and consistent with patients' needs. This negatively impacted quality, coordination, and safety of patient care. Findings include: 1. Refer to G170 as it relates to a failure of the agency to ensure skilled nursing services were furnished in accordance with the plan of care. 2. Refer to G173 as it relates to the agency's failure to ensure that nursing staff developed and updated POCs to ensure patients' medical and nursing needs were met. 3. Refer to G174 as it relates to the agency's failure to ensure patients with specialized nursing needs received care as ordered from qualified nurses. 4. Refer to G176 as it relates to the agency's failure to ensure that staff informed the physician and other members of the health care team of changes in patients' conditions. 5. Refer to G177 as it relates to the failure of the agency to ensure a registered nurse counseled the patient and family in meeting nursing and related needs. 6. Refer to G332 as it relates to the failure of the	G 168 G 168	Refer to G170 Refer to G 173 Refer to G 174 Refer to G 176 Refer to G 177 Refer to G 332 Refer to G 337		

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G 168	Continued From page 54 agency to ensure an RN completed a comprehensive assessment of the patient within 48 hours of referral.	G 168			
G 170	6. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment completed by the RN included a medication review to obtain a current list of patient medications, evaluation of drug interactions, identification of possible significant side effects or noncompliance, and reconciliation of the medications with the physician. The cumulative effects of these negative practices seriously impeded the ability of the agency to provide services of adequate quality. 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 3 of 12 patients (#1, #2, and #3) who received nursing services and whose records were reviewed. Failure to follow the established POC had the potential to result in negative patient outcomes. Findings include: 1. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period	G 170			

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G 170	<p>Continued From page 55 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included physician orders for home health services, signed by the physician on 4/25/14. The fax date stamp indicated the orders were faxed from the hospital to the agency on 4/25/14. The physician orders stated Patient #3 was to receive a blood draw for a basic metabolic panel to be completed in 2 days.</p> <p>Patient #3's record included a SOC SN assessment, signed by the RN and dated 4/28/14, 3 days after the referral order was received. The assessment did not document completion of a blood draw for a basic metabolic panel, ordered to be completed on 4/27/14.</p> <p>During an interview on 2/20/15 at 8:15 AM, the DON confirmed the laboratory test was not completed as ordered by the referring physician.</p> <p>The agency failed to ensure SN services were provided per the POC.</p> <p>2. Patient #1 was a 32 year old male admitted to the agency on 10/06/14 for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His medical record, including the POC, for the certification period 10/06/14 to 12/04/14, was reviewed.</p> <p>Patient #1's POC included orders for blood glucose management and education. His POC included Humalog Insulin to be given on a sliding scale (dosage based on blood glucose level as measured by a blood glucose monitor.) The orders stated the sliding scale insulin was to be taken 4 times a day, at meals and bedtime.</p>	G 170	<p>G170 Action: Skilled nursing educated to review the referral upon acceptance of client for any immediate needs and procedure to follow if not able to meet need. See also G158.</p> <p>Description: Education ensures that Nursing is aware of the need to follow the care plan. This also ensures that any interventions needed upon admit to HHA are thorough.</p> <p>Compliance date: April 20, 2015</p> <p>Monitoring: DPS, ADPS or Designee will review open for any needs upon admission and coordinate with Case Manager to ensure orders are followed.</p>	

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G 170	<p>Continued From page 56</p> <p>A nursing intervention note, dated 10/13/14, and signed by the RN, documented Patient #1 did not have a blood glucose monitor to check his blood sugar levels. The note did not state whether Patient #1 was taking insulin, or how he would determine how much insulin to take without a monitor to measure his blood glucose level. Additionally, the note did not document Patient #1 was educated on the importance of monitoring his blood sugar and taking insulin as ordered.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN reviewed the record and confirmed Patient #1 did not have a blood glucose monitor in his home. She stated she sent an interim order for the blood glucose monitor to his physician on 10/10/14, but it was not signed prior to the 10/13/14 visit. The RN confirmed she had not contacted Patient #1's physician after the visit regarding Patient #1's inability to take his insulin as ordered.</p> <p>The agency failed to ensure Patient #1's POC was followed for SN services related to insulin administration, blood glucose monitoring and patient education.</p> <p>3. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His records, including the POC's for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #2's POC, for the certification period 1/29/15 to 3/29/15, included wound care orders for a traumatic wound to his left lower extremity. The wound care orders stated to cleanse the wound, apply Bacitracin to the wound bed, then</p>	G 170			

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G 170	Continued From page 57 cover with a band-aid. The POC did not specify how the wound was to be cleansed. - A nursing intervention note dated 2/02/15, and signed by the RN documented the wound was cleansed with Skintegrity wound cleanser. - A nursing intervention note dated 2/04/15, and signed by the RN documented Patient #2's wound was cleansed with Skintegrity and covered with a Duoderm dressing. - A nursing intervention note dated 2/09/15, and signed by the RN documented the wound was cleansed with Skintegrity and left open to air. The RN documented the wound opening had closed. Patient #2's record did not include updated physician orders for wound care. During an interview on 2/19/15 at 1:30 PM, the RN reviewed the record and confirmed she had not followed Patient #2's POC for wound care orders.	G 170			
G 173	The agency failed to ensure the RN provided Patient #2's wound care as ordered on his POC. 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on review medical records and staff interview, it was determined the agency failed to ensure RNs developed and updated POCs to	G 173			

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G 173	<p>Continued From page 58</p> <p>ensure medical and nursing needs were met, for 1 of 12 patients (#3), who received SN care and whose records were reviewed. This resulted in incomplete POCs, inadequate patient care, and had the potential to result in negative patient outcomes. Findings include:</p> <p>Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 8/26/14, was reviewed.</p> <p>Patient #3's record included physician orders for home health services, signed by the physician on 4/25/14. The fax date stamp indicated the orders were faxed from the hospital to the agency on 4/25/14. The physician orders stated Patient #3 was to receive education related to insulin injections and blood glucose monitoring.</p> <p>Patient information faxed to the agency with the orders stated Patient #3 had been admitted to the hospital on 4/21/14, due to a blood glucose level of 600 mg/dl. The American Diabetes Association website, accessed on 2/24/15, stated a diabetic's blood glucose level after a meal should be less than 180 mg/dl. The information stated Patient #3 had not been checking her blood glucose levels prior to her hospital admission because her monitor was not working. Additionally, the referral information stated Patient #3 was to take Lantus Insulin 10 units daily at bedtime. Therefore, she required assessment and education related to blood glucose monitoring and insulin injections.</p>	G 173	<p>G173</p> <p>Action: Nursing was educated as to when to call or see a client earlier that is missing medications or equipment that is vital to their diagnosis. Nursing was instructed that a phone call to the client would be acceptable and that the MD must be notified of issues preventing client from obtaining needed items for POC. And to document phone calls on communication note.</p> <p>Description: Following up with client either face to face or by phone will ensure that the client receives the necessary equipment to fulfill POC.</p> <p>Compliance date: April 20, 2015</p> <p>Monitoring: DPS or ADPS will review Start of Care and Nursing interventions for any notations of missing items and follow up with the case manager to ensure that they are addressing issues needed for client.</p>	

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G 173	<p>Continued From page 59</p> <p>Patient #3's record included an SOC SN assessment, signed by the RN and dated 4/28/14, 3 days after the order was received. The assessment documented Patient #3 had not obtained a blood glucose monitor or insulin, therefore she was not checking her blood glucose level or taking her insulin as ordered by the physician upon discharge from the hospital. The note documented Patient #3 was encouraged to obtain her Insulin and glucose monitor that day, however, Patient #3's record did not include documentation to indicate she was contacted prior to the next SN visit to ensure she had obtained the insulin and glucose monitor.</p> <p>Patient #3's next SN visit was documented on 5/02/14, 4 days after the initial assessment. The 5/02/14 SN visit note stated Patient #3 had started taking her insulin on 5/01/14, 6 days after discharge from the hospital. The note did not document an assessment of Patient #3's understanding of her diabetic regimen, including her ability to use a blood glucose monitor and to manage her insulin injections.</p> <p>During an interview on 2/19/14 at 3:10 PM, the RN confirmed Patient #3's SOC assessment visit was completed 3 days after the referral from the hospital. She confirmed Patient #3 did not have a blood glucose monitor or insulin at the time of the SOC visit, and stated she did not contact her to ensure they had been obtained. She stated she was unsure why an SN visit was not done prior to 5/02/14 to ensure Patient #3 had obtained her monitor and insulin. The RN stated she did not remember whether she evaluated Patient #3's ability to use her blood glucose monitor or to manage her insulin injections during the visit on 5/02/14.</p>	G 173			

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G 173	Continued From page 60	G 173			
G 174	<p>During an interview on 2/19/14 at 5:10 PM, the DON reviewed Patient #3's record and stated a visit should have been completed on 4/29/14 to evaluate Patient #3's ability to manage her needs related to diabetes. The DON confirmed the 5/02/14 SN visit note did not include documentation of assessment or education related to blood glucose monitoring or insulin injections.</p> <p>The agency did not ensure the RN initiated a POC that addressed all of Patient #3's needs.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse furnishes those services requiring substantial and specialized nursing skill.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, policy review and record review, it was determined the agency failed to ensure specialized and substantial nursing services were provided consistent with the agency's policies and procedures and current standards of practice. These negative practices directly affected 3 of 14 patients (#3, #5 and #13), whose records were reviewed. This resulted in the lack of appropriate nursing care for patients with intravenous access devices, wounds, and diabetes, and had to potential to result in patient harm. Findings include:</p> <p>An agency policy titled "Central Venous Catheter Maintenance," effective 2/14, stated the dressing</p>	G 174			

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G 174	<p>Continued From page 61</p> <p>change of a central venous catheter is a sterile dressing change and sterile technique will be used when doing the dressing change to reduce the risk of infection.</p> <p>An agency policy MP-13 "Wound Care and Assessments," effective 10/08, stated "All wounds or areas of potential skin breakdown will be observed at each dressing change. Wound reassessments will be completed weekly or more often if the general health of the patient or the status of the wound changes. For clean (non-sterile) dressing changes: the irrigation solution bottle will be dated when the bottle is opened and the solution is good for 30 days from that date." These policies were not followed. Examples include:</p> <p>1. Patient #5 was a 67 year old female admitted to the agency on 1/06/15, for SN services related to wound care. Her medical record, including the POC, for the certification period 1/06/15 to 3/06/15, was reviewed.</p> <p>Patient #5's POC Included orders for wound VAC care and PICC line dressing changes to be provided 3 times a week by SN services. The wound was being treated with a VAC (Vacuum assisted closure device.) Patient #5 also had a PICC line in her left arm. A PICC (Peripherally inserted central catheter) is used for long term IV therapy treatment.</p> <p>A home visit was conducted on 2/17/15, beginning at 10:30 AM, to observe skilled nursing services provided to Patient #5.</p> <p>At the beginning of the home visit, Patient #5 stated she was at the wound clinic the previous</p>	G 174			

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G 174	<p>Continued From page 62</p> <p>day. She stated the right hip wound dressing was changed during the visit. Patient #5 did not believe the dressing needed to be changed again. The RN looked at the dressing, which was secure and intact, and the VAC that was functioning without problems, then told Patient #5 she would change the dressing.</p> <p>- The RN changed the PICC line dressing first. Patient #5 was upright on the couch with her left arm extended. A PICC line dressing change required using sterile technique. The APIC (Association for Professionals in Infection Control) website, accessed on 2/25/15, stated "Sterile technique involves strategies used in patient care to reduce and maintain objects and areas as free from microorganisms as possible." The RN put on a mask, and stated Patient #5 did not like to wear a mask, and "would just turn her head the other way." During the dressing change Patient #5 turned her head towards the open and undressed PICC site numerous times. By Patient #5 turning her head towards the undressed catheter site, without wearing a mask, there was the possibility of introducing microorganisms through the PICC line insertion site.</p> <p>- The dressing was removed from the PICC line and the catheter was observed to slide out from the insertion site approximately an inch and a half. The RN cleansed the site with Betadine, then alcohol, then Chlorhexidine.</p> <p>- After cleansing the site, the nurse slid the catheter back into the insertion site, up to the hub. The line was secured and a new occlusive dressing was applied. After completing the PICC line dressing change, the RN flushed the line and started the antibiotic infusion.</p>	G 174	<p>G174</p> <p>Action: Nurses were re-educated as to the policies and procedures associated with wound care. Reviewed the need to start education from open related to client's diagnosis and reason for admit. See also G121. Wound care video shown assisted to reinforce proper wound measuring.</p> <p>Description: This education will ensure that clients' receive wound care and dressing changes per policy. And that education is provided timely and appropriately.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: DPS will review nursing interventions for education and wound measurements. During intervention review DPS will ensure weekly measurement addendum is performed.</p>	

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G 174	<p>Continued From page 63</p> <p>The RN told Patient #5 she decided she would change the wound VAC, even though it was changed the day before. As Patient #5 positioned herself on the couch, the RN washed her hands and organized her supplies for the wound VAC and dressing change.</p> <ul style="list-style-type: none"> - The RN removed the VAC and occlusive dressing. After cleansing the wound with wound cleanser, she was noted to place her non sterile gloved finger inside the tunneled part of the wound to measure the depth. The RN did not change her gloves after removing the dressing and cleaning the wound, before placing the soiled gloved finger into the deepest part of the wound. - The RN measured the bed of the wound by placing the tape measure directly on top of it, potentially contaminating the wound. - The wound cleansing supplies were stored in a plastic bag. The bag contained a bottle of saline solution, a bottle of wound cleanser, a large syringe, and unwrapped 4 x 4 gauze. The bottle of saline solution was previously opened and was not dated for expiration, as required by agency policy. - The nurse was observed reaching into the bag multiple times to pull out the gauze, wound cleanser, irrigation solution, or syringe. She did not change her gloves before reaching into the plastic bag for the supplies. - The RN was observed reaching into her right pocket with her soiled gloves on. She pulled out a pen and wrote the date on the wound VAC dressing, and placed the pen back in her pocket. 	G 174			

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G 174	<p>Continued From page 64</p> <p>- After the wound care was finished, the RN placed the wound cleanser, opened bottle of irrigation solution, unwrapped 4 X 4 gauze, and large syringe back into the gallon sized plastic bag. The RN placed the items in the bag without wiping them down or isolating them from each other. She then put the bag in a box with other dressing supplies.</p> <p>The APIC website, accessed on 2/25/15, stated "Clean technique involves meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves, sterile instruments, and prevention of direct contamination of materials and supplies."</p> <p>The DON was interviewed on 2/19/15 at 5:00 PM, and asked about policies and procedures for wound care and IV therapy. She stated the agency had an IV therapy manual and they also have a clinical procedural resource for wound care, wound VAC, and wound dressings. The DON stated she also utilized videos on social media.</p> <p>The agency's wound care clinical procedure resource, undated, stated "All wounds must be measured weekly and dressing changes have to be according to the POC." The procedural resource for wound care, stated "Put on disposable latex gloves and gently take off the old dressing. Remove your gloves and throw away used dressings and disposable supplies right away. Wash your hands again. Put on a new pair of gloves. Be sure to wash your hands again."</p> <p>Patient #5's RN was interviewed on 2/19/15 at</p>	G 174			

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G 174	<p>Continued From page 65</p> <p>2:15 PM. She discussed the surveyor's observation of the PICC line and wound VAC dressing changes and wound care that was provided during the home visit. The RN stated she realized the catheter had come out a bit from the insertion site, but then it went back in, so she thought it was acceptable. The RN confirmed the saline irrigation solution and the syringe she used to irrigate the wound were not sterile. She stated as the wound care was a "clean" procedure, she did not have to use sterile supplies. She stated she stored the opened 4 X 4 gauze in the plastic bag with the other supplies, and confirmed she did not wipe the wound cleanser container or other items after handling them with soiled gloves. The RN confirmed she had opened the saline irrigation solution during a previous visit, and did not date the bottle to indicate the date it should be discarded.</p> <p>When asked, the RN stated she decided to change the clean and intact wound VAC dressing because she thought the surveyor would want to see Patient #5's wound.</p> <p>The RN failed to provide wound care and PICC line dressing changes within acceptable practice standards and per agency policies.</p> <p>2. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included physician orders for home health services, signed by the physician on</p>	G 174			

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G 174	<p>Continued From page 66</p> <p>4/25/14. The fax date stamp indicated the orders were faxed from the hospital to the agency on 4/25/14. The physician orders stated Patient #3 was to receive education related to insulin injections and a blood draw for a basic metabolic panel to be completed in 2 days.</p> <p>Patient information faxed to the agency with the orders stated Patient #3 had been admitted to the hospital on 4/21/14, due to a blood glucose level of 600 mg/dl. The American Diabetes Association website, accessed on 2/24/15, stated a diabetic's blood glucose level after a meal should be less than 180 mg/dl. The information stated Patient #3 had not been checking her blood glucose levels prior to her hospital admission as her monitor was not working. Additionally, the referral information stated Patient #3 was to take Lantus insulin 10 units daily at bedtime. Therefore, she required education related to blood glucose monitoring and insulin injections.</p> <p>Patient #3's record included an SOC SN assessment, signed by the RN and dated 4/28/14, 3 days after the order was received. The assessment did not document completion of a blood draw for a basic metabolic panel, ordered to be completed on 4/27/14. Additionally, the assessment documented Patient #3 had not obtained a blood glucose monitor or insulin, therefore she was not checking her blood glucose level or taking her insulin as ordered by the physician upon discharge from the hospital. The note documented Patient #3 was encouraged to obtain her insulin and glucose monitor that day, however, Patient #3's record did not include documentation to indicate she was contacted that day or the next day to ensure she had obtained</p>	G 174			

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G 174	<p>Continued From page 67</p> <p>the insulin and glucose monitor. The next SN visit was documented on 5/02/14, 4 days after the initial assessment. The 5/02/14 SN visit note stated Patient #3 had obtained her insulin on 5/01/14, 6 days after discharge from the hospital.</p> <p>During an interview on 2/19/14 at 3:10 PM, the RN confirmed the SOC assessment visit was completed 3 days after the referral from the hospital. She stated she was not aware of the physician's order for a laboratory test and confirmed it was not completed. She stated she was unsure why a SN visit was not done prior to 5/02/14 to ensure Patient #3 had obtained her monitor and insulin.</p> <p>The agency failed to meet Patient #3's needs for an SN assessment, education, and laboratory tests.</p> <p>3. Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #13's record included a SN visit note dated 12/21/14, and signed by the RN. The visit notes included a wound care addendum which documented appearance of the wound, amount of drainage, and wound measurements.</p> <p>Patient #13's record included SN visit notes dated 12/23/14, 12/24/14, 12/26/14, 12/31/14, 1/01/15, 1/03/15, 1/06/15, 1/07/15, and 1/09/15, signed by the RN. The 9 visit notes did not include a wound</p>	G 174			

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G 174	Continued From page 68 care addendum and did not document the appearance of the wound, amount of drainage or wound measurements. Patient #13's record included documentation from a wound care clinic, including wound measurements, dated 1/12/15. During an interview on 2/19/15, the DON reviewed Patient #13's record and confirmed a description of his wound with measurements was not documented between 12/21/14 and 1/12/15. The agency failed to ensure Patient #13's wound was assessed and measured weekly as required per agency policy.	G 174		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure RNs informed physicians of changes in patients' conditions for 5 of 12 patients (#1, #2, #3, #9 and #13) who received SN services and whose records were reviewed. This had resulted in unmet patient needs and negatively impacted the quality of patient care. Findings include: 1. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record,	G 176	G176 Action: Education was provided to Nursing and therapy staff on when to contact the MD and when to notify of changes. Any changes from baseline or preventing initiation of POC will need to be followed up on. Description: This education will ensure that the client will receive timely updates to their POC. Compliance Date: April 20, 2015 Monitoring: DPS will monitor all interventions for the need of changes to POC. Weekly Care Coordination update with Case Managers.	

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G 176	<p>Continued From page 69 including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>a. Patient information faxed to the agency with the orders stated Patient #3 had been admitted to the hospital on 4/21/14, due to a blood glucose level of 600 mg/dl. The American Diabetes Association website, accessed on 2/24/15, stated a diabetic's blood glucose level after a meal should be less than 180 mg/dl. The information stated Patient #3 had not taken insulin injections prior to her hospitalization, and she had not been checking her blood glucose levels as her monitor was not working. Therefore, she required education related to blood glucose monitoring and insulin injections.</p> <p>Patient #3's record included a start of care SN assessment, signed by the RN, and dated 4/28/14. The assessment documented Patient #3 had not obtained a blood glucose monitor or insulin, therefore she was not checking her blood glucose level or taking her insulin as ordered by the physician upon discharge from the hospital. The assessment did not document Patient #3's physician was notified she had not obtained a blood glucose monitor and was not taking insulin as ordered.</p> <p>During an interview on 2/19/14 at 3:10 PM, the RN confirmed she did not notify the physician that Patient #3 had not obtained insulin or a blood glucose monitor and was therefore unable to follow her discharge instructions.</p> <p>The RN did not notify the physician Patient #3 was unable to follow discharge instructions because she did not have the necessary equipment and supplies.</p>	G 176			

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G 176	<p>Continued From page 70</p> <p>b. Patient #3's record included a form titled "Transfer to Inpatient Facility," dated 5/04/14, and signed by an RN. The form stated she was readmitted to the hospital due to difficulties with blood glucose levels. Patient #3's record included information from the hospital which stated her blood glucose level on arrival to the hospital on 5/04/14, was 600 mg/dl.</p> <p>Patient #3's record included a referral from the hospital to continue home health services after her discharge from the hospital on 5/06/14. Information sent to the agency by the hospital included Patient #3's discharge prescriptions, which included Novolog insulin to be taken 3 times a day, on a sliding scale basis (dosage based on blood glucose level as measured by a blood glucose monitor.)</p> <p>A resumption of care assessment completed on 5/07/14, and signed by the RN, documented her blood glucose level as 343. There was no documentation stating Patient #3's physician was notified of her elevated blood glucose. Additionally, the note did not document whether Patient #3 was taking her insulin as ordered.</p> <p>Patient #3's POC, updated on 5/07/14, following her hospitalization, included a goal of a blood glucose level between 75 and 175.</p> <p>Patient #3's record included an SN visit note, dated 5/09/14, and signed by the RN. It documented her blood glucose level as 370. There was no documentation stating Patient #3's physician was notified of her elevated blood glucose. Additionally, the note did not document whether Patient #3 was taking her insulin as</p>	G 176			

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G 176	<p>Continued From page 71 ordered.</p> <p>During an interview on 2/19/14 at 3:10 PM, the RN confirmed she did not notify the physician of Patient #3's elevated blood glucose levels on 5/07/14 and 5/09/14. She confirmed her notes did not document whether Patient #3 was taking her insulin as ordered.</p> <p>The RN did not notify Patient #3's physician of her elevated blood glucose levels. Additionally, she did not document Patient #3's use of sliding scale insulin as ordered.</p> <p>2. Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>During an interview on 2/19/15 at 2:55 PM, the DON stated vital sign parameters are listed as a goal on the POC for all patients. She stated clinicians are expected to report to the physician all vital signs outside of the parameters listed on the patient's POC.</p> <p>Patient #13's record included POCs, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15. Both POCs listed parameters for Patient #13's vital signs. The BP parameters were a systolic (top number) BP of 90 to 130 and a diastolic (bottom number) BP between 60 and 90. The POC also indicated Patient #13's heart rate was to be kept between 60 and 90. Vital signs were documented to be outside of</p>	G 176			

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G 176	<p>Continued From page 72 parameters as follows:</p> <ul style="list-style-type: none"> - An SN visit note, dated 12/01/14, documented a BP of 89/61, showing a low systolic BP, and low heart rate of 58. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 12/03/14, documented a BP of 82/60, indicating a low systolic BP. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 12/23/14, documented a BP of 126/97, reflecting high diastolic BP. The note also included a high heart rate of 136. The section of the note used to document contact with the physician was blank. -An SN visit note dated 12/26/14, documented a high systolic and low diastolic BP of 132/45. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 12/31/14, documented a BP level of 118/96, reflecting a high diastolic level. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 1/06/15, documented high systolic and diastolic BP levels of 142/98. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 1/14/15, documented BP of 80/56, reflecting low systolic and diastolic levels. The section of the note used to document contact with the physician was blank. -An SN visit note, dated 1/21/15, documented BP 	G 176			

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G 176	<p>Continued From page 73 of 160/71, reflecting a high systolic level. The section of the note used to document contact with the physician was blank.</p> <p>-An SN visit note dated 2/02/15, documented BP of 93/55, reflecting a low diastolic level. It also noted a high heart rate of 95. The section of the note used to document contact with the physician was blank.</p> <p>-An SN visit note, dated 2/09/15, documented BP of 95/41, reflecting a low diastolic level. The section of the note used to document contact with the physician was blank.</p> <p>During an interview on 2/19/15 at 2:55 PM, the DON reviewed Patient #13's record and confirmed the vitals signs listed above were outside of established parameters for Patient #13 and should have been reported to his physician.</p> <p>The agency failed to ensure the RN notified Patient #13's physician of vital signs outside of established parameters.</p> <p>3. Patient #1 was a 32 year old male admitted to the agency on 10/06/14 for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His medical record and POC, for the certification period 10/06/14 to 12/04/14, were reviewed.</p> <p>A nursing intervention note, dated 10/13/14, and signed by the RN, documented Patient #1 went to the emergency room over the weekend and was told he had a "slight heart attack." The RN documented Patient #1 was seeing a specialist on 10/23/14. Additionally, Patient #1's blood pressure was 150/100.</p>	G 176			

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G 176	<p>Continued From page 74</p> <p>The RN further documented Patient #1's skin color was pale, ashen, and gray and he had slowed speech.</p> <p>There was no documentation the physician was notified of Patient #1's condition during or after the visit.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN reviewed the record. She confirmed she did not notify the physician of Patient #1's emergency room visit, blood pressure, or skin color.</p> <p>Patient #1's physician was not informed of his emergency room visit or changed health status.</p> <p>4. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His medical record, including the POCs, for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #2's POC, for the certification period 1/29/15 to 3/29/15, included goals to keep vital signs within agency established parameters. The blood pressure parameters listed were systolic 90-140 and diastolic 60-90.</p> <p>a. A nursing intervention note, dated 2/02/15, and signed by the RN, documented Patient #2's blood pressure was 163/80. Additionally, the RN documented he was having interrupted sleep. The intervention note included a section "Care Coordination." There was no documentation the RN communicated Patient #2's loss of sleep or elevated systolic blood pressure to his physician.</p>	G 176			

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G 176	Continued From page 75 b. A nursing intervention note dated 2/09/15, and signed by the RN, documented Patient #2's blood pressure was 134/95. Additionally, the RN documented he had lost 9 pounds in one week. The intervention note included a section "Care Coordination." There was no documentation the RN communicated Patient #2's weight loss or elevated diastolic blood pressure to his physician. c. A nursing intervention note dated 2/12/15, and signed by the RN documented Patient #2's blood pressure was 87/48. Additionally, the RN documented he was depressed and had insomnia with interrupted sleep. The intervention note included a section "Care Coordination" which was left blank. There was no documentation the RN communicated Patient #2's depression, continued loss of sleep, or low blood pressure with his physician. During an interview on 2/19/15 at 1:30 PM, the RN reviewed the record and confirmed she had not called Patient #2's physician about his blood pressure readings that were outside of the agency established parameters. She stated it was dependent on the patient whether the vital sign goals were considered parameters which needed to be reported to the physician. During an interview on 2/19/15 at 1:50 PM, the assistant to the DON stated the vital sign goals listed on patients' POCs are agency established parameters and the patient's physician should be contacted when vital sign measurements fall outside of these parameters. She stated the clinicians are aware they must notify the physician of all vital signs outside of the agency established parameters. The assistant to the	G 176			

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(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 176	Continued From page 76 DON confirmed notification to the physician is not specified on the POC. Patient #2's was not notified of his change in health status or labile blood pressure measurements. 5. Patient #9 was a 55 year old male admitted to the agency on 2/10/15, for PT and OT services. Diagnoses included care involving rehabilitation, hemiplegia left side, chronic airway obstruction, sleep apnea, hypertension, depression, high cholesterol, tobacco use, and peripheral vascular disease. Patient #9's record, including the POC, for the certification period 2/10/15 to 4/10/15, was reviewed. Patient #9's record included an SOC assessment dated 2/10/15, and signed by the RN. The RN documented there was no palpable pulse in Patient #9's left foot. Additionally, the RN documented Patient #9 had edema (swelling) to the left lower extremity. There was no documentation his physician was notified. During an interview on 2/19/15 at 1:25 PM, the RN who completed the SOC assessment confirmed she was not able to feel a pulse in Patient #9's left foot. She stated the circulation, sensation, and motor function were present. The RN confirmed there was no documentation Patient #9's circulation, sensation, and motor function were intact during the SOC assessment. The RN confirmed the physician was not notified. Patient #9's physician was not informed he did not have a palpable pedal pulse in his left foot.	G 176			
G 177	484.30(a) DUTIES OF THE REGISTERED	G 177			

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G 177	<p>Continued From page 77</p> <p>NURSE</p> <p>The registered nurse counsels the patient and family in meeting nursing and related needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff and patient caregiver interview, it was determined the agency failed to ensure the RN provided necessary instruction to patients or caregivers for 2 of 12 patients (#3 and #6) who received SN services and whose records were reviewed. This resulted in the rehospitalization of one patient and created the potential for other diabetic patients to experience adverse outcomes due to diabetic complications. Findings include:</p> <p>1. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included physician orders for home health services, signed by the physician on 4/25/14. The fax date stamp indicated the orders were faxed from the hospital to the agency on 4/25/14. The physician orders stated Patient #3 was to receive education related to insulin injections and blood glucose monitoring.</p> <p>Patient information faxed to the agency with the orders stated Patient #3 had been admitted to the hospital on 4/21/14, due to a blood glucose level of 600 mg/dl. The American Diabetes Association website, accessed on 2/24/15, stated</p>	G 177	<p>Action: Education provided to Nursing about the importance of education upon admission to clients and to family that may be involved in care. Reminders of written materials available to review with client to reinforce teachings.</p> <p>Description: This will ensure that all clients/caregivers receive education related to diagnosis.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: DPS or ADPS will ensure that educational materials are given to the Case Manager to review with client/ family based on the Start of Care needs. Nursing interventions will be reviewed to ensure that education is being documented.</p>		

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G 177	<p>Continued From page 78</p> <p>a diabetic's blood glucose level after a meal should be less than 180 mg/dl. The information stated Patient #3 had not been checking her blood glucose levels prior to her hospital admission because her monitor was not working. Additionally, the referral information stated Patient #3 was to take Lantus insulin 10 units daily at bedtime. Therefore, she required education related to diabetic management, blood glucose monitoring and insulin injections.</p> <p>Patient #3's record included a SOC SN assessment, signed by the RN and dated 4/28/14. The assessment documented Patient #3 had not obtained a blood glucose monitor or insulin, therefore she was not checking her blood glucose level or taking her insulin as ordered by the physician upon discharge from the hospital. The note stated Patient #3 was living with her daughter, who was assisting with her care.</p> <p>The SOC visit note documented Patient #3 was encouraged to obtain a blood glucose monitor and insulin. However, there was no documentation of patient/caregiver education related to frequency of blood glucose monitoring, when to notify the RN or physician of readings out of normal range, or of insulin injection process.</p> <p>Patient #3's next SN visit was documented on 5/02/14, 4 days after the initial assessment. The 5/02/14 SN visit note stated Patient #3 had started taking her insulin on 5/01/14. The SN visit note did not document patient/caregiver education related to use of the blood glucose monitor or insulin injections.</p> <p>Patient #3's record included a form titled "Transfer to Inpatient Facility," dated 5/04/14, and</p>	G 177			

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G 177	<p>Continued From page 79</p> <p>signed by an RN. The form stated she was admitted to the hospital due to difficulties with blood glucose levels. Patient #3's record included information from the hospital which stated her blood glucose level on arrival to the hospital on 5/04/14, was 600 mg/dl.</p> <p>Patient #3's record included a referral from the hospital to continue home health services after her discharge from the hospital on 5/06/14. Information sent to the agency by the hospital included Patient #3's discharge prescriptions, which included Novolog insulin to be taken 3 times a day, on a sliding scale basis (dosage based on blood glucose level as measured by a blood glucose monitor.)</p> <p>Patient #3's record included a resumption of care visit note, completed on 5/07/14, and signed by the RN. The visit note did not document education related to sliding scale insulin.</p> <p>Patient #3's record included a POC, updated on 5/07/14, following her resumption of care. The POC included Novolog insulin, sliding scale to be taken as needed. It did not document how many times a day Patient #3 should monitor her blood glucose, how often the sliding scale should be taken, or the amount of insulin to be taken based on the blood glucose test result.</p> <p>During an interview on 2/19/14 at 3:10 PM, the RN confirmed she did not educate Patient #3 or her daughter on sliding scale insulin. She confirmed Patient #3's POC, updated on 5/07/14, did not include specific information on her sliding scale insulin. The RN stated she assumed the patient had specific instructions for the sliding scale insulin in her home, but she could not say</p>	G 177		

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G 177	<p>Continued From page 80 for sure.</p> <p>During an interview on 2/19/14 at 5:10 PM, the DON reviewed Patient #3's record and confirmed the 5/07/14 SN visit note did not include documentation of assessment or education related to blood glucose monitoring or insulin injections. She confirmed the resumption of care visit note did not document patient/caregiver education related to sliding scale insulin, and the POC did not include specific instructions for sliding scale.</p> <p>Patient #3's RN did not complete patient/caregiver education related to her diabetic status and related needs.</p> <p>2. Patient #6 was an 80 year old male admitted to the agency on 2/04/15, for care related to right shoulder pain. Additional diagnoses included dementia, peripheral neuropathy and diabetes type II. He received SN, PT, OT, HHA and MSW services. His record, including the POC, for the certification period 2/04/15 to 4/04/15, was reviewed. Patient #6 lived with his wife, who was his caregiver.</p> <p>Patient #6's record included an SOC assessment, completed on 2/04/15, and signed by the RN. The assessment documented Patient #6 was diabetic and used sliding scale insulin (dosage based on blood glucose level as measured by a blood glucose monitor.)</p> <p>Patient #6's record included a POC and medication profile which listed his medications, including dose and frequency. The medication list included Lantus insulin twice daily and Novolog insulin, sliding scale. However, it did not</p>	G 177			

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G 177	<p>Continued From page 81</p> <p>document how many times a day Patient #6 should monitor his blood glucose, how often the sliding scale should be taken, or the amount of insulin to be taken based on the blood glucose test result.</p> <p>Patient #6's record included SN visit notes dated 2/04/15, 2/12/15 and 2/17/15. The notes did not document patient/caregiver education related to blood glucose monitoring or sliding scale insulin administration.</p> <p>Patient #6's record included an MSW evaluation dated 2/05/15, and signed by the MSW. It stated Patient #6 took insulin injections 5 times a day.</p> <p>A visit was made to Patient #6's home on 2/18/15, to observe a PT visit. During the visit, Patient #6's wife stated he checked his blood glucose level and took sliding scale insulin 3 times a day, with meals.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN who completed the SOC assessment confirmed Patient #6's POC and medication profile did not include frequency or dosage of his sliding scale insulin. She stated she had not confirmed the sliding scale frequency or dosage with Patient #6's physician, however, she thought Patient #6 was to check his blood glucose level and take sliding scale insulin once a day, in the morning. She stated she had not provided education to Patient #6 or his wife regarding his blood glucose monitoring or sliding scale insulin.</p> <p>The agency did not ensure Patient #6 and his caregiver received education related to his diabetes and insulin regimen.</p>	G 177			

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G 196 G 196	Continued From page 82 484.34 MEDICAL SOCIAL SERVICES The social worker participates in the development of the plan of care. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure the social worker participated in the development of POCs for 1 of 2 patients (Patient #6) who recieved social services and whose records were reviewed. This resulted in a lack of direction and focus for staff providing social services, as well as unmet patient needs. Findings include: 1. Patient #6 was an 80 year old male admitted to the agency on 2/04/15, for care related to right shoulder pain. Additional diagnoses included dementia, peripheral neuropathy and diabetes type II. He received SN, PT, OT, HHA and MSW services. His record, including the POC, for the certification period 2/04/15 to 4/04/15, was reviewed. Patient #6's record included physician orders for home health services, dated 2/03/15. The orders included "Social work needs to evaluate for placement to LTC [long term care.] Patient #6's record included an MSW visit note, dated 2/05/15, and signed by the MSW. The note documented the purpose of the visit was "patient has many medical problems." The note documented Patient #6's medical history, family involvement, and financial issues. The note did not document conversation with Patient #6 or his wife, regarding placement in an LTC facility.	G 196 G 196	G196 Action: MSW educated as to the need to address the reason for admission to services. Also educated on the need to communicate with case manager prior to seeing client and after visit. Description: This will ensure that client needs are addressed. And care is coordinated. Comliance Date: April 20, 2015 Monitor: Visits will be reviewed by DPS to ensure the the reason for referral was addressed and to ensure that communication is being done and documented.		

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G 196	Continued From page 83 The MSW visit note, dated 2/05/15, documented Patient #6 would like to have grab bars for his bathroom and would like information on obtaining a medical alert system. However, as of 2/20/15, the record did not include documentation of follow-up by the MSW to assist Patient #6 in obtaining these items. Patient #6's record did not document communication between the MSW and the RN, prior to, or following the MSW visit, to effectively coordinate care and ensure his POC addressed all his needs. During an interview on 2/20/15 at 11:40 AM, the MSW stated he could not recall if he was aware of the physician order regarding LTC facility placement. He stated that 99% of the time physicians did not state a reason for an MSW referral. He stated he did not communicate with Patient #6's physician, before or after his visit. Additionally, he stated he did not communicate with the RN regarding Patient #6's status or needs. The MSW did not address Patient #6's needs, as ordered by his physician. Additionally, he did not communicate with the RN regarding Patient #6's status, or to establish a plan to ensure his needs were met.	G 196			
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home	G 224			

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G 224	<p>Continued From page 84 health aide under paragraph (d) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the RN provided written instructions for the home health aide for 1 of 5 patients (#13) who received aide services and whose records were reviewed. This had the potential to negatively impact quality, completeness, and coordination of patient care. Findings include:</p> <p>Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #13's record included an order for a HHA for bathing assistance 1-2 times per week. Patient #13's record included an Aide Care Plan, completed on 9/03/14, updated on 11/29/14, and signed by the RN. In addition to personal care tasks, the care plan directed the HHA to complete prescribed exercises 2 times per week. However, Patient #13's record did not document instruction to the HHA regarding the exercises to be completed.</p> <p>During an interview on 2/19/15 at 2:55 PM, the DON stated the RN who completed the HHA care plan was no longer employed by the agency. The DON reviewed Patient #13's record and confirmed the HHA care plan included an order for prescribed exercises. Additionally, the DON</p>	G 224	<p>G 224 Action: Nurses were educated on the proper way to address items on the bath aid care plan to fit the clients needs. Exercises are at the direction of the MD or PT.</p> <p>Description: This will ensure that the proper disciplines are addressing exercises for the care plan.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: DPS or ADPS will review Aid Care plan to ensure that Case Manager has met all the needs of the client and that the proper interventions are available to the CNA.</p>	

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G 224	Continued From page 85 confirmed there was no documentation of instruction to the HHA regarding the exercises to be completed.	G 224			
G 225	The agency failed to ensure Patient #13's HHA received written instructions from the RN regarding exercises to be provided during HHA visits. 484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the HHA provided services in accordance with the POC for 2 of 5 patients (#6 and #13) who received HHA services and whose records were reviewed. This had the potential to interfere with safety and quality of patient care. Findings include: 1. Patient #6 was an 80 year old male admitted to the agency on 2/04/15, for care related to right shoulder pain. Additional diagnoses included dementia, peripheral neuropathy and diabetes type II. He received SN, PT, OT, HHA and MSW services. His record, including the POC, for the certification period 2/04/15 to 4/04/15, was reviewed. Patient #6's POC included an order for a HHA for bathing assistance 1-2 times per week. Patient	G 225	G225 Actions: Aides educated as to the need to follow the care plan and when to call the office. Aides will begin reviewing careplan in the office prior to accepting client. Aide will cosign careplan. Description: This education and review will ensure the all needed tasks are addressed on the care plan and followed by the aide Compliance Date: April 20, 2015 Monitor: Case Manager, DPS, ADPS or A&D coordinating RN will review careplan with aide for completeness and understanding. Case manager will review aid interventions prior to performing supervisory visits to ensure that careplan is being followed.		

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G 225	<p>Continued From page 86</p> <p>#6's record included an Aide Care Plan, completed on 2/04/15, and signed by the RN. In addition to personal care tasks, the care plan included the following housekeeping tasks to be completed by the HHA: Clean bathroom twice a week, change linens 1 time a week, and empty trash as needed.</p> <p>Patient #6's record included HHA visit notes dated 2/06/15, 2/09/15 and 2/13/15. The 3 notes documented assistance with personal care, however, they did not document the HHA cleaned the bathroom or changed linens as ordered on the care plan.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN confirmed Patient #6's HHA care plan included orders for the HHA to clean the bathroom twice a week, change linens 1 time a week, and empty trash as needed. She stated she had not communicated with the HHA regarding the care plan and was not aware the housekeeping tasks were not being completed as ordered. The RN stated she would expect the HHA to call her if she was unable to complete the tasks on the care plan for any reason.</p> <p>The agency did not ensure Patient #6 received HHA services as ordered in his POC.</p> <p>2. Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification periods 11/30/14 to 1/28/15, and 1/29/15 to 3/29/15, were reviewed.</p>	G 225			

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G 225	Continued From page 87 Patient #13's record included an order for a HHA for bathing assistance 1-2 times per week. Patient #13's record included an Aide Care Plan, completed on 9/03/14, updated on 11/29/14, and signed by the RN. In addition to personal care tasks, the care plan directed the HHA to complete prescribed exercises 2 times per week. Patient #13's record included 14 HHA visit notes during the certification period 11/30/14 to 1/28/14. The 14 notes did not document completion of prescribed exercises. There was no documentation to explain why the exercises were not completed as ordered. During an interview on 2/19/15 at 2:55 PM, the DON stated the RN who completed Patient #13's HHA care plan was no longer employed by the agency. The DON reviewed Patient #13's record and confirmed the HHA care plan included an order for prescribed exercises. Additionally, the DON confirmed there was no documentation stating the exercises were completed during Patient #13's HHA visits.	G 225			
G 229	The agency failed to ensure Patient #13 received exercises during his HHA visits as ordered. 484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review, policy review and staff	G 229			

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NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 10TH STREET FRUITLAND, ID 83619		
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G 229	<p>Continued From page 88</p> <p>interview, it was determined the agency failed to ensure the RN completed a comprehensive assessment of HHA services no less frequently than every 2 weeks for 1 of 5 patients (Patient #13), who received aide services and whose records were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include:</p> <p>The agency's policy, CR-17, Patient Care Plan - HHA, effective 3/98, included "The HHA's daily worksheet must exactly mirror the Care Plan. Any deviations must be phoned to the nurse. All areas of the Care Plan that apply must be filled out."</p> <p>The agency's policy, AP-20, Certified Home Health Aide, effective 4/13, updated 1/15, included "No less than every two weeks, the Case Manager...will evaluate the Certified Home Health Aide's services and the patient's continuing need of those services."</p> <p>Patient #13 was an 82 year old male admitted to the agency on 8/02/14, for care related to a decubitus ulcer on his upper back. Additional diagnoses included diabetes type II, hypertension and depression. He received SN and HHA services. His record, including the POC, for the certification period 11/30/14 to 1/28/15, was reviewed.</p> <p>Patient #13's record included an order for a HHA for bathing assistance 1-2 times per week. Patient #13's record included an Aide Care Plan, completed on 9/03/14, updated on 11/29/14, and signed by the RN. Two of the tasks ordered on the Aide Care Plan were "brush teeth" 2 times per week, and "prescribed exercises" 2 times per</p>	G 229	<p>G229</p> <p>Action: Nursing staff educated to check aide intervention sheets prior to performing supervisory visits to ensure that aide is following the care plan. See also G225.</p> <p>Drscription: Reviewing the aide intervetion sheets will ensure that the aide care plan is being followed and adjusted as needed to meet the clients' needs.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: Quality Assurance Specialist, Dallas Head, will continue to review bath aide supervisor visits to ensure they are performed in the appropriate time frame. QAS will also compare the aide intervensions to the care plan to alert Case Manager/ CNA of any issues.</p>		

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G 229	Continued From page 89 week. Patient #13's record included 14 HHA visit notes during the certification period 11/30/14 to 1/28/14, completed and signed by the HHA. The notes documented the tasks completed by the HHA on each visit, however, the 14 notes did not document the tasks "brush teeth" or "prescribed exercises" were completed by the HHA. Patient #13's record included Aide Supervision Sheets, dated 12/10/14, 12/24/14, 1/07/15, and 1/21/15, completed and signed by the RN. The 4 Aide Supervision Sheets documented the HHA always completed tasks as assigned. Patient #13's record did not include documentation of communication between the RN and the HHA regarding the HHA care plan and tasks assigned. During an interview on 2/20/15 at 9:20 AM, the DON stated during a HHA supervisory visit, the RN is expected to review the HHA care plan with the patient to ensure the HHA completed all tasks as ordered. The DON reviewed Patient #13's record and confirmed the HHA did not complete all tasks as ordered. Additionally, she confirmed the 4 Aide Supervision Sheets completed by the RN did not accurately reflect the performance of the HHA. The agency failed to ensure the Patient #13's HHA was supervised to ensure he received HHA services as ordered.	G 229			
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and	G 236			

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G 236	<p>Continued From page 90</p> <p>current findings in accordance with accepted 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.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and staff interview it was determined the agency failed to ensure medical records contained complete and accurate documentation for 3 of 14 patients (Patients #3, #12, and #14) whose records were reviewed. This failure had the potential to interfere with clarity of the record and impede coordination and safety of patient care. Findings include:</p> <p>1. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>a. Patient #3's record included physician orders for home health services, dated 4/24/14. The orders included "Social Work for home safety."</p> <p>Patient #3's record included an MSW visit note, dated 4/30/14, and signed by the MSW. The note documented the purpose of the visit was "Safety issues in home." The visit note stated "Patient is</p>	G 236	<p>Action: Education provided to Nursing and therapy regarding the need to notify the MD of the availability of a DC summary when a client is transferred to an inpatient facility. HHA was not utilizing the back page of the current TIF assessment. This area will be filled out with every TIF and sent to the MD for review regardless of the location of transfer. See also G164</p> <p>Description: This will ensure that MD is notified of a TIF/DC.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: Therapy manager will ensure proper follow up on all therapy transfers. DPS or ADPS will ensure follow up on all Nursing transfers.</p>		

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G 236	<p>Continued From page 91</p> <p>now living with her daughter, so safety issues not relevant." The note did not include documentation of a home safety assessment, such as, a description of the home, including the presence of steps, fall hazards, electrical or fire hazards, presence of others in the home that may pose a safety risk, etc.</p> <p>Patient #3's record included an SN SOC assessment, completed on 4/28/14, and signed by the RN. The note stated Patient #3 was bathing on her own, but should have help due to weakness. There was no documentation by the MSW as to whether the help needed was available.</p> <p>During an interview on 2/20/15 at 11:30 AM, the MSW stated Patient #3's house was fine and her family was involved. He did not recall communicating with Patient #3's RN regarding her status or safety needs. He stated if he had communicated with her he would have documented the conversations in his note.</p> <p>The MSW visit note did not include sufficient information to verify the absence of safety issues.</p> <p>b. Patient #3's record included a "Transfer to Inpatient Facility" note dated 5/12/14, and signed by the RN. The note documented Patient #3 was admitted to a hospital on 5/11/14. Additionally, the note documented Patient #3's son informed the RN the family was planning admission to a nursing home following her discharge from the hospital.</p> <p>Patient #3's record included a "Notification of Changes" form dated 5/11/14, and signed by the Medical Records Director. The form documented</p>	G 236			

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G 236	<p>Continued From page 92</p> <p>Patient #3 was hospitalized. However, there was no discharge summary included in Patient #3's record.</p> <p>During an interview on 2/20/15 at 9:30 AM, the DON reviewed the record and confirmed Patient #3's record did not include a discharge</p> <p>The agency failed to complete a discharge summary for Patient #3. discharge.</p> <p>2. Patient #14 was a 21 day old female admitted to the agency on 10/16/14, for SN services. Diagnoses included non-healing surgical wound, spina bifida, neurogenic bladder, disturbance of skin sensation, and loss of weight. Patient #14's record, including the POC, for the certification period 10/16/14 to 12/14/14, was reviewed.</p> <p>Patient #14's record included a discharge summary note which indicated it was partially filled out on 10/30/14, by the Assistant to the DON, who was also an RN. The discharge summary documented Patient #14 was transferred to a hospital and discharged from the home health agency the same day.</p> <p>The discharge summary form was not completed and the RN who filled out the form did not sign or date the form.</p> <p>During an interview on 2/19/15 at 1:20 PM, the RN who completed the SN visits stated the Assistant to the DON was responsible for transfer and discharge summaries.</p> <p>During an interview on 2/19/15 at 1:50 PM, the Assistant to the DON confirmed she had entered the information about Patient #14 for the</p>	G 236		

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G 236	<p>Continued From page 93</p> <p>discharge summary note. She confirmed It was not completed, but could not recall why it was not completed.</p> <p>Patient #14's record did not include a completed discharge summary.</p> <p>3. Patient #12 was a 67 year old male admitted to the agency on 1/02/15, for SN, PT, and OT services. Diagnoses included end stage renal disease, DM Type II, polyneuropathy, myalgia and myositis, anemia, esophageal reflux, BPH, osteoarthritis, and dysphagia. Patient #12's record, including the POC, for the certification period 1/02/15 to 3/02/15, was reviewed.</p> <p>Patient #12's record included a "Transfer to Inpatient Facility" note dated 1/13/15, and signed by the Therapy Director. The note documented Patient #12 was admitted to a hospital on 1/08/15 and discharged from the agency.</p> <p>Patient #12's record included a "Notification of Changes" form dated 1/09/15, and signed by the Medical Records Director. The form documented Patient #12 was hospitalized and his therapists were informed by the office staff via phone.</p> <p>Patient #12's record did not state his physician was informed of his discharge. Additionally, there was no discharge summary included in the record.</p> <p>During an interview on 2/20/15 at 10:50 AM, the Therapy Director reviewed the record and confirmed there was no documentation in the record Patient #12's physician was notified of the hospitalization or discharge. She further confirmed she did not complete a discharge</p>	G 236		

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G 236	Continued From page 94 summary.	G 236			
G 238	<p>Patient #12's record did not include a completed discharge summary.</p> <p>484.48(a) RETENTION OF RECORDS</p> <p>If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patient medical information was provided to a medical facility for 5 of 5 (#1, #2, #5, #12, and #14) patients whose records were reviewed for transfer of patient records. This had the potential to result in insufficient medical information for the receiving facility to fully assess and treat the patient. Findings include:</p> <p>1. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His medical record, including the POCs for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>Patient #2's record included a TIF, dated 1/20/15, which indicated he was transferred to a hospital on 1/16/15. There was no documentation the agency sent a copy of the record or abstract with Patient #2.</p> <p>Patient #2's record included a "Notification of Changes" form dated 1/15/15, and signed by the</p>	G 238	<p>Action: Educated Skilled nursing and therapy staff on the need to send information regarding the current Plan of Care to the receiving facility when a patient transfers to an inpatient facility. Updated policy MP-14 (see attached) to support the above education.</p> <p>Description: This will ensure continuity of care.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: Therapy manager will ensure proper follow up on all therapy transfers. DPS or ADPS will ensure proper follow up on all Nursing transfers.</p>		

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G 238	<p>Continued From page 95</p> <p>Medical Records Director. The form documented Patient #2 was hospitalized and his therapists were informed by home health office staff via a phone call.</p> <p>During an interview on 2/20/15 at 8:30 AM, the DON reviewed the record and confirmed a discharge summary was not sent with Patient #2 to the receiving hospital.</p> <p>The agency failed to provide a transfer summary or copy of Patient #2's record to the receiving facility.</p> <p>2. Patient #1 was a 32 year old male admitted to the agency on 10/06/14, for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His medical record, including the POC, for the certification period 10/06/14 to 12/04/14, was reviewed.</p> <p>Patient #1's record included a TIF, dated 10/16/14, which indicated he was transferred to a hospital on 10/13/14. The RN documented Patient #1's roommate had called her stating Patient #1 was incoherent that morning. Patient #1's roommate had taken him to the emergency room where he was admitted to the critical care unit. There was no documentation the agency sent a copy of the record or abstract with Patient #1.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN reviewed the record and confirmed she did not send a copy of his record to the receiving hospital.</p> <p>The agency failed to provide a discharge summary or copy of Patient #1's record to the</p>	G 238			

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G 238	<p>Continued From page 96 receiving facility.</p> <p>3. Patient #5 was a 67 year old female admitted to the agency on 1/06/15, for SN services related to wound care. Her medical record, including the POC, for the certification period 1/06/15 to 3/06/15, were reviewed.</p> <p>Patient #5's record included a TIF, dated 1/21/15, which indicated she was transferred to an inpatient facility on 1/19/15. There was no documentation the agency sent a copy of the record or abstract with Patient #5.</p> <p>During an interview on 2/18/15 at 3:40 PM, the DON reviewed the record and stated the discharge summary on the last page of the TIF was not completed because it is not required by the agency. She confirmed a discharge summary or copy of the record was not sent to the receiving facility.</p> <p>The agency failed to provide a discharge summary or copy of Patient #5's record to the receiving facility.</p> <p>4. Patient #12 was a 67 year old male admitted to the agency on 1/02/15, for SN, PT, and OT services. Diagnoses included end stage renal disease, DM Type II, polyneuropathy, myalgia and myositis, anemia, esophageal reflux, BPH, osteoarthritis, and dysphagia. Patient #12's record, including the POC, for the certification period 1/02/15 to 3/02/15, was reviewed.</p> <p>Patient #12's record included a "Transfer to Inpatient Facility" note dated 1/13/15, and signed by the Therapy Director. The note documented Patient #12 was admitted to a hospital on</p>	G 238			

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G 238	<p>Continued From page 97 1/08/15.</p> <p>Patient #12's record included a "Notification of Changes" form dated 1/09/15, and signed by the Medical Records Director. The form documented his therapists were informed via a phone call.</p> <p>No documentation was found in Patient #12's record indicating a copy of his record, or a summary of his care, was sent to the receiving hospital.</p> <p>During an interview on 2/20/15 at 10:50 AM, the Therapy Director reviewed the record and confirmed there was no documentation a copy of Patient #12's record was sent to the hospital.</p> <p>The agency failed to provide medical information to the hospital after Patient #12's transfer.</p> <p>5. Patient #14 was a 21 day old female admitted to the agency on 10/16/14, for SN services. Diagnoses included non-healing surgical wound, spina bifida, neurogenic bladder, disturbance of skin sensation, and loss of weight. Patient #14's record, including the POC, for the certification period 10/16/14 to 12/14/14, was reviewed.</p> <p>Patient #14's record included a discharge summary note which indicated it was filled out on 10/30/14, by the Assistant to the DON, who was also an RN. The discharge summary documented Patient #14 was transferred to a hospital and discharged from the home health agency the same day.</p> <p>The discharge summary form was not completed. The RN did not sign or date the form. There was no documentation in Patient #14's record to</p>	G 238			

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G 238	Continued From page 98 Indicate a copy of her record or summary of care was sent to the receiving hospital. During an interview on 2/19/15 at 1:20 PM, the RN who completed the SN visits stated she was unaware who completed discharge summaries at the agency. The RN confirmed she did not send information to the receiving hospital. During an interview on 2/19/15 at 1:50 PM, the Assistant to the DON confirmed she had entered the information about Patient #14 for the discharge summary note. She confirmed it was not completed. The Assistant to the DON confirmed she did not send a summary of care or copy of the record to the receiving hospital.	G 238			
G 242	484.52 EVALUATION OF THE AGENCY'S PROGRAM This CONDITION is not met as evidenced by: Based on review of agency policies, administrative documentation, meeting minutes, and staff interview, it was determined the agency failed to ensure an evaluation of the its program was conducted. This resulted in the inability of the agency to evaluate patient care services and generate changes to improve the delivery of those services. Findings include: 1. Refer to G245 as it relates to the agency's failure to ensure an annual evaluation was performed to assess the extent to which the	G 242			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2015
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 16TH STREET FRUITLAND, ID 83619		
(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 242	Continued From page 99 agency's program was appropriate, adequate, effective and efficient.	G 242	Refer to G 245		
	2. Refer to G249 as it relates to the agency's failure to ensure mechanisms were established in writing for the collection of data for the evaluation.		Refer to G 249		
G 245	The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to determine whether the services it provided were of adequate quality. 484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by: Based on review of agency policies, meeting minutes, quality assurance documentation, and staff interview, it was determined the agency failed to ensure an annual evaluation was performed to assess the extent to which the agency's program was appropriate, adequate, effective and efficient. This failure had the potential to result in missed opportunities to streamline services and improve patient care. Findings include: The agency's "Quality Assurance Performance Improvement" policy, effective August 2012, stated data regarding the effectiveness of the agency program is collected, compiled, and analyzed on a monthly basis. The performance measurement data is submitted to the Board of	G 245	G245 Action: QI/QM program re-evaluated for completeness. Agenda for the PAC review was generated. TIF report added to the PIMEP. All infections, falls, and skin breakdown will be reviewed each month. Quarterly audits will include review of Deyta information available at the time of pulling the report. All tools used to generate QI/QM will be kept in the QI/QM binder. Description: This action will ensure that all items are addressed on a monthly basis as well as quarterly and annually. And that the information supporting the percentages is available for review. Compliance Date: April 20, 2015 Monitoring: Director of Professional services will lead the QI/QM meeting to ensure that all areas are documented. DPS will generate report for annual governing body review.		

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G 245	<p>Continued From page 100</p> <p>Directors for review and evaluation at least annually and more often if necessary.</p> <p>Professional Advisory Group meeting minutes for calendar years 2013, and 2014, and Governing Body meeting minutes for the calendar year 2014, were reviewed. Quality assurance documentation for the calendar year 2014 was reviewed. There was no documentation that an annual agency evaluation was conducted.</p> <p>The DON provided a copy of worksheets titled "PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN" (PIMEP). She stated much of the data obtained for the reports are from patient medical record audits. She stated additional information was from patient survey response obtained from DEYTA (a data collection and quality improvement software system) reports, and phone calls to patients by an office manager.</p> <p>The PIMEP included data results for 9 "Priority Focus Areas," (PFA). They were identified as Infection Control, Patient Satisfaction, Skin Breakdown, Reconciliation of Medications, Drug Reactions, Medication Errors, Start of Care within 48 hours, Pain Management, and Fall Risk Assessment.</p> <p>1. The Performance Measure/Outcome for Infection Control on the PIMEP worksheet included:</p> <p>a. Priority Focus Area (PFA) of "CDC Hand Hygeine Guidelines and Standard Precautions will be adhered to by all staff." The benchmark/goal was 100%. The agency data worksheet indicated the agency met the goal of</p>	G 245			

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G 245	<p>Continued From page 101 100% for each month in 2014.</p> <p>The DON stated the data was derived from patient chart audits, however she was unable to produce documentation to support the results of 100% noted on the worksheet.</p> <p>b. PFA of "Does your nurse/aide/therapist wash their hands or use hand sanitizer while in your home?" The benchmark/goal was 100%. The agency data worksheet indicated the patient phone calls resulted in a range of 12-94% "yes" response over 12 months, and 0-9% "no" responses over 12 months.</p> <p>The DON stated the worksheets were not easy for her to understand, and she thought there might be a more effective way to obtain data. She stated she did not have the supportive data that included the actual gathering of information for the worksheet performance results.</p> <p>2. The Performance Measure/Outcome for Start of Care within 48 hours of referral on the PIMEP worksheet included a benchmark/goal of 100%. The agency data worksheet indicated the agency met the goal with results of 100% for each month in 2014. However, record review of 14 randomly selected records during the survey found 4 patients with a SOC greater than 48 hours. For details, refer to G332 as it relates to the agency's failure to ensure initial patient assessments were completed within 48 hours.</p> <p>The DON was interviewed on 2/20/15 at 9:30 AM. She reviewed patient records and confirmed the delay in SOC assessments. She was unable to provide documentation to support the data obtained for the PIMEP worksheet.</p>	G 245			

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G 245	Continued From page 102 3. The Performance Measure/Outcome for Medication Reconciliation on the worksheet included a benchmark/goal of 100%. The agency data worksheet indicated the agency met the goal with results of 100% for each month of 2014. During the above interview with the DON, she was unable to provide documentation to support the findings of 100% compliance for medication reconciliation. She stated the data was obtained from patient record review. Additionally, she stated the individual who was assigned to contact patients for survey, asked the patients or family members if the nurse or therapist asked them about medication changes. She was unable to provide documentation of the collected information. Record review of 14 randomly selected records during the survey found 10 patient records with incomplete and/or erroneous medication review assessment. For details refer to G337 as it relates to the failure of the agency to ensure patients' medication reviews were thoroughly completed. The DON was interviewed on 2/20/15 at 9:30 AM. She stated the Professional Advisory Group meetings in 2014 did not discuss the results documented on the PIMEP worksheets, and confirmed the agency had not conducted an annual evaluation of the agency using the PIMEP worksheet data to assess the appropriateness, adequacy, effectiveness, and efficiency of the program. The agency failed to complete a comprehensive agency evaluation.	G 245		
G 249	484.52(a) POLICY AND ADMINISTRATIVE	G 249		

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G 249	<p>Continued From page 103 REVIEW</p> <p>Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.</p> <p>This STANDARD is not met as evidenced by: Based on review of agency policies, quality assurance documentation, and staff interview, it was determined the agency failed to ensure mechanisms were established in writing for the collection of data for the evaluation. This resulted in a lack of guidance to staff conducting the evaluation. Findings include:</p> <p>The agency's "Quality Assurance Performance Improvement" policy, effective August 2012, stated data regarding the effectiveness of the agency program is collected, compiled, and analyzed on a monthly basis. The performance measurement data is submitted to the Board of Directors for review and evaluation at least annually and more often if necessary.</p> <p>Professional Advisory Group meeting minutes for calendar years 2013, and 2014, and Governing Body meeting minutes for the calendar year 2014, were reviewed. Quality assurance documentation for calendar year 2014 was reviewed. There was no documentation that an annual agency evaluation was conducted. The policy did not specify which forms to use or how quality indicators would be evaluated.</p> <p>The lack of specificity led to unclear objectives. For example, the above policy stated both internal and external data sources may be used to monitor and assess home health services for quality of health care, however, there was no</p>	G 249	<p>G249 Action: HHA will continue to use the Quality Assurance survey performed within 2 weeks admission to evaluate for handwashing. We will also utilize infection reports, incident reports, and random 20% chart review to collect our data as discussed during interview. HHA will begin keeping the documents that are used to collect the data for analysis. All incidents, infections, skin breakdowns and TIFs will be reviewed and not subject to random audit. Percentages will be generated from this data.</p> <p>Description: This will ensure that all supporting documentation used to generate percentages will be available to support the data collected.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: DPS will collect all data and supporting documentation use to generate percentages and place in QI/QM binder.</p>		

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G 249	Continued From page 104 method to show how the information would be measured, analyzed and reported. The DON was interviewed on 2/20/15 beginning at 9:30 AM. She stated she took over the responsibility for data collection about 6 months ago, and she was unfamiliar with the worksheet the agency used for data collection. She was unable to demonstrate or explain how data was obtained, and how the information was used for program evaluation.	G 249			
G 332	Mechanisms were not established to guide the agency's annual evaluation. 484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on review of agency policies, patient medical records, and staff interview, it was determined the agency failed to ensure the initial patient assessment was performed within 48 hours from physician referral for 4 of 12 patients (#1, #3, #8 and #10) whose records were reviewed for SOC assessments. This had the potential to result in unmet patient needs. Findings include: An agency policy titled "Acceptance and Assignment," effective 11/93, stated "Patient's eligibility for services by a Care at Home discipline will be evaluated in a timely manner: Skilled nursing within 48 hours of the referral, unless otherwise specified by the referral source."	G 332			

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G 332	<p>Continued From page 105</p> <p>Additionally, the policy stated "Physical therapists, speech pathologists, occupational therapists, medical social workers, and home health aides within 48 hours unless otherwise specified by the referral source."</p> <p>The policy did not include postponement of admissions due to lack of weekend staff.</p> <p>1. Patient #1 was a 32 year old male admitted to the agency on 10/06/14, for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His record included a referral from the hospital. The referral had a fax time stamp indicating it was received by the agency on 10/03/14 at 11:52 AM. His record also included an "Intake/Referral Form," which documented the RN and Physical Therapist were notified on 10/03/14, and planned SOC for 10/05/14.</p> <p>Patient #1's SOC comprehensive assessment was completed 10/06/14. The reason the SOC assessment was delayed 3 days was not documented. Additionally, the record did not include documentation of physician approval of the delayed SOC.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN who performed the SOC assessment reviewed Patient #1's record and confirmed the assessment was performed 3 days after the referral was received. She stated the Caldwell branch of the agency is closed on weekends, and admissions are delayed until Monday. She stated the individual that takes the referral information on a Friday usually asks the hospital discharge planner or the patient if it is okay to wait until Monday to admit the patient.</p>	G 332	<p>G332</p> <p>Action: Policy AP-05 was adjusted to cover the notification to MD if SOC will be greater than the 48 hours time frame. See Also G157</p> <p>Description: This will ensure that proper procedure is followed for a delay in the SOC.</p> <p>Compliance Date: April 20, 2015</p> <p>Monitoring: Same process as G157</p>	

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G 332	<p>Continued From page 106</p> <p>Patient #1's assessment was not completed until 3 days after the physician referral.</p> <p>2. Patient #10 was a 75 year old female admitted to the agency on 1/20/15, for SN, PT, OT, and HHA services related to cellulitis, malaise and fatigue, and HTN. Her record included a referral from the rehabilitation facility she was discharged from. The referral was dated 1/16/15. Her record also included an "Intake/Referral Form," which documented the RN, Physical Therapist, and Occupational Therapist were notified. The referral indicated Patient #1 was to be discharged from the facility on 1/16/15.</p> <p>Patient #10's SOC comprehensive assessment was completed on 1/20/15. The reason the SOC assessment was delayed 4 days was not documented. Additionally, the record did not include documentation a physician authorized the delay.</p> <p>During an interview on 2/20/15 at 12:35 PM, the RN who completed the SOC assessment reviewed Patient #10's record and confirmed the SOC assessment was 4 days after the referral was received. She confirmed the referral was received on a Friday, and the SOC was on a Tuesday, however, a reason the for the delay was not provided.</p> <p>Patient #10's SOC assessment was not completed until 4 days after the referral date.</p> <p>3. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She</p>	G 332			

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G 332	<p>Continued From page 107</p> <p>received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>Patient #3's record included an Intake/Referral form. The form stated the order for home health services was received from the hospital on Friday, 4/25/14. The form also stated Patient #3 was discharged from the hospital on 4/25/14.</p> <p>Patient #3's record included physician orders for home health services, signed by the physician on 4/25/14. The fax date stamp indicated the orders were faxed from the hospital to the agency on 4/25/14.</p> <p>Patient #3's record included a SOC assessment, signed by the RN and dated 4/28/14, 3 days after the order was received.</p> <p>During an interview on 2/20/15 at 8:15 AM, the DON confirmed the SOC assessment was completed 3 days after the referral and physician's order were received. She stated the agency did not always have an RN to do visits on weekends, therefore, when a referral was received on a Friday, the agency would have the referral source ask the physician if the SOC could be delayed until Monday. The DON confirmed there was no documentation in Patient #3's record stating her physician had authorized a delay in the SOC.</p> <p>Patient #3's SOC assessment was not completed until 3 days after the physician ordered SOC.</p> <p>4. Patient #8 was an 86 year old male admitted to the agency on 2/10/15, for PT and OT services. Diagnoses included care involving rehabilitation</p>	G 332			

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G 332	Continued From page 108 services, muscle weakness, Alzheimer's disease, dementia, dysphagia, esophageal reflux, coronary atherosclerosis, myocardial infarction, and anxiety. Patient #8's record, including the POC for the certification period 2/10/15 to 4/10/15, was reviewed. Patient #8's record included an Intake/Referral form dated 2/06/15, and signed by the Medical Records Director. The SOC assessment note, dated 2/10/15, signed by the RN, documented the SOC assessment was delayed 4 days due to the spouse's request. There was no documentation the physician was notified of, and authorized, the request for a delayed SOC visit. During an interview on 2/20/15 at 8:20 AM, the DON reviewed the record and confirmed Patient #8's SOC assessment was delayed per the spouse's request. She confirmed the RN did not notify the physician of the delayed initial visit. Patient #8's initial assessment visit was completed greater than 48 hours after the referral was received.	G 332			
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:	G 337			

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G 337	<p>Continued From page 109</p> <p>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 and non-compliance with drug therapy for 9 of 14 patients, (#1, #2, #3, #5, #6, #7, #9, #10 and #12) whose records were reviewed. This resulted in the potential for patients to experience adverse outcomes related to medications. Findings include:</p> <p>During an interview with the DON and Administrator on 2/17/15 beginning at 8:45 AM, the Administrator stated a comprehensive drug review was conducted for each patient during the SOC assessment. She stated during each nursing or therapy visit the staff also asked the patient if any medication changes had occurred. Additionally, during the interview, the Administrator stated after the SOC, patient medications were entered into the agency software program by the Medical Records Clerk. If interactions, contraindications, or duplicative therapy was noted, the clerk sent notification to the physician.</p> <p>An agency policy titled "Drug Regimen Review Protocol," effective date March 2010, stated during the SOC visit, the RN listed all medications the patient was currently taking. The RN then identified any clinically significant medication issues, such as ineffective drug therapy, drug interactions, duplicate therapy, dosage errors, non-compliance, or side effects. The nurse was to notify the physician within one calendar day to resolve any medication issues that were</p>	G 337	<p>G337</p> <p>Action: Care at Home policy MP-20 was updated and reviewed with all nursing staff to ensure proper Drug regimen review. This policy is included in the orientation manual. New process will be that medications list will be returned to the office after the open is performed so the medications can be entered into the computer by DPS, ADPS, or Medical records professional and interaction reports can be generated and sent to MD upon discovery of interactions. Interaction reports will be printed and given to Case Manager as well as sent to MD for review of all contraindications and major interactions.</p> <p>Description: This education and policy change will ensure that a proper review is completed during the SOC and that medication interactions are addressed within appropriate time frame.</p> <p>Compliance date: April 20, 2015</p> <p>Monitoring: DPS and ADPS will monitor all opens to ensure that the medication list is reviewed during the open and returned to the office the day of the Start of Care. ADPS or DPS will review interaction reports and send to MD.</p>		

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G 337	<p>Continued From page 110</p> <p>Identified. Additionally, the policy noted the RN provided education related to high-risk medications such as hypoglycemic, narcotics, and anticoagulants, etc. This policy was not followed. Examples include:</p> <p>1. Patient #3 was a 67 year old female admitted to the agency on 4/28/14, for care related to uncontrolled diabetes. Additional diagnoses included liver cancer and acute pancreatitis. She received SN, PT and MSW services. Her record, including the POC, for the certification period 4/28/14 to 6/26/14, was reviewed.</p> <p>a. The agency's SOC assessment included a drug regimen review that asked, "Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?" Patient #3's SOC assessment, dated 4/28/14, signed by the RN Case Manager, documented the answer as "No problems found during review." The answer was inaccurate, as follows:</p> <p>- Patient information and physician orders were faxed to the agency on 4/25/14. The faxed information stated Patient #3 had been admitted to the hospital on 4/21/14, due to a blood glucose level of 600 mg/dl. Patient #3's medication orders, received from the hospital at the time of her discharge on 4/25/14, included Lantus insulin 10 units, daily at bedtime. The SOC assessment completed on 4/28/14, documented Patient #3 had not obtained Lantus insulin. This was noted on the SOC assessment.</p> <p>- Patient #3's SOC assessment was completed</p>	G 337		

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G 337	<p>Continued From page 111</p> <p>4/28/14, 3 days after her discharge from the hospital. She had failed to obtain insulin, to be taken daily per physician orders. The medication non-compliance was identified on the SOC assessment.</p> <p>- On 2/19/15, the Medical Records Director entered Patient #3's medications into the agency software program, and an interaction report was generated. The report identified 4 major medication interactions.</p> <p>Patient #3's SOC assessment documented her physician was not notified of the omission, non-compliance or drug interactions.</p> <p>During an interview on 2/19/15 at 3:10 PM, the RN confirmed she did not contact the physician after the SOC assessment to tell him Patient #3 had not obtained her insulin. Additionally, she stated patient medications were checked for interactions by the office and she was not aware of major interactions between Patient #3's medications.</p> <p>b. Patient #3's record documented she was hospitalized from 5/04/14 to 5/06/14. Patient #3's record included information from the hospital stating her blood glucose level was 600 mg/dl on arrival. Her record included a resumption of care assessment, completed 5/07/14, and signed by the RN. Patient #3's POC was updated at the time of the assessment. The medication review completed with the assessment was incomplete, as follows:</p> <p>- Patient #3's record included discharge instructions, dated 5/06/14, faxed to the agency from the hospital. The discharge medication</p>	G 337			

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G 337	<p>Continued From page 112</p> <p>Included Novolog insulin to be taken 3 times a day, on a sliding scale basis (dosage based on blood glucose level as measured by a blood glucose monitor.) Patient #3's updated POC effective 5/06/14, included "Novolog Insulin, sliding scale, as needed." The resumption of care assesment and POC did not include how often it was to be taken, or how many units of insulin should be taken, based on the blood glucose result.</p> <p>-Patient #3's updated POC and medication profile included the medications as listed on her discharge instructions. Citalopram was not included on the list, however, the SOC assessment documented Patient #3 had Citalopram. The note did not document Patient #3's physician was contacted to determine if she was to take Citalopram.</p> <p>-Patient #3's record included an SN visit note, dated 5/09/14, and signed by the RN. It documented Patient #3 was educated on Protonix (used to treat excess stomach acid) and Nystatin (used to treat fungal infections.) Protonix and Nystatin were not included on Patient #3's updated POC or medication profile. Her record did not document her physician was contacted to determine if she was to take these medications.</p> <p>During an interview on 2/19/15 at 3:10 PM, the RN who completed the resumption of care assessment confirmed Patient #3's updated POC did not include the frequency or insulin doses for her sliding scale insulin. She stated she did not know what medications were included on Patient #3's updated POC as the POC was created in the office and she was unsure if she had seen it.</p>	G 337			

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G 337	<p>Continued From page 113</p> <p>During an interview on 2/19/15 at 5:10 PM, the DON reviewed Patient #3's record, and confirmed the sliding scale insulin order did not include frequency or doses of insulin. Additionally, she confirmed Protonix and Nystatin were not included on Patient #3's updated POC. She stated she was unsure if Patient #3 was to be taking them or not.</p> <p>Patient #3's POC and medication profile were not accurate to reflect the medications she was taking. Additionally, Patient #3's medications were not reconciled with her physician to ensure she was taking her medications as ordered.</p> <p>2. Patient #1 was a 32 year old male admitted to the agency on 10/06/14, for SN and PT services related to ESRD, Diabetes Type I, major depression, and chronic pain. His medical record, including the POC, for the certification period 10/06/14 to 12/04/14, was reviewed.</p> <p>a. The SOC assessment, dated 10/16/14, stated no problems were found during the medication review. On 2/19/15, the Medical Records Director entered Patient #1's medications into the agency software program and an medication interaction report was generated. The report identified 7 major interactions, 8 moderate interactions, and 2 contraindicated medication combinations of Reglan and Prozac, as well as, Reglan and Phenergan when used concurrently.</p> <p>One of the major interactions noted was between Coumadin and Prozac. When used concurrently, they may increase the risk of bleeding.</p> <p>The SOC assessment was not completed accurately.</p>	G 337			

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G 337	<p>Continued From page 114</p> <p>b. Patient #1's POC included orders for blood glucose management and education. His POC included Humalog insulin to be given on a sliding scale (dosage based on blood glucose level as measured by a blood glucose monitor.) The orders stated the slding scale insulin was to be taken 4 times a day, at meals and bedtime.</p> <p>A nursing intervention note, dated 10/13/14, signed by the RN, documented Patient #1 did not have a blood glucose monitor to check his blood sugar levels. The note did not state how often Patient #1 was taking insulin, or how he would determine how much insulin to take without a monitor to measure his blood glucose level. Additionally, there was no documentation that Patient #1 was educated on the importance of monitoring his blood sugar and taking insulin as ordered.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN who completed the SOC assessment confirmed she documented no problems were found during the medication review. She indicated she rarely received an alert regarding medication interactions from the office staff who entered the medications into the computer program. The RN confirmed Patient #1 did not have a blood glucose monitor in his home. She stated she sent an interim order for the blood glucose monitor to his physician on 10/10/14, but it was not signed prior to the 10/13/14 visit.</p> <p>Patient #1's POC and medication profile did not accurately reflect medication discrepancies.</p> <p>3. Patient #2 was an 82 year old male who was admitted to the agency on 12/31/14, and again</p>	G 337			

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G 337	<p>Continued From page 115</p> <p>after a brief hospitalization, on 1/29/15. He received SN and PT services related to CHF, COPD, and HTN. His medical record, including the POCs, for the certification periods 12/31/14 to 2/28/15, and 1/29/15 to 3/29/15, were reviewed.</p> <p>A SOC assessment was completed on 1/29/15, and signed by the RN. The RN documented the medications Patient #2 was taking at home. The medications documented on the SOC assessment were compared with those on the POC for certification period 1/29/15 - 3/29/15. The following discrepancies were noted:</p> <ul style="list-style-type: none"> - The POC listed Pravastatin 40 mg, 2 tabs daily. However, on the SOC assessment it was listed as Pravastatin 40 mg daily. - The POC listed Docusate 100 mg, 1 cap twice daily. However, the SOC assessment stated it was to be taken only as needed. <p>During an interview on 2/19/15 at 1:30 PM, the RN who completed the SOC assessment confirmed she had written down the medications from the discharge paperwork the hospital had sent with the referral to the agency. She confirmed the Lasix was increased on 2/04/15, but did not know why the Pravastatin dose was incorrect on the POC.</p> <p>Patient #2's POC and medication profile were not accurate to reflect the medications he was taking. Additionally, his medications were not reviewed to identify discrepancies.</p> <p>4. Patient #10 was a 75 year old female admitted to the agency on 1/20/15, for SN, PT, OT, and HHA services related to cellulitis, malaise and</p>	G 337			

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G 337	<p>Continued From page 116 fatigue, and HTN. Her medical record, including the POC, for the certification period 1/20/15 to 3/20/15, was reviewed.</p> <p>During a home visit, on 2/19/15 beginning at 10:30 AM, the caregiver for Patient #10 brought out a plastic bin with Patient #10's name on it. She stated all of Patient #10's medications were stored in the bin. The medications were compared with those included on Patient #10's POC. The following discrepancies were noted:</p> <p>a. The POC included medications that were of different dosages, or that Patient #10 was not taking, or not taking as ordered:</p> <ul style="list-style-type: none"> - The POC included Clindamycin 150 mg, 3 tablets, three times daily, for 21 days. The POC did not include start or stop dates for the Clindamycin. The caregiver stated Patient #10 has been living in her residence since September, and she has not been on Clindamycin during that time. -The POC included Prilosec 20 mg, daily, however, the caregiver stated Patient #10 has not taken that medication since before September. - The POC included Senokot, 2 tablets daily, the caregiver stated Patient #10 did not take that medication. - The POC included Folic Acid, 1 mg daily, however, the caregiver stated Patient #10 did not take that medication. -The POC included Fish Oil, 1000 mg, 1 capsule daily, however the bottle indicated it was 1200 mg, and the caregiver stated Patient #10 took 2 	G 337			

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G 337	<p>Continued From page 117</p> <p>capsules in the morning and 2 capsules at night. The dose on the POC was 1000 mg daily, versus 4800 mg daily which she was taking.</p> <p>b. The caregiver stated Patient #10 was taking the following medications which were in the bin, however, they were not included on her POC.</p> <ul style="list-style-type: none"> - Albuterol Nebulizer treatments, 3-4 times daily - Lovastatin, 20 mg daily - Alendronate (Fosamax) 70 mg, once weekly - Gabapentin 300 mg, 2 tablets each evening - Calcium, 600 mg, 2 tablets each morning, and 1 tablet each evening - Tylenol, 500 mg, 1 tablet twice daily <p>c. On the SOC assessment, dated 1/20/15, stated no problems were found during the medication review. On 2/19/15, the Medical Records Director entered Patient #10's medications into the agency software program, and an interaction report was generated. The report identified 7 major medication interactions, and 1 contraindicated medication combination of Norco and Duoneb when used concurrently.</p> <p>One of the major interactions noted was between Fish Oil and Warfarin. When used concurrently, they may increase the risk of bleeding. Patient #10 was taking 4800 mg of Fish Oil daily, however, 1000 mg was ordered on her POC.</p> <p>During an interview on 2/19/15 beginning at 1:30 PM, the RN stated she bought a drug information book and referred to it when checking for medication interactions. She stated she was not aware the agency had a software program to identify medication interactions, and contraindications. Additionally, stated she did not</p>	G 337			

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G 337	<p>Continued From page 118</p> <p>look at Patient #10's medications during the SOC visit. She stated she developed the POC for Patient #10 based on the medication list that was provided with the referral information.</p> <p>Patient #10's POC and medication profile were not accurate to reflect the medications she was taking. Additionally, her medications were not reviewed to identify discrepancies.</p> <p>5. Patient #5 was a 67 year old female admitted to the agency on 1/06/15, for SN services related to wound care. Her medical record, including the POC, for the certification period 1/06/15 to 3/06/15, was reviewed.</p> <p>a. During a home visit on 2/18/15 beginning at 10:30 AM, Patient #5's medications were compared with her POC. Patient #5 was taking the following medications which were not listed on her POC:</p> <ul style="list-style-type: none"> - Glucosamine (Bio-Flex), 1 tablet daily - Calcium, 1 tablet daily - Fish Oil, 1 capsule daily <p>b. On 2/19/15, the DON provided an interaction report after Patient #5's medications were entered into the agency software program, and an interaction report was generated. The report included 1 contraindicated medication combination of Lisinopril and Promethazine, and 6 major interactions of medications listed on her POC.</p> <p>During an interview on 2/19/15 at 2:15 PM, the RN who completed the SOC assessment, reviewed Patient #5's record, and confirmed she was taking medications that were not included on</p>	G 337			

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G 337	<p>Continued From page 119</p> <p>the POC. She stated during each visit she asked patients about additional medications and over the counter supplements they may be taking. The RN stated she did not perform a medication interaction check with Patient #5's medications, and was not aware the agency had a system to check medication interactions.</p> <p>Patient #5's POC and medication profile were not accurate to reflect the medications she was taking. Additionally, her medications were not reviewed to identify discrepancies.</p> <p>6. Patient #6 was an 80 year old male admitted to the agency on 2/04/15, for care related to right shoulder pain. Additional diagnoses included dementia, peripheral neuropathy and diabetes type II. He received SN, PT, OT, HHA and MSW services. His record, including the POC, for the certification period 2/04/15 to 4/04/15, was reviewed.</p> <p>Patient #6's record included a SOC assessment, dated 2/04/15, and signed by the RN. The drug review section of the assessment stated "No problems found during review", indicating clinically significant drug issues were not identified. This response was inaccurate, as noted in the following examples:</p> <p>a. Patient #6's SOC assessment documented Patient #6 was diabetic and used sliding scale insulin (dosage based on blood glucose level as measured by a blood glucose monitor.)</p> <p>Patient #6's record included a POC and medication profile which listed his medications, including dose and frequency. The medication list included Lantus insulin twice daily and</p>	G 337			

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G 337	<p>Continued From page 120</p> <p>Novolog insulin, sliding scale. However, it did not document how many times a day Patient #6 should monitor his blood glucose, how often the sliding scale insulin should be taken, or the amount of insulin to be taken based on the blood glucose test result.</p> <p>Patient #6's record included an MSW evaluation dated 2/05/15, and signed by the MSW. It stated Patient #6 took insulin injections 5 times a day.</p> <p>A visit was made to Patient #6's home on 2/18/15, to observe a PT visit. During the visit, Patient #6's wife stated he checked his blood glucose level and took sliding scale insulin 3 times a day, with meals.</p> <p>During an interview on 2/19/15 at 3:35 PM, the RN who completed the SOC assessment confirmed Patient #6's POC and medication profile did not include frequency or dosage of his sliding scale insulin. She stated she had not confirmed the sliding scale frequency or dosage with Patient #6's physician, however, she thought Patient #6 was to check his blood glucose level and take sliding scale insulin once a day, in the morning.</p> <p>Patient #6's medications were not reconciled with his physician to determine the frequency and dosage of his sliding scale insulin.</p> <p>b. On 2/19/15 the Medical Records Director entered Patient #6's medications into the agency software program, and an interaction report was generated. The report identified 13 major medication interactions, and 2 contraindicated medication combinations. Three of the major interactions noted using the medications</p>	G 337			

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G 337	<p>Continued From page 121 concurrently may increase the risk of bleeding.</p> <p>Documentation Patient #6's physician was informed of the major interactions between his medications was not found in his medical record. Additionally, his record did not include documentation of patient education regarding the medication interactions, including precautions to take, and signs and symptoms of adverse effects to report to the RN or physician.</p> <p>During an interview on 2/19/15 beginning at 3:35 PM, the RN stated she used a drug information book to check for medication interactions. She stated someone in the office entered the medications into the software system and she would be informed of any problems. However, she stated she rarely received a call from the office regarding medication interactions. The RN Case Manager stated she was not informed by the office of drug interactions for Patient #6.</p> <p>Patient #6's her medications were not reviewed to identify discrepancies.</p> <p>7. Patient #7 was an 89 year old female admitted to the agency on 4/18/13, for care related to rheumatoid arthritis. Additional diagnoses included hypertension and glaucoma. She received SN and HHA services. Her record, including the POC, for the certification period 2/07/15 to 4/07/15, was reviewed.</p> <p>Patient #7's record included a recertification assessment, dated 2/05/15, and signed by the RN. The drug review section of the assessment stated "No problems found during review", indicating clinically significant drug issues were not identified. The response was inaccurate, as</p>	G 337			

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G 337	<p>Continued From page 122 follows:</p> <p>a. Based on the assessment Patient #7's POC and medication profile was updated 2/07/15. They included "SUPPOSITORIES daily as needed." However, the POC and medication profile did not state what kind of suppositories she was to take, or the reason she would take them.</p> <p>Patient #7's record did not include documentation of physician contact to clarify the order for suppositories.</p> <p>During an interview on 2/19/15 at 1:45 PM, the DON reviewed Patient #7's record and confirmed the order for suppositories lacked necessary details.</p> <p>b. On 2/19/15, the medical records clerk entered Patient #7's medications into the agency software program, and an interaction report was generated. The report identified 7 major medication interactions.</p> <p>Patient #7's record did not include documentation her physician was informed of the major interactions between her medications. Additionally, documentation of patient education regarding the medication interactions, including precautions to take, and signs and symptoms of adverse effects to report to the RN or physician, was not found in Patient #7's record.</p> <p>During an interview on 2/19/15 at 1:45 PM, the DON confirmed Patient #7's medications were not reviewed for interactions or reconciled with her physician.</p>	G 337			

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

PRINTED: 03/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2015
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 16TH STREET FRUITLAND, ID 83619		
(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)	(X6) COMPLETION DATE	
G 337	<p>Continued From page 123</p> <p>The agency failed to ensure Patient #7's medications were reviewed for completeness and interactions.</p> <p>8. Patient #12 was a 67 year old male admitted to the agency on 1/02/15, for SN, PT, and OT services. Diagnoses included end stage renal disease, DM Type II, polyneuropathy, myalgia and myositis, anemia, esophageal reflux, BPH, osteoarthritis, and dysphagia. Patient #12's record, including the POC for the certification period 1/02/15 to 3/02/15, was reviewed.</p> <p>The SOC assessment was completed on 1/02/15, by the RN. The RN documented problems were found during the medication review and she was unable to contact the physician for reconciliation within 1 calendar day. There was documentation in the record Patient #12's physician was contacted "Monday in the AM." The documentation did not include clarification of the problems identified with the medications, or document whether changes were made to Patient #12's prescribed medications.</p> <p>A Patient Medication List was included in the record, dated 1/14/15, and signed by the Therapy Director. The Therapy Director documented the medication list was reviewed for contraindications. There was no documentation of contraindications on the medication list.</p> <p>During an interview on 2/19/15 at 1:35 PM, the RN who completed the SOC assessment confirmed she documented problems were found during the medication review. She stated Patient #12 was non-compliant with his medications. The RN stated she did not see medication interaction reports for Patient #12. She stated</p>	G 337			

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2015
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 929 NW 16TH STREET FRUITLAND, ID 83619		
(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 124</p> <p>she looked through a nursing drug book to check for any contraindications. The RN stated she was not aware of programs that check medication interactions.</p> <p>Patient #12's medication profile was not reconciled or clarified for problems identified during the medication review.</p> <p>9. Patient #9 was a 55 year old male admitted to the agency on 2/10/15, for PT and OT services. Diagnoses included care involving rehabilitation, hemiplegia left side, chronic airway obstruction, sleep apnea, hypertension, depression, high cholesterol, tobacco use, and peripheral vascular disease. Patient #9's record, including the POC, for the certification period 2/10/15 to 4/10/15, was reviewed.</p> <p>The agency's SOC assessment included a drug regimen review that asked, "Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?" Patient #9's SOC assessment, dated 2/10/15, signed by the RN Case Manager, documented the answer as "No problems found during review." On 2/19/15, the Medical Records Director entered Patient #9's medications into the agency software program, and an interaction report was generated. The report identified 3 major interactions and 3 moderate interactions.</p> <p>One of the major interactions noted was between Clopidogrel and Escitalopram. When used concurrently, they may increase the risk of bleeding.</p>	G 337			

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G 337	Continued From page 125 During an interview on 2/19/15 at 1:35 PM, the RN who completed the SOC assessment confirmed she documented no problems were found during the medication review. The RN stated she looked through a nursing drug book to check for any contraindications. She stated she was not aware of programs that check medication interactions. The RN stated she did not see a medication interaction report for Patient #9. Patient #9's medication profile was not reviewed to identify discrepancies or possible interactions.	G 337			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2015
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho state licensure survey of your home health agency conducted from 2/17/15 to 2/20/15. The surveyors conducting the licensure review were: Laura Thompson, RN, BSN, HFS Team Leader Nancy Bax, RN, BSN, HFS Susan Costa, RN, HFS	N 000		
N 016	03.07020. ADMIN. GOV. BODY N016 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: b. A patient has a right to be informed of his rights and has a right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient's bill of rights will be included in the patient's medical record. This Rule is not met as evidenced by: Refer to G101	N 016	N106 Please see G tag 101. This tag refers to Patients Rights and Responsibilities. All clients are provided a copy of their rights and responsibilities during opening assessment.	
N 039	03.07020. ADMIN.GOV. BODY N039 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following:	N 039		

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2015
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N 039	Continued From page 1 d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: a) The extent to which payment may be expected from third party payors.; and This Rule is not met as evidenced by: Refer to G113	N 039	N039 Please refer to G tag 113. This tag refers to Rights and Responsibilities as related to notification of liability.	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143 and G144	N 062	N062 Please refer to G tag 143 & 144. These tags refer to the need to ensure care coordination among all disciplines.	
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G170	N 091	N091 Please refer to G tag 170. This tag refers to the need for proper Skilled Nursing oversight of the CNA skilled bathing aids.	

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N 094	Continued From page 2	N 094		
N 094	03.07024. SK. NSG. SERV. N094 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G173	N 094	N 094 Please see G tag 173. This tag refers to the need for the Plan of Care to be accurate and updated with clients' condition.	
N 095	03.07024. SK. NSG. SERV. N095 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: c. Provides those services requiring substantial and specialized nursing skill; This Rule is not met as evidenced by: Refer to G174	N 095	N095 Please see G tag 174. This tag refers to the need for proper assessment and wound care, as well as coordination of care.	
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that	N 098		

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N 098	Continued From page 3 all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G176	N 098	N098 Please see G tag 176. This tag refers to the need for coordination of care between the disciplines and the MD.	
N 099	03.07024.SK. NSG. SERV. N099 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: g. Counsels the patient and family in meeting nursing and related needs; This Rule is not met as evidenced by: Refer to G177	N 099	N 099 Please refer to G tag 177. This tag refers to the need to educate both client and caregiver on issues discovered during the assessment.	
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether	N 119	N 119 Please refer to G tag 229. This tag refers to the need for RN oversight of the bath aide, and the proper procedure for performing that oversight.	

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N 119	Continued From page 4 goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G229	N 119		
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G224	N 122	N 122 Please refer to G tag 224. This tag refers to the need for the aide to follow the care plan and ensure the care plan meets the clients' needs.	
N 140	03.07026 SOC.SERV. N140 02. Social Worker. A social worker performs the following duties: b. Participates in the development of the plan of care; This Rule is not met as evidenced by: Refer to G196	N 140	N 140 Please refer to G tag 196. This tag refers to the process of the MSW and the need to follow the reason for admit and to coordinate care.	
N 151	03.07030.PLAN OF CARE N151 030. PLAN OF CARE. Patients are accepted for treatment on the basis of a reasonable expectation that the	N 151	N151 Please refer to G tag 157. This tag refers to the process of accepting clients for services and the process in the event there is a delay in care.	

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NAME OF PROVIDER OR SUPPLIER
CARE AT HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**929 NW 16TH STREET
FRUITLAND, ID 83619**

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N 151	Continued From page 5 patient's medical, nursing, and social needs can be met adequately by the agency in the patient's plan of care. This Rule is not met as evidenced by: Refer to G157	N 151		
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158	N 152	N152 Please refer to G tag 158. This tag refers to the need for all disciplines to have an accurate care plan and coordinate care.	
N 155	03.07030. PLAN OF CARE N155 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: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G159	N 155	N155 Please refer to G tag 159. This tag refers to the need for a complete POC.	
N 170	03.07030.04.PLAN OF CARE	N 170		

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N 170	Continued From page 6 N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to G160	N 170	N 170 Please refer to G tag 160. This tag refers to the need to have proper signatures in place for approval of the POC prior to seeing the patient.	
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164	N 172	N 172 Please refer to G tag 164. This tag refers to the need to promptly alert the MD of changes in a patient.	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337	N 173	N 173 Please refer to G tag 337. This tag refers to the need to alert the MD of missing medications or DME that is vital to diagnosis.	

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N 180	Continued From page 7	N 180		
N 180	<p>03.07031.CLINICAL REC.</p> <p>N180 02. Contents. Clinical records must include:</p> <p style="padding-left: 40px;">f. Signed and dated clinical and progress notes;</p> <p>This Rule is not met as evidenced by: Refer to G236</p>	N 180	<p>N 180</p> <p>Please refer to G tag 236. This tag refers to the need to alert the MD of the availability of a summar in the event the patient is transferred or discharged to another provider.</p>	
N 190	<p>03.07031.07.CLINICAL REC.</p> <p>N190 07. Copies of Records. There must be a means of submitting a copy of the clinical record or an abstract and copy of most recent summary report with the patient in the event of patient transfer to another agency or health care facility.</p> <p>This Rule is not met as evidenced by: Refer to G238</p>	N 190	<p>N 190</p> <p>Please refer to G tag 238. This tag refers to the need to coordinate care with a receiving provider in the event of a TIF.</p>	
N 195	<p>03.07040.02 AGENCY EVAL.</p> <p>N195 02. Evaluation Criteria and Purpose. The evaluation consists of an overall policy and administrative review and a clinical record review and assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient.</p> <p>This Rule is not met as evidenced by: Refer to G245</p>	N 195	<p>N195</p> <p>Please refer to G tag 245. This process refers to the QI/QM, quality assurance process.</p>	