IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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May 8, 2015

Karen Young, Administrator
Progressive Nursing Services
1514 Shoshone Street
Boise, ID 83705

RE: Progressive Nursing Services, Provider #137049

Dear Ms. Young:

This is to advise you of the findings of the Medicare/Licensure survey at Progressive Nursing Services, which was concluded on April 23, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

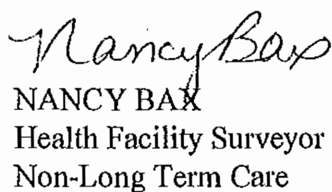
An acceptable plan of correction (PoC) contains the following elements:

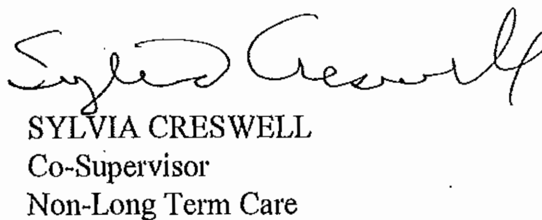
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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 the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **May 20, 2015**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

Sincerely,





NANCY BAX
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

NB/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137049	A. BUILDING ______ B. WING ______	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE NURSING SERVICES	1514 SHOSHONE STREET BOISE, ID 83705

(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 recertification were: Nancy Bax, RN, BSN,HFS, Team Leader Gary Guiles, RN, HFS Acronyms used in this report include: BP - Blood Pressure CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure D/C - discharge DM - Diabetes Mellitus DME - Durable Medical Equipment HHA - Home Health Aide HTN - Hypertension mcg - micrograms mg - milligrams mg/dl - milligrams per deciliter MSW - Medical Social Worker NS - Normal Saline OASIS - Outcome and Assessment Information Set OT - Occupational Therapist POC - Plan of Care PRN - as needed PT - Physical Therapy RN- Registered Nurse SN - Skilled Nurse SOC - Start of Care VAC - vacuum assisted closure	G 000	CORRECTION TO SURVEY DATES The Medicare Recertification Survey was done 04/20/15 to 04/23/15. RECEIVED MAY 20 2015 FACILITY STANDARDS	5/20/15
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158	G158 (484.180)Acceptance of Patients, PoC (PoC), Med Supervision Deficiency:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN | TITLE: Administrator | (X6) DATE: 5/20/15

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 158	Continued From page 1 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 2 of 12 patients (#11 and #12) whose records were reviewed. This resulted in omissions of care and unmet patient needs. Findings include: 1. Patient #11 was a 53 year old male admitted to the agency on 3/21/15, for care related to epilepsy. Additional diagnoses included muscle weakness, bipolar disorder and spinal stenosis. His record, including the POC, for the certification period 3/21/15 to 5/19/15, was reviewed. Patient #11's POC, signed by his physician on 4/01/15, included an order for SN visits 1 time a week for 4 weeks. Patient #11's record did not document an SN visit during week 4 of his certification period. During an interview on 4/23/15 at 9:45 AM, the Administrator reviewed Patient #11's record and confirmed an SN visit was not completed as ordered during week 4 of his certification period. Patient #11 did not receive SN visits as ordered on his POC. 2. Patient #12's medical record documented a 72 year old male whose SOC was 11/21/14. He was discharged on 1/19/15. Patient #12 was hospitalized on 12/12/14/ for a pulmonary embolism. Home Health care was resumed on	G 158	G158 (484.180)ACCEPTANCE OF PATIENTS, PLAN OF CARE(PoC), MED SUPERVISION DEFICIENCY: Agency failed to ensure care of patient #11 followed the physician's PoC. When the patient refused care in week 4, per agency policy, the RN, should have notified the MD of the patient's refusal and obtained an order to discharge or provided MD with Missed Visit Notification by fax. Second Patient #12 had OT ordered and OT services were not provided. MD notification of the patient's refusal was not documented in the clinical record. Clinical Supervisor/Clinical Director will assure that referral to all disciplines has been scheduled by the scheduler by Day 5 and if the services are denied there will be substantiating documentation in the record of the patient refusal of care. Patient # 12 was discharged. The agency did not assure all disciplines received notification of discharge and the aide went to the home after discharge. Scheduler should have notified all disciplines of discharge as soon as directive was provided and assured confirmation.	5/20/15

Kyong RN

Plan of Corrections for G158 484.18
Acceptance of Patient, PoC and Med Supervision
Continued on Inserted Pages 2A and 2B

Progressive Nursing Services Inc.

Pages 2A

Plan of Corrections for G158 484.18
Acceptance of Patient, PoC and Med
Supervision

Action/procedures to correct:
Agency failure to obtain physician approval for additions or modifications to the PoC.

- Clinicians developing the PoC will obtain orders for required frequency and duration.
- Daily scheduling by the Scheduling Coordinator with Multi-Disciplinary Team will assure reconciliation of Visits Ordered and Visits Provided.
- RN Supervisor/Clinical Director oversight of the visits ordered vs scheduled. Will utilize Scheduled Not Made and Made Not Scheduled Reports from the EMR software to assure orders are followed.
- Clinical Supervisor/Clinical Director will review all frequency and duration orders, reductions in care and assure proper orders have been received.
- Scheduling coordinator, Clinical Supervisor/Clinical Director will verify timely Evaluations and delivery of care by all disciplines ordered. MD order for change in the PoC will be obtained as needed.
- Scheduling Coordinator will assure all disciplines are

5/20/15
Completion
K Yong RN
Admin

notified at the time of discharge to assure PoC and frequency orders are followed.

- Clinical Supervisor/Clinical Director will monitor compliance with frequency orders by review of SNM and MNS. Plan of correction has been implemented effective 5/20/15
- QAPI team will perform end of episode triple check process. QAPI (Quality Assurance Performance improvement) team will consist of Medical Record Manager, Scheduling Coordinator, RN supervisor, HR Director, Clinical Director/Administrator and other staff as available.
- Quality review will be performed at the end of every episode to evaluate compliance frequency and duration, PoC and orders. Education/counseling of staff will occur as indicated.
- Monitoring will include the use of following monitoring tools and processes:
  -Intake /Referral Quality monitor
  -Frequency Ordered VS Scheduled Monitor
  -Frequency Calendar tool
  -Scheduled not made reports from EMR software
  -Made not scheduled reports from EMR software

5/20/15
Completion
K Young RN Admin
Progressive Nursing Services

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G 158	Continued From page 2 12/17/14. On 12/22/14, the RN requested and received an order for occupational therapy. Patient #12's record did not document that occupational therapy services were provided. In addition, Patient #12's medical record contained an order, dated 12/02/14, to discontinue HHA services. However, an HHA visit was documented on 12/05/15. The Administrator was interviewed on 4/22/15 beginning at 11:25 AM. She reviewed Patient #12's record and confirmed the occupational therapy order. She stated there was no record of Patient #12 receiving occupational therapy services. She stated the record did not explain why Patient #12 did not receive occupational therapy services as ordered. She also confirmed the HHA visit was provided after the order had been written to discontinue HHA services. The agency did not follow Patient #12's written POC and provide occupational therapy services.	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:	G 159	DEFICIENCY SITED G159 (484.18)a PLAN OF CARE (PoC): Agency will assure PoC includes all pertinent supplies and interventions. Clinical Director will assure education and Compliance of the staff by 5/20/15. Action/procedure to correct: Failure of the agency to ensure all pertinent diagnoses in the PoC A detailed description of the individualized plan to meet the needs of the patient will be included in the PoC. Documentation will extend beyond monitoring and assessing and will provide more specific interventions and actions specific to the patients	5/20/15 5/20/15

Karen McLoring RN

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G 159	Continued From page 3 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 7 of 12 patients (#2, #5, #7, #9, #10, #11 and #12) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include: 1. Patient #12's medical record documented a 72 year old male whose SOC was 11/21/14. He was discharged on 1/19/15. Patient #12's SOC assessment, dated 11/21/14 at 2:50 PM, stated he had open heart surgery 5 weeks ago and had lost 30 pounds since the surgery. Patient #12's POC for the certification period 11/21/14 to 1/19/15, stated his primary diagnosis was "Loss of Weight." Patient #12's POC stated "SN to assess: caregiver abilities, coping skills, disease process, symptom management/reporting, personal care, nutrition, hydration, weight monitoring PRN & therapeutic diet." No other direction to staff regarding weight loss was mentioned in Patient #12's POC. The Administrator was interviewed on 4/22/15 beginning at 11:25 AM. She reviewed Patient #12's POC and confirmed specific direction to staff regarding weight loss was not included in his POC. Patient #12's POC did not address his primary diagnosis of weight loss. 2. Patient #2's medical record documented a 65 year old male whose SOC was 3/04/13. He was currently a patient as of 4/23/15. His primary diagnosis was schizophrenia.	G 159	diagnosis, problems and needs. Quality review of the assessment and PoC by the RN supervisor will assure the Clinician has clearly documented education of patient and caregivers, interventions by professional staff, goals and and progress toward goals within the Electronic Medical Record (EMR). Interventions and Education will be documented specific to medication side effects, pain management interventions, any abnormal findings, specification of parameters outside accepted ranges and who will notify the MD when findings are outside of parameters. When assessment identifies pain, interventions will be specified to identify actions and interventions that may be taken to monitor and mitigate pain. Patient satisfaction with pain relief will be articulated within the PoC and visits will substantiate the monitoring and interventions as well as notification of the MD if relief is unsatisfactory. PoC for patients requiring oxygen will include the Oxygen delivery system used such as liquid tank, concentrator, CPAP, compression machine, etc.	7/20/15

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G 159	Continued From page 4 Patient #2's POC for the certification period 2/20/15 to 4/20/15 was reviewed. The POC stated the nurse was to visit Patient #12 every 2 weeks to administer a shot of Fluphenazine Deconate, an antipsychotic medication, to treat his schizophrenia. Medline Plus, a web site operated by the National Institutes of Health, was queried on 4/23/15. It stated Fluphenazine could cause serious side effects. It stated for patients taking Fluphenazine, "If you experience any of the following symptoms, call your doctor immediately: jaw, neck, and back muscle spasms, slow or difficult speech, shuffling walk, persistent fine tremor or inability to sit still, fever, chills, sore throat, or flu-like symptoms, [or] difficulty breathing or swallowing." Patient #2's POC did not specifically direct staff in caring for or monitoring his schizophrenia, behaviors, or the side effects of the medication nurses administered for his schizophrenia. The surveyor accompanied the RN on a visit to Patient #2's residence on 4/20/15 beginning at 2:00 PM. The RN conducted a recertification assessment. The RN did not inquire regarding Patient #2's symptoms related to his schizophrenia or the side effects of his antipsychotic medication. It was also observed the RN did not physically examine Patient #2 for side effects of his antipsychotic medication. The RN was interviewed on 4/22/15 beginning at 2:10 PM. She reviewed Patient #2's POC and confirmed it did not address his schizophrenia or monitoring the effects of the antipsychotic medication he took.	G 159	Monitoring of the initial and ongoing assessments, PoC (485) and orders will occur with each new episode and follow up Clinical Record Review will be assured by the Clinical Supervisor/Clinical Director. Clinical Supervisor/Clinical Director will ensure the PoC addresses all pertinent diagnosis and interventions to be performed.	5/20/15 Kz

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G 159	Continued From page 5 Patient #2's POC did not address his primary diagnosis. 3. Patient #11 was a 53 year old male admitted to the agency on 3/21/15, for care related to epilepsy. Additional diagnoses included muscle weakness, bipolar disorder and spinal stenosis. His record for the certification period 3/21/15 to 5/19/15, was reviewed. Patient #11's record included a comprehensive admission assessment completed by the RN on 3/21/15. The assessment included the locations and levels of pain reported by Patient #11. His pain levels were reported on a scale of 0-10, with 10 being the worst pain. Patient #11 reported bilateral foot pain at a constant level of 7, bilateral hand pain that ranged from 4 to 8, migraine headaches that ranged from 0-7, and generalized aching pain that ranged from 0-6. Patient #11's POC for the certification period 3/17/15 to 5/15/15, did not include interventions to monitor and mitigate his reported pain. During an interview on 4/22/15 at 1:15 PM, the Administrator reviewed Patient #11's record and confirmed it did not include pain management interventions. Patient #11 reported significant levels of pain, however his POC did not include interventions related to pain management. 4. Patient #5 was a 60 year old male admitted to the agency on 3/07/15, for care related to a splenic abscess. Additional diagnoses included	G 159	Clinical Supervisor/Clinical Director will ensure the PoC addresses interventions related to monitoring and mitigation of Pain when it has been identified by the clinician	Kng 5/20/15

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

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G 159	Continued From page 6 sepsis, cirrhosis, pancreatitis, insulin dependent DM and chronic pain. His record for the certification period 3/07/15 to 5/05/15, was reviewed. Patient #5's record included an admission comprehensive assessment completed on 3/07/15, and signed by the RN. The assessment stated his POC included specific parameters for notifying his physician of changes in his vital signs or other clinical findings. However, his POC for the certification period 3/07/15 to 5/05/15, completed by the RN, did not include parameters to indicate when the clinicians should notify Patient #5's physician of clinical findings outside of normal levels. Patient #5's admission assessment documented his blood sugar readings ranged from 76-300 mg/dl. The American Diabetes Association website, accessed 4/24/15, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl. A SN visit note dated 3/19/15, and signed by the RN, documented Patient #5's blood sugar as 326. A SN visit note dated 4/18/15, and signed by the RN, documented Patient #5's blood sugars had ranged from 367 to 406. However, his POC did not state at what level his blood sugar results should be reported to his physician. During an interview on 4/23/15 at 10:10 AM, the Administrator reviewed Patient #5's record and confirmed it did not include specific parameters for notifying his physician of blood sugar readings. Patient #5's POC was not comprehensive to	G 159	Staff has been educated that when questions M2250 on the comprehensive assessment is answered "yes" that parameters for notifying physician if changes have been identified. The clinician will identify the parameters and documentation will substantiate MD notification of changes in vital signs outside parameters or pain. Monitoring will be performed by Clinical Supervisor/Clinical Director to assure clinicians are documenting variances.	5/20/15

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G 159	Continued From page 7 indicate when his physician should be notified of abnormal clinical findings. 5. Patient #7 was an 81 year old female admitted to the agency on 3/20/15, for care related to COPD. Additional diagnoses included emphysema, pneumonia and CHF. Her record for the certification period 3/20/15 to 5/18/15, was reviewed. a. Patient #7's record included a comprehensive admission assessment completed on 3/20/15, and signed by the RN. The assessment documented Patient #7 reported chronic migraine headaches. She stated her headache was currently a level 4, and sometimes escalated to a level of 10, on a 0-10 pain scale. Patient #7's POC for the certification period 3/20/15 to 5/18/15, did not include interventions to monitor and mitigate her reported pain. During an interview on 4/23/15 at 10:50 AM, the Administrator reviewed Patient #7's record and confirmed it did not include pain management interventions. Patient #7 reported migraine headaches, however her POC did not include interventions related to pain control. b. Patient #7's comprehensive assessment and medication profile documented she used oxygen due to her respiratory disease. However, her POC for the certification period 3/20/15 to 5/18/15, did not include equipment used to deliver her oxygen, such as an oxygen concentrator or cylinders.	G 159		5/20/15 Kg

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G 159	Continued From page 8 During an interview on 4/23/15 at 10:50 AM, the Administrator reviewed Patient #7's record and confirmed it did not include the equipment used to deliver her oxygen. Patient #7's POC was not comprehensive to include all equipment required for her care. 6. Patient #9 was a 58 year old female admitted to the agency on 4/02/10. Her diagnoses included lymphedema, depressive disorder, schizoaffective disorder and non-insulin dependent DM. Her record for the certification period 3/22/15 to 5/20/15, was reviewed. Patient #9's record included a recertification assessment, completed on 3/26/15, and signed by the RN. The assessment documented Patient #9 used a CPAP machine, and a compression machine to her lower extremities. However, her POC for the certification period 3/20/15 to 5/18/15, did not include CPAP or compression machines. During an interview on 4/22/15 at 1:10 PM, the Administrator reviewed Patient #9's record and confirmed her POC did not include CPAP or compression machines. Patient #9's POC was not comprehensive to include all equipment required for her care. 7. Patient #10 was a 60 year old male admitted to the agency on 3/17/15, for care related to an ankle ulcer. Additional diagnoses included insulin dependent DM, peripheral vascular disease, hypertension and COPD. His record for the certification period 3/17/15 to 5/15/15, was reviewed.	G 159		5/20/15 Kr

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G 159	Continued From page 9 Patient #10's record included an admission comprehensive assessment completed on 3/17/15, and signed by the RN. a. Patient #10's comprehensive assessment documented he used oxygen due to his respiratory disease. However, his POC for the certification period 3/17/15 to 5/15/15, did not include equipment used to deliver his oxygen, such as an oxygen concentrator or cylinders. During an interview on 4/23/15 at 10:35 AM, the Administrator reviewed Patient #10's record and confirmed it did not include the equipment used to deliver his oxygen. Patient #10's POC was not comprehensive to include all equipment required for his care. b. Patient #10's admission comprehensive assessment stated his POC included specific parameters for notifying his physician of changes in his vital signs or other clinical findings. However, his POC for the certification period 3/17/15 to 5/15/15, completed by the RN, did not include parameters to indicate when the clinicians should notify Patient #10's physician of clinical findings outside of normal levels. During an interview on 4/23/15 at 10:35 AM, the Administrator reviewed Patient #10's record and confirmed it did not include specific parameters for notifying his physician of findings outside of normal levels. Patient #10's POC was not comprehensive to indicate when his physician should be notified of abnormal clinical findings.	G 159		5/20/15 Kn

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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 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 2 of 12 patients (#7, and #11) whose records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include: The agency policy, titled "ADMISSION CRITERIA AND PROCESS FOR HOME HEALTH PATIENTS," dated 10/14, stated "...an initial Plan of Care will be developed in consultation with the physician..." This policy was not followed for all patients. Examples include: 1. Patient #11 was a 53 year old male admitted to the agency on 3/21/15, for care related to epilepsy. Additional diagnoses included muscle weakness, bipolar disorder and spinal stenosis. His record for the certification period 3/21/15 to 5/19/15, was reviewed. Patient #11's record included an admission comprehensive assessment dated 3/21/15, and signed by the RN. His record did not include documentation of contact with his physician to obtain a verbal order for ongoing services. Patient #11's record included a POC for the certification period 3/21/15 to 5/19/15, signed by	G 160	DEFICIENCY : G160 484.18(a) PoC Action/procedure to correct will include: writing and obtaining orders from the Physician to approve the PoC or modifications to the PoC. RN placed multiple calls to the MD of patient # 7 and #11 , spoke with the MD staff, however the response and approval by the MD to proceed with care was not documented. The PoC was signed after the PoC was put in place. Action to resolve deficiency: Clinical Supervisor/Clinical Director will verify that the signing physician will be available prior to acceptance of patient for care by the Agency. The professional Clinician who completes the Comprehensive Assessment will be responsible to obtain Verbal order prior to proceeding with the PoC. Clinical Supervisor/Clinical Director Has educated all Professional Disciplines to assure orders are received from the MD for approval of PoC and Modification of the PoC before plan is implemented. • As part of the scheduling process the Scheduling Coordinator will verify orders prior to input into EMR Schedule. • Scheduling Coordinator will	5/20/15

Kng 5/20/15

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G 160	Continued From page 11 his physician on 4/01/15. However, SN visits were documented on 3/23/15 and 3/31/15, prior to physician approval of his POC. During an interview on 4/22/15 at 1:15 PM, the Administrator reviewed Patient #11's record and confirmed there was no documentation of physician orders for ongoing services prior to 4/01/15, when his physician signed his POC. Patient #11's physician was not consulted to approve his POC and additional SN visits following the admission assessment. 2. Patient #7 was an 81 year old female admitted to the agency on 3/20/15, for care related to COPD. Additional diagnoses included emphysema, pneumonia and CHF. Her record for the certification period 3/20/15 to 5/18/15, was reviewed. Patient #7's record included an admission comprehensive assessment dated 3/20/15, and signed by the RN. Patient #7's record did not include documentation of contact with her physician to obtain a verbal order for ongoing services. Patient #7's record included a POC for the certification period 3/20/15 to 5/18/15, signed by her physician on 4/03/15. However, SN visits were documented on 3/25/15 and 4/02/15, prior to physician approval of her POC. During an interview on 4/23/15 at 10:50 AM, the Administrator reviewed Patient #7's record and confirmed there was no documentation of physician orders for ongoing services prior to 4/03/15, when her physician signed her POC.	G 160	verify visits daily, Scheduled Not Made and Made Not Scheduled. • Nursing Supervisor/Clinical Director will confirm visits for the day with scheduler . • Nursing Supervisor / Clinical Director will validate verbal orders have been received prior to implementation of PoC and scheduling. Education of all staff has been provided to assure verbal orders are written timely for all care approved by the physician effective 5/20/15. • Monitoring will be assured by the Clinical Supervisor/Clinical Director. • On-going monitoring will be done by the QAPI team to evaluate compliance with writing and obtaining MD verbal order or written order for the PoC and modifications. Team will include: Medical Record Manager, Scheduling Coordinator, Clinical Director, See continuation on page 12A	5/20/15 Kg

Continuation of 12A: G160 484.18(a)

HR Director and Clinical Director and a representative of each discipline.

- Monitoring will include the following QAPI monitoring tools and processes:
  -Calendar with Frequency ordered for each discipline for each Patient
  -Monitoring of Visits input into EMR (Mobile Touch and Data Validator reports)
  -Intake Check list to be QA by Medical Records.
  -Medical Record review will be performed by the Scheduling Coordinator for all non-episodic patients, daily and at the end of episode to reconcile what was ordered was provided and what was provided was ordered and approved by the Clinical Supervisor/ Clinical Director.

Karen M Young RN, Admin
5/20/15
Progressive Nursing Services

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G 160	Continued From page 12 Patient #7's physician was not consulted to approve her POC and additional SN visits following the admission assessment.	G 160		
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 (#10) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include: Patient #10 was a 60 year old male admitted to the agency on 3/17/15, for care related to an ankle ulcer. Additional diagnoses included insulin dependent DM, peripheral vascular disease, hypertension and COPD. His record for the certification period 3/17/15 to 5/15/15, was reviewed. Patient #10's record included an SN visit note dated 4/01/15, and signed by the RN. The note documented Patient #10's physician was contacted and an order was received to discontinue his wound VAC, and apply a dressing to his wound. Patient #10's record did not include	G 166	Deficiency sited : G166 484.18 (c) Conformance with Physician Orders Agency will ensure that verbal orders are written, signed, and dated by the RN who received the orders. All professional staff receiving orders have been educated that all verbal orders must be transcribed by the professional into a written order and sent to physician for signature. • Action/procedure to correct will include over-site by the Clinical Supervisor/Clinical Director. and completed by QAPI team to include Medical Record Manager, Scheduling Coordinator, RN supervisor, HR director and Clinical Director • Monitoring will include the following QAPI monitoring tools and processes:	5/20/15 [handwritten initials]

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G 166	Continued From page 13 a written order dated 4/01/15, to remove his wound VAC. Patient #10's record included an SN visit note dated 4/06/15, and signed by the RN. The note documented Patient #10's physician was contacted and an order was received to reapply his wound VAC. Patient #10's record did not include a written order dated 4/06/15, to reapply his wound VAC. During an interview on 4/23/15 at 10:35 AM, the Administrator reviewed Patient #10's record and confirmed the verbal orders received by the RN on 4/01/15, and 4/06/15, were not written, signed and dated by the RN. The agency failed to ensure verbal orders from Patient #10's physician were written, signed and dated by the RN who received them.	G 166	Monitoring of corrective action will be assured by: • Clinical Supervisor/Clinical Director will perform QA checks on every note prior to distribution of notes into the EMR that will ensure any MD communication or directives have been transcribed into a verbal order.	5/20/15
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, observations in the home, and staff interview, it was determined the agency failed to ensure a comprehensive drug regimen review for 6 of 12 patients (#2, #5, #7, #8, #10, and #11) whose records were reviewed. This had the potential to result in adverse events, duplicative drug therapy, or negative drug	G 337	Deficiency sited: G337 484.55 (c) DRUG REGIMEN REVIEW • Comprehensive assessment will include review visualization of all prescribed and over- the- counter medications that 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 non-compliance with drug therapy. Comprehensive Assessment will always include a visual review of all medications taken by the patient by the clinician completing the comprehensive assessment. Medication list in the EMR and the home will reflect reconciled and approved —	5/20/15

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G 337	Continued From page 14 interactions. Findings include: 1. Patient #2's medical record documented a 65 year old male whose SOC was 3/04/13. His diagnosis was schizophrenia. He was currently a patient as of 4/21/15. Patient #2's POC for the certification period 2/20/15-4/20/15, included medication orders for Oxycodone 5 mg 4 times a day as needed (for pain). He also had an order for Nitroglycerin pills every 5 minutes as needed for chest pain (cardiac pain). The surveyor accompanied the RN on a recertification visit to Patient #2, which included a comprehensive assessment. The visit occurred on 4/20/15 beginning at 2:00 PM. The recertification included a review of Patient #2's medications. During the review, Patient #2 stated he was taking between 4 and 8 Oxycodone per day. He also stated he took Nitroglycerin daily for "heartburn." It appeared Patient #2 was not taking the medications per the physician's orders. The RN did not visualize Patient #2's medications to see how many Oxycodone and Nitroglycerin pills he was actually taking. She did not review his other medications to see if Patient #2 was taking them correctly. A form by the RN, titled "Recertification and Other Follow Up," dated 4/21/15 but not timed, stated Patient #2's medications were reviewed during the visit. The form stated problems were found during Patient #2's medication review. The form stated Patient #2 took pain medications "outside of prescribed method." The form stated Patient #2's physician was aware of his non-compliance	G 337	medication list. Modification of the medication list by the physician when PoC is signed will be updated within the EMR and updated medication list will be found in the EMR and the home. If medication is inactive or discontinued, medication list will be updated after confirmation has been received from physician. If medication changed are identified by the physician verbally or in writing, medication list will be updated and copy to EMR and home. If discrepancy between hospital mediation list and in-home medication reconciliation occurs, physician will be contacted to reconcile and clarify medications to be taken by patient in the home. Documentation will substantiate communication with the physician.	5/20/15

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G 337	Continued From page 15 with pain medications. The RN was interviewed on 4/22/15 at 1:59 PM. The RN confirmed she did not visualize Patient #2's medications during the visit on 4/20/15. She stated another RN would visit Patient #2 on 4/24/15, and would examine his medications then. The agency failed to perform a comprehensive assessment including a review of all medications Patient #2 was taking. 2. Patient #8 was a 62 year old male admitted to the agency on 7/02/10. His diagnoses included acute systolic heart failure, epilepsy, hepatitis C and chronic pain. His record for the certification period 2/24/15 to 4/24/15, was reviewed. Patient #8's record included a POC for the certification period 2/24/15 to 4/24/15, signed by his physician on 3/27/15. The medications listed on his POC included Naproxen 500 mg to be taken twice daily. However, the physician signed POC included a line marked through Naproxen on the medication list. A visit was made to Patient #8's home on 4/22/15 at 3:30 PM, to observe a SN visit, which included a 2 week set up of his medications in a pill organizer. A medication list, dated 4/02/15, and left in Patient #8's home by the RN, included Naproxen 500 mg, to be taken twice daily. The RN reviewed Patient #8's electronic record on a laptop while in his home, and stated the Naproxen was "inactive," however, he was not able to determine when the medication was discontinued. He stated the pill organizer set up	G 337	Monitoring will include the following QAPI monitoring tools and processes: • Clinical Supervisor /Clinical Director will monitor that medications listed on PoC have been reconciled with physician medication list/transferring facility list and patient's home medications.; upon review prior to distribution of skilled nurse intervention notes, Nursing Supervisor/Clinical Director will validate medication reconciliation has been document in the clinical record. Documentation of any discrepancies, omissions, or errors will substantiate communicate with the physician.	5/20/15 [handwritten initials]

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G 337	Continued From page 16 by the RN one week prior contained Naproxen. During an interview on 4/22/15 at 12:40 PM, the RN confirmed the Naproxen listed on Patient #8's POC had been marked through by his physician, indicating the medication was to be discontinued. She stated she noted the change on the POC on 4/21/15 and discontinued Naproxen in Patient #8's record at that time. During an interview on 4/22/15 at 12:40 PM, the Administrator stated Patient #8's POC was signed by his physician on 3/27/15, and faxed to the agency. She stated faxes were received at the front desk and given to the medical records department to be scanned into the electronic medical record. The Administer confirmed there was no documentation in Patient #8's record to indicate the medication change made by the physician was noted or addressed. The agency failed to review the physician signed POC to identify medication changes. 3. Patient #11 was a 53 year old male admitted to the agency on 3/21/15, for care related to epilepsy. Additional diagnoses included muscle weakness, bipolar disorder and spinal stenosis. His record for the certification period 3/21/15 to 5/19/15, was reviewed. Patient #11's record included a POC for the certification period 3/21/15 to 5/19/15, signed by his physician on 4/01/15. The medications listed on his POC included Lorazepam 1 mg to be taken 3 times a day. However, the physician signed POC included a line marked through Lorazepam on the medication list. Additionally, the physician signed POC included a handwritten	G 337	Clinical Supervisor/Clinical Director will ensure the modification of the PoC made by the MD on the signed and returned PoC are updated on the Home Medication Profile and in the EMR. Professional Staff have been educated.	5/20/15 Kg

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G 337	Continued From page 17 entry of ASA (aspirin) 81 mg. His POC did not include Aspirin. Patient #11's medication profile was not updated with the changes. During an interview on 4/22/15 at 1:15 PM, the Administrator reviewed Patient #11's record and confirmed the physician made changes to the medication list on the POC, prior to faxing it to the agency. Additionally, she confirmed Patient #11's current medication profile, as of 4/22/15 included Lorazepam and did not include ASA 81 mg. The agency failed to review the physician signed POC to identify medication changes. 4. Patient #5 was a 60 year old male admitted to the agency on 3/07/15, for care related to a splenic abscess. Additional diagnoses included sepsis, cirrhosis, pancreatitis, insulin dependent DM and chronic pain. His record for the certification period 3/07/15 to 5/05/15, was reviewed. Patient #5 was discharged from a hospital on 3/06/15. His record included information from the discharging hospital, faxed to the agency on 3/06/15. The information included a medication list indicating medications that should be continued or resumed upon hospital discharge. Patient #5's record included a POC for the certification period 3/07/15 to 5/05/15. The POC included a list of her medications, as of 3/07/15. The medications listed on his home health POC did not match the hospital discharge medication list, as follows: -The hospital list included Pancrealipase (pancreatic enzymes) 4 capsules to be taken 3	G 337	Clinical Director has educated professional staff and will monitor all changes and discontinued meds on incoming signed PoC will be update in the EMR and Home Medication Profile.	Kng 5/20/15

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G 337	Continued From page 18 times a day. Pancrealipase was not included on her POC. -The hospital list included Prilosec, for acid reflux, 20 mg to be taken daily. Prilosec was not included on her POC. -The hospital list included Vitamin D2, 50,000 units, to be taken daily. Vitamin D2 was not included on her POC. -The hospital list included Ferrous Sulfate (iron supplement), 325 mg to be taken daily. Ferrous Sulfate was not included on her POC. -The hospital list included Synthroid (thyroid hormone replacement), 200 mcg to be taken daily. Synthroid 200 mcg was not included on her POC. -The hospital list included Synthroid (thyroid hormone replacement), 50 mg, 1 tab to be taken on Monday, Wednesday, Friday, Saturday and Sunday, and 1/2 tab to be taken on Tuesday and Thursday. Her POC included Synthroid 50 mcg to be taken daily. Patient #5's record did not document his physician was contacted to reconcile his medications, and to determine the medications and dosages he should take at home. During an interview on 4/23/15 at 10:10 AM, the Administrator reviewed Patient #5's record and confirmed the discrepancies between the hospital discharge medication list and the home health POC. Additionally, she confirmed Patient #5's physician was not contacted to reconcile his medications.	G 337		Krg 5/20/15

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G 337	Continued From page 19 Patient #5's medications were not reconciled with his physician to ensure he was taking the correct medications at the correct dosages. 5. Patient #7 was an 81 year old female admitted to the agency on 3/20/15, for care related to COPD. Additional diagnoses included emphysema, pneumonia and CHF. Her record for the certification period 3/20/15 to 5/18/15, was reviewed. Patient #7's record included a POC for the certification period 3/20/15 to 5/18/15. The POC included her current medications. The list of medications included Aspirin to be taken every AM. However, it did not include the number of milligrams of Aspirin she should take. Patient #7's record did not include documentation of contact with her physician to determine the dosage of Aspirin she was to take. During an interview on 4/23/15 at 10:50 AM, the Administrator reviewed Patient #7's record and confirmed the dosage of Aspirin was not stated on her POC or medication profile. Additionally, she confirmed Patient #7's physician was not contacted to determine the prescribed dosage of Aspirin. Patient #7's medications were not reconciled with her physician to ensure she was taking the correct dosage of Aspirin. 6. Patient #10 was a 60 year old male admitted to the agency on 3/17/15, for care related to an ankle ulcer. Additional diagnoses included insulin dependent DM, peripheral vascular disease, hypertension and COPD. His record for the	G 337		Kg 5/20/15

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

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G 337	Continued From page 20 certification period 3/17/15 to 5/15/15, was reviewed. Patient #10's admission assessment documented use of oxygen, however, oxygen was not included on Patient #10's POC or medication list for the certification period 3/17/15 to 5/15/15. Therefore, his POC and medication list did not state the oxygen flow rate ordered by his physician. During an interview on 4/23/15 at 10:35 AM, the Administrator reviewed Patient #10's record and confirmed oxygen was not included on his POC or medication list. Patient #10's medication list and POC did not include his oxygen.	G 337	Clinical Supervisor/Clinical Director will ensure oxygen delivery and dose is included on the PoC and or medication list when oxygen need identified during the assessment. Education of staff has been provided and PoC will be monitored by Clinical Supervisor/Clinical Director.	5/20/15
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, it was determined the agency failed to ensure comprehensive assessments occurred during the last 5 days of every 60 day episode, and additional services were not provided until	G 339	Deficiency sited G339 484.55 UPDATE OF THE COMPREHENSIVE ASSESSMENT Action to correct: Comprehensive Assessment was not consistently performed within the 56-60th day. During a joint visit with Surveyors and patient # 8 the RN failed to include all required elements of the Comprehensive assessment . Comprehensive assessment should have included weight, skin assessment, review of systems, pain assessment , safety check, Bedroom and kitchen and general questions about the patient's ability to perform daily activities. The comprehensive assessment for recertification was not completed within the 56th to 60th day.	5/20/15

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G 339	Continued From page 21 the comprehensive assessment was completed, for 4 of 7 patients (#1, #2, #8 and #9) who received care for more than 60 days and whose records were reviewed. This resulted in the failure of the agency to have a current assessment and POC, and had the potential to impact the quality of patient care. Findings include: 1. Patient #8 was a 62 year old male admitted to the agency on 7/02/10. His diagnoses included acute systolic heart failure, epilepsy, hepatitis C and chronic pain. His record for the certification period 2/24/15 to 4/24/15, was reviewed. a. A visit was made to Patient #8's home on 4/22/15 at 3:30 PM, to observe a SN visit. During the visit, the RN informed Patient #8 he was there to complete a recertification assessment for the certification period to begin on 4/25/15. The SN visit observed on 4/22/15, did not include a comprehensive assessment. The RN completed an assessment of Patient #8's vital signs, oxygen saturation and lungs sounds, and set up his medications for 2 weeks. However, the RN did not weigh him, complete a skin assessment, or review of systems, and did not question Patient #8 regarding his level of pain. Patient #8 had moved to a different apartment in the prior 2 weeks, however, the RN did not observe his kitchen, bathroom and bedroom to assess for safety concerns, or question him about his ability to perform his activities of daily living. During an interview on 4/23/15 at 9:35 AM, the Administrator stated during a recertification assessment the RN should gather information necessary to create a POC for the new	G 339	• Education has been provided to the clinicians of all the elements required during the comprehensive assessment such as pain, skin assessment, weight, vitals signs, oxygen saturation and lung sounds, medications, and observation of environment such as bathroom to bedroom safety concerns and ADLs . • Distribution of the policy to all clinicians' who perform comprehensive assessments. • Each comprehensive Assessment will be monitored and reviewed by the Clinical Supervisor or Clinical Director prior to transmission to state to assure timeliness and completion of are required elements. • Joint visit will be made by the Clinical Director or delegated Supervisor to supervise the comprehensive assessment at least one time per year to review the RN's technique and compliance	5/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137049	A. BUILDING ____ B. WING ____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE NURSING SERVICES	1514 SHOSHONE STREET BOISE, ID 83705

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G 339	Continued From page 22 certification period. She stated the patient's problem list should be reviewed and revised, if necessary. The Administrator confirmed Patient #8's visit completed on 4/22/15, was not an adequate recertification assessment. Patient #8 recertification assessment was not comprehensive to determine his current needs and create a POC to address his needs. b. Patient #8's record included a POC for the certification period 2/24/15 to 4/24/15, signed by her physician on 3/27/15. However, the comprehensive assessment used to create his POC was not completed until 3/04/15, 8 days after the POC went into effect. During an interview on 4/22/15 at 12:40 PM, the Administrator reviewed Patient #8's record and confirmed his comprehensive assessment was not completed during the last 5 days of his certification period. She stated Patient #8 received visits every 2 weeks for medication management, and the assessment was delayed until his next scheduled visit. Patient #8's comprehensive assessment was not completed during the last 5 days of his certification period. 2. Patient #1 was a 72 year old female admitted to the agency on 11/03/09, for care related to rheumatoid arthritis. Additional diagnoses included contracture of hand joint, chronic pain and osteoarthritis. Her record for the certification period 4/06/15 to 6/04/15, was reviewed. Patient #1's record included a POC for the certification period 4/06/15 to 6/04/15, signed by	G 339	Action to correct: Comprehensive Assessment for patient # 9, #2 and #1 did not have their recertification comprehensive assessments done within the 56-60th day. A Therapy visit was done before the RN completed the recertification visit on Patient #1. Agency policy does require comprehensive assessment to be performed within the 56-60th day. Scheduling Coordinator will schedule within the EMR software. Recertification visit within day 56 to 60 of the Certification period. Scheduling Coordinator will reconcile visits scheduled daily. A weekly Conference will be held with the RN supervisor/ Clinical Director, Scheduling Coordinator, Medical record Manager and Case Managers to assure timely scheduling of recertifications. RN Case Manager or Supervisor will obtain permission to perform the comprehensive assessment within the required 56-60th day. Orders will be requested from the MD for visits to be done within the required 56-60th day of the episode. Weekly monitoring of the Re-certifications Due List will be	5/30/15

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

PRINTED: 05/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137049	A. BUILDING ______ B. WING ______	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 339	Continued From page 23 her physician on 4/13/15. However, the comprehensive assessment and collection of OASIS data, used to create her POC, was not completed until 4/07/15, 7 days after the POC went into effect. Patient #1's record included a PT visit note dated 4/06/15, and signed by the Physical Therapist. The PT visit was completed in the new certification period, however, the comprehensive assessment had not been completed to determine Patient #1's health status and continued need for home health services. During an interview on 4/22/15 at 1:15 PM, the Administrator reviewed Patient #1's record and confirmed her comprehensive assessment was not completed during the last 5 days of her certification period. She stated Patient #1 was out of town at that time, and the assessment was delayed until she returned to town. Patient #1's comprehensive assessment was not completed during the last 5 days of her certification period, and services were provided prior to the comprehensive assessment. 3. Patient #9 was a 58 year old female admitted to the agency on 4/02/10. Her diagnoses included lymphedema, depressive disorder, schizoaffective disorder and non-insulin dependent DM. Her record for the certification period 3/22/15 to 5/20/15, was reviewed. Patient #9's record included a POC for the certification period 3/22/15 to 5/20/15. However, the comprehensive assessment used to create her POC was not completed until 3/26/15, 4 days after the POC went into effect.	G 339	performed by the Clinical Supervisor/Clinical Director. Review will include all Recerts due for next 14 days. Education and monitoring process to assure compliance with timely recerts has been confirmed by the Clinical Director effective 5/20/15.	5/20/15 [initials]

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	137049	A. BUILDING ______ B. WING ______	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 339	Continued From page 24 During an interview on 4/22/15 at 1:10 PM, the Administrator reviewed Patient #9's record and confirmed her comprehensive assessment was not completed during the last 5 days of her certification period. She stated Patient #9 received visits every 2 weeks for medication management, and the assessment was delayed until her next scheduled visit. Patient #9's comprehensive assessment was not completed during the last 5 days of her certification period. 4. Patient #2's medical record documented a 65 year old male whose SOC was 3/04/13. His diagnosis was schizophrenia. He was currently a patient as of 4/21/15. Patient #2's record included a POC for the certification period 2/20/15-4/20/15, signed by his physician on 3/19/15. However, the comprehensive assessment used to create his POC, was not completed until 2/27/15, 7 days after the POC went into effect. During an interview on 4/22/15 at 1:59 PM, the RN who visited Patient #2 on 4/20/15, confirmed the comprehensive assessment was not completed during the last 5 days of the certification period from 12/22/15-2/20/15. Patient #2's comprehensive assessment was not completed during the last 5 days of his certification period.	G 339		5/20/15

Karen McJoring RN

PRINTED: 05/05/2015
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001460	A. BUILDING: ______ B. WING ______	04/23/2015

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PROGRESSIVE NURSING SERVICES	1514 SHOSHONE STREET BOISE, ID 83705

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho state licensure surveyof your agency from 3/02/15 to 3/05/15. The surveyors conducting the survey were: Nancy Bax, RN, BSN,HFS, Team Leader Gary Guiles, RN, HFS Acronyms used in this report include: BP - Blood Pressure CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure D/C - discharge DM - Diabetes Mellitus DME - Durable Medical Equipment HHA - Home Health Aide HTN - Hypertension mcg - micrograms mg - milligrams mg/dl - milligrams per deciliter MSW - Medical Social Worker NS - Normal Saline OASIS - Outcome and Assessment Information Set OT - Occupational Therapist POC - Plan of Care PRN - as needed PT - Physical Therapy RN- Registered Nurse SN - Skilled Nurse SOC - Start of Care VAC - vacuum assisted closure	N 000	RECEIVED MAY 20 2015 FACILITY STANDARDS	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be	N 152	N152 01.7030.01 Plan of Care (PoC) See Plan of Correction for G158 pages 1,2,2A and 2B	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen M Young RN
TITLE: Administrator
(X6) DATE: 5/20/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001460	A. BUILDING: ____ B. WING ____	04/23/2015

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N 152	Continued From page 1 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	Continued from page 1 of 4 See pages 1,2,2A and 2B	5/20/15 [initials]
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 0307030 PoC See Plan of Corrections for G159 Pages 3-7	5/20/15 [initials]
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	N 155	N155 0307030 PoC See Plan of Corrections for G159 Pages 3-7	5/20/15 [initials]

Bureau of Facility Standards

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N 155	Continued From page 2 equipment required; This Rule is not met as evidenced by: Refer to G159 as it relates to the failure of the agency to ensure patients' POCs included all pertinent services and equipment.	N 155	N155 0307030 PoC See Plan of Corrections for G159 Pages 3-7	5/20/15
N 160	03.07030.PLAN OF CARE N160 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: h. Nutritional requirements; This Rule is not met as evidenced by: Refer to G 159 as it relates to the failure of the agency to include patients' nutritional needs on the POC.	N 160	N160 0307030 PoC See Plan of Corrections for G159 Pages 3-7	5/20/15
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 as it refers to the failure of the	N 161	N161 0307030 PoC See Plan of Corrections for G159 Pages 3-7	5/20/15

Bureau of Facility Standards

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N 161	Continued From page 3 agency to ensure the POC included all pertinent treatments.	N 161		
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 as it relates to the agency's failure to obtain physician approval for additions or modifications to the plan of care.	N 170	N170 03.07030.04 PoC See Plan of Corrections for 160 Pages 11,12,12A	5/20/15
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels; drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G 337 as it relates to the agency's failure to ensure comprehensive medication reviews were completed, and to ensure verbal orders were put into writing and signed by the physician.	N 173	N173 03.07030.07 PoC See Plan of Corrections for 337 Pages 14-15-16-17-21	5/20/15

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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May 27, 2015

Karen Young, Administrator
Progressive Nursing Services
1514 Shoshone Street
Boise, ID 83705

Provider #137049

Dear Ms. Young:

An unannounced on-site complaint investigation was conducted from April 20, 2015 to April 23, 2015 at Progressive Nursing Services. The complaint allegation, findings, and conclusion are as follows:

Complaint #ID00006929

Allegation: An employee falsified patient medical records.

Findings: The Owner and the Human Resources Director were interviewed on 4/21/15 beginning at 10:20 AM. They confirmed the allegation. The Owner stated the former Director of Nursing (DON) had modified nursing visit notes to make it appear as if she had made the visit instead of the nurse who actually made the visit. The DON was then paid for the visit in place of the nurse who made it.

The agency audited all of its medical records. The agency had documentation the incidents occurred between May 2014 and January 2015. A review of visits for the time frame revealed the number of verified falsified visit notes was 116. Only the dates and times of the visit notes were changed. The agency confirmed personal information such as vital signs, weights, and treatment provided was not changed.

The Owner stated the agency changed its electronic medical record software on 2/01/15. The installation of the new software led to the discovery of the falsified notes. After the discovery of the falsified notes, the agency tested the system and determined medical records were safe from tampering. The affected records were corrected and re-signed by the nurses who actually made the visits.

Upon discovery of the falsified documents, the agency terminated the DON. The agency reported the events to the police and the Board of Nursing.

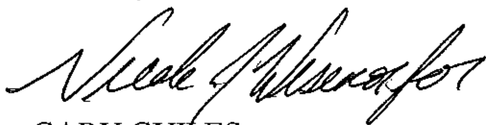
The allegation was substantiated. However, the agency had taken action to correct the deficient practices. No deficiencies were cited.

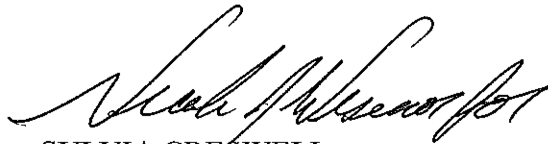
Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,





GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt