IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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March 17, 2015

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

RE: Access Home Care, Provider #137110

Dear Mr. Mangum:

On March 6, 2015, an on-site follow-up revisit was conducted to verify that Access Home Care was in compliance with all Conditions of Participation. The agency's allegation of compliance indicated your agency was in substantial compliance as of February 23, 2015. However, based on our on-site revisit conducted March 6, 2015, your agency remains out of compliance with the following Condition of Participation:

- **Acceptance of Patients, Plan of Care, Medical Supervision (42 CFR 481.18)**

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

The deficiencies, which caused the condition to be unmet, substantially limit the capacity of Access Home Care to furnish services of sufficient level and quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies. Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing corrected deficiencies, is also enclosed.

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

An acceptable Plan of Correction contains the following elements:

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

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **March 30, 2015.** It is strongly recommended that the agency's Credible Allegation /Plan of Correction for the Condition of Participation and related standard level deficiences show compliance no later than **April 20, 2015** (45 days from survey exit). We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

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

Consistent with the provisions of 42 CFR 488, Alternative Sanctions for Home Health Agencies, the following remedies were recommended to the Centers for Medicare/Medicaid (CMS) Region X Office, following the January 9, 2015,recertification survey of your agency:

- Termination (42 CFR 488.865)

You were notified of this recommendation in our January 26, 2015, letter, sent following the January 9, 2015, recertification survey.

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

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

We urge you to begin correction immediately.

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

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Marie Fe Yamada, CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137110	A. BUILDING _____ B. WING _____	R 03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HOME CARE	240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS The following deficiencies were cited during the follow-up survey of your agency on 3/06/15. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Nancy Bax, RN, BSN,HFS Acronyms used in this report include: BP - Blood Pressure DM - Diabetes Mellitus HHA - Home Health Aide POC - Plan of Care PT - Physical Therapy PTA - Physical Therapy Assistant RN- Registered Nurse SN - Skilled Nurse SOC - Start of Care TED Hose- Thromb Embolic Deterrent stockings	{G 000}	RECEIVED MAR 20 2015 FACILITY STANDARDS	
{G 156}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on staff and patient interview, review of medical records and agency policies, and observation, it was determined the agency failed to ensure systems to plan for care and supervise the medical care of patients were implemented. These failures resulted in unmet patient needs and negatively impacted the continuity, safety, and quality of patient care. Findings include: 1. Refer to G168 as it relates to the failure of the	{G 156}	G156 - 484.18 Acceptance of Patients, POC, MED Super Refer to plan of correction G158 Refer to plan of correction G159 Refer to plan of correction G164	

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

Camie Zupp, RN | Director of Operations | 3/20/15

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 156}	Continued From page 1 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 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. 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 and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 1 of 8 patients (#1) whose records were reviewed. This resulted in wound care provided without a physician's order and had the potential to result in unmet patient needs. Findings include: Patient #1 was a 71 year old female admitted to the agency on 2/26/15, following a hospitalization for pneumonia. Additional diagnoses included exacerbation of asthma, chronic diastolic heart	{G 158}	G158 - 484.18 Acceptance of Patients, POC, MED Super Initial inservice was held week of 3/9/15 in all main and branch locations. Inservcie was conducted by Director of Operations under the guidance of the administrator. Follow up inservices to be held week of 3/16/15 to all staff and clinicians under the direction of the administrator by the director of operations. Inservice to include how to appropriately write a wound protocol on the initial order and the 485 plan of care.. Agency will be in compliance of this plan of	

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{G 158}	Continued From page 2 failure and insulin dependent diabetes. She received SN, PT and HHA services from the agency. Her record, including the POC, for the certification period 2/26/15 to 4/26/15, was reviewed. Patient #1's record included a physician's verbal order, dated 2/26/15, and digitally signed by the RN. It stated the information included in the verbal order had been reviewed with Patient #1's physician's office. The order included the frequency of SN visits, and interventions to be completed during the visits. The interventions included wound care to her left buttock wound, however, it did not include specific orders for wound care, to indicate products to be used to cleanse, treat and cover the wound. Patient #1's record included a SN SOC visit note, dated 2/26/15, and signed by the RN. The note documented Patient #1 had a wound on her left buttock. It stated the RN cleansed the wound with normal saline, patted it dry, applied silvagel (an antimicrobial wound gel) and covered it with exuderm (a sterile occlusive dressing.) Patient #1's record included a SN visit note, dated 3/03/15, and signed by the RN. The note documented the RN cleansed Patient #1's wound with normal saline, applied Silvagel and covered it with Exuderm. During an interview on 3/06/15 at 2:45 PM, the RN who completed the SOC visit and signed the physician's verbal order, stated the specific order for wound care was included on Patient #1's POC, however, her POC was not signed by her physician as of 3/06/15. The RN confirmed the physician's verbal order she signed on 2/26/15,	{G 158}	correction on 3/17/2015. Follow up to this plan of correction will be monitored by the quality assurance team. 100 percent of all orders will be reviewed for compliance by quality assurance nurses that consist of all RN's.	

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{G 158}	Continued From page 3 did not include orders for silvagel and exuderm. Additionally, she confirmed wound care was completed during SN visits on 2/26/15, and 3/03/15, prior to receipt of physician orders for the wound care protocol. Patient #1's wound care was provided without physician's orders.	{G 158}		
{G 159}	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure POCs included all pertinent information, including supplies and nursing interventions, for 2 of 8 patients (#3 and #4) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include: 1. Patient #3 was a 56 year old male, admitted to the agency on 2/24/15, for services related to late effects of spinal cord injury. Additional diagnoses included peripheral vascular disease and exacerbation of asthma. He received SN and PT services. His record, including the POC, for the	{G 159}	G159 – 484.18 Plan of Care Initial inservice was held week of 3/9/15 in all main and branch locations. Inservcie was conducted by Director of Operations under the guidance of the administrator. Follow up inservices to be held week of 3/16/15 to all staff and clinicians under the direction of the administrator by the director of operations. Inservice to include all necessary items to list on the plan of care, and specifically dme supplies, specific oxegyn supplies, and proper parameters for vital signs and blood sugars. Agency will be in compliance of this plan of correction on 3/17/2015. Follow up to this plan of correction will be monitored by the quality assurance team. 100 percent of all admits will be reviewed for compliance by quality assurance nurses that	

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{G 159}	Continued From page 4 certification period 2/24/15 to 4/24/15, was reviewed. Patient #3's record included a SN SOC assessment, completed on 2/24/15, and signed by the RN. The assessment documented Patient #3 wore TED hose to prevent blood clots in his legs, and used a condom catheter due to incontinence. Additionally, the assessment documented Patient #3 used oxygen at 3 liters per minute. However, Patient #3's POC did not include condom catheters, TED hose or supplies used to deliver his oxygen, such as oxygen concentrator or tanks. During an interview on 3/06/15 at 2:20 PM, the Director of Operations, who was also the Acting Administrator, reviewed Patient #3's record and confirmed his POC did not include condom catheters, TED hose or supplies used to deliver his oxygen. Patient #3's POC was not comprehensive to include all supplies used in his home. 2. Patient # 4 was a 61 year old male, admitted to the agency on 2/23/15, for services related to uncontrolled, insulin dependent diabetes. Additional diagnoses included end stage renal disease and muscle weakness. He received SN and PT services. His record, including the POC, for the certification period 2/23/15 to 4/23/15, was reviewed. Patient #4's record included a POC, signed by his physician on 2/27/15. The POC included orders for sliding scale insulin (dosage based on blood glucose reading) and orders for the RN to educate Patient #4 on diabetes management,	{G 159}	consist of all RN's. In addition to the quality assurance audits, the direct of operations, the quality assurance director, and the administrator will be conducting independent random surveys to monitor for compliance. The director of nursing in each office will have daily reports given to them by their RN case managers to make sure the plan of care is being followed and all necessary items are on the plan of care.	

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{G 159}	Continued From page 5 including signs and symptoms to report. However, his POC did not include parameters for his blood sugar, to indicate when Patient #4's physician should be notified of blood glucose readings that were out of acceptable range. During an interview on 3/06/15 at 2:15 PM, the Director of Operations, who was also the Acting Administrator, reviewed Patient #4's record, and confirmed his POC did not include parameters to indicate when his physician should be notified of blood glucose results that were out of acceptable range. Patient #4's POC did not include all pertinent information.	{G 159}		
{G 164}	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of patient records 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 2 of 2 patients (#1 and #2) 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: 1. Patient #1 was a 71 year old female admitted to the agency on 2/26/15, following a	{G 164}	G164 – 484.18b Periodic Review of the Plan of Care Initial inservice was held week of 3/9/15 in all main and branch locations. Inservcie was conducted by Director of Operations under the guidance of the administrator. Follow up inservices to be held week of 3/16/15 to all staff and clinicians under the direction of the administrator by the director of operations. Inservice to include when to notify the patients physician in changes of the plan of care. Agency will be in compliance of this plan of correction on 3/17/2015. Follow up to this plan	

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{G 164}	Continued From page 6 hospitalization for pneumonia. Additional diagnoses included exacerbation of asthma, chronic diastolic heart failure and insulin dependent diabetes. She received SN, PT and HHA services from the agency. Her record, including the POC, for the certification period 2/26/15 to 4/26/15, was reviewed. Patient #1's record included a Patient Communication note, dated 3/02/15, and written by the PTA. The note stated the PTA notified Patient #1's Physical Therapist and RN Case Manager that Patient #1 was not feeling well, and was only able to participate in limited therapy due to complaints of shortness of breath and fatigue. The note stated Patient #1 declined to get out of bed during the PTA visit. Additionally the note stated Patient #1's left upper extremity was visibly swollen as compared to her right upper extremity. Patient #1's record did not document her physician was notified of the change in her condition. Patient #1's record included an SN visit note, dated 3/03/15, and signed by the RN Case Manager. The note documented Patient #1's lung sounds were diminished in all fields. The note documented an oxygen saturation level of 88%, increasing to 89% with deep breathing. The Mayo Clinic website, accessed 3/09/15, stated "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low." Additionally, the note documented Patient #1 refused to use an oxygen mask. Patient #1's record did not document her physician was notified of her condition. Patient #1's record included a PT visit note, dated	{G 164}	of correction will be monitored by the quality assurance team. 100 percent of all admits will be reviewed for compliance by quality assurance nurses that consist of all RN's. In addition to the quality assurance audits, the direct of operations, the quality assurance director, and the administrator will be conducting independent random surveys to monitor for compliance. The director of nursing in each office will have daily reports given to them by their RN case managers to make sure the plan of care is being followed; physician and members of the IDT will be notified.	

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{G 164}	Continued From page 7 3/04/15, and signed by the PTA. The note documented a diastolic blood pressure of 46. Patient #1's POC included an order to notify her physician of diastolic blood pressure levels less than 50. The PT note, dated 3/04/15, also documented Patient #1 reported feeling extremely short of breath, and her husband reported she was not eating well and seemed to have declined in the last few days. Patient #1's record included a Patient Communication note, dated 3/04/15, and signed by the PTA. The note stated the PTA notified Patient #1's Physical Therapist and RN Case Manager that Patient #1 showed cyanosis (a bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood) of the left fingers and foot. Additionally, the note stated Patient #1's blood pressure was below normal limits, and she became short of breath with transfer. Patient #1's record did not document her physician was notified of the change in her condition. Patient #1's record included a document titled "Transfer to Inpatient Facility" dated 3/05/15, which stated she was transferred to the hospital by ambulance on 3/05/15. During an interview on 3/06/15 at 3:55 PM, the RN Case Manager confirmed the PTA notified her of Patient #1's condition on 3/02/15. She stated she left a message for Patient #1's physician on 3/02/15, and received a return call on 3/03/15. The RN confirmed she did not document the phone call in Patient #1's record. Additionally, the RN Case Manager confirmed the PTA notified her of Patient #1's condition on 3/04/15. She confirmed she did not make a visit to Patient #1	{G 164}		

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{G 164}	Continued From page 8 or contact her physician on 3/04/15. She stated she made a visit to Patient #1 at 2:05 PM on 3/05/15. She stated Patient #1's lips were cyanotic and her oxygen saturation levels were in the low 80's. She stated she called Patient #1's physician, and she was transferred to the hospital. The agency failed to promptly notify Patient #1's physician of her acute symptoms. 2. Patient # 2 was a 55 year old female admitted to the agency on 2/23/15, following a hospitalization for gastrointestinal bleeding and heart failure. Additional diagnoses included pancytopenia, non-insulin dependent diabetes and chronic kidney disease. She received SN services. Her record, including the POC, for the certification period 2/23/15 to 4/23/15, was reviewed. Patient #2's POC included an order for the SN to instruct her on all aspects of diabetic management, to include the use of a glucometer (a meter used to measure blood glucose levels.) Patient #2's record included SN visit notes dated 2/26/15, 3/02/15, and 3/06/15. The 3 SN visit notes included the documentation, "Pt [Patient] states her glucometer is broken, but she has a plan to get a new one." Patient #2's record did not document her physician was notified she was unable to measure her blood glucose levels due to the broken glucometer. During an interview on 3/06/15 at 2:25 PM, the Director of Operations, who was also the Acting Administrator, reviewed Patient #2's record and confirmed her physician was not notified the RN	{G 164}		

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{G 164}	Continued From page 9 was unable to instruct her in blood glucose monitoring as ordered in her POC. Patient #2's physician was not notified she was unable to measure her blood glucose levels as ordered in her POC.	{G 164}		

Bureau of Facility Standards

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{N 000}	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the follow-up survey of your agency on 3/06/15. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Nancy Bax, RN, BSN,HFS Acronyms used in this report include: BP - Blood Pressure DM - Diabetes Mellitus HHA - Home Health Aide POC - Plan of Care PT - Physical Therapy PTA - Physical Therapy Assistant RN- Registered Nurse SN - Skilled Nurse SOC - Start of Care TED Hose- Thromb Embolic Deterrent stockings	{N 000}	RECEIVED MAR 20 2015 FACILITY STANDARDS N098 – Skilled Nursing Service Initial Inservice was held week of 3/9/15 in all main and branch locations. Inservcie was conducted by Director of Operations under the guidance of the administrator. Follow up inservices to be held week of 3/16/15 to all staff and clinicians under the direction of the administrator by the director of operations. Inservice to include when to notify the patients physician in changes of the plan of care. Agency will be in compliance of this plan of correction on 3/17/2015. Follow up to this plan of correction will be monitored by the quality assurance team. 100 percent of all admits will be reviewed for compliance by quality assurance nurses that consist of all RN's. In addition to the quality assurance audits, the direct of operations, the quality assurance director, and the administrator will be conducting independent random surveys to monitor for compliance. The director of nursing in each office will have daily reports given to them by their RN case managers to make sure the plan of care is being followed; physician and members of the IDT will be notified.	
{N 098}	03.07024. SK. NSG. SERV. N098 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: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G164 as it relates to the agency's failure to inform the physician of changes in the patient's condition and needs.	{N 098}		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Camie Zipp RN	Director of Operations	3/20/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001015	A. BUILDING: _____ B. WING _____	R 03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HOME CARE	240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(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 as it relates to the failure of the agency to ensure care followed a written plan of care.	(N 152)	N152 – Plan of Care Initial inservice was held week of 3/9/15 in all main and branch locations. Inservcie was conducted by Director of Operations under the guidance of the administrator. Follow up inservices to be held week of 3/16/15 to all staff and clinicians under the direction of the administrator by the director of operations. Inservice to include how to appropriately write a wound protocol on the initial order and the 485 plan of care. Agency will be in compliance of this plan of correction on 3/17/2015. Follow up to this plan of correction will be monitored by the quality assurance team. 100 percent of all orders will be reviewed for compliance by quality assurance nurses that consist of all RN's.	
(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; This Rule is not met as evidenced by: Refer to G159 as it relates to the failure of the agency to ensure the plan of care covered all pertinent diagnoses.	(N 153)	N153- Plan of Care Initial inservice was held week of 3/9/15 in all main and branch locations. Inservcie was conducted by Director of Operations under the guidance of the administrator. Follow up inservices to be held week of 3/16/15 to all staff and clinicians under the direction of the administrator by the director of operations. Inservice to include all necessary items to list on the plan of care, and specifically dme supplies, specific oxegyn supplies, and proper parameters for vital signs and blood sugars. Agency will be in compliance of this plan of correction on 3/17/2015. Follow up to this plan of correction will be monitored by the quality assurance team. 100 percent of all admits will be reviewed for compliance by quality assurance nurses that consist of all RN's. In addition to the quality assurance audits, the direct of operations, the quality assurance director, and the administrator will be conducting independent random surveys to monitor for compliance. The director of nursing in each office will have daily reports given to them by their RN case managers to make sure the plan of care is being followed and all necessary items are on the plan of care.	