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

Alan Bird, Administrator
Franklin County Medical Center Home Care
44 North 100 East
Preston, Idaho 83263

CMS Certification Number: 13-7058

Re: Notice of Enforcement Action on Franklin County Medical Center Home Care
Recertification survey completed, Conditions of Participation Not Met
Suspension of payments for new admissions if not back in compliance effective 05/04/2015
Termination if not back in compliance effective 09/04/2015

Dear Mr. Bird:

This is to inform you that based on careful review of the findings of the recertification survey conducted at your agency on March 5, 2015 by the Idaho Department of Health and Welfare, Bureau of Facility Standards, the Centers for Medicare and Medicaid Services (CMS) has determined that Franklin County Medical Center Home Care 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 agency 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 March 5, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at your agency and found two 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

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 **May 4, 2015.** This suspension of payment for new admissions also applies to Medicare patients who are members of managed care plans.

If Franklin County Medical Center Home Care fails to meet all home health agency Conditions of Participation, your Medicare provider agreement will be terminated no later than **September 4, 2015.** CMS will publish a legal notice in the local newspaper at least **fifteen days** prior to the termination date.

APPEAL RIGHTS

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

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

A request for a hearing must identify the specific issues, and findings of fact and conclusions of law with which you disagree. Additionally, you must specify the basis for contending that the findings and

conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense.

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

Sincerely,

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

cc: Idaho Bureau of Facility Standards

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

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

March 19, 2015

Alan Bird, Administrator
Franklin County Medical Center Home Care
44 North 100 East
Preston, ID 83263

RE: Franklin County Medical Center Home Care, Provider #137058

Dear Mr. Bird:

Based on the survey completed at Franklin County Medical Center Home Care, on , by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation:**

- **Condition of Participation: Acceptance of Patients, Plan of Care, Medical Supervision (42 CFR 484.18) and**
- **Condition of Participation: Skilled Nursing Services (42 CFR 484.30)**

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

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

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed, on page 1 of **both the state and federal 2567 forms.**

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **April 1, 2015**. It is strongly encouraged that the agency's Credible Allegation/Plan of Correction for each Condition of Participation, and related standard level deficiences, show compliance no later than **April 19,** 45 days from survey exit. We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies complaince.

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 effective **September 5, 2015** (6 Months from exit date) [42 CFR 488.865]
- Suspension of payment for all new Medicare admissions effective **May 4, 2015** (60 days from exit date) [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.

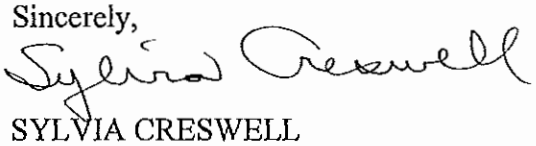
In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal dispute resolution

(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 **April 1, 2015.** If your request for IDR is received after **April 1, 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/pt

Enclosures

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

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

PRINTED: 03/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare Recertification survey of your agency from 3/02/15 to 3/05/15. The surveyors conducting the survey were: Nancy Bax, RN, BSN,HFS, Team Leader Susan Costa, RN, HFS Acronyms used in this report include: A-Fib - Atrial Fibrillation BP - Blood Pressure CHF - Congestive Heart Failure CMS - Centers for Medicare and Medicaid COPD - Chronic Obstructive Pulmonary Disease D/C - discharge DM - Diabetes Mellitus DME - Durable Medical Equipment HHA - Home Health Aide HTN - Hypertension LCSW - Licensed Clinical Social Worker LPN - Licensed Practical Nurse mg - milligrams MSW - Medical Social Worker NS - Normal Saline OASIS - Outcome and Assessment Information Set OT - Occupational Therapist PICC - peripherally inserted central catheter POC - Plan of Care PRN - as needed PT - Physical Therapy RN- Registered Nurse ROM - Range of Motion SN - Skilled Nurse SQ - subcutaneous SOC - Start of Care	G 000	RECEIVED MAR 31 2015 FACILITY STANDARDS Refer to attached document for plan of correction for all cited deficiencies S. Creswell	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: AeH | TITLE: CEO | (X6) DATE: 3-27-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 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 Medicare patients were fully informed of their right to appeal a discharge from home health services for 2 of 3 discharged patients (#6 and #11) 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. 1. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #6's record included a discharge assessment, dated 2/20/15, and signed by the	G 101		

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G 101	Continued From page 2 RN. Additionally, it included a discharge summary, dated 2/20/15. Patient #6'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 2/20/15. The back of the form was signed by Patient #6 to indicate receipt of the notice. Patient #6's signature was dated 2/20/15, the date of her final home health visit and discharge from the agency. The RN who completed Patient #6's discharge assessment and discharge summary was interviewed on 3/05/15 at 11:50 AM. She reviewed the record and confirmed the NOMNC form was presented to, and signed by Patient #6 on 2/20/15, the day of her discharge. The RN confirmed Patient #6 was not notified of her right to appeal her discharge from home health services at least 2 days prior to her discharge. She stated she knew the NOMNC form was to be signed by the patient upon discharge, however, she was not aware of the requirement to inform patients of discharge at least 2 days in advance. Patient #6, a Medicare beneficiary, was not notified prior to her discharge, of her right to appeal discontinuation of home health services. 2. Patient #11 was an 81 year old male admitted to the agency on 1/31/15, for services related to malaise and fatigue. Additional diagnoses included depression and hypertension. He received SN, HHA and MSW services. His record, including the POC, for the certification period 1/31/15 to 3/31/15, was reviewed.	G 101		

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G 101	Continued From page 3 Patient #11'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 2/17/15. The back of the form was signed by Patient #11 to indicate receipt of the notice. Patient #11's signature was dated 2/17/15, the date of his final home health visit and discharge from the agency. The RN who completed Patient #11's discharge assessment and discharge summary was interviewed on 3/05/15 at 11:30 AM. She reviewed the record and confirmed the NOMNC form was presented to, and signed by Patient #11 on 2/17/15, the day of his discharge. The RN confirmed Patient #11 was not notified of his right to appeal his discharge from home health services at least 2 days prior to his discharge. Patient #11, a Medicare beneficiary, was not notified prior to his discharge, of his right to appeal discontinuation of home health services.	G 101		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care coordination between disciplines for	G 143		

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G 143	Continued From page 4 5 of 12 patients (#2, #5, #6, #7, and #8) who received services from more than one discipline and whose records were reviewed. This interfered with quality, safety and continuity of patient care. Findings include: 1. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's record included an Aide Progress Note documenting HHA visits on 2/02/15 and 2/05/15, and signed by the HHA. The form included a comment, dated 2/05/15, stating "Client fell this morning has a sore on left wrist. Aide will report to nurse." Patient #2's record did not include documentation of communication with the RN regarding a fall on 2/05/15. Additionally, it did not include documentation of a SN visit to assess Patient #2 following the documented fall. During an interview on 3/05/15 at 11:00 AM, the RN who completed Patient #2's SOC assessment reviewed her record and confirmed she was not contacted by the HHA regarding Patient #2's fall. The HHA did not report Patient #2's fall to the RN. 2. Patient #5 was a 97 year old female, admitted to the agency on 9/26/14, due to a history of non-compliance with her medications. Additional diagnoses included syncope (fainting), dementia, HTN and hypothyroidism. Her record, including	G 143		

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G 143	Continued From page 5 the POC, for the certification period 1/24/15 to 3/24/15, was reviewed. Patient #5's record included an Aide Progress Note documenting HHA visits on 2/16/15, 2/18/15 and 2/20/15, and signed by the HHA. The note included a comment, dated 2/18/15, stating "Lft [left] eye red and sore." Patient #5's record did not include documentation of communication with the RN regarding her reddened eye on 2/18/15. The next SN visit note, completed on 2/24/15, and signed by the RN, did not document an assessment of Patient #5's left eye. During an interview on 3/05/15 at 10:30 AM, Patient #5's RN Case Manager confirmed she was not contacted by the HHA regarding Patient #5's reddened eye. She stated the HHAs are expected to communicate patient complaints to the RN Case Manager. The HHA did not report Patient #2's reddened and sore eye to the RN Case Manager. 3. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #6's record included an Aide Progress Note documenting HHA visits on 2/17/15 and 2/20/15, and signed by the HHA. The note included 2 comments, dated 2/17/15, stating "Client was on floor when I arrived. She got down to look for her phone and couldn't get back up,"	G 143		

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G 143	Continued From page 6 and "Client dizzy but moving ok." The note also included 1 comment dated 2/20/15, stating "Client c/o dizzy [dizziness]." Patient #6's record did not include documentation of communication with the RN regarding her dizziness on 2/17/15 and 2/20/15. Patient #6's record included an SN discharge assessment, completed on 2/20/15, and signed by the RN. The discharge assessment did not document Patient #6's complaints of dizziness or an assessment related to dizziness. During an interview on 3/05/15 at 11:50 AM, the RN Case Manager stated the HHA called her to report Patient #6's complaints of dizziness, however, the RN stated she was not aware the HHA had found Patient #6 on the floor and unable to get up. The HHA did not communicate with the RN Case Manager regarding Patient #6's inability to get up from the floor due to dizziness. 4. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. Patient #8's record included a PT Progress Note, dated 12/16/14, and signed by the Physical Therapist. The note stated Patient #8 had experienced a fall the previous night, and required maximum assistance from a neighbor to get up from the floor.	G 143		

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G 143	Continued From page 7 Patient #8's record did not include documentation of communication with the RN regarding his fall on 12/15/14. Patient #8's record included an SN visit note, completed on 12/18/14, and signed by the RN. The visit note did not include documentation regarding Patient #8's fall. During an interview on 3/05/15 at 12:10 PM, the RN Case Manager confirmed the Physical Therapist did not notify her of Patient #8's fall on 12/15/14. Patient #8's Physical Therapist did not communicate his fall to his RN Case Manager. 5. Patient #7 was an 85 year old female who was admitted to the agency on 2/07/15, for SN, PT, and HHA services following a hospitalization and back surgery. Her record and POC for the certification period 2/07/15 to 4/07/15, were reviewed. a. A physical therapy visit note dated 2/09/15, included documentation Patient #7 "blacked out" twice during the therapy session. The record did not indicate Patient #7's RN Case Manager or physician were notified. b. A physical therapy visit note dated 2/18/15, included documentation that Patient #7 was not feeling well. He noted Patient #7 was not as alert as usual and when attempts were made to stand or participate in therapeutic activities, she promptly blacked out and slumped backward onto the bed. The visit note did not include documentation Patient #7's RN Case Manager or physician were notified.	G 143		

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G 143	Continued From page 8 c. A physical therapy visit note dated 2/23/15, documented Patient #7's blood pressure was 80/50. After performing ROM exercises, the therapist documented Patient #7's blood pressure increased to 50/100. (According to WebMD website, accessed on 3/18/15, hypotension or low blood pressure is less than 80/60. Additionally, the website noted that low blood pressure may be a sign of an underlying problem, especially in the elderly, where it may cause inadequate blood flow to the heart, brain, and other vital organs). The record did not indicate Patient #7's RN Case Manager or physician were notified of her low blood pressure. During an interview on 3/05/15 beginning at 10:00 AM, Patient #7's RN Case Manager reviewed her record and confirmed the documented low blood pressures and black out episodes. She stated she was aware of Patient #7's hypotension, although each event was not reported to her. The RN stated Patient #7's physician was trying to adjust her blood pressure medications. Results of abnormal vital signs and reports of Patient #7's black out episodes were not communicated to the RN Case Manager.	G 143		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on medical record review, policy review, observations during home visits and staff interview, it was determined the agency failed to	G 156		

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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 156	Continued From page 9 ensure care was provided in accordance with patients' POCs, that the POCs included all pertinent information, and the physician was notified if the POCs were altered or patients' conditions changed. This resulted in unmet patient needs, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with POCs. 2. Refer to G159 as it relates to the failure of the agency to ensure the POC included all pertinent diagnoses, types of services and equipment required. 3. Refer to G160 as it relates to the failure of the agency to consult physicians to approve POCs following evaluation visits. 4. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs. 5. Refer to G166 as it relates to the agency's failure to ensure verbal physician orders were put in writing. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.	G 156		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established	G 158		

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	137058		03/05/2015

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G 158	Continued From page 10 and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record and policy review, and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 6 of 12 patients (#1, #5, #6, #8, #9, and #12) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include: 1. Patient #9 was a 27 year old female who was admitted to the agency on 10/22/14, for severe nausea and vomiting related to pregnancy. Her record and POC for the certification periods 10/22/14 to 12/20/14, and 12/21/14 to 2/18/15, were reviewed. a. Patient #9's POC for the certification period 10/22/14 to 12/20/14, included orders for SN visits. The orders were for the SN to assess Patient #9's vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen. Patient #9's POC included a goal that her weight would be maintained between 150 and 190 pounds during the certification period, however, no baseline weight was noted in her record. Patient #9's POC for the initial certification period of 10/22/14 to 12/20/14, included orders for assessment of vital signs. However, vital signs were documented on only 4 visits, and were not	G 158		

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G 158	Continued From page 11 inclusive of a full assessment as follows: - 10/22/14 at 2:20 PM, the RN did not document a temperature reading or respiratory rate. An agency policy titled "Physician's Orders," revised 1/07/18, stated "Licensed staff will provide timely intervention by notifying the physician of changes in the patient's condition, expected progress, or regress." The policy further indicated the following were to be reported to the physcian: -Systolic (top number) blood pressure reading of less than 85 or greater than 190 when the patient is exhibiting symtoms, - Diastolic (bottom number) blood pressure reading of less than 50 or greater than 110, when the patient is exhibiting symptoms. - 10/27/14 at 1:20 PM, B/P documented as 98/60, no other vital signs were recorded. The systolic blood pressure was not within the parameters as established by the agency policy. The record did not indicate Patient #9's physician was alerted to the low blood pressure. Patient #9's record did not include documentation of further evaluation or assessment for additional symptoms. - 11/04/14 at 8:50 AM, Patient #9's temperature and blood pressure were not documented. - 12/11/14 at 6:10 PM, Patient #9's temperature and blood pressure were not documented. b. Patient #9's POC for the certification period 12/21/14 to 2/18/15, included orders for SN visits. The orders were for the SN to assess Patient #9's	G 158		

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G 158	Continued From page 12 vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen. Patient #9's POC also included a goal that her weight would be maintained between 150 and 190 pounds during the certification period, however, no baseline weight was noted in her record. Patient #9 had 9 SN visits during the second certification period between 12/21/14 and 2/03/15. The 9 SN visit notes did not include documentation of Patient #9's vital signs and weight. During an interview on 3/05/15 beginning at 12:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed vital signs and weights were not assessed as ordered on the POCs. She stated Patient #9 often refused to have her vitals assessed. She stated with a peripheral IV in Patient #9's right arm, and a blood clot in her left arm, she was not able to assess blood pressures. The RN Case Manager stated she only had an arm blood pressure cuff, and therefore was unable to take a reading from her wrist. The RN Case Manager stated Patient #9's physician was monitoring her weight so she did not perform that assessment. Care was not provided to Patient #9 as ordered on her POC, nor was there evidence her physician was contacted to alter her POCs. 2. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a	G 158		

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G 158	Continued From page 13 hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15 were reviewed. a. Patient #8's record did not include an order, signed by a physician, for home health services prior to his SOC on 12/02/14. During an interview on 3/05/15 at 12:10 PM, the RN Case Manager presented Patient #8's hospital discharge instructions, dated 12/01/14. The instructions included home health services. However, the instructions were not signed by a physician. The RN Case Manager confirmed the agency did not have signed physician orders for home health services implemented on 12/02/14. Patient #8's home health care was initiated without a physician's order. b. Patient #8's record included a POC for the certification period 12/02/14 to 1/30/15. The POC included the following SN order "DRESSING CHANGES TO RIGHT HEEL AS ORDERED, THREE TIMES A WEEK." However, the POC did not include specific wound care orders, to include products to be used to cleanse, treat and cover the wound. Patient #8's record included a verbal order, dated 12/16/14, and signed by the RN. The order stated dressing changes were decreased to 2 times per week. However, it did not include specific wound care orders. Patient #8's record documented wound care	G 158		

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G 158	Continued From page 14 provided during SN visits, as follows: 12/02/14, mepilex (foam dressing) applied 12/03/14, cleansed, mepilex applied, secured with hypafix (adhesive fabric) 12/05/14, cleansed with caraklenz (wound cleanser), mepilex applied, secured with hypafix 12/08/14, cleansed with caraklenz, mepilex applied, secured with hypafix 12/10/14, cleansed with caraklenz, mepilex applied, secured with hypafix 12/12/14, cleansed with caraklenz, dried with gauze, mepilex applied, secured with hypafix 12/15/14, cleansed with caraklenz, mepilex applied, secured with hypafix 12/18/14, cleansed with caraklenz, mepilex applied, secured with hypafix 12/22/14, cleansed with caraklenz, mepilex applied, secured with hypafix 12/26/14, foam dressing 12/29/14, cleansed with caraklenz, mepilex applied, secured with hypafix 1/01/15, cleansed with caraklenz, mepilex applied, secured with hypafix 1/05/15, wound cleansed and dressed with mepilex Patient #8's record included a verbal order, dated 1/06/15, and signed by the RN Case Manager. The order added Medi-Honey (used to remove necrotic tissue) to the twice weekly dressing changes, however, the order did not specify products to be used to cleanse and cover the wound. SN visit notes completed on 1/08/15, 1/09/15, 1/12/15, 1/15/15, 1/19/15, 1/22/15, 1/26/15, 1/29/15, and 2/02/15 documented Patient #8's right heel wound was cleansed with caraklenz,	G 158		

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G 158	Continued From page 15 Medi-Honey applied, mepilex applied and secured with hypafix. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager reviewed Patient #8's record and confirmed the wound care orders did not specify products to be used to cleanse and cover his right heel wound. Patient #8's wound care was provided without a specific physician's order. 3. Patient #12 was a 60 year old female who was admitted to the agency on 1/15/15, for SN services related to wound care and diabetic management. Patient #12's record included a signed physician's order, dated 1/13/15. The order stated "Home Health for diabetic foot ulcer. Daily dressing changes- wet to dry; patient to keep off foot." Patient #12's record included a POC for the certification period 1/15/15 to 3/15/15. The POC included the following SN order: "SN wound care to include daily wet to moist dressing changes to diabetic foot ulcer." The orders on the POC differed from that of the physician referral. Additionally, Patient #12's record did not include evidence the RN spoke with the physician to reduce the frequency of dressing changes from daily to 6 times a week, and to change from wet to dry dressing changes to wet to moist. The POC was not specific to the type of wound care which would include products to cleanse, treat, and cover the wound. The POC included an "off loading boot," however,	G 158		

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G 158	Continued From page 16 the physician referral order, dated 1/13/15, specifically stated Patient #12 was to keep off her foot. The record did not indicate the RN communicated with Patient #12's physician to clarify if she was to use the off loading boot or to remain off her foot. During an interview on 3/05/15, beginning at 11:00 AM, Patient #12's RN Case Manager reviewed her record and confirmed the POC did not include specific wound care orders. She verified that the physician orders of wet to dry dressing changes were not what was included on the POC. The RN stated the frequency of dressing changes was adjusted within the first week that Patient #12 started care. The RN confirmed Patient #12 used an off loading boot, and stated she was not aware that the physician had ordered Patient #12 to remain off her foot. Patient #12's written physician orders differed from those on the POC. 4. Patient #1 was an 83 year old female admitted to the agency on 3/03/15, following a hospital and rehabilitation center admission for pericarditis (inflammation of the sac surrounding the heart). Additional diagnoses included muscle weakness, Parkinson's disease, HTN, depression and chronic kidney disease. She received SN, PT, OT and HHA services. Her record, including the POC, for the certification period 3/03/15 to 5/01/15, was reviewed. Patient #1's record included an order for home health services, dated 2/27/15. However, the order was signed by an APRN (Advanced Practice Registered Nurse). Patient #1's record did not include an order for home health services	G 158		

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G 158	Continued From page 17 signed by a doctor of medicine, osteopathy or podiatric medicine. During an interview on 3/05/15 at 10:00 AM, the RN Case Manager stated Patient #1 was discharged from a rehabilitation center in another state. She stated the orders for home health services were signed by an APRN in another state, and confirmed the agency did not obtain orders from a physician licensed in, and practicing in, Idaho prior to initiating Patient #1's services. Patient #1's home health care was initiated without a physician's order. 5. Patient #5 was a 97 year old female, admitted to the agency on 9/26/14, due to a history of non-compliance with her medications. Additional diagnoses included syncope, dementia, HTN and hypothyroidism. Her record, including the POC and recertification assessment, for the certification period 1/24/15 to 3/24/15, was reviewed. Patient #5's physician ordered POC for her previous certification period ended on 1/23/15. Patient #5's record did not include a physician's order to continue her care past 1/23/15, the end of her certification period. The POC for the certification period 1/24/15 to 3/24/15, was signed by her physician on 1/30/15. However, a SN visit was completed on 1/27/15, and HHA visits were completed on 1/26/15, and 1/28/15, prior to physician authorization. During an interview on 3/05/15 at 10:50 AM, the RN Case Manager reviewed Patient #5's record and confirmed the agency did not have a	G 158		

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G 158	Continued From page 18 physician's order to continue services past 1/23/15. Services were provided to Patient #5 without a physician's order. 6. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #6's POC included an order for SN visits 1-2 times a week for 6 weeks, to assess vital signs and all body systems. Patient #6's record documented SN visits completed 1 time a week from 1/10/15 to 2/20/15. SN visit notes completed on 1/10/15, 1/16/15, 1/30/15, 2/06/15, 2/13/15, and 2/20/15, did not document vital signs. During an interview on 3/05/15 at 11:50 AM, the RN Case Manager reviewed Patient #6's record and confirmed vital signs were not documented on the above SN visit notes. She stated she sometimes relied upon the HHA to take and record vital signs. The RN Case Manager did not assess Patient #6's vital signs as ordered by her physician.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional	G 159		

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G 159	Continued From page 19 limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of patient records, observation, and staff interview, it was determined the agency failed to ensure POCs included all pertinent information, including diagnoses, goals and nursing interventions, equipment, wound care instructions, and all pertinent treatments for 4 of 12 patients (#3, #7, #8, and #9) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include: 1. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. a. Patient #8 was discharged from the hospital on 12/01/14. His record included discharge instructions and a medication list from the hospital, dated 12/01/14. Patient #8's POC for the certification period 12/02/14 to 1/30/15, was not comprehensive to include all his needs. Examples include: -Discharge instructions included oxygen 2 liters/minute to be used continuously. Patient #8's POC did not include oxygen or equipment	G 159		

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G 159	Continued From page 20 used to deliver his oxygen. -Discharge instructions included blood sugar checks twice a day. Patient #8's POC did not include orders for blood sugar checks twice a day, a glucometer to measure his blood sugars, or patient/caregiver education in the use of the glucometer. -Discharge medication list included Lantus insulin to be given daily. Patient #8's POC did not include Lantus insulin. -Discharge instructions included an 1800 calorie diabetic diet. Patient #8's POC stated his diet was ADA (American Diabetes Association,) however, it did not specify the number of calories. -Discharge instructions stated to educate Patient #8's wife to give him nebulizer treatments. Patient #8's POC did not include a nebulizer, or patient/caregiver education in the use of a nebulizer. -Patient #8's record included a SN visit note, dated 12/12/14, and signed by the RN. The note documented Patient #8 had edema in his lower extremities and was wearing doubled tubigrip stocking on his right leg and single tubigrip stocking on his left leg. Tubigrips are elastic bandages used to aid venous and lymphatic return in the management of venous disorders of the legs and arms. However, Patient #8's POC did not include an order for tubigrip bandages. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager reviewed Patient #8's POC and confirmed it did not include oxygen or oxygen equipment, blood sugar checks, glucometer or	G 159		

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G 159	Continued From page 21 glucometer education, insulin, 1800 calorie diabetic diet, nebulizer or nebulizer education, or tubigrip bandages. Patient #8's POC was not comprehensive to include all medications, equipment, diet and education needs. b. Patient #8's record included a POC for the certification period 12/02/14 to 1/30/15. The POC included the following SN order "DRESSING CHANGES TO RIGHT HEEL AS ORDERED, THREE TIMES A WEEK." However, the POC did not include specific wound care orders, to include products to be used to cleanse, treat and cover the wound. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager reviewed Patient #8's POC and confirmed it did not include specific wound care orders for his right heel wound. Patient #8's POC did not include specific wound care orders. 2. Patient #3 was a 71 year old male who was admitted to the agency on 2/15/15, for SN, PT, and HHA services related to a right total hip replacement. His record and POC for the certification period 2/15/15 to 4/15/15, were reviewed. a. Patient #3 was discharged from the hospital on 2/14/15. His record included discharge instructions and a medication list from the hospital, dated 2/13/15. Patient #3's POC for the certification period 2/15/15 to 4/15/14, was not comprehensive to include all his needs. Examples include:	G 159		

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G 159	Continued From page 22 -His discharge medication list included Eliquis 5 mg orally, twice a day. (Eliquis is an anticoagulant medication used to reduce the risk of stroke and blood clots.) Patient #3's POC did not include Eliquis. -Patient #3's record included a pre-operative history and physical dated 1/28/15. The H&P included additional diagnoses of diabetes, neuropathic pain, sleep apnea, blindness, and depression. Patient #3's POC did not include the additional diagnoses. During an interview on 3/05/15 at 9:05 AM, the RN who completed the SOC assessment reviewed Patient #3's record and confirmed she did not include the additional diagnoses, equipment, and the anticoagulant medication when she developed the POC. The RN stated she did not include the additional diagnoses on the POC, as Patient #3 was primarily receiving care for therapy related to his hip replacement. She stated Patient #3's CPAP machine he used for sleep apnea should have been included as DME on the POC. Patient #3's POC was not comprehensive to include all his medications, pertinent diagnoses, and equipment. 3. Patient #7 was an 85 year old female who was admitted to the agency on 2/07/15, for SN, PT, and HHA services following a hospitalization and back surgery. Her record and POC for the certification period 2/07/15 to 4/07/15, were reviewed. During a home visit on 3/04/15 at 12:30 PM,	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 159	Continued From page 23 Patient #7 was noted to have a back brace, as well as, a wheelchair. These items were not included as DME on her POC. During an interview on 3/05/15 beginning at 10:00 AM, Patient #7's RN Case Manager reviewed her record and confirmed the items were not included as DME. Patient #7's POC did not include all DME. 4. Patient #9 was a 27 year old female who was admitted to the agency on 10/22/14, for severe nausea and vomiting related to pregnancy. Her record and POC for the certification periods 10/22/14 to 12/20/14, and 12/21/14 to 2/18/15, were reviewed. a. Patient #9's POC for the certification period 10/22/14 to 12/20/14, included orders for SN visits. The orders were for the SN to assess Patient #9's vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen. The referral order for Patient #9 dated and signed by her physician on 10/21/14, noted she was to have a PICC line placed on 10/22/14, as an outpatient procedure before her SOC with the agency. He ordered 1 liter of IV fluids and anti-nausea medication to be administered daily as needed. Patient #9's medical record noted a PICC line was placed on 10/22/14, the same day as her SOC. However, Patient #9's POC did not include PICC line care, patient education related to	G 159		

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	137058		03/05/2015

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G 159	Continued From page 24 having a PICC line, orders for flushes and dressing changes, or supplies related to the PICC line and maintenance. Patient #9's record included an ultrasound report dated 11/03/14, which described a blood clot in her left arm. Her record indicated the PICC was discontinued and a peripheral IV was placed. Patient #9's record included a copy of a physician order dated 11/03/14, written on a prescription sheet, for Lovenox injections to be administered 2 times daily. b. Patient #9's POC for the certification period 12/21/14 to 2/18/15, included orders for SN visits. The orders were for the SN to assess Patient #9's vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen. The POC did not include orders for a peripheral IV, or include supplies related to maintanence of an IV such as additional start kits, dressing supplies, flushes, etc. Patient #9's record included an order signed by her physician on 12/01/14, to educate her mother on how to administer IV medications. Patient #9's POC did not include the care giver teaching as ordered by her physician. Additionally, the POC did not include patient or care giver instruction regarding the administration of the SQ Lovenox injections. Patient #9's POC did not include assessments of fetal well being or patient education related to	G 159		

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G 159	Continued From page 25 pregnancy and nutrition. During an interview on 3/05/15 beginning at 12:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed the POC's did not include additional orders for maintanence of the PICC and peripheral lines, as well as, patient and caregiver education. Patient #9's POC was not comprehensive to include treatments, patient teaching, and DME.	G 159		
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on review of patient records, agency policies, and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 8 of 12 patients (#5, #6, #7, #8, #9, #10, #11, and #12) whose records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include: An agency policy titled "Plan of Treatment," dated 1/07/08, stated "If a physician refers a patient under a plan of treatment that cannot be completed until after an evaluation visit, the physician is consulted to approve any additions or modifications." 1. Patient #9 was a 27 year old female who was admitted to the agency on 10/22/14, for SN	G 160		

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G 160	Continued From page 26 services related to severe nausea and vomiting related to pregnancy. Patient #9's record and POC for the certification periods 10/22/14 to 12/21/14, and 12/22/14 to 2/18/15, were reviewed. a. Patient #9's record included a SOC assessment, completed on 10/22/14, signed by the RN Case Manager. However, Patient #9's record did not include documentation of contact with Patient #9's physician to authorize a POC for continued services. Patient #9's record included a POC for the certification period 10/22/14 to 12/21/14. The POC included orders for SN visits 2-4 times a week for 9 weeks with 4 PRN visits. The POC was signed by Patient #9's physician on 10/28/14. Patient #9's record included SN visit notes, dated 10/22/14, 10/23/14, 10/16/14, 10/27/14, and 10/28/14. However, her physician did not approve her POC until 12/28/14. b. Patient #9's record also included a recertification assessment, completed and signed by the RN on 12/17/14. The assessment did not include documentation of contact with Patient #9's physician to obtain approval for continued services. The POC for the certification period 12/21/14 to 2/18/15, included orders for SN visits 1-4 times a week for 9 weeks, and was signed by the physician on 12/29/14. Patient #9's record included 2 SN visit notes, both dated 2/26/14, however, her physician was not contacted to approve her visits on 2/26/14.	G 160		

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G 160	Continued From page 27 During an interview on 3/05/15 beginning at 12:00 PM, Patient #9's RN Case Manager reviewed her record and confirmed additional visits were completed after the SOC assessment and the recertification assessments before receiving physician orders. Patient #9's physician was not consulted to approve her POC and additional visits following the SOC and recertification assessments. 2. Patient #10 was a 75 year old male admitted to the agency on 12/31/14, for SN, PT, and MSW services related to debility, malaise, and fatigue. Additional diagnoses included CHF, A-Fib, HTN, and depression. Patient #10's record and POC for the certification period 12/31/14 to 2/28/15, were reviewed. Patient #10's record included orders for home health and physical therapy, written by his physician before his hospital discharge on 12/30/14. Patient #10's POC for the certification period 12/31/14 to 2/28/15, included orders for SN visits 1-2 times weekly for 2 weeks, PT 1-2 times weekly for 8 weeks, and MSW visits 1-2 times weekly for 6 weeks. The POC had a stamped physician signature, dated 1/05/15. - Patient #10's record included a SOC assessment dated 12/31/14, completed and signed by the RN Case Manager. However, Patient #10's record did not include documentation of contact with Patient #10's physician to obtain approval for continued services. - Patient #10's record included a PT evaluation	G 160		

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G 160	Continued From page 28 completed on 1/01/15, recommending PT services 2 times weekly for 3 weeks. Patient #10's record did not include documentation his physician was contacted to approve a PT POC. - Patient #10's record included a "Medical Social Services Visit Note," dated 1/02/15, recommending visits 1-2 times weekly for 6 weeks. However, Patient #10's record did not include documentation his physician was contacted to approve the MSW POC. Additionally, Patient #10's record did not include orders for a Medical Social Service visit. During an interview on 3/05/15 at 11:30 AM, the RN Case Manager reviewed Patient #10's record and confirmed the MSW visit occurred before a physician's order was received. The RN stated that during the SOC comprehensive assessment on 12/31/14, Patient #10 discussed his depression. She stated it was a holiday weekend, and contacted the MSW for an evaluation. The RN stated she was unsure, but probably notified Patient #10's physician the following Monday. Patient #10's physician was not consulted after the assessment and evaluation visits to approve the POC. 3. Patient #12 was a 60 year old female who was admitted to the agency on 1/15/15, for SN services related to wound care and diabetic management. Patient #12's record and POC for the certification period 1/15/15 to 3/15/15, were reviewed. Patient #12's record included an SOC comprehensive assessment, completed on	G 160		

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	137058		03/05/2015

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G 160	Continued From page 29 1/15/15, and signed by the RN Case Manager. However, Patient #12's record did not include communication with Patient #12's physician to approve a POC for ongoing services. Patient #12's record included a POC for the certification period 1/15/15 to 3/15/15. The POC included orders for SN visits 3 times a week for 1 week, and 6 times a week for 3 weeks. The POC was signed on 1/20/15, by Patient #12's physician. Patient #12's record included SN visit notes, dated 1/16/15, 1/17/15, 1/18/15, and 1/19/15, and signed by the RN Case Manager. However, her physician did not approve her POC until 1/20/15. During an interview on 3/05/15 beginning at 11:00 AM, the RN Case Manager reviewed Patient #12's record and confirmed there was no documentation her physician was contacted to approve the POC before 1/20/15. Patient #12's physician was not consulted after the SOC assessment visit to approve the POC. 4. Patient #7 was an 85 year old female who was admitted to the agency on 2/07/15, for SN, PT, and HHA services following a hospitalization for back surgery. Her record and POC for the certification period 2/07/15 to 4/07/15, were reviewed. Patient #7's record included a SOC assessment, completed on 2/07/15, signed by the RN Case Manager. However, Patient #7's record did not include documentation of contact with Patient #7's physician to approve her POC.	G 160		

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G 160	Continued From page 30 Patient #7's record included a POC for the certification period 2/07/15 to 4/07/15. The POC included orders for SN visits 1-3 times a week for 4 weeks, and 2-3 times a week for 6 weeks. The POC was signed by Patient #7's physician on 2/11/15. Patient #7's record included an SN visit note, dated 2/10/15, signed by the RN Case Manager. However, her physician did not approve the POC and ongoing services until 2/11/15. During an interview on 3/05/15 at 10:00 AM, Patient #7's RN Case Manager reviewed her record and confirmed she did not contact Patient #7's physician for further orders after the SOC assessment. She stated she did not usually speak with the physician after the SOC visit. She stated she faxed a form to the physician which included frequency the type and number of visits, and indicated that the POC would follow. Patient #7's physician was not consulted to approve her POC and additional visits following the SOC assessment. 5. Patient #5 was a 97 year old female, admitted to the agency on 9/26/14, due to a history of non-compliance with her medications. Additional diagnoses included syncope, dementia, HTN and hypothyroidism. Her record, including the POC, for the certification period 1/24/15 to 3/24/15, was reviewed. Patient #5's previous certification period and physician ordered POC ended on 1/23/15. Her record included a recertification comprehensive assessment, dated 1/21/15, and signed by the RN Case Manager. The assessment did not	G 160		

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	137058		03/05/2015

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G 160	Continued From page 31 include documentation of contact with Patient #5's physician. Patient #5's record included a POC for the certification period 1/24/15 to 3/24/15, signed by the RN Case Manager on 1/23/15. The POC included orders for SN visits 1 time a week for 9 weeks. The POC was signed by Patient #5's physician on 1/30/15. Patient #5's record included a SN visit note, dated 1/27/15, and signed by the RN Case Manager. However, her physician was not contacted to approve her POC prior to 1/27/15, and the POC was not signed by her physician until 1/30/15. During an interview on 3/05/15 at 10:30 AM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #5's physician to obtain verbal approval for the POC. She stated the POC was sent to Patient #5's physician, and his signature indicated his approval. The RN Case Manager confirmed 1 SN visit was provided prior to physician approval of the POC on 1/30/15. Patient #5's physician was not consulted to approve her POC and additional visits following the SN recertification assessment. 6. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #6's record included a SOC assessment, completed on 1/10/15, and signed by the RN	G 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 160	Continued From page 32 Case Manager. The assessment did not include documentation of contact with Patient #6's physician to obtain a verbal order for ongoing services. Patient #6's record included a PT evaluation visit note, completed on 1/13/15, and signed by the Physical Therapist. The note did not include documentation of contact with Patient #6's physician. Patient #6's record included a POC for the certification period 1/10/15 to 3/10/15. The POC included orders for SN visits 1-2 times a week for 6 weeks, and PT visits 2 times a week for 5 weeks. The POC was signed by Patient #5's physician on 1/22/15. Patient #6's record included an SN visit note, dated 1/16/15, signed by the RN. It also included PT visit notes dated 1/16/15, and 1/19/15, signed by the Physical Therapist. However, Patient #6's POC was not signed by her physician until 1/22/15. During an interview on 3/05/15 at 11:50 AM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #6's physician to obtain verbal approval for the POC. She stated the POC was sent to Patient #6's physician, and the date of his signature indicated the approval date. The RN Case Manager confirmed 1 SN visit and 2 PT visits were provided prior to physician approval of the POC on 1/22/15. Patient #6's physician was not consulted to approve her POC and additional visits following the SN SOC assessment and PT evaluation.	G 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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G 160	Continued From page 33 7. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15 were reviewed. Patient #8's record included a SOC assessment, completed on 12/02/14, and signed by the RN Case Manager. However, his record did not include documentation of contact with Patient #8's physician to obtain approval for the POC and ongoing services. Patient #8's record included an OT evaluation visit note, completed on 12/02/14, and signed by the Occupational Therapist. However, Patient #8's record did not include documentation of contact with Patient #8's physician for approval of an OT POC. Patient #8's record included a POC for the certification period 12/02/14 to 1/30/15. The POC included orders for SN visits 3-5 times a week for 2 weeks. Patient #8's record included SN visit notes, dated 12/03/14, 12/04/14, 12/05/14 and 12/08/14, signed by the RN Case Manager. However, Patient #8's POC was not signed by her physician until 12/09/14. Patient #8's POC also included orders for OT visits 2 times a week for 2 weeks. Patient #8's record included an OT visit note dated 12/04/15, and signed by the Occupational Therapist. However, Patient #8's POC was not signed by her physician until 12/09/14.	G 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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G 160	Continued From page 34 During an interview on 3/05/15 at 12:10 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #8's physician to obtain verbal approval for the POC. She stated the POC was sent to Patient #8's physician, and the date of his signature indicated the approval date. The RN Case Manager confirmed 4 SN visits and 1 OT visit were provided prior to physician approval of the POC on 12/09/14. Patient #8's physician was not consulted to approve her POC and additional visits following the SOC assessment and OT evaluation. 8. Patient #11 was an 81 year old male admitted to the agency on 1/31/15, for services related to malaise and fatigue. Additional diagnoses included depression and hypertension. He received SN, HHA and MSW services. His record, including the POC, for the certification period 1/31/15 to 3/31/15, was reviewed. Patient #11's record included a SOC assessment, completed on 1/31/15, signed by the RN Case Manager. However, Patient #11's record did not include documentation of contact with Patient #11's physician to authorize his POC and initiation of ongoing services. Patient #11's record included a POC for the certification period 1/31/15 to 3/31/15. The POC included orders for SN visits 1 time a week for 3 weeks. The POC was signed by Patient #11's physician on 2/04/15. Patient #11's record included an SN visit note, dated 2/03/15, and signed by the RN. However,	G 160		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 160	Continued From page 35 his physician did not approve his POC until 2/04/15. During an interview on 3/05/15 at 11:30 AM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #11's physician to obtain verbal approval for the POC. She stated the POC was sent to Patient #11's physician, and the date of his signature indicated the approval date. The RN Case Manager confirmed 1 SN visit was provided prior to physician approval of the POC on 2/04/15. Patient #11's physician was not consulted to approve his POC and additional visits following the SN SOC assessment.	G 160		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of patient records, policy review, and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the POC for 4 of 12 patients (#2, #7, #8, and #10) 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: An agency policy titled "Physician's Orders,"	G 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 164	Continued From page 36 revised 1/07/18, stated "Licensed staff will provide timely intervention by notifying the physician of changes in the patient's condition, expected progress, or regress." The policy further indicated the following were to be reported to the physcian: -Systolic (top number) blood pressure reading of less than 85 or greater than 190 when the patient is exhibiting symtoms - Diastolic (bottom number) blood pressure reading of less than 50 or greater than 110, when the patient is exhibiting symptoms - Heart rate of less than 50 or greater than 120, when the patient is exhibiting symptoms - Incident involving suspected injury - Mental status changes The following examples include abnormal vital signs and/or changes in patients' conditions that occurred without physician notification: 1. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's record included a PT visit note, dated 2/06/15, and signed by the Physical Therapist. The note documented Patient #2 told the Physical Therapist she had fallen the previous night. She reported pain in her tailbone area, making it	G 164		

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	137058		03/05/2015

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G 164	Continued From page 37 difficult to get out of bed. Patient #2's record did not document her physician was notified of her fall or of her pain. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager reviewed the record and confirmed Patient #2's physician was not notified of her fall or pain. The agency did not ensure Patient #2's physician was notified she had fallen and experienced pain as a result of her fall. 2. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. Patient #8's record included a PT visit note, dated 12/16/14, signed by the Physical Therapist. The note stated Patient #8 had experienced a fall the previous night, and required maximum assistance from a neighbor to get up from the floor. Patient #8's record did not include documentation of communication with his physician regarding his fall on 12/15/14. During an interview on 3/05/15 at 12:10 PM, the RN Case Manager confirmed the Physical Therapist did not notify Patient #8's physician of his fall on 12/15/14. The agency did not ensure Patient #8's physician was notified he had fallen and required maximum	G 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 164	Continued From page 38 assistance to get up from the floor. 2. Patient #7 was an 85 year old female who was admitted to the agency on 2/07/15, for SN, PT, and HHA services following a hospitalization and back surgery. Her record and POC for the certification period 2/07/15 to 4/07/15, were reviewed. a. The RN documented Patient #7's blood pressure was 92/48 on the SOC comprehensive assessment dated 2/07/15. Her record did not indicate her physician was notified of her low diastolic BP. b. A PT visit note dated 2/09/15, included documentation Patient #7 "blacked out" twice during the therapy session. Her record did not indicate Patient #7's physician was notified. c. A PT visit note dated 2/11/15, documented Patient #7's blood pressure was 98/50 and her pulse was 133. The Physical Therapist noted he had Patient #7 rest lying down, then retook the vital signs. Patient #7's blood pressure was 78/51 and her pulse was 128. The Physical Therapist documented he notified Patient #7's RN Case Manager. On 2/11/15, Patient #7's RN Case Manager documented that the Physical Therapist notified her of Patient #7's low blood pressure. She documented she went to assess Patient #7 and her blood pressure was 72/50, her heart rate was 116. The RN Case Manager documented she encouraged Patient #7 to see her physician, and offered to call an ambulance. The RN Case Manager documented Patient #7's husband declined. There was no indication Patient #7's	G 164		

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	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 164	Continued From page 39 physician was notified that Patient #7's systolic BP remained below 85. e. A PT visit note dated 2/18/15, included documentation that Patient #7 was not feeling well. He noted Patient #7 was not as alert as usual and when attempts were made to stand or participate in therapeutic activities, she promptly blacked out and slumped backward onto the bed. The visit note did not include documentation Patient #7's RN Case Manager or physician was notified. During an interview on 3/05/15 beginning at 10:00 AM, Patient #7's RN Case Manager reviewed her record and confirmed the documented low blood pressures and black out episodes. She confirmed she did not notify Patient #7's physician about each low blood pressure reading and black out episode. Patient #7's physician was not alerted to changes in her condition that may have required changes to her POC. 3. Patient #10 was a 75 year old male who was admitted to the agency on 12/31/14, for SN, and PT services related to debility, malaise, and fatigue. Additional diagnoses included CHF, A-Fib, HTN, and depression. Patient #10's record and POC for the certification period 12/31/14 to 2/28/15 were reviewed. Patient #10's record included a SOC assessment dated 12/31/14, completed and signed by the RN Case Manager. The assessment indicated Patient #10 was anxious all the time. The assessment also indicated a standardized	G 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 164	Continued From page 40 depression screening tool was utilized. The results showed Patient #10 expressed little interest or pleasure in doing things and felt down, depressed, or hopeless nearly every day. The RN did not document contact with Patient #10's physician after completion of the SOC comprehensive assessment to communicate her findings of depression and anxiety. Patient #10's record included a "Medical Social Services Visit Note," dated 1/02/15. Under the section "Emotional/Behavioral Status," the LCSW documented "[Patient #10] is suffering from major depression with suicidal ideations. He is receptive to services and agrees to cognitive treatment." The LCSW documented that he provided the following treatment: "Cognitive Therapy- psycho-analytical exploration with resolution therapy." Additionally, he documented he instructed Patient #10 "positive thinking." The LCSW noted the frequency of visits to be 1-2 times weekly for 6 weeks. Patient #10's record did not include documentation Patient #10's physician was contacted regarding his suicidal ideation and severe depression. During an interview on 3/05/15 at 11:30 AM, the RN Case Manager reviewed Patient #10's record and confirmed the LCSW's documentation regarding his severe depression and suicidal ideation. She stated the LCSW did not notify her about his findings after completing the evaluation. She stated that during the SOC comprehensive assessment she identified that Patient #10 had	G 164		

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	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 164	Continued From page 41 depression, and initiated the LCSW orders on the POC before notification to his physician. Patient #10's RN Case Manager and LCSW failed to notify his physician of his depression and suicidal ideation.	G 164		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure verbal orders were put in writing for 1 of 12 patients (#8) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include: Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. Patient #8's record included a verbal order dated 12/16/14, and signed by the RN Case Manager, for blood to be drawn the following week for	G 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 166	Continued From page 42 laboratory tests. However, the order did not specify what laboratory tests were to be completed for Patient #8. Patient #8's record included a SN visit note, dated 12/22/14, signed by the RN Case Manager. The note documented blood was drawn for 3 tests, CBC, CMP, and PT/INR. It was unclear how the RN determined what blood tests were to be completed. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager stated she received an order from Patient #8's physician to draw blood for a CBC, CMP, and PT/INR, however, she did not document the tests to be completed when she wrote the verbal order. She confirmed the physician's verbal order was incomplete. The RN Case Manager did not accurately document the verbal order received from Patient #8's physician.	G 166		
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on record review, policy review, observation, and patient 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 G173 as it relates to the agency's failure to ensure that patients' POCs were	G 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 168	Continued From page 43 developed and updated to ensure that patients' medical and nursing needs were met. 2. 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. 3. Refer to G175 as it relates to the failure of the agency to ensure a registered nurse initiated appropriate preventive and rehabilitative nursing procedures. 4. 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. 5. Refer to G331 as it relates to the failure of the agency to ensure accurate and comprehensive assessments were completed at the SOC. 6. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment included a comprehensive medication review of current 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 scope and quality.	G 168		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 173	Continued From page 44 necessary revisions. 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 RNs developed and updated POCs to ensure medical and nursing needs were met, for 7 of 12 patients (#1, #2, #6, #7, #8, #9, and #11), who received SN care and whose records were reviewed. This resulted in incomplete POCs, and had the potential to result in negative patient outcomes. Findings include: 1. Patient #1 was an 83 year old female admitted to the agency on 3/03/15, following a hospital and rehabilitation center admission for pericarditis. Additional diagnoses included muscle weakness, Parkinson's disease, HTN, depression and chronic kidney disease. She received SN, PT, OT and HHA services. Her record, including the POC, for the certification period 3/03/15 to 5/01/15, was reviewed. Patient #1's record included a SOC comprehensive assessment visit note, completed on 3/03/15, and signed by the RN Case Manager. Patient #1's SOC visit note included a pain assessment. The pain assessment documented Patient #1 stated she experienced low back pain that she rated as a 5 on a scale of 1-10. The assessment documented Patient #1 experienced this pain daily, but not constantly. Patient #1's SOC visit note included a fall risk assessment. The assessment documented Patient #1's score as 14. The assessment indicated a score greater than 10 equaled a high	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 173	Continued From page 45 risk for falls. Patient #1's record included a POC for the certification period 3/03/15 to 5/01/15, created by the RN Case Manager. The POC included orders for treatments and interventions to be provided during the certification period. Patient #1's SOC assessment identified pain and fall risk, however, her POC did not include interventions to monitor and mitigate her pain, or to decrease her risk of falls. During an interview on 3/05/15 at 10:00 AM, the RN Case Manager confirmed Patient #1's POC did not address her needs related to pain and fall risk. The agency did not ensure all of Patient #1's needs were addressed in her POC. 2. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's record included a SOC comprehensive assessment visit note, completed on 1/15/15, and signed by the RN Case Manager. Patient #2's SOC visit note included a pain assessment. The pain assessment documented Patient #2 stated she experienced knee pain that she rated as a 5 on a scale of 1-10. Patient #2's SOC visit note included a fall risk	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 173	Continued From page 46 assessment. The assessment documented Patient #2's score as 20. The assessment indicated a score greater than 10 equaled a high risk for falls. Patient #2's SOC visit note included a pressure ulcer risk assessment. The assessment documented Patient #2's score as 16. A score of less than 18 indicated a risk for development of pressure ulcers. Patient #2's record included a POC for the certification period 1/15/15 to 3/15/15, created by the RN Case Manager. The POC included orders for treatments and interventions to be provided during the certification period. Patient #2's SOC assessment identified pain, fall risk, and risk of developing pressure ulcers, however, her POC did not include interventions to monitor and mitigate her pain, decrease her risk of falls or decrease her risk of developing pressure ulcers. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager confirmed Patient #2's POC did not address her needs related to pain, fall risk, or risk of developing pressure ulcers. The agency did not ensure all of Patient #2's needs were addressed in her POC. 3. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed.	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 173	Continued From page 47 Patient #6's record included a SOC comprehensive assessment visit note, completed on 1/10/15, and signed by the RN Case Manager. Patient #6's SOC visit note included a fall risk assessment. The assessment documented Patient #1's score as 22. The assessment indicated a score greater than 10 equaled a high risk for falls. Patient #6's SOC visit note included a depression screening. The assessment documented Patient #6 expressed she felt down, depressed and hopeless several days during the last 2 weeks. Patient #6's medication list included Coumadin, an anticoagulant. Patients taking anticoagulants have an increased risk of bleeding. Patient #6's record did not document how long she had been on Coumadin, or an assessment of her understanding of bleeding risks related to Coumadin, and precautions necessary to decrease the bleeding risk. Patient #6's record included a POC for the certification period 1/10/15 to 3/10/15, created by the RN Case Manager. The POC included orders for treatments and interventions to be provided during the certification period. Patient #6's SOC assessment identified fall risk, signs of depression, and increased risk of bleeding, however, her POC did not include interventions to decrease her risk of falls, or to monitor her depression. Additionally, it did not include interventions to educate Patient #6 on anticoagulant therapy and associated risks. During an interview on 3/05/15 at 11:50 AM, the RN Case Manager confirmed Patient #6's POC	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 173	Continued From page 48 did not address her needs related to fall risk or depression. Additionally, she confirmed Patient #6's knowledge regarding anticoagulant therapy and associated risks was not assessed, to determine a need for patient education related to Coumadin. The agency did not ensure all of Patient #6's needs were addressed in her POC. 4. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. Patient #8's record included a SOC comprehensive assessment visit note, completed on 12/02/14, and signed by the RN Case Manager. Patient #8's SOC visit note included a pain assessment. The pain assessment documented Patient #8 stated he experienced shoulder pain that he rated as a 4 on a scale of 1-10. Patient #8's SOC visit note included a fall risk assessment. The assessment documented Patient #8's score as 13. The assessment indicated a score greater than 10 equaled a high risk for fall. Patient #8's SOC visit note included a depression screening. The assessment documented Patient #8 expressed he felt down, depressed and hopeless several days during the last 2 weeks.	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

(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 173	Continued From page 49 Patient #8's SOC visit note included a pressure ulcer risk assessment. The assessment documented Patient #2's score as 15. A score of less than 18 indicated a risk for development of pressure ulcers. Patient #8's SOC visit note documented a stage III pressure ulcer that required dressing changes. Patient #8's record included a POC for the certification period 12/02/14 to 1/30/15, created by the RN Case Manager. The POC included orders for treatments and interventions to be provided during the certification period. Patient #8's SOC assessment identified pain, fall risk, signs of depression, risk of developing additional pressure ulcers and presence of a pressure ulcer requiring dressing changes. However, his POC did not include interventions to monitor and mitigate his pain, decrease his risk of falls, monitor for signs of depression, or decrease his risk of developing additional pressure ulcers. Additionally, Patient #8's POC did not include specific wound care orders for care of his pressure ulcer. During an interview on 3/05/15 at 12:10 AM, the RN Case Manager confirmed Patient #8's POC did not address his needs related to pain, fall risk, depression,or pressure ulcer prevention. Additionally, she confirmed Patient #8 required wound care, but his POC did not include specific wound care orders. The agency did not ensure all of Patient #8's needs were addressed in his POC.	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 173	Continued From page 50 5. Patient #11 was an 81 year old male admitted to the agency on 1/31/15, for services related to malaise and fatigue. Additional diagnoses included depression and hypertension. He received SN, HHA and MSW services. His record, including the POC, for the certification period 1/31/15 to 3/31/15, was reviewed. Patient #11's record included a SOC comprehensive assessment visit note, completed on 1/31/15, and signed by the RN Case Manager. Patient #11's SOC visit note included a pain assessment. The pain assessment documented Patient #11 stated he experienced generalized body pain that he rated as a 4 on a scale of 1-10. Patient #11's SOC visit note included a fall risk assessment. The assessment documented Patient #11's score as 20. The assessment indicated a score greater than 10 equaled a high risk for falls. Patient #11's SOC visit note included a depression screening. The assessment documented Patient #11 expressed he felt down, depressed and hopeless several days during the last 2 weeks. Patient #11's record included a POC for the certification period 1/31/15 to 3/31/15, created by the RN Case Manager. The POC included orders for treatments and interventions to be provided during the certification period. Patient #11's SOC assessment identified pain, fall risk, and signs of depression, however, his POC did not include interventions to monitor and mitigate his pain, decrease his risk of falls, or	G 173		

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G 173	Continued From page 51 monitor for signs of depression. During an interview on 3/05/15 at 11:30 AM, the RN Case Manager confirmed Patient #11's POC did not address his needs related to pain, fall risk, or depression. The agency did not ensure all of Patient #11's needs were addressed in his POC. 6. Patient #7 was an 85 year old female admitted to the agency on 2/04/15, for SN, PT, and HHA servcies related to back pain. Patient #7's record included a SOC comprehensive assessment, dated 2/04/15, and signed by the RN Case Manager. Patient #7's SOC visit note included a pain assessment. The pain assessment documented Patient #7 stated she experienced right shoulder pain that she rated as a 6 on a scale of 1-10. The assessment documented Patient #7 experienced the shoulder pain all of the time. Patient #7's SOC visit note included a fall risk assessment, which documented her score as 15, and indicated she was at high risk for falls. Patient #7's POC for the certification period 2/07/15 to 4/07/15, included orders for treatments and interventions to be provided during the certification period. Patient #7's SOC assessment identified pain and fall risk, however her POC did not include interventions to monitor and mitigate her pain, or to decrease her risk of falls.	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 173	Continued From page 52 During an interview on 3/05/15 beginning at 10:00 AM, Patient #7's RN Case Manager reviewed her record and confirmed the POC did not address her needs related to pain and fall prevention. Patient #7's POC was not comprehensive. 7. Patient #9 was a 27 year old female who was admitted to the agency on 10/22/14, for severe nausea and vomiting related to pregnancy. Her record and POC for the certification periods 10/22/14 to 12/20/14, and 12/21/14 to 2/18/15, were reviewed. a. Patient #9's POC for the certification period 10/22/14 to 12/20/14, included orders for SN visits. The orders were for the SN to assess Patient #9's vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen. The referral order for Patient #9, dated and signed by her physician on 10/21/14, noted she was to have a PICC line placed that day before her SOC, and ordered 1 liter of IV fluids and anti nausea medication to be administered daily as needed. Patient #9's medical record noted a PICC line was placed on 10/22/14, the same day as her SOC. However, Patient #9's POC did not include PICC line care, patient education related to having a PICC line, orders for flushes and dressing changes, or supplies related to PICC line and maintenance. Patient #9's record included an ultrasound report	G 173		

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G 173	Continued From page 53 dated 11/03/14, which described a blood clot in her left arm. Her record indicated the PICC was discontinued and a peripheral IV was placed. Patient #9's record included a physician order for Lovenox injections to be administered 2 times daily. Patient #9's record did not include documentation of patient and caregiver information related to management of a blood clot, precautions, and teaching related to her Lovenox injections. b. Patient #9's POC for the certification period 12/21/14 to 2/18/15, included orders for SN visits. The orders were for the SN to assess Patient #9's vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen. The POC did not include orders for a peripheral IV, or include supplies related to maintanence of an IV, such as additional start kits, dressing supplies, flushes, etc. Patient #9's record included an order signed by her physician on 12/01/14, to educate her mother on how to administer IV medications. Patient #9's POC did not include the caregiver teaching as ordered by her physician. Additionally, the POC did not include Patient or care giver instruction regarding the administration of the SQ Lovenox injections. Patient #9's POC did not include assessments of fetal well being or patient education related to pregnancy and nutrition. Her record did not	G 173		

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G 173	Continued From page 54 include documentation related to patient education regarding pregnancy and nutrition. During an interview on 3/05/15 beginning at 12:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed there was no documentation related to patient education regarding management of a blood clot, use and precautions for Lovenox injections, and patient and caregiver administration of medications. The RN Case Manager confirmed Patient #9's POC's did not include additional orders for maintanence of PICC and peripheral lines, as well as, patient and caregiver education. Patient #9's RN Case Manager did not implement a comprehensive POC, with revisions as her condition changed.	G 173		
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure specialized and substantial nursing services were provided consistent with current standards of practice. These negative practices directly affected 1 of 12 patients (#9), whose records were reviewed. This resulted in the lack of appropriate nursing care for a patient with an intravenous access device, and injected anti-coagulants, and had to potential to result in patient harm. Findings include:	G 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 174	Continued From page 55 Patient #9 was a 27 year old female who was admitted to the agency on 10/22/14, for SN services related to pregnancy related nausea and vomiting. Her record and POC for the certification periods 10/22/14 to 12/10/14, and 12/21/14 to 2/18/15, were reviewed. Patient #9 was noted to have severe nausea and vomiting. Her POC included PRN medications of Phenergan 25 mg IV, every 6-8 hours, Zofran, 4-8 mg IV, 3 times daily, and Reglan 10 mg, orally, 3 times daily, as needed. a. Patient #9's record did not include evidence of patient education, or teaching regarding the medications, side effects, and frequency of administration. b. Patient #9's record did not include evidence that a diary or medication administration record was used to document how often the IV solution and PRN anti-nausea medications were given. c. Nursing notes that were reviewed during both certification periods included documentation the RN pre-filled syringes with Phenergan and Zofran to be administered intravenously to Patient #9 by her family members as she needed them. Her record did not indicate education was provided to Patient #9 and her family members regarding administration, storage and safety of medications in pre-filled syringes. d. Patient #9's PICC line was discontinued on 11/03/14, after a blood clot was identified. At that time she was started on Lovenox injections. Patient #9's record did not include education	G 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 174	Continued From page 56 regarding her blood clot and use of Lovenox, which would include administration of injected anti-coagulants, precautions, and injection sites. During an interview on 3/05/15 beginning at 12:00 PM, the RN who provided cares to Patient #9 reviewed her record. She confirmed there was no documentation of patient/caregiver education. Additionally, she confirmed a medication diary was not maintained, and stated she did not have a tracking method to determine when the PRN medications were used. The RN stated she contacted the community pharmacist regarding pre-filling syringes, and was told that they would be stable for at least a week. She stated she placed them in a labeled baggie and the syringes were stored in Patient #9's refrigerator. The agency failed to provide Patient #9 and her caregivers thorough education, and tracking of intravenous therapy and anticoagulant therapy, to ensure her care was provided in a safe manner.	G 174		
G 175	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. This STANDARD is not met as evidenced by: Based on medical record review, and staff interview it was determined the agency failed to ensure the registered nurse effectively evaluated patients to determine needed preventative or rehabilitative nursing measures for 3 of 12 patients (#2, #6, #8) whose records were reviewed. Failure to properly identify and	G 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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G 175	Continued From page 57 implement necessary precautions had the potential to place patients at risk for negative outcomes. Findings include: 1. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. a. The Home Care Manager and the Clinical Director were interviewed on 3/02/15, beginning at approximately 2:00 PM. They stated patient wounds were to be assessed and measured at least 1 time a week. Measurements were to be documented in the SN visit notes. Patient #8's record included a SOC comprehensive assessment, completed on 12/02/14, and signed by the RN Case Manager. The assessment documented a wound on his right heel, measuring 1.5 by 2.5 inches. SN visits were completed 2-3 times per week from 12/02/14 to 1/30/15. Wound care was provided during the SN visits. However, no additional wound measurements were documented, to assess the status of Patient #8's right heel wound, and determine the effectiveness of wound care provided. During an interview on 3/05/15 at 12:10 PM, the RN Case Manager reviewed Patient #8's record and confirmed it did not include measurements of his right heel wound after the SOC visit.	G 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 175	Continued From page 58 The agency failed to assure Patient #8's wound was measured weekly. b. Patient #8's record included a History and Physical (H&P) assessment dictated by his physician on 11/07/14, upon Patient #8's admission to the hospital. The H&P documented Patient #8 was admitted to the hospital due to CHF. The Mayo Clinic website, accessed on 3/13/15, stated CHF occurs when the heart doesn't pump blood as well as it should, resulting in excess fluid in the tissues and lungs. Patients with CHF should monitor their weight to determine if excess fluid is accumulating. Excessive weight gain should be reported to the physician. Patient #8's record included an SOC comprehensive assessment, completed on 12/02/14, and signed by the RN Case Manager. The assessment documented Patient #8's weight as 210 pounds. However, it did not indicate how his weight was measured, if he was weighed during the visit, or if he reported his weight from a previous measurement. The goals documented on Patient #8's POC for the certification period 12/02/14 to 1/30/15, included "The patient's weight will be maintained between 210 and 220 pounds for this cert period." Patient #8's record included SN visit notes documenting SN visits 2-3 times per week from 12/02/14 to 1/30/15. However, the notes did not document Patient #8's weight. Patient #8's record included a SN visit completed on 12/12/15, and signed by the RN. The note stated there was no scale in the home and	G 175		

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G 175	Continued From page 59 Patient #8's wife was encouraged to obtain a scale, monitor his weight and report changes to medical personnel. However, subsequent SN visit notes did not include Patient #8's weight, or document follow up related to obtaining a scale. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager confirmed Patient #8's weight was not obtained after his SOC visit. She was unsure why a scale was not obtained. The agency failed to ensure Patient #8's status related to CHF was fully assessed, to prevent a decline in his condition. c. Patient #8's record included an SN visit note, dated 1/01/15, and signed by the RN Case Manager. The respiratory assessment documented bilateral lower lobe expiratory (while exhaling) wheezing was noted. The visit note documented Patient #8's physician was notified, and ordered 10 days of Doxycycline, an antibiotic used to treat infections. Patient #8's record included an SN visit note, dated 1/26/15, and signed by the RN Case Manager. The respiratory assessment documented expiratory (while exhaling) wheezing in the left lower lobe, fine crackles in the right lower lobe, and increased shortness of breath. The visit note documented Patient #8's physician was notified, and ordered Zithromax, an antibiotic used to treat infections. Patient #8's record included an SN visit note, dated 2/02/15, and signed by an RN. The note documented the RN called Patient #8's physician to report signs and symptoms of upper respiratory infection.	G 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 175	Continued From page 60 Patient #8's POC for the certification period 12/02/14 to 1/30/15, included an order to assess vital signs and all body systems. However, the 22 SN visits documented between 12/02/14 and 2/02/15, did not document Patient #8's temperature, to assess for fever, a common sign of infection. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager reviewed Patient #8's record and confirmed the 22 SN visit notes did not include temperature readings. She stated she had a forehead scanning thermometer, however, it did not work well after being stored in her car during cold weather. She stated she would need to obtain a different thermometer to allow her to assess temperatures. The agency failed to ensure Patient #8's status was fully assessed. 2. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's record included an SOC comprehensive assessment, completed on 1/15/15, and signed by the RN Case Manager. The comprehensive assessment identified patient needs related to pain, fall prevention and pressure ulcer prevention. Patient #2's record included a POC for the certification period 1/15/15 to 3/15/15, created by	G 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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G 175	Continued From page 61 the RN Case Manager and signed by Patient #2's physician on 1/20/15. The POC included orders for SN visits 1-2 times a week for 2 weeks, to assess and educate Patient #2. Patient #2's record included documentation of a missed SN visit on 1/23/15. It stated the visit was not made because Patient #2 had an appointment with a specialist that day. No additional SN visit notes were included in Patient #2's record, as of 3/05/15. Her record did not include documentation to explain why SN visits were not completed as ordered in her POC. Additionally, there was no documentation stating Patient #2's physician was notified she did not receive SN visits as ordered. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager confirmed Patient #2 did not receive additional SN visits after the SOC visit. She stated the purpose of the SN visits were to monitor Patient #2's BP, and she didn't feel it was necessary to continue to monitor her BP after she was seen by the specialist. The RN Case Manager confirmed Patient #2's physician was not notified she did not receive SN visits as ordered. The agency did not ensure Patient #2 received SN services as ordered in her POC. 3. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed.	G 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 175	Continued From page 62 Patient #6's POC for the certification period 1/10/15 to 3/10/15, included an order for SN visits 1-2 times a week for 6 weeks, to assess vital signs, all body systems, and signs and symptoms of complications necessitating medical attention. Patient #6's current medications included 2 anti-hypertensive medications, Lasix and Valsarton. Additionally, she was taking Topral, a beta-blocker used to treat angina, and/or hypertension. Nursing 2015 Drug Handbook lists hypotension as a possible adverse reaction of Lasix, Valsarton and Toprol. Patient #6's record documented SN visits completed 1 time a week from 1/10/15 to 2/20/15. SN visit notes completed on 1/10/15 (SOC comprehensive assessment,) 1/16/15, 1/30/15, 2/06/15, 2/13/15, and 2/20/15, did not document vital signs, including BP to monitor for abnormally high or low readings. During an interview on 3/05/15 at 11:50 AM, the RN Case Manager reviewed Patient #6's record and confirmed vital signs were not documented on the above SN visit notes dated. She stated she sometimes relied upon the HHA to take and record vital signs. The RN failed to assess Patient #6's vital signs during her SN visits.	G 175		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs.	G 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

(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 177	Continued From page 63 This STANDARD is not met as evidenced by: Based on record review, observation during home visits, and staff and patient interview, it was determined the agency failed to ensure the RN provided necessary instruction to patients or caregivers for 2 of 12 patients (#5 and #9) who received SN services and whose records were reviewed. This created the potential for patients to experience adverse outcomes. Findings include: 1. Patient #5 was a 97 year old female, admitted to the agency on 9/26/14, due to a history of non-compliance with her medications. Additional diagnoses included syncope, dementia, HTN and hypothyroidism. She received SN and HHA services. Her record, including the POC, for the certification period 1/24/15 to 3/24/15, was reviewed. Patient #5's POC included an order for the SN to fill her pill organizer weekly and monitor her medication compliance. Patient #5's medication list included Fosamax 70 mg, to be taken weekly. Merck and Company's package insert for Fosamax, revised 2/2015, accessed on-line on 3/12/15, included the following instructions for administration of Fosamax: Instruct patients to: - Swallow tablets whole with 6-8 ounces plain water at least 30 minutes before the first food, drink, or medication of the day. - Not lie down for at least 30 minutes after taking FOSAMAX and until after food. A visit was made to Patient #5's home on 3/04/15	G 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 177	Continued From page 64 at 8:30 AM, to observe an HHA visit. During the visit, Patient #5's medications were reviewed. Her pills were observed to be in a weekly pill planner that contained one compartment for each day of the week. Patient #5 was unable to state which day of the week she took Fosamax, and was not aware she took a medication that should be taken alone prior to eating. Patient #5 stated she took medications only one time per day, and took all that day's pills together, either before or after breakfast. During an interview on 3/05/15 at 10:30 AM, the RN Case Manager confirmed Patient #5 was not taking her Fosamax correctly, and stated Patient #5 had a hard time remembering specific instructions. She then stated perhaps the RN or HHA could remind her to take her Fosamax correctly during one of their scheduled visits. The agency failed to ensure Patient #5 received on-going education to ensure she took her medications properly. 2. Patient #9 was a 27 year old female who was admitted to the agency on 10/22/14, for severe nausea and vomiting related to pregnancy. Her record and POC for the certification periods 10/22/14 to 12/20/14, and 12/21/14 to 2/18/15, were reviewed. a. Patient #9's POC for the certification period 10/22/14 to 12/20/14, included orders for SN visits. The orders were for the SN to assess Patient #9's vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen.	G 177		

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G 177	Continued From page 65 The referral order for Patient #9, dated and signed by her physician on 10/21/14, noted she was to have a PICC line placed, and ordered 1 liter of IV fluids and anti nausea medication to be administered daily as needed. Patient #9's medical record noted a PICC line was placed on 10/22/14, the same day as her SOC. However, Patient #9's POC did not include patient education related to having a PICC line. Patient #9's record included an ultrasound report dated 11/03/14, which described a blood clot in her left arm. Her record indicated the PICC was discontinued and a peripheral IV was placed. Patient #9's record included a physician order for Lovenox injections to be administered 2 times daily. Patient #9's record did not include documentation of patient and caregiver information related to management of a blood clot, precautions, and teaching related to her Lovenox injections. Patient #9's record did not include documentation of patient teaching consistent with her medical needs. b. Patient #9's POC for the certification period 12/21/14 to 2/18/15, included orders for SN visits. The orders were for the SN to assess Patient #9's vital signs, and assess her body systems. Additionally, the SN was to assess Patient #9's knowledge of disease process and its associated care and treatment, as well as, her medication regimen. The certification period spanned the period of	G 177		

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G 177	Continued From page 66 time between Patient #9's 16th and 25th week of pregnancy. Her POC and record did not include assessments of fetal well being or patient education related to pregnancy and nutrition. Patient #9's record included an order signed by her physician on 12/01/14, to educate her mother on how to administer IV medications. Patient #9's POC did not include the caregiver teaching as ordered by her physician. Additionally, the POC did not include patient or caregiver instruction regarding the administration of the SQ Lovenox injections. During an interview on 3/05/15 beginning at 12:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed there was no documentation related to patient education regarding management of a blood clot, use and precautions for Lovenox injections, and patient and caregiver administration of medications. Patient #9's RN Case Manager did not ensure comprehensive education was provided related to pregnancy, IV management, blood clot management, and SQ injections.	G 177		
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 health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by:	G 224		

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G 224	Continued From page 67 Based on record review, and staff interview, it was determined the agency failed to ensure the HHA provided services in accordance with the HHA care plan drafted by the RN, for 4 of 7 patients (#3, #5, #6, and #11) who received aide services and whose records were reviewed. Failure of the aide to follow the care plan had the potential to negatively impact the quality of patient care. Findings include: 1. Patient #3 was a 71 year old male who was admitted to the agency on 2/15/15, for SN, PT, and HHA services related to a total hip replacement. Additional diagnoses included diabetes, blindness, HTN, depression, and sleep apnea. The record and POC for the certification period 2/15/15 to 4/15/15, were reviewed. The "Aide/Homemaker Care Plan," dated 2/15/15, included HHA duties to include vital signs once weekly, hand and foot care (clean and file nails, and to soak his feet) twice weekly, and exercise per PT. Patient #3's record included forms titled "Alternative Care Services," which indicated the duties performed by the HHA during the twice weekly visits. HHA services were provided to Patient #3 that were not on the POC, or were contraindicated related to his diagnoses, or were not provided as ordered on his POC. a. The POC included hand and foot care, however, Patient #3 was a diabetic, and providing foot care to a diabetic patient is not within a HHA scope of practice. HHA visits were completed on 2/17/15, 2/20/15, 2/24/15, and 2/27/15. The HHA documented she	G 224		

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G 224	Continued From page 68 provided nail and foot care to Patient #3 on 2/24/15. b. The POC included exercises twice weekly per physical therapy, however, there was no indication the therapist provided direction to the HHA related to specific exercises. HHA visits were completed on 2/17/15, 2/20/15, 2/24/15, and 2/27/15. The HHA documented she provided ROM, both active and passive to Patient #3 on 2/17/15, and 2/20/15. c. The POC did not include housekeeping activities, however, the HHA notes indicated housekeeping activies were provided. HHA visits were completed on 2/17/15, 2/20/15, 2/24/15, and 2/27/15. The HHA documented she provided activities which included vacuuming, dusting, cleaning the bathroom and kitchen, changing the bed, and laundry during each visit. During an interview on 3/05/15 at 9:05 AM, Patient #3's RN Case Manager confirmed the HHA provided the services as documented. She stated the HHA would only file Patient #3's toenails, and not cut them. The RN stated when she completed the HHA POC the section regarding exercises per physical therapy, she thought it meant that physical therapy was providing Patient #3 with exercises, not the HHA. Patient #3's HHA POC was not completed accurately, and the HHA did not follow the POC. 2. Patient #5 was a 97 year old female, admitted to the agency on 9/26/14, due to a history of non-compliance with her medications. Additional	G 224		

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G 224	Continued From page 69 diagnoses included syncope, dementia, HTN and hypothyroidism. Her record, including the POC, for the certification period 1/24/15 to 3/24/15, was reviewed. Patient #5's record included a HHA Care Plan, completed on 9/26/14, and signed by the RN Case Manager. The Care Plan included instructions to complete exercises on every visit, per physical therapy. However, there was no indication the Physical Therapist provided direction to the HHA regarding specific exercises to be completed. HHA visit notes dated 1/26/15, 1/28/15, 1/30/15, 2/02/15, 2/04/15, 2/09/15, 2/11/15, 2/13/15, 2/16/15, 2/18/15, and 2/20/15, documented active and passive ROM was provided by the HHA to Patient #5. During an interview on 3/05/15 at 10:30 AM, the RN Case Manager confirmed Patient #5's HHA Care Plan included instruction to the HHA to complete exercises per PT. However, she stated that meant Patient #5 was receiving PT services and did not indicate the HHA should provide exercises. The agency did not ensure instructions for Patient #5's HHA services were clear and complete. 3. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #6's record included a HHA Care Plan,	G 224		

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G 224	Continued From page 70 completed on 1/10/15, and signed by the RN Case Manager. The Care Plan included instructions to complete exercises on every visit, per PT/OT/SP. However, there was no indication a therapist provided direction to the HHA regarding specific exercises to be completed. HHA visit notes dated 1/20/15, and 1/23/15, documented therapy was provided by the HHA to Patient #6. A note indicated "Massage back." A HHA note dated 1/27/15, documented therapy was provided by the HHA to Patient #6. A note indicated "Rub back." During an interview on 3/05/15 at 11:50 AM, the RN Case Manager confirmed Patient #6's HHA Care Plan included instruction to the HHA to complete exercises per PT. However, she stated that meant Patient #6 was receiving PT services and did not indicate the HHA should provide exercises. The agency did not ensure instructions for Patient #6's HHA services were clear and complete. 4. Patient #11 was an 81 year old male admitted to the agency on 1/31/15, for services related to malaise and fatigue. Additional diagnoses included depression and hypertension. He received SN, HHA and MSW services. His record, including the POC, for the certification period 1/31/15 to 3/31/15, was reviewed. Patient #11's record included a HHA Care Plan, completed on 2/01/15 and signed by the RN Case Manager. The Care Plan included a check mark and a frequency of 2 times per week next to tub bath, shower, bed bath and assist bath-chair. The Care Plan did not indicate how the HHA	G 224		

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G 224	Continued From page 71 would determine which type of bath should be completed on each visit. During an interview on 3/05/15 at 11:30 AM, the RN Case Manager reviewed Patient #11's record and confirmed the HHA Care Plan did not provide clear direction to the HHA regarding the type of bath she should provide. The agency did not ensure instructions for Patient #11's HHA services were clear and complete.	G 224		
G 225	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 observation, patient and staff interview, and review of medical records, it was determined the agency failed to ensure HHAs provided services in accordance with the plan of care for 5 of 7 patients (#2, #4, #5, #6, and #8) who received HHA services. This had the potential to interfere with safety and quality of patient care. Findings include: 1. Patient #4 was a 93 year old male who was admitted to the agency on 1/06/14, for SN and HHA services related to debility and weakness. During a home visit on 3/03/15 beginning at 10:00 AM, Patient #4 was telling his RN how satisfied he was with the HHA. He stated "I used to get up about 4 times every night to go to the bathroom,	G 225		

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G 225	Continued From page 72 but [name of HHA], bought me some medicine, and now I just get up twice each night." The medicine he referred to was ZZZ-Quil, and it was not included on his POC or his medication profile. During an interview on 3/05/15 beginning at 10:45 AM, the RN from the home visit on 3/03/15, confirmed the medication was not included on the POC. The RN stated she was surprised by the fact that the HHA bought the medication and offered it to Patient #4 before speaking with her. The RN confirmed that activity was not included on the HHA POC. The HHA purchased and provided medication to Patient #4, which was not within her scope of practice. 2. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's record included an HHA Care Plan, developed on 1/15/15, and signed by the RN Case Manager. The care plan included instruction to the HHA to measure Patient #2's vital signs, including temperature, BP, pulse and respirations, every week and as needed. Vital signs were not completed weekly, as follows: Week 1 - An HHA visit note, dated 1/16/15, documented Patient #2's blood pressure and pulse only. Temperature and respirations were not documented.	G 225		

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G 225	Continued From page 73 Week 2 - HHA visit notes dated 1/19/15, and 1/22/15, did not document vital signs. Week 3 - HHA visit notes dated 1/26/15, and 1/29/15, did not document vital signs. The HHA visit note included a note, dated 1/29/15, and signed by the RN Case Manager. It stated "Discussed the need for VS [vital signs] et [and] the requirement for them from this point on." Week 4 - An HHA visit note dated 2/02/15 documented respirations only. A HHA visit note dated 2/05/15 did not document vital signs. Week 5 - HHA visit notes dated 2/09/15, and 2/12/15, did not document vital signs. The HHA visit note included a note, dated 2/12/15, and signed by the RN Case Manager. It stated "Discussed with aide the need for VS [vital signs] from this point on." Week 6 - HHA visit notes dated 2/16/15, and 2/19/15, did not document vital signs. Week 7 - An HHA visit note dated 2/23/15, documented BP, pulse and respirations. Tempurature was not documented. A HHA visit note dated 2/26/15, did not document vital signs. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager reviewed Patient #2's record and confirmed the HHA did not complete vital signs as instructed on the HHA care plan. Patient #2's HHA did not provide vital signs as ordered in the POC. 3. Patient #5 was a 97 year old female, admitted to the agency on 9/26/14, due to a history of	G 225		

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G 225	Continued From page 74 non-compliance with her medications. Additional diagnoses included syncope, dementia, HTN and hypothyroidism. Her record, including the POC, for the certification period 1/24/15 to 3/24/15, was reviewed. Patient #5's record included an HHA Care Plan, developed on 9/26/14, updated on 1/21/15, and signed by the RN Case Manager. The care plan included instruction to the HHA to measure Patient #5's vital signs, including temperature, BP, pulse and respirations every week and as needed. Patient #5's record included 2 HHA visit notes for week 3 of her certification period, dated 2/02/15, and 2/04/15. The visit notes did not document vital signs. During an interview on 3/05/15 at 10:30 AM, the RN Case Manager reviewed the record and confirmed the HHA Care Plan included orders for weekly vital signs, however, the HHA did not document vital signs during week 3 of Patient #5's certification period. Patient #5's HHA did not provide vital signs weekly as ordered in her POC. 4. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #6's record included an HHA Care Plan, developed on 1/10/15, and signed by the RN Case Manager. The care plan included	G 225		

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G 225	Continued From page 75 instruction to the HHA to measure Patient #6's vital signs, including temperature, BP, pulse and respirations every week and as needed. Patient #6's record included 2 HHA visit notes for week 3 of her certification period, dated 1/20/15, and 1/23/15. The visit notes did not document vital signs. Patient #6's record included 2 HHA visit notes for week 4 of her certification period, dated 1/27/15, and 1/30/15. The visit notes did not document vital signs. During an interview on 3/05/15 at 11:50 AM, the RN Case Manager reviewed the record and confirmed the HHA Care Plan included orders for weekly vital signs, however, the HHA did not document vital signs during weeks 3 and 4 of Patient #6's certification period. Patient #6's HHA did not provide vital signs weekly as ordered in her POC. 5. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. Patient #8's record included an HHA Care Plan, developed on 1/10/15, and signed by the RN Case Manager. The care plan included instruction to the HHA to measure Patient #6's vital signs, including temperature, BP, pulse and	G 225		

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FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 225	Continued From page 76 respirations every week and as needed. Patient #8's record included an HHA visit note for week 7 of her certification period, dated 1/16/15. The visit note did not document vital signs. Patient #8's record included an HHA visit note for week 8 of her certification period, dated 1/23/15. The visit note did not document vital signs. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager reviewed the record and confirmed the HHA Care Plan included orders for weekly vital signs, however, the HHA did not document vital signs during weeks 7 and 8 of Patient #8's certification period. Patient #8's HHA did not provide vital signs weekly as ordered in his POC.	G 225		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure home health aide supervisory visits were conducted every 14 days for 1 of 7 patients (#2) who received home health aide services and whose records were reviewed. This had the potential to interfere with the quality and safety of patient care. Findings include:	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 229	Continued From page 77 The agency's policy, titled Supervisory Visits, approved 11/13/06, and revised 1/07/08, included "A visit will be conducted every two weeks to patients who require skilled services (Home Health Aide.) 1. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's POC included an order for HHA visits 1 time a week for 1 week and 2 times a week for 5 weeks. Patient #2's record included 13 HHA visit notes between 1/16/15 and 2/26/15, completed and signed by the HHA. However, there were no HHA supervisory visits documented in Patient #2's record for the certification period 1/15/15 to 3/15/15. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager reviewed Patient #2's record and confirmed no HHA supervisory visits were completed during the certification period 1/15/15 to 3/15/15. The agency failed to ensure HHA supervisory visits were completed every 14 days.	G 229		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 236	Continued From page 78 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. This STANDARD is not met as evidenced by: Based on review of medical records and agency policy and staff interview it was determined the agency failed to ensure medical records contained clear, complete, and accurate documentation for 3 of 12 patients (#2, #3, and #7) 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: An agency policy titled "Documentation/Charting," dated 5/16/07, noted clinical notes must be completed within 24 hours of service. Additionally, the policy noted that accurate, current charting is essential as charting plays an important role in care planning and coordination. 1. Patient #3 was a 71 year old male, admitted to the agency on 2/15/15, for SN, PT, and HHA services following his hospital discharge related to a right total hip replacement. Additional diagnoses included Type II diabetes, blindness, neuropathic pain, low back pain, depression, and sleep apnea. His records and POC for the certification period 2/15/15 to 4/15/15, were reviewed. Patient #3's record was not complete and	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 236	Continued From page 79 accurate. Examples include: a. The SOC comprehensive assessment, dated 2/15/15, did not include vital signs. b. The comprehensive assessment, dated 2/15/15, supplement, on page 2, included a section to list caregivers. The RN's written response was "No changes since last assessment." There was no previous assessment of Patient #3, and the response was inappropriate to the question. c. The comprehensive assessment supplement on page 3, under the heading "Safety Measures," the RN entered "Anticoagulant Measures," however, his POC and medication profile did not include anticoagulant medications. d. The HHA POC, dated 2/15/15, included conflicting documentation. One section noted Patient #3 lived with his son. The bottom part of the POC, under "Pertinent Information," the box was marked to indicate Patient #3 lived alone. During an interview on 3/05/15 beginning at 9:05 AM, Patient #3's RN Case Manager reviewed his record and confirmed the vital signs were not entered on the comprehensive assessment. She stated she took Patient #3's vital signs, but due to a software problem, not all the computers are able to print the vital signs on the printed assessment. She was unable to provide documentation the vital signs were obtained that day. Additionally, the RN confirmed her documentation on the SOC assessment stated no changes in relation to caregivers. She stated that entry was made in error. The RN confirmed that Patient #3 was not on anticoagulants at the	G 236		

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	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 236	Continued From page 80 time of his admission, and the entry was made in error. Entries in Patient #3's record were inaccurate, and incomplete. 2. Patient #7 was an 85 year old female who was admitted to the agency on 2/07/15, for SN, PT, and HHA services following a hospitalization and back surgery. Her record and POC for the certification period 2/07/15 to 4/07/15, were reviewed. A nursing note electronically dated 2/16/15, was crossed out and dated 2/17/15, and initialled by Patient #7's RN Case Manager. The note included documentation that was not clear as follows: a. "Dr.[name] saw pt [patient] for tachycardia et [and] dizziness. He stopped her Losartan et told her to resume the Metropolol. She states that she has felt much better since then." The entry did not include times or dates of when Patient #7 saw her physician, or when she changed her medications. b. The nursing note documented Patient #7's pain as daily but not constantly, and that her pain medications were effective. However, there was no level of pain as rated on a pain scale. During an interview on 3/05/15 beginning at 10:00 AM, Patient #7's RN Case Manager reviewed her record and confirmed the documentation was not clear and complete. She stated Patient #7's physician would quite often stop by her home after his office closes, and make a home visit. She stated that was probably how Patient #7	G 236		

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	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 236	Continued From page 81 received medication change instructions. Patient #7's record did not include clear and accurate documentation. 3. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's record included a POC for the certification period 1/15/15 to 3/15/15. Locator 27 of the POC stated "Attending Physician's Signature and Date Signed." Locator 27 did not include the signature of Patient #2's physician. It contained the stamped name of Patient #2's physician. A CMS Survey and Certification Group memorandum, S&C-08-22, dated 5/30/08, stated "Effective immediately, HHAs and hospices may not accept physicians' rubber stamp signatures for their clinical record documentation. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager reviewed Patient #2's POC and confirmed Locator 27 contained a stamped name, and the POC did not include her physician's signature. Patient #2's POC did not contain her physician's signature to confirm physician approval of her POC.	G 236		
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA	G 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 322	Continued From page 82 The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure encoded OASIS data reflected the patient's status at the time of assessment for 2 of 12 patients whose records were reviewed (#2 and #8). This resulted in inaccuracies between the SOC assessment and OASIS data. Findings include: 1. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. Patient #2's record included a POC for the certification period 1/15/15 to 3/15/15, created by the RN Case Manager, and signed by her physician on 1/20/15. Locator 18.A on the POC, Functional Limitations, contained a check mark next to "Dyspnea [shortness of breath] with Minimal Exertion." Patient #2's record included a SOC comprehensive assessment, including OASIS data, completed on 1/15/15, and signed by the RN Case Manager. The respiratory section of Patient #2's assessment documented "WNL" (within normal limits.) OASIS item M1400 asks "When is the patient dyspneic or noticeably Short of Breath?" The	G 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 322	Continued From page 83 clinician must choose 1 of 5 answers, as follows: 0-Patient is not short of breath 1-When walking more than 20 feet, climbing stairs 2-With moderate exertion 3-With minimal exertion 4-At rest Patient #2's OASIS item M1400, completed during her SOC assessment on 1/15/15, was answered with option number 1, indicating Patient #2 became short of breath when walking more than 20 feet, climbing stairs. However, her POC indicated she was dyspneic (short of breath) with minimal exertion. During an interview on 3/05/15 at 11:00 AM, the RN who completed the SOC and OASIS assessment confirmed the M1400 OASIS data did not match Patient #2's SOC assessment. She was unable to explain the discrepancy. Patient #2's OASIS data did not accurately reflect her respiratory status. 2. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. Patient #8's record included an SOC comprehensive assessment, including OASIS data, completed on 12/02/14, and signed by the RN Case Manager.	G 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

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G 322	Continued From page 84 OASIS item M1308 asked for the current number of unhealed pressure ulcers at each stage. A pressure ulcer is a localized injury to skin and/or tissue, caused by pressure. Pressure ulcers are defined by stages I-IV, based on the depth of tissue injury. An ulcer that cannot be visualized, due to necrotic tissue or blistering, is documented as unstageable. Patient #8's OASIS assessment, item M1308, was answered with "b. Stage III: Full thickness tissue loss." However, the wound section of Patient #8's SOC assessment described his wound as a blood filled blister, and stated the blister was intact. The manual, Instant OASIS Answers, 2015 edition, provided CMS based guidance for accurate completion of OASIS questions. The manual provided instruction in staging of pressure ulcers. It defined M1308 answer d.3 as "Suspected deep tissue injury in evolution...blood filled blister due to damage of underlying soft tissue from pressure and/or shear." Therefore, the correct answer on Patient #8's SOC OASIS assessment, question M1308, was d.3 Unstageable, rather than b. Stage III. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager stated she was not aware of the OASIS definition of an unstageable pressure ulcer, and thought if there was blood it was always a stage III pressure ulcer. She confirmed this was incorrect, based on the OASIS definition of pressure ulcers. Patient #8's OASIS data did not accurately reflect the status of his pressure ulcer.	G 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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G 331	Continued From page 85	G 331		
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the SOC assessment was comprehensive and OASIS data items were incorporated into the agency's SOC assessment for 4 of 12 patients (#2, #6, #8 and #11) whose records were reviewed. This resulted in a SOC assessment that was not thorough to determine all patient needs. Findings include: 1. Patient #6 was a 78 year old female, admitted to the agency on 1/10/15, for services related to malaise and fatigue, and adult failure to thrive. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/10/15 to 3/10/15, was reviewed. Patient #6's record included a form titled "PHYSICAL ASSESSMENT," dated 1/15/15, and signed by the RN Case Manager. The assessment included a review of Patient #6's health history and body systems, and an assessment of risks for falls and rehospitalization. The assessment did not document Patient #6's vital signs. Patient #6's record included form titled "COMPREHENSIVE ASSESSMENT," dated 1/15/15, and signed by the RN. The assessment	G 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 331	Continued From page 86 included OASIS data items only. However, the OASIS data items and additional assessment items were not integrated to ensure a comprehensive assessment that reflected Patient #6's current status. During an interview on 3/05/15 at 11:50 AM, the RN Case Manager reviewed Patient #6's record. She confirmed Patient #6's SOC assessment did not include vital signs. Additionally, she confirmed the OASIS data items were not integrated into the agency's assessment to provide a comprehensive assessment. She stated the agency's electronic health record did not integrate OASIS data items into the SOC assessment. Patient #6's SOC assessment was not comprehensive to include her vital signs and OASIS data items were not integrated into her SOC assessment. 2. Patient #11 was an 81 year old male admitted to the agency on 1/31/15, for services related to malaise and fatigue. Additional diagnoses included depression and hypertension. He received SN, HHA and MSW services. His record, including the POC, for the certification period 1/31/15 to 3/31/15, was reviewed. Patient #11's record included a form titled "PHYSICAL ASSESSMENT," dated 1/31/15, and signed by the RN Case Manager. The assessment included a review of Patient #11's health history and body systems, and an assessment of risks for falls and rehospitalization. The assessment did not document Patient #11's vital signs. Patient #11's record included a form titled	G 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 331	Continued From page 87 "COMPREHENSIVE ASSESSMENT," dated 1/15/15, and signed by the RN. The assessment included OASIS data items only. However, the OASIS data items and additional assessment items were not integrated to ensure a comprehensive assessment that reflected Patient #6's current status. During an interview on 3/05/15 at 11:30 AM, the RN Case Manager reviewed Patient #11's record. She confirmed Patient #11's SOC assessment did not include vital signs. Additionally, she confirmed the OASIS data items were not integrated into the agency's assessment to provide a comprehensive assessment. She stated the agency's electronic health record did not integrate OASIS data items into the SOC assessment. Patient #11's SOC assessment was not comprehensive to include her vital signs and OASIS data items were not integrated into her SOC assessment. 3. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed. a. Patient #2's record included a SOC comprehensive assessment, dated 1/15/15, and signed by the RN Case Manager. The assessment did not include Patient #2's vital signs. The assessment included a note stating "Dizziness, BLOOD PRESSURE IS LOW." However, a BP measurement was not	G 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 331	Continued From page 88 documented. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager reviewed Patient #2's SOC assessment and confirmed it did not include documentation of vital signs. Patient #2's SOC assessment was not comprehensive to include her vital signs. b. Patient #2's record included a SN SOC comprehensive assessment, completed on 1/15/15, and signed by the RN Case Manager. The assessment did not include Patient #2's BP, pulse, respiratory rate, or temperature, to thoroughly assess her status. During an interview on 3/05/15 at 11:00 AM, the RN Case Manager reviewed Patient #2's SOC assessment and confirmed it did not include vital signs. She was unable to explain why vital signs were not documented as part of the assessment. The RN failed to assess Patient #2's vital signs during her comprehensive assessment. c. Patient #2's record included a POC for the certification period 1/15/15 to 3/15/15, created by the RN Case Manager, and signed by her physician on 1/20/15. The POC stated Patient #2 became SOC with minimal exertion. Patient #2's record included a SOC comprehensive assessment, including OASIS data, completed on 1/15/15, and signed by the RN Case Manager. The respiratory section of Patient #2's assessment documented "WNL" (within normal limits.)	G 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

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G 331	Continued From page 89 OASIS item M1400 asks "When is the patient dyspneic or noticeably Short of Breath?" The clinician must choose 1 of 5 answers, as follows: 0-Patient is not short of breath 1-When walking more than 20 feet, climbing stairs 2-With moderate exertion 3-With minimal exertion 4-At rest Patient #2's OASIS item M1400, completed during her SOC assessment on 1/15/15, was answered with option number 1, When walking more than 20 feet, climbing stairs. However, her POC indicated she was dyspneic with minimal exertion. During an interview on 3/05/15 at 11:00 AM, the RN who completed the SOC and OASIS assessment confirmed the M1400 OASIS data did not match Patient #2's SOC assessment. She was unable to explain the discrepancy. Patient #2's SOC comprehensive assessment did not accurately reflect her respiratory status. 4. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. a. Patient #8's record included a SN SOC comprehensive assessment, dated 12/02/14, and signed by the RN Case Manager. The assessment did not include Patient #8's vital	G 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137058		03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER HOME CARE	126 EAST FIRST NORTH PRESTON, ID 83263

(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 331	Continued From page 90 signs. During an interview on 3/05/15 at 12:10 AM, the RN Case Manager reviewed Patient #8's SOC assessment and confirmed it did not include documentation of vital signs. Patient #8's SOC assessment was not comprehensive to include his vital signs. b. Patient #8's record included a SOC comprehensive assessment, including OASIS data, completed on 12/02/14, and signed by the RN Case Manager. OASIS item M1308 asked for the current number of unhealed pressure ulcers at each stage. A pressure ulcer is a localized injury to skin and/or tissue, caused by pressure. Pressure ulcers are defined by stages I-IV, based on the depth of tissue injury. An ulcer that cannot be visualized, due to necrotic tissue or blistering, is documented as unstageable. Patient #8's OASIS assessment, item M1308, was answered with "b. Stage III: Full thickness tissue loss." However, the wound section of Patient #8's SOC assessment described his wound as a blood filled blister, and stated the blister was intact. The manual, Instant OASIS Answers, 2015 edition, provided CMS based guidance for accurate completion of OASIS questions. The manual provided instruction in staging of pressure ulcers. It defined M1308 answer d.3 as "Suspected deep tissue injury in evolution...blood filled blister due to damage of underlying soft tissue from pressure and/or shear." Therefore,	G 331		

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G 331	Continued From page 91 the correct answer on Patient #8's SOC OASIS assessment, question M1308, was d.3 Unstageable, rather than b. Stage III. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager stated she was not aware of the definition of an unstageable pressure ulcer, and thought if there was blood it was always a stage III pressure ulcer. She confirmed this was incorrect, based on the definition of pressure ulcers. Patient #8's SOC comprehensive assessment did not accurately reflect the status of his pressure ulcer.	G 331		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, policy review, observations in the home, and patient and staff interview it was determined the facility failed to ensure a comprehensive drug regimen review for 8 of 12 patients (#1, #2, #3, #4, #5, #8, #9 and #10) whose records were reviewed. This had the potential to result in adverse events, duplicative drug therapy, or negative drug interactions. Findings include: An agency policy titled "Medication Review," dated 11/01/06, stated the SN would review all	G 337		

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G 337	Continued From page 92 prescribed medications frequently with the patient, teaching such things as side effects, purpose of medication, adverse reactions, etc. The policy noted the medication sheet should include all medications, including over the counter medications and herbs. Additionally, the SN would educate the patient and document teaching about medication side effects. The policy noted the patient medication list would be updated every recertification and when new medications were ordered. Lastly, the policy noted that each patient would have a home folder which included a medication sheet with the name and purpose of each medication. The staff failed to follow the policy as noted in the following examples: 1. Patient #3 was a 71 year old male, admitted to the agency on 2/15/15, for SN, PT, and HHA services following his hospital discharge related to a right total hip replacement. Additional diagnoses included Type II diabetes, blindness, neuropathic pain, low back pain, depression, and sleep apnea. His records and POC for the certification period 2/15/15 to 4/15/15, were reviewed. a. Patient #3's hospital discharge medication list, dated 2/13/15, was compared with the SOC medication list dated 2/15/15. The hospital medication list included (an anticoagulant medication) Eliquis 5 mg, orally, twice a day. The medication was not included on the SOC assessment or on the POC. Additionally, on the SOC comprehensive assessment dated 2/15/15, under locator M2000, the RN noted "No problems found during review." The RN documented on Locator M2010, "Patient not taking any high risk drugs." However, anticoagulants are high risk drugs, due to the risk of excessive bleeding.	G 337		

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G 337	Continued From page 93 b. Patient #3's record did not include evidence his medications were reviewed for duplicative therapy, contraindications, or interactions. On 3/03/15 at 7:15 AM, Patient #3's medications were entered into a database on Drugs.com, and a drug interaction report was printed. The report included 3 major drug interactions: - Tramadol and escitalopram may increase the risk of a rare but serious condition called Serotonin syndrome. - Simvastatin and fenofibrate, when used together increases the risk of a rare but serious condition called rhabdomyolysis that involves the breakdown of skeletal muscle tissue. It may cause kidney damage and even death. - Hydrocodone and tramadol, when used together may increase the risk of seizures, breathing problems, or other side effects. The report also stated if the medications are prescribed together, a special test may be needed to determine if both medications may be taken together safely. During an interview on 3/05/15 at 9:05 AM, the RN who completed the SOC assessment reviewed Patient #3's record and confirmed she did not include Eliquis on the POC or the medication sheet. She stated she did not see Eliquis on Patient #3's discharge medication list, and he did not have it in the home on the day of the SOC visit. Additionally, the RN stated her process of medication reconciliation was to review the medications, and based on her knowledge, instruct the patient if there were any anticipated side effects. The RN stated she was not aware of "Drugs.com," or any other database	G 337		

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G 337	Continued From page 94 to screen for contraindications and interactions. On 3/05/15 at 11:30 AM, Patient #3's RN stated she confirmed Patient #3 never received the Eliquis. She stated that when she contacted the pharmacy, she was told the medication was held until the physician provided further information to his insurance company. Patient #3's medication list was incomplete, a comprehensive medication review was not performed, and as a result he did not receive an essential anti-coagulant medication that was ordered upon his discharge. 2. Patient #4 was a 93 year old male who was admitted to the agency on 3/03/15, for SN and HHA services related to malaise and fatigue. His record and POC for the certification period 1/01/15 to 3/01/15, and 3/02/15 to 4/30/15, were reviewed. During a home visit on 3/03/15 beginning at 10:00 AM, to observe SN services, Patient #4's medications were reviewed. Medications were found that Patient #4 stated he was taking, that were not found on the POC. The following medications were noted: - Antifungal ointment, topical - Muprocin 2% ointment - Mucinex, a decongestant - ZZZ-Quil, diphenhydramine, a sleep aid. During an interview on 3/05/15 beginning at 10:45 AM, the RN from the home visit on 3/03/15, confirmed the medications identified that day were not included on the POC.	G 337		

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G 337	Continued From page 95 The RN who performed Patient #4's reassessment on 2/24/15, was interviewed on 3/05/15 at 11:00 AM. She stated her process of medication reconciliation was to review the medications, and based on her knowledge, instruct the patient if there are any anticipated side effects. The RN stated she was not aware of "Drugs.com," or any other database to screen for contraindications and interactions. Patient #4's medication list was incomplete. 3. Patient #9 was a 27 year old female who was admitted to the agency on 10/22/14, for SN services related to pregnancy related nausea and vomiting. Her record and POC for the certification periods 10/22/14 to 12/20/14, and 12/21/14 to 2/18/15, were reviewed. Nursing notes on 12/16/14, documented Patient #9 was taking a stool softener, however it was not included on her POC. During an interview on 3/05/15 beginning at 12:00 PM, the RN who provided cares to Patient #9 reviewed the record and confirmed the stool softener was not included on the POC. Patient #9's medications were not reconciled at the SOC or during the recertification assessment. 5. Patient #10 was a 75 year old male who was admitted to the agency on 12/31/14, for SN, PT, and MSW services related to debility, CHF, A-Fib, HTN, and depression. His record and POC for the certification period 12/31/14 to 2/28/15, were reviewed. The section of the comprehensive assessment	G 337		

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G 337	Continued From page 96 dated 12/31/14, under locator M2000, "Drug Regimen Review," the box which indicated "No problems found during review" was marked. The section of the comprehensive assessment under locator M2010, "Patient/Caregiver High Risk Drug Education," "Yes" was marked. However, there was no further documentation to indicate what kind of drug education was provided, and for which drugs. On 3/04/15 at 7:00 AM, Patient #10's medications were entered into a database on Drugs.com, and a drug interaction report was printed. The report included 5 major drug interactions: - Escitalopram and duloxetine, when used together may increase the risk of Serotonin Syndrome. - Tramadol and duloxetine, when used together may increase the risk of Serotonin Syndrome. - Morphine and tramadol, when used together may increase the risk of seizures, breathing problems, or other side effects. The report also stated if the medications are prescribed together, a special test may be needed to determine if both medications may be taken together safely. - Hydrocodone and tramadol, when used together may increase the risk of seizures, breathing problems, or other side effects. The report also stated if the medications are prescribed together, a special test may be needed to determine if both medications may be taken together safely. - Tramadol and escitalopram may increase the risk of a rare but serious condition called	G 337		

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G 337	Continued From page 97 Serotonin syndrome. During an interview on 3/05/15 at 11:30 AM, the RN who completed the SOC comprehensive assessment and developed the POC confirmed she did not use a resource for medication reconcilliation. She described her process of medication review, and stated she reviewed the medication list with the medications Patient #10 had in his home. The RN stated she was familliar with many of the medications, and by looking at the medication list, would be able to determine if Patient #10 would need further education about side effects. The RN stated she was unaware of on line resources for medication review. A comprehensive drug review was not performed. 6. Patient #8 was a 91 year old male, admitted to the agency on 12/02/14, following a hospitalization for CHF. Additional diagnoses included diabetes, pressure ulcer on the heel, hypoxemia and HTN. He received SN, PT, OT and HHA services. His record, including the POC, for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15, were reviewed. a. Patient #8's record included a SOC assessment, dated 12/02/14, signed by the RN Case Manager. The assessment documented Patient #8 was an insulin dependent diabetic, however, insulin was not included on Patient #8's POC or medication list for the certification period 12/02/14 to 1/30/15. b. Patient #8's SOC assessment, item M1410, documented use of oxygen, however, oxygen was not included on Patient #8's POCs or	G 337		

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G 337	Continued From page 98 medication list for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15. c. Patient #8's SOC assessment included a pain assessment. The assessment documented Patient #8 took Tylenol and/or Advil for his right shoulder pain, however, Tylenol and Advil were not included on Patient #8's POCs or medication list for the certification periods 12/02/14 to 1/30/15, and 1/31/15 to 3/31/15. d. Patient #8's SOC assessment stated a complete drug regimen review was completed, and it did not indicate significant medication issues, including drug interactions. Patient #8's medications were entered into "Drugs.com" (an internationally recognized database and public access website established as a standard for nurses and clinical staff in determination of drug interactions) to check for drug interactions. A major interaction was identified between 2 of Patient #8's medications, Coumadin and Aspirin, due to the risk of increased bleeding. Patient #8's record did not document his physician was contacted to resolve his major drug interaction. e. Patient #8's record included an SN visit note, dated 12/04/14, and signed by the RN Case Manager. The note documented Patient #8 was having diarrhea, and his caregiver stated she was giving him Pepto Bismol without relief. Additionally, the note documented the caregiver gave Patient #8 a dose of Imodium during the SN visit. Patient #8's POC and medication list did not include Pepto Bismol or Imodium. f. Patient #8's record included an SN visit note,	G 337		

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G 337	Continued From page 99 dated 1/12/15, and signed by the RN Case Manager. The note documented Patient #8's physician told his caregiver to stop his Insulin and Glimiperide (used to control blood sugar.) Patient's #8's record did not document his physician was contacted to confirm the medication changes. Additionally, his medication record was not updated with the medication changes. During an interview on 3/05/15 at 12:45 PM, the RN Case Manager reviewed the record. She confirmed Patient #8 was taking insulin, oxygen, Tylenol and Advil at the time of his admission to home health, and they should have been included on his POCs and medication list. She confirmed she did not complete a review of his medications to determine contraindications, and stated she was not aware there was an on-line resource she could use to determine interactions. Additionally, she confirmed Patient #8's medication list was not updated when medications were added or discontinued. Patient #8's POC and medication profile were not accurate to reflect the medications he was taking. Additionally, Patient #8's medications were not reviewed for interactions and were not reconciled with his physician to ensure he was taking medications as ordered. 7. Patient #2 was an 83 year old female admitted to the agency on 1/15/15, for care following a fall. Additional diagnoses included debility and abnormality of gait. She received SN, PT and HHA services. Her record, including the POC, for the certification period 1/15/15 to 3/15/15, was reviewed.	G 337		

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G 337	Continued From page 100 a. A visit was made to Patient #2's Assisted Living apartment on 3/04/15 at 12:45 PM, to observe a PT visit. After the visit, a list of Patient #2's current medications was obtained from the Assisted Living staff. Patient #2's record included a POC and medication list for the certification period 1/15/15 to 3/15/15. They were compared to her current medications on the Assisted Living list. The following medications were missing from her POC and home health medication list: Icap (multivitamin) 1 tablet bid Timolol 0.5%, 1 drop in each eye bid Tylenol 500 mg, 2 tablets daily Tylenol 500 mg, 1 tablet every 4-6 hours, as needed Bismuth Subsalicylate 262 mg, 2 tablets, 4-5 times a day, as needed Norco 5/325 mg every 4 hours, as needed b. Patient #2's SOC assessment stated a complete drug regimen review was completed, and it did not indicate significant medication issues, including drug interactions. Patient #2's medications were entered into "Drugs.com" to check for drug interactions. A major interaction was identified between 2 of Patient #8's medications, Norvasc and Simvastatin. Combining these medications may significantly increase the blood levels of Simvastatin, leading to increased risk of liver damage and rhabdomyolysis (breakdown of skeletal muscle tissue.) Patient #2's record did not document her physician was contacted to resolve the issue.	G 337		

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G 337	Continued From page 101 During an interview on 3/05/15 at 11:00 AM, The RN Case Manager reviewed Patient #2's record and confirmed her POC and medication list did not contain all the medications she was taking. Additionally, she confirmed Patient #2's medications were not reviewed for interactions and were not reconciled with her physician. Patient #2's medication list was not accurate to include all medications she was taking. Additionally, her medications were not reviewed for interactions and were not reconciled with her physician to ensure she was taking medications as ordered. 8. Patient #1 was an 83 year old female admitted to the agency on 3/03/15, following a hospital and rehabilitation center admission for pericarditis. Additional diagnoses included muscle weakness, Parkinson's disease, HTN, depression and chronic kidney disease. She received SN, PT, OT and HHA services. Her record, including the POC, for the certification period 3/03/15 to 5/01/15, was reviewed. Patient #1's record included a SOC assessment, dated 3/03/15, and signed by the RN Case Manager. The assessment documented a complete drug regimen review was completed, and it did not indicate significant medication issues, including drug interactions. Patient #1's medications were entered into "Drugs.com" to check for drug interactions. Four major drug interactions were identified, as follows: -Citalopram and Azilect - combining these medications can increase the risk of a rare but	G 337		

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G 337	Continued From page 102 serious condition called serotonin syndrome. -Tramadol and Citalopram - combining these medications can also increase the risk of serotonin syndrome. - Tramadol and rasagiline - combining these medications can also increase the risk of serotonin syndrome. -Omeprazole and Citalopram - combining these medications may increase the blood levels of citalopram and increase the risk of certain side effects, including an irregular heart rhythm that may be serious or life-threatening. Patient #1's record did not document her physician was contacted to ensure the physician was aware of the major drug interactions. During an interview on 3/05/15 at 10:00 AM, the RN Case Manager reviewed Patient #2's record and confirmed she did not identify the major drug interactions or contact Patient #2's physician to reconcile her medications. Patient #1's medications were not reviewed for interactions and were not reconciled with her physician. 9. Patient #5 was a 97 year old female, admitted to the agency on 9/26/14, due to a history of non-compliance with her medications. Additional diagnoses included syncope, dementia, HTN and hypothyroidism. Her record, including the POC, for the certification period 1/24/15 to 3/24/15, was reviewed. A visit was made to Patient #5's home on 3/04/15	G 337		

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G 337	Continued From page 103 at 8:30 AM, to observe an HHA visit. During the visit, Patient #5's medications were reviewed. Her pills were observed in a weekly pill planner that contained one compartment for each day of the week. Patient #5 stated the RN had visited 2 days before and filled the weekly pill planner from her medication bottles. Patient #5's medication bottles included Optivitamins, however, the Optivitamins were not observed in the weekly pill planner. Patient #5 stated she had an appointment with the eye doctor over a week ago, and was given the Optivitamins at that appointment. She stated she informed the RN of the new medication during her visit 2 days before. Patient #5's medication list was reviewed on 3/05/15. The medication list was not updated to include Optivitamins. During an interview on 3/05/15 at 10:30 AM, the RN Case Manager stated she was aware of Patient #5's new medication and thought she added the Optivitamins to her pill planner. The RN Case Manager confirmed she did not update Patient #5's medication list to include Optivitamins. Patient #5's medication list was not accurate to include all medications she was taking.	G 337		

Bureau of Facility Standards

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	OAS001180		03/05/2015

NAME OF PROVIDER OR SUPPLIER: FRANKLIN COUNTY MEDICAL CENTER HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 126 EAST FIRST NORTH, PRESTON, ID 83263

(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) COMPLETE DATE
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 3/02/15 to 3/05/15. The surveyors conducting the licensure review were: Nancy Bax, RN, BSN, HFS Team Leader Susan Costa, RN, HFS	N 000	RECEIVED MAR 3 1 2015 FACILITY STANDARDS	
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	Refer to attached document for plan of correction for all deficiencies Cited. S. Creswell	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical	N 062		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: AKR | TITLE: CEO | (X6) DATE: 3-27-15

Bureau of Facility Standards

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N 062	Continued From page 1 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	N 062		
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 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;	N 095		

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N 095	Continued From page 2 This Rule is not met as evidenced by: Refer to G174	N 095		
N 096	03.07024. SK. NSG. SERV. N096 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: d. Initiates appropriate preventive and rehabilitative nursing procedures; This Rule is not met as evidenced by: Refer to G175	N 096		
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		

Bureau of Facility Standards

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N 122	Continued From page 3	N 122		
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 G122	N 122		
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158	N 152		
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses;	N 153		

Bureau of Facility Standards

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N 153	Continued From page 4 This Rule is not met as evidenced by: Refer to G159	N 153		
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		
N 161	03.07030.PLAN OF CARE N161 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: i. Medication and treatment orders; This Rule is not met as evidenced by: Refer to G159	N 161		
N 168	03.07030.02. PLAN OF CARE N168 02. Goals of Patient Care. The	N 168		

Bureau of Facility Standards

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N 168	Continued From page 5 goals of patient care must be expressed in behavioral terms that provide measurable indices for performance. This Rule is not met as evidenced by: Refer to G159	N 168		
N 170	03.07030.04.PLAN OF CARE 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 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 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	N 173		

Bureau of Facility Standards

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N 173	Continued From page 6 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 176	03.07031.CLINICAL REC. N176 02. Contents. Clinical records must include: b. Assessments by appropriate personnel. This Rule is not met as evidenced by: Refer to G236	N 176		
N 179	03.07031.CLINICAL REC. N179 02. Contents. Clinical records must include: e. Drug, dietary treatment, and activity orders; This Rule is not met as evidenced by: Refer to G236	N 179		
N 180	03.07031.CLINICAL REC. N180 02. Contents. Clinical records must include:	N 180		

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N 180	Continued From page 7 f. Signed and dated clinical and progress notes; This Rule is not met as evidenced by: Refer to G236	N 180		

PLAN OF CORRECTION FOR THE STATE OF IDAHO - FRANKLIN COUNTY MEDICAL CENTER -HOME CARE

Date of Survey: March 05, 2015 **POC deadline: April 19, 2015**

Criteria: Include dates when corrective action will be completed.

1. **Action(s) that will be taken to correct each specific deficiency cited?**
2. **How will action improve the processes that led to deficiency cited**
3. **Procedure for implementing the acceptable plan of correction**
4. **Completion date for the correction of deficiency**
5. **Monitoring/tracking procedures to ensure POC is effective and Home Health remains in compliance**
6. **Title of person responsible for implementing the acceptable POC**

Signature of Administrator **Date** 3-27-15

TAG NUMBER	CRITERIA	FACILITY RESPONSE AND CORRECTIONS
		This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to Home Health. This plan of correction does not constitute as admission of liability, and such liability is hereby denied. The submission of this plan does not constitute agreement by the agency that the surveyor's constitute a deficiency, or that the severity of the deficiencies cited is correctly applied.
G101		Patient rights - NOMNC 2 days before
	1.	The RN who completed the discharge assessment was in serviced and the two patients cited in the deficiency (Patient #6 and Patient #11) are closed.. See attached in service. The Skilled meeting that is held every other week –the upcoming discharges are discussed and upcoming NOMNC See attached 3-23-2015meeting. Updated Nurses billing form to remind them of new processes - see attached
	2.	Gives clients two days prior to discharge to appeal and ensures that all staff know when the expected discharge date is.
	3.	Every other week Medicare clients will have their records reviewed.
	4.	COMPLETION DATE=04-10-2015
	5.	Every month, the charts will be audited for NOMNC given to client two days before discharge validated by Quality Management every month. See attach blank form
	6.	Implemented by the Home Care Manger and monitored by the Home Care Secretary
G143		Coordination o patient services
	1.	All Home Care Staff were in serviced regarding the importance of coordinated care between all disciplines Patient's #5 and # 7 were reviewed on 3-17-2015. See attached.
	2.	Home Care aides (HHA) were taught about notifying the SN of any changes that would affect the plan of care. A new communication board has been installed for SN's to communicate with HHA and other disciplines. See attached Photo.
	3.	When a HHA or other disciplines see something that might affect the plan of care, they will call Home Care Secretary. The Secretary will write a sticky note and attached the note to the appropriate nurses' board. The SN will check the communication board every day to retrieve the notes belonging to her.
	4.	COMPLETION DATE =04-10-15
	5.	Every month, the charts will be audited for notifications and documentations of such and validated by Quality Management every month. for 3 months.
	6.	Implemented by the Home Care Manger and monitored by the Home Care Secretary
G156		**Acceptance of Patient's ,POC Med Super –Condition of Participation refer to G158, G159,G160,G164,G166**

TAG NUMBER	CRITERIA	FACILITY RESPONSE AND CORRECTIONS
G158		Care follows written Plan of Care
	1.	All Skilled Nurse (SN) were in serviced regarding the importance of documenting Verbal order to initiate POC until 485 is completed and signed Patient's #5 and # 12 were reviewed on 3-17-2015. Updated Nurses billing form to remind them of new processes - see attached
	2.	SN will have visual cues to remind them to document Verbal Orders
	3.	Each client has a billing form that the nurses take with them to the client's house. This form is used in conjunction with visit note for that day.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor all new admits for 2 weeks and 30% monthly for 2 months to ensure compliance with Verbal orders.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G 159		Plan of Care- all diagnosis, equipment, services etc
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of documenting pertinent diagnosis as well as all equipment used will be documented on the 485 in the sections for discipline and treatment on 3-17-2015. Patients # 3 and # 7 have been reviewed on 3-17-2015
	2.	Updated Nurses billing form to remind them of new processes - see attached
	3.	Each client has a billing form that the nurses take with them to the client's house. This form is used in conjunction with visit note for that day.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor all new admits for 2 weeks and 30% monthly for 2 months to ensure compliance with Verbal orders.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G160		Plan of Care approved after Evaluation
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of contacting the physician to approve the Plan of Care 3-17-2015. Patients# 5 and # 7and #12 have been reviewed on 3-17-2015
	2.	Updated Nurses billing form to remind them of new processes - see attached
	3.	Each client has a billing form that the nurses take with them to the client's house. This form is used in conjunction with visit note for that day.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor all new admits for 2 weeks and 30% monthly for 2 months to ensure compliance with verbal orders.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G 164		Periodic review of Plan of care
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of reviewing the plan of care and reporting changes to MD if it alters the POC. Patient #7 has been reviewed on 3-17-2015
	2.	Updated Nurses billing form to remind them of new processes - see attached
	3.	Each client has a billing form that the nurses take with them to the client's house. This form is used in conjunction with visit note for that day.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current client monthly for 2 months to ensure compliance with Plan of Care.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G166		Conformance with physician Orders
	1.	All Skilled Nurse (SN) were in serviced regarding the importance of conformance to physician orders 3-17-2015.

TAG NUMBER	CRITERIA	FACILITY RESPONSE AND CORRECTIONS
	2.	Updated Nurses billing form to remind them of new processes - see attached
	3.	Each client has a billing form that the nurses take with them to the client's house. This form is used in conjunction with visit note for that day.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current client monthly for 2 months to ensure compliance with Physician orders.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G 168		Skilled Nursing service refer to G174, G175, G177, G331,G337
G173		Duties of the Registered Nurse – Initiates Plan Of Care and Revisions
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of contacting the physician for revision to the Plan of Care 3-17-2015. Patient # 7 has been reviewed on 3-17-2015
	2.	Updated Nurses billing form to remind them of new processes - see attached
	3.	Each client has a billing form that the nurses take with them to the client's house. This form is used in conjunction with visit note for that day.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current client monthly for 2 months to ensure Plan of Care s were developed and updated.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G174		Duties of the Registered Nurse – furnishes services requiring nursing skill
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of education for clients on 3-23-2015.
	2.	Updated Nurses billing form to remind them of new processes - see attached
	3.	Each client has a billing form that the nurses take with them to the client's house. This form is used in conjunction with visit note for that day.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure patient education is completed and documented
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G175		Duties of the Registered Nurse – RN initiates preventative/ rehabilitative procedures
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of full vital signs, wound measurements weekly on 3-17-2015. Some clients do not have scales to weight them. We have ordered analog scales for every nurse to keep in their car to weigh clients accurately as ordered. Temporal thermometers that we have been using are subject to the heat and cold in the nurses bags. We will change back to the digital oral thermometer to avoid this problem. Nurses were given the new oral thermometers on 03-25-2015
	2.	The nurses having scales will ensure that clients can be weighed accurately and thermometers resist the heat and cold problem.
	3.	The nurses have scales in their cars and thermometers in their bags to take to their clients.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure patient vital signs, wounds are measured and weight obtained.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G 177		Duties of the Registered Nurse- RN Counsels patient family regarding nursing needs

TAG NUMBER	CRITERIA	FACILITY RESPONSE AND CORRECTIONS
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of comprehensive patient education regarding diagnoses and use of medication including side effects on 3-17-2015. Nurse educated client # 5 and gave her a different pill box for the weekly medication and the HHAs are cueing her to take it when they are there. Also gave a nightly pill box for nightly medications.
	2.	Client has the equipment that she needs as well as the education needed to minimize complication from diagnoses.
	3.	SN will review medications, teach clients about medications and give them a copy of medication education sheets.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure patient education and medication compliance.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G 224		Assignment and duties of Home Health aide – RN prepares a plan of care for the HHA to follow.
	1.	In service held with the HHA's regarding following of POC as outlined by the RN, what to report to RN, and scope of practice for HHA's 3-17-2015 Client #5 was reviewed on 3-17-15.
	2.	Discussed with SN the need to correctly fill out aide assignment sheet (ie: type of bath, VS to be taken, housekeeping duties to perform) SN will not mark HHA follow exercise plan, unless there is one outlined in home from PT for the aide to follow.
	3.	HHA will follow plan of care as listed on aide assignment sheet. HHA duties reviewed with staff and all HHA's signed job description on 3-25-15 stating they are aware of their duties allowed.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure HHA following POC as outlined by SN.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G225		Assignment and duties of Home Health aide
		In service held with the HHA's regarding following of POC as outlined by the RN, what to report to RN, and scope of practice for HHA's 3-17-2015 Client #5 was reviewed on 3-17-15.
		Discussed with HHAs that they will follow POC as listed on HHA assignment sheet and outlined on HHA job description.
	3.	HHA duties reviewed with staff and all HHA's signed job description on 3-25-15 stating they are aware of the duties allowed.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure HHA following scope of practice as outlined in job description.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor.
G229		Supervision of Home Health aide
	1.	In service held with SN/PT on 3-23-15 regarding need for SV to be completed for HHA every 14 days. PT and SN billing sheets to include cues to remind staff to perform supervisory visit. See attachment.
	2.	SN/PT aware of requirement for SV to be completed every 14 days.
	3.	Billing sheet changed to add cues for SV to be performed at least every 14 days.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure supervisory visits are being completed.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor
G236		Medical Records clear, complete and accurate
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of clear and concise documentation of vital signs, diagnoses and pain

TAG NUMBER	CRITERIA	FACILITY RESPONSE AND CORRECTIONS
		3-17-2015. Patients # 3 and # 7 have been reviewed on 3-17-2015 Home care Manager spoke with the physician of patient #2 regarding the need of signature and not a rubber stamp.
	2.	Physician will read and sign orders to ensure orders are correct and SN will have form that will cue the nurses to evaluate and document all areas of diagnosis, vital signs and pain.
	3.	Updated Nurses billing form to remind them of new processes - see attached
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure vital signs are taken and documented, comorbidities are included and vital signs and pain is being addressed.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor
G322		Accuracy of encoded Oasis Data
	1.	All Skilled Nurse (SN) were in serviced regarding the importance of the 485 coinciding with Oasis 3-17-2015
	2.	The new form will cue the SN to examine both the Oasis and 485 and ensure they match one another.
	3.	Updated Nurses billing form to remind them of new processes - see attached
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure that both the Oasis and 485 match.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor
G331		Initial assessment visit- Vital signs
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of the vital signs as part of the comprehensive assessment and Pressure Ulcer Stages and Categories according the National Pressure Ulcer Advisory Panel (NPUAP) and Oasis C-1 staging. 3-26-2015
	2.	The new form will cue the SN to examine both the Oasis and 485 and ensure they match one another.
	3.	Updated Nurses billing form to remind them of new processes - see attached
	4.	COMPLETION DATE =04-10-15
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor per Kaylene Owen 4/17/15
	5.	Monitor 30% of clients monthly x2 months to ensure that the OASIS and 485 match.
G337		Drug Regimen Review
	1.	All Skilled Nurses (SN) were in serviced regarding the importance of reconciling the medications from the hospital to the home setting and the side effects and interactions. We are now using Drug.com to look up all medications and have written a high risk medications policy on 3-26-2015
	2.	The nurses now have access to a drug interaction tool for their clients. SN will be able to educate their clients about the mediation's they are taking.
	3.	The new form will cue the SN to reconcile the mediations from the hospital to the home setting or other locations that they might receive medications from.
	4.	COMPLETION DATE =04-10-15
	5.	We will monitor 30% of current clients monthly for 2 months to ensure that medications are reconciled from all locations.
	6.	Implemented by the Home Care Manger and monitored by Clinical Supervisor

TAG NUMBER	CRITERIA	FACILITY RESPONSE AND CORRECTIONS
N-016		REFER to G-101
N-062		REFER to G-143
N-094		REFER to G-173
N-095		REFER to G-174
N-096		REFER to G175
N-099		REFER to G 177
N-122		REFER to G122
N-152		REFER to G158
N-153		REFER to G159
N-155		REFER to G159
N-161		REFER to G159
N-168		REFER to G159
N-170		REFER to G160
N-172		REFER to G 164
N-173		REFER to G 337
N-176		REFER to G236
N-179		REFER to G236
N-180		REFER to G236