



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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June 26, 2015

Vickie Nostrant, Administrator
North Idaho Home Health
2426 North Merritt Creek Loop
Coeur d'Alene, Idaho 83814

RE: North Idaho Home Health, Provider #137019

Dear Ms. Nostrant:

This is to advise you of the findings of the Medicare/Licensure survey at North Idaho Home Health, which was concluded on June 12, 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 agency into compliance, and that the 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 Form CMS-2567 and State Form 2567.

Vickie Nostrant, Administrator
June 26, 2015
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **July 9, 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,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

/sc
Enclosures

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

PRINTED: 08/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2015
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2426 NORTH MERRITT CREEK LOOP COEUR D'ALENE, ID 83814	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your home health agency on 6/08/15 through 6/12/15. The surveyors conducting the recertification were:</p> <p>Susan Costa RN, HFS, Team Lead Nancy Bax RN, HFS Dennis Kelly RN, HFS</p> <p>Acronyms used in this report include:</p> <p>abd - abdomen BG - Blood Glucose BID - twice daily CAD - Coronary Artery Disease CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease CVA - Cerebral Vascular Accident DME - Durable Medical Equipment DM II - Type 2 Diabetes Mellitus DON - Director of Nursing D/T - due to ER - Emergency Room GERD - Gastroesophageal Reflux Disease H & P - History and Physical HTN - Hypertension HV - Home Visit IM - Intramuscular IV - Intravenous LPN - Licensed Practical Nurse MD - Medical Doctor MD SBAR - Physician Communication tool (Situation Background Assessment & Recommendation) MI - Myocardial Infarction mg - milligram ml - milliliter</p>	G 000	<p>RECEIVED</p> <p>JUL 10 2015</p> <p>FACILITY STANDARDS</p>	

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

Vickie Doshaw

TITLE

DON

(X6) DATE

7/10/15

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 000	Continued From page 1 MSW - Medical Social Worker NOMNC - Notice of Medicare Non-Coverage OASIS - Outcome and Assessment Information Set OT - Occupational Therapy POC - Plan of Care prn - as needed pt - patient PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse ROC - Resumption of Care SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy UTI - Urinary Tract Infection	G 000		
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients were fully informed of their right to appeal a discharge from home health services for 1 of 1 patients (#1) who were Medicare beneficiaries with a planned discharge, and whose records were reviewed. This had the potential for services to be terminated without the patients' understanding of their ability to appeal the discharge. Findings include: The CMS Manual System, Pub 100-04 includes direction to the provider that they must include the effective date (i.e. the last day of coverage) on	G 101	An occurrence report has been submitted on patient #1. In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and description was reviewed with staff. The Notice of Medicare Non-coverage and LHC policy 2.1.004 Patient Discharge/Transfer Process was reviewed with staff and education has been provided that the notice is to be delivered at least two days prior to discharge.	7/9/15

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G 101	<p>Continued From page 2</p> <p>the "Notice Of Medicare Non-Coverage" (NOMNC) form. Additionally, it states: "The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily." The NOMNC is to be signed and dated by the patient to indicate receipt of notice of discharge.</p> <p>Patient #1 was an 82 year old male, admitted to the agency on 1/11/15. He received SN and PT services related to an infection in his blood stream, irregular heart beat, and lymphoma. His records, including the POC, for the certification period 1/11/15 to 3/11/15, were reviewed.</p> <p>In a "Visit Note Report," dated 1/28/15, Patient #1's RN noted the plan for the next visit was to follow up cardiac and respiratory assessments. There was no documentation of plans to discharge Patient #1, or that he was provided information regarding his right to appeal the termination of his home health services.</p> <p>Patient #1's record included a discharge assessment dated 2/11/15, signed by the RN.</p> <p>Patient #1's record included a form, titled "Notice of Medicare Non-Coverage," (NOMNC.) The section of the form which stated "The Effective Date Coverage of Your Current Home Health Services Will End:___," was completed with the date 2/11/15. The back of the form was signed by Patient #1 to indicate receipt of the notice. Patient #1's signature was dated 2/11/15, the date of his final home health visit.</p> <p>During an interview on 6/11/15 beginning at 2:35 PM, the DON reviewed Patient #1's record and</p>	G 101	<p>Process Change:</p> <ol style="list-style-type: none"> All staff will be given additional NOMNC forms. Care conference in discharge planning will include the reminder and addition of a point care alert in Home Care Home Base to be added to the visit date by skilled clinician planning to do the discharge, at least 48 hours, prior to planned discharge. DON/TL to review 100% of synced discharges for the Notice on Medicare Non-coverage. If it is found to be absent from the record, and is required, the discharge will be held and the patient will be presented the notice and associated education on the non-coverage notice. Discharge from agency will not occur until the 48 hours has been completed. Should the patient request a discharge without notice, documentation in the visit note narrative or discharge note should reflect that request. 	7/16/15	

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G 101	Continued From page 3 stated the form should have been presented to Patient #1 during his second to last visit, rather than during his last visit. She stated she had educated the nursing staff about the NOMNC form, and the timing of its presentation to the patients. Additionally, she stated the RN that was Patient #1's case manager was no longer employed by the agency.	G 101	Ongoing Monitoring: Beginning 8/1/15, the DON/TL will review 100% of discharges from the previous week to verify the NOMNC was administered forty-eight hours prior to discharge. The review will be conducted for 8 weeks and until greater than 94% compliance for 4 consecutive weeks. DON is responsible for implementing the corrective action.	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care coordination between disciplines for 1 of 9 patients (#4) who received services from more than 1 discipline and whose records were reviewed. This had the potential to interfere with quality, safety and continuity of patient care. Findings include: Patient #4 was an 83 year old female admitted to the agency on 5/15/15, following hospitalization for an acute MI. Additional diagnoses included CAD and CHF. She received SN, PT and OT services. Her record, including the POC, for the certification period 5/15/15 to 7/13/15, was reviewed.	G 143	An occurrence report has been submitted on patient #4 regarding care coordination. In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC Policy 2.1.017 Coordination of Care was reviewed with staff. Process Change: 1. A process Changes has been implemented requiring all LPNs and PTAs to contact the Case Manager for a verbal report when a change in status or symptoms are identified or reported.	7/16/15 7/9/15 7/9/15

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G 143	Continued From page 4 Patient #4's record included a SN visit note dated 5/29/15, signed by the LPN. The note documented her heart rate was 110 bpm, and irregular. Patient #4's POC stated a heart rate greater than 100 bpm should be reported to the physician. Additionally, the note stated Patient #4 reported four episodes of diarrhea that morning. The LPN did not document communication with Patient #4's RN Case Manager regarding her elevated and irregular heart rate, or her diarrhea. During an interview on 6/11/15 at 9:25 AM, the RN Case Manager reviewed the record and confirmed she was not notified of Patient #4's elevated and irregular heart rate, or her complaints of diarrhea. Patient #4's symptoms and change in status were not reported to the RN Case Manager.	G 143	Ongoing monitoring: Beginning 8/1/15, 2 visit notes per week for each LPN and PTA will be reviewed for evidence of care coordination. The review will be conducted by the DON/TL for 8 weeks and until a greater than 94% compliance is reached for 4 consecutive weeks. DON is responsible for implementing corrective action.	8/1/15	
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, review of agency policies and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 3 of 12 patients (#2, #4, and #12) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include:	G 158	An occurrence report has been submitted on patients' #2, #4, #12 for each individual item identified in the deficient report. In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC Policy 2.1.002 Patient Assessment, Initial and Reassessment, 2.1.007 Plan of Care, 2.1.008 Physician Orders were reviewed with staff with the focus on the following:	7/16/15 7/9/15	

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G 158	<p>Continued From page 5</p> <p>1. Patient #2 was a 72 year old male admitted to the agency on 12/22/14, for services related to an open wound on his knee. Additional diagnoses included HTN and asthma. He received SN, PT and OT services. His record, including the POC, for the certification period 12/22/14 to 2/19/15, was reviewed.</p> <p>a. The agency's policy 2.1.002 "Patient Assessment, Initial and Reassessment," revised 1/01/15, stated initial evaluations by disciplines including PT, ST, OT, and MSW, would occur within 5 days from the referral or sooner if medically necessary.</p> <p>Patient #2's record included a Physician's Interim order, dated 12/22/14, signed by his physician on 1/05/15. The order included an MSW visit for community resources.</p> <p>Patient #2's record documented he was admitted to the hospital on 1/07/15, 16 days after his SOC. His record did not include documentation of an MSW visit during the 16 days prior to his transfer to the hospital.</p> <p>Patient #2's home health services were resumed on 1/13/15, following his discharge from the hospital. Patient #2's record included resumption of care orders dated 1/13/15. The orders included MSW to evaluate and develop a SW POC.</p> <p>Patient #2's record documented he was admitted to the hospital on 1/28/15, 15 days after his resumption of care. However, Patient #2's record did not include an evaluation completed by the MSW during the 15 days following his resumption of care and prior to his second transfer to the</p>	G 158	<ol style="list-style-type: none"> All add on discipline evaluations are to be completed within 5 days of referral. All care implemented must have a written or verbal order before initiation. Any orders obtained must be complete and thorough, to include multiple wounds sites and site specific orders as needed. All orders must be implemented as specifically ordered. All visit frequency must be accomplished as ordered or evidence of physician notification of missed visit must be evident in the record. <p>Process Change: Add on Evaluations-</p> <ol style="list-style-type: none"> The DON/TL (who input the referrals) will schedule all add on disciplines within 5 days of referral. 	7/16/15	

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G 158	<p>Continued From page 6 hospital.</p> <p>During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #2's record and confirmed an MSW evaluation was ordered at his SOC and resumption of care, and was not completed.</p> <p>Patient #2 did not receive MSW evaluations as ordered by his physician.</p> <p>b. Patient #2's record included 3 Visit Note Reports completed by the RN Case Manager dated 1/15/15, 1/16/15 and 1/20/15, that stated the SN performed wound care to the patient's right elbow.</p> <p>Patient #2's record included a Physician Verbal Order, dated 1/22/15, for wound care to his right elbow. His record did not contain orders for right elbow wound care prior to 1/22/15.</p> <p>During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #2's record and confirmed the RN Case Manager performed wound care to his right elbow before physician's orders were received.</p> <p>Wound care was provided to Patient #2 without a physician's order.</p> <p>c. Patient #2's record included a physician order dated 1/12/15, for an ROC following hospitalization, with diagnoses that included pneumonia, failure to thrive, and protein/calorie malnutrition. The orders included weight monitoring by SN.</p> <p>Patient #2's record did not document his weight was obtained at the ROC visit, dated 1/13/15, or</p>	G 158	<p>2. If an add on evaluation is unable to be done in the 5 days, the agency will contact the physician and refer the patient to another provider who can meet the patient needs.</p> <p>Weights not performed:</p> <p>1. Oasis clinician will document weight parameters within the Home Care Home Base vital sign parameters pathway at SOC/ROC/RECERT.</p> <p>2. Oasis clinician to put in a point care alert for each visit to designate that a weight or other vital sign must be documented.</p> <p>Care without orders:</p> <p>1. Physician/TL/DON will be contacted with any changes in patient status.</p> <p>2. Verbal orders will be obtained and reduced to writing prior to delivery of care.</p>	7/16/15	7/16/15

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G 158	<p>Continued From page 7 on 4 subsequent SN visits dated 1/15/15, 1/16/15, 1/22/15 and 1/24/15.</p> <p>During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #2's record and confirmed SN Visit Note Reports did not include documentation of his weight as ordered by the physician.</p> <p>The agency failed to ensure the RN Case Manager followed Patient #2's written POC.</p> <p>2. Patient #4 was an 83 year old female, admitted to the agency on 5/15/15, following hospitalization for an acute MI. Additional diagnoses included CAD and CHF. She received SN, PT and OT services. Her record, including the POC, for the certification period 5/15/15 to 7/13/15, was reviewed.</p> <p>Patient #4's record included a physician signed update to the POC dated 6/02/15, that increased the SN visit frequency to 3 times a week for 4 weeks, effective 6/01/15. However, Patient #4's record documented 2 SN visits for the week of 6/01/15, on 6/01/15 and 6/05/15.</p> <p>During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #4's record and confirmed 3 SN visits were ordered for the week of 6/01/2015, and 2 SN visits were provided.</p> <p>The agency failed to ensure the registered nurse followed the written POC.</p> <p>3. Patient #12 was a 53 year old female admitted to the agency on 5/22/15, for services related to acute heart failure. Additional diagnoses included CHF, CAD, Insulin dependent diabetes and</p>	G 158	<p>Visit frequency:</p> <p>1. Missed visit notification will be faxed to the physician by the office manager/assistant when scheduled visits are unable to be completed as ordered and affect the plan of care.</p> <p>Monitoring beginning 8/1/15:</p> <p>1. Evals: DON/TL will review 100% of MSW evals to verify they have been scheduled and performed within 5 days. The audit will be conducted for 3 months and until 100% compliance is achieved for 2 consecutive months.</p> <p>2. Weekly, TL will review 3 visit notes to verify that weights have been performed as ordered. The review will be conducted for 8 weeks and until greater than 94% compliance has been achieved for 4 consecutive weeks.</p>	7/16/15	

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G 158	Continued From page 8 kidney failure. Her record, including the POC, for the certification period 5/22/15 to 7/20/15, was reviewed. Patient #12's POC, signed by her physician on 6/01/15, included an order for the MSW to evaluate her and develop a POC based on the evaluation. However, Patient #12's record did not include an evaluation completed by the MSW. During an interview on 6/11/16 at 10:00 AM, the RN Case Manager and the DON reviewed Patient #12 record and confirmed an MSW evaluation was not completed as ordered in her POC. The agency failed to ensure Patient #12 received an MSW evaluation as ordered in her POC.	G 158	3. Care without orders: DON/TL to review 6 visit notes per week for evidence that care has not been provided without orders. The review will continue for 8 weeks and until the findings are greater than 94% compliance for 4 consecutive weeks. DON is responsible for implementing the corrective action		
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 record review and staff interview, it was determined the agency failed to ensure plans of care covered all pertinent information for 4 of 12 patients (#1, #2, #8 and #11) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient	G 159	An occurrence report has been submitted on patients' #1, #2, #8, and #11 for deficiencies identified in the report. In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policy 2.1.007 Plan of Care, 2.1.008 Physicians Orders, and TJC NPSG #15-Oxygen Safety were reviewed with staff with the focus on the following:	7/16/15	

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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 159	<p>Continued From page 9 outcomes. Findings include:</p> <p>1. Patient #8 was an 83 year old female, admitted to the agency on 5/09/15, for services related to a CVA. Additional diagnosis included CHF, atrial fibrillation, CAD, dysphagia, and depressive disorder. She received SN, PT, OT and ST services. Her record, including the POC, for the certification period 5/09/15 to 7/07/15, was reviewed.</p> <p>Patient #8's record included 2 H & P evaluations, dated 4/15/15 and 4/17/15, provided to the agency at the time of referral. Each H & P included a diagnosis of rectal prolapse. In addition, the physician stated in the H & P dated 4/15/15, "the patient is at risk for bleeding and need for transfusion due to blood thinner."</p> <p>Patient #8's POC did not include the rectal prolapse diagnosis (a condition in which the rectum drops out of its normal location and pushes through the anal opening. Johns Hopkins Medicine website identifies pain and rectal bleeding as common symptoms with rectal prolapse).</p> <p>Patient #8's POC included two anticoagulants taken concurrently (medications that thin the blood and increase the chance of bleeding). The diagnosis of rectal prolapse was clinically significant given Patient #8's use of anticoagulant medications.</p> <p>Patient #8's record included an On Call Note dated 5/10/15 at 9:00 AM, completed by the RN Case Manager. The On Call Note stated the "client's daughter called to report client had spent evening in the ER D/T rectal bleeding and</p>	G 159	<p>1. All appropriate and applicable diagnoses and associated codes should be included in the POC.</p> <p>2. All applicable DME and equipment should be included in the POC in locator 14.</p> <p>3. All orders received on a referral or ROC must be included in the POC.</p> <p>4. All Oasis clinicians have been provided a list of commonly used ICD-9 codes and will be presented a list of the mostly commonly used ICD-10 codes during the transition.</p> <p>Process Change:</p> <p>1. DON/TL will review H & P, Oasis, add on evaluations, and the POC to review all possible diagnosis and DME that may impact the POC.</p> <p>2. DON/TL will make recommended revisions to the plan of care for the clinician to approve.</p>	7/16/15	

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G 159	<p>Continued From page 10 prolapse."</p> <p>During an interview on 6/11/15 at 1:55 PM, the DON and the Clinical Lead reviewed Patient #8's record. They confirmed the POC did not include the Patient #8's history of rectal prolapse.</p> <p>Patient #8's POC did not include all pertinent diagnoses.</p> <p>2. Patient #1 was an 82 year old male, admitted to the agency on 1/11/15. He received SN and PT services related to an infection in his blood stream, irregular heart beat, and lymphoma. His records, including the POC, for the certification period 1/11/15 to 3/11/15, were reviewed.</p> <p>a. The SOC assessment, dated 1/11/15, included a narrative note which described Patient #1 as having 2+ pitting edema, with areas on his legs that were weeping. The RN documented Patient #1 was wearing knee high ted hose compression stockings. However, his POC did not include ted hose.</p> <p>b. A PT evaluation, dated 1/12/15, documented Patient #1 used a cane. However, the POC did not include a cane.</p> <p>During an interview on 6/11/15 beginning at 2:30 PM, the DON reviewed Patient #1's record and confirmed his POC did not include the ted hose and cane. She stated the RN that developed Patient #1's POC was no longer employed by the agency, and was not available for interview.</p> <p>Patient #1's POC did not include all pertinent items.</p>	G 159	<p>Monitoring: Beginning 8/1/15, DON/TL will review 100% of plans of care and documentation weekly to verify that all pertinent diagnosis(es) and Durable Medical Equipment have been included. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved to identify clinicians needing further education. Monitoring will be ongoing. DON is responsible for implementing the corrective action.</p>		

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G 159	<p>Continued From page 11</p> <p>3. Patient #11 was a 78 year old male admitted to the agency on 5/11/15 for Physical Therapy services related to weakness and back pain. Additional diagnoses included COPD, chronic pain, CHF, and pneumonia. His record, including the POC, for the certification period 5/11/15 to 7/09/15, was reviewed.</p> <p>Patient #11's referral information noted he was discharged from the hospital on 5/06/15, after a 10 day stay related to pneumonia and acute respiratory failure. His POC did not include that information as an additional pertinent diagnoses, which may have impacted his ability to tolerate therapy, and/or indicated a need for SN services.</p> <p>During an interview on 6/11/15 beginning at 8:00 AM, the Physical Therapist reviewed Patient #11's record and confirmed that pneumonia and respiratory failure were not included on the POC.</p> <p>Patient #11's POC did not include all pertinent diagnoses.</p> <p>4. Patient #2 was a 72 year old male admitted to the agency on 12/22/14, for services related to an open wound on his knee. Additional diagnoses included HTN and asthma. He received SN, PT and OT services. His record, including the POC, for the certification period 12/22/14 to 2/19/15, was reviewed.</p> <p>Patient #2's record included a ROC assessment dated 1/13/15, completed by the RN Case Manager. Physician orders dated 5/13/15, included oxygen and monitoring of his oxygen saturation, assessing for any hazards related to oxygen therapy and instructing on safety issues identified regarding oxygen therapy. However, the</p>	G 159			

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G 159	Continued From page 12 POC update did not include oxygen equipment. During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #2's record and confirmed oxygen was included in the physician orders dated 6/13/15, for his resumption of care, however oxygen equipment was not included in his updated POC. The agency failed to ensure all equipment required by Patient #2 was documented in the POC.	G 159			
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 4 of 12 patients (#4, #6, #9, and #12) whose records were reviewed. This had the potential to result in patients receiving incomplete and/or inappropriate services and treatments. Findings include: 1. Patient #6 was a 72 year old female, admitted to the agency on 5/19/15, for SN and PT services following a short hospitalization after abdominal surgery. Additional diagnoses included GERD, depression, and degenerative arthritis. Her records, including the POC, for the certification period 5/19/15 to 7/17/15, were reviewed.	G 160	Occurrence reports have been submitted on patients' # 4, # 6, #9, and # 12. All outstanding MDSBAR orders have been signed by the Physicians and the MDSBAR is no longer in use for "interim orders" as of 6/17/15. 100% of review of all orders to verify signature is obtained timely 6/17/15. In a mandatory staff meeting 6/17/15 and with individual counseling as needed, the standard and description was reviewed with staff.	7/16/15 6/17/15	

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G 160	<p>Continued From page 13</p> <p>Patient #6's record included a referral request dated 5/17/15. The referral information included discharge orders, noted as telephone orders, taken by an RN. The discharge orders were not signed by a physician. The discharge orders included instructions for home health SN visits 3 times weekly, and PT.</p> <p>During an interview on 6/11/15 beginning at 1:30 PM, the Clinical Lead reviewed Patient #6's record and stated she took the referral. Interim orders to provide services were signed and dated by Patient #6's physician on 6/10/15.</p> <p>The SOC assessment and SN visits were performed before a signed physician order for services was received as follows:</p> <ul style="list-style-type: none"> - SOC on 5/19/15, - SN visit on 5/26/15, - SN visit on 5/29/15, - SN visit on 6/01/15, - SN visit on 6/03/15, - SN visit on 6/05/15, - SN visit on 6/08/15, <p>During an interview on 6/11/15 at 12:45 AM, the RN Case Manager reviewed Patient #6's record and confirmed she did not contact Patient #6's physician after the SOC visit on 5/19/15. She stated interim orders in the form of an MD SBAR were sent to Patient #6's physician for approval. The RN Case Manager confirmed she did not contact Patient #6's physician for verbal orders prior to sending the MD SBAR. She reviewed the signed and dated MD SBAR in Patient #6's record and confirmed it was signed and dated by Patient #6's physician on 6/10/15.</p>	G 160	<p>The LHC verbal order power point training was reviewed, the LHC policy on admission process was reviewed, the LHC policy on physician orders was reviewed.</p> <p>Process Change: Effective 6/17/15, all orders after evaluation must be obtained verbally from the MD or his designee before subsequent care is initiated or visits made. The POC must reflect the communication and direction given from the MD. All MDSBAR/written communications with the MD will be restricted to "for your information" quality needs.</p> <p>Monitoring: Beginning 6/17/15, the DON/TL will review 100% of all SOC to view that appropriate verbal orders were obtained following the initial evaluations. This will be completed by viewing the documentation and VSOC date. The review will be conducted for 8 weeks and until 100% compliance is achieved for 4 consecutive weeks.</p> <p>DON is responsible for implementing corrective action.</p>	6/17/15 6/17/15	

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G 160	<p>Continued From page 14</p> <p>A PT evaluation and additional PT visits were performed before a signed physician order for services was received as follows:</p> <ul style="list-style-type: none"> - PT evaluation on 5/20/15, - PT visit on 5/26/15, - PT visit on 5/29/15, - PT visit on 6/01/15, - PT visit on 6/05/15. <p>During an interview on 6/11/15 beginning at 8:00 AM, the Physical Therapist reviewed Patient #6's record. She confirmed she conducted the therapy evaluation on 5/20/15 at 2:37 PM. She stated she did not contact Patient #6's physician for orders or to discuss the POC. She said an MD SBAR was sent to the physician to sign. MD SBAR included a requested authorize orders for ongoing services to which was signed on 6/10/15.</p> <p>SN and PT services were provided for Patient #6 before a physician's order was received.</p> <p>2. Patient #12 was a 53 year old female admitted to the agency on 5/22/15, for services related to acute heart failure. Additional diagnoses included CHF, CAD, Insulin dependent diabetes and kidney failure. Her record, including the POC, for the certification period of 5/22/15 through 7/20/15 was reviewed.</p> <p>Patient #12's record included an SOC assessment completed on 5/22/15, signed by the RN Case Manager. There was no documentation the RN Case Manager communicated with Patient #12's physician to obtain verbal approval of her POC. Patient #12's record included a physician order request dated 5/22/15, for SN visits 2 times a week for 8 weeks, to assess,</p>	G 160		

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G 160	<p>Continued From page 15</p> <p>monitor and educate. The order was signed by her physician on 6/09/15. Patient #12's POC was signed by her physician on 6/01/15. However, SN visits were completed on 5/26/15 and 5/29/15, prior to physician approval of Patient #12's POC.</p> <p>During an interview on 6/11/15 at 10:00 AM, the RN Case Manager reviewed Patient #12's record and confirmed 2 SN visits were completed prior to physician approval of her POC.</p> <p>Patient #12's physician was not consulted to approve her POC and additional SN visits following the SN SOC assessment.</p> <p>3. Patient #4 was an 83 year old female admitted to the agency on 5/15/15, following hospitalization for an acute MI. Additional diagnoses included CAD and CHF. She received SN, PT and OT services. Her record, including the POC, was reviewed.</p> <p>a. Patient #4's record included a SOC assessment completed on 5/15/15, and signed by the RN Case Manager. There was no documentation the RN Case Manager communicated with Patient #4's physician to obtain verbal approval of her POC. Patient #4's record included a physician order request dated 5/19/15, for SN visits 1 time a week for 2 weeks, and 2 times a week for 8 weeks, to assess, monitor and educate. The order was signed by her physician on 5/28/15. Patient #4's POC was signed by her physician on 6/05/15.</p> <p>Patient #4's record documented SN visits on 5/19/15, 5/22/15, 5/25/15, 5/29/15 and 6/01/15, prior to physician approval of her POC.</p>	G 160			

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G 160	<p>Continued From page 16</p> <p>During an interview on 6/11/15 at 9:25 AM, the RN Case Manager reviewed Patient #4's record and confirmed 5 SN visits were completed prior to physician approval of her POC. The RN Case Manager stated "the doctors don't want to have conversatlons with us. We send an MD SBAR [a request for Interim orders] over the fax. That is standard operating procedure here. The standard in this agency is MD SBAR, period".</p> <p>During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #4's record and confirmed 5 SN visits were made prior to physician approval of her POC.</p> <p>Patient #4's physician was not consulted to approve her POC and additional SN visits following her SOC assessment.</p> <p>b. Patient #4's record included a PT Add-on Evaluation competed on 5/15/15, and signed by the PT. There was no documentation the physical therapist communicated with Patient #4's physician to obtain verbal approval for her PT POC.</p> <p>Patient #4's record included a Physician Verbal Order dated 5/15/15, signed by the Physical Therapist for PT visits 1 time a week for 1 week and 2 lmes a week for 6 weeks, to evaluate/assess and develop a POC. The order stated "the licensed professional completing the physical therapy evaluation attests that orders were received on 5/15/15, received from Dr [name]."</p> <p>During an interview on 6/11/15 at 2:30 PM, the DON and the Clinical Lead were asked to clarify the PT statement in Patient #4's POC that stated</p>	G 160		

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G 160	<p>Continued From page 17</p> <p>"the licensed professional completing the physical therapy evaluation attests that orders were received on 5/15/15". The DON and the Clinical Lead confirmed the therapists "usually have not spoken with the the physician because the physicians here prefer we fax them an MD SOAP for orders and we wait for it to come back."</p> <p>The agency failed to ensure Patient #4's POC was developed in collaboration with the physician prior to starting services.</p> <p>4. Patient #9 was a 71 year old male admitted to the agency on 5/27/15, for care related to the after effects of a CVA. Additional diagnoses included HTN, CAD and aphasia (Impaired speech). He received PT services. His record, including the POC, for the certification period 5/27/15 to 7/25/15, was reviewed.</p> <p>Patient # 9's record included a SOC assessment completed on 5/27/15, and signed by the Physical Therapist. The record did not document communication with Patient #9's physician to obtain approval of the POC following the SOC assessment.</p> <p>Patient # 9's POC was signed by his physician on 6/03/15. Patient #9 received PT visits on 5/29/15 and 6/02/15, prior to physician approval of his POC.</p> <p>During an interview on 6/11/15 at 2:05 PM, the DON reviewed Patient #9's record and confirmed 2 PT visits were completed prior to physician approval of Patient #9's PT POC.</p> <p>The agency failed to ensure Patient #9's POC was developed in collaboration with the physician</p>	G 160		

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G 160	Continued From page 18 prior to starting services.	G 160	Occurrence reports have been submitted on patients' #1, and #2, and #3. The physician has been notified of patient #3 weight changes. In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policies 2.1.002 Patient Assessment, Initial and Reassessment, 2.1.007 Plan of Care, 2.1.008 Physicians Orders, 2.1.011 Pain Assessment, 2.1.020 Vital Signs were reviewed with staff. The requirements are that ongoing notification of patient changes will be reported to the physician as those changes occur. The POC will include individual parameters for physician notification. Specifically: Established parameters must be communicated to the MD. Parameters should be modified in the POC as ordered or appropriate. Parameters should be flexible to reflect the visit schedule and applicable to the diagnosis.	7/16/15	
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 clinical 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 plan of care for 3 of 12 patients (#1, #2, and #3) whose records were reviewed. This resulted in missed opportunities for the physician to offer patients' POCs to meet their needs. Findings include: 1. Patient #1 was an 82 year old male who was admitted to the agency on 1/11/15. He received SN and PT services related to an infection in his blood stream, CHF, an irregular heart beat, and lymphoma. Patient #1's record indicated he was on continuous oxygen and diuretics (drugs that increase the volume of urine produced by promoting excretion of salt and water from the kidneys). His record, including the POC for the certification period 1/11/15 to 3/11/15, was reviewed. Patient #1's POC included orders to obtain weights each visit and to notify his physician for weight gain or loss of 2-3 pounds within 1 day. Additionally, the POC included orders to alert his physician for changes in his weight of <156 and/or >175. Nursing visits performed on the	G 164		7/9/15	

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G 164	<p>Continued From page 19 following dates indicated weight loss of greater than 16 pounds over a 17 day period that was not reported to his physician:</p> <ul style="list-style-type: none"> - 1/11/15, the SOC assessment, and weight of 166 pounds, - 1/14/15, weight 159 pounds, which indicated a loss of 7 pounds over 3 days, - 1/22/15, weight 150 pounds, a loss of 9 pounds over 8 days. - 1/28/15, weight 149.7 pounds, and Patient #1's date of discharge from the agency. <p>During an interview on 6/11/15 beginning at 2:35 PM, the DON reviewed Patient #1's record and confirmed there was no documentation that his physician was notified of his weight loss. The DON further stated the RN who provided care to Patient #1 no longer was employed by the agency.</p> <p>Patient #1's RN did not report his weight loss to his physician as ordered on his POC.</p> <p>2. Patient #3 was an 85 year old female, admitted to the agency for nursing and therapy services on 5/17/15, following a short hospitalization after a heart attack, cardiac catheterization, and stent placement. Additional diagnoses included UTI, and GERD. Her record including the POC for the certification period 5/17/15 to 7/15/15, was reviewed.</p> <p>Patient #3's POC included orders to weigh her each visit and notify the physician for weight gain or loss of 5 pounds within 7 days or 2 pounds in 1</p>	G 164	<p>2. Reports of pain outside the established parameters must be communicated to the MD. Any unrelieved pain or reported pain level of 7 or greater should be reported or documentation of why it was not reported.</p> <p>Process Change:</p> <ol style="list-style-type: none"> 1. Physician ordered weight and pain parameters will be entered into the Vital Sign parameter pathway in Home Care Home Base by all Oasis clinicians. 2. DON/TL will verify the weight and pain parameters are entered and are evident on the POC and in Home Care Home Base correctly. 3. Clinician will notify the physician when ordered VS are unable to be obtained. 	7/9/15 7/16/15	

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G 164	<p>Continued From page 20</p> <p>day. The POC also included an order to report to the physician if Patient #3's weight was outside of the established parameters of 186-196 pounds. Nursing visits on the following dates indicated Patient #3 was not within the ordered parameters, and her physician was not contacted to report the weights, or to obtain new parameters:</p> <ul style="list-style-type: none"> - SOC assessment dated 5/17/15, the RN documented a weight was not obtained, and Patient #3's reported hospital weight was 191 pounds. - 5/19/15, weight was 176.4 pounds, which was a 14 pound loss, and below the ordered parameters on her POC. - 5/22/15, weight was 173 pounds, which was a 3 pound loss, and below the ordered parameters on her POC. - 5/27/15, weight was 174.4 pounds, and below the ordered parameters on her POC. - 5/29/15, weight was 175.4 pounds, and below the ordered parameters on her POC. - 6/01/15, weight was 174.4 pounds, and below the ordered parameters on her POC. - 6/05/15, weight was 175 pounds, and below the ordered parameters on her POC. - 6/08/15, weight was 175 pounds, and below the ordered parameters on her POC. <p>During an interview on 6/11/15 at 9:25 AM, the RN Case Manager reviewed Patient #3's record and confirmed the established parameters for</p>	G 164	<p>Monitoring:</p> <p>Beginning 8/1/15, the DON/TL will review 100% of SOC and 6 charts weekly to ensure all parameters are being entered and followed and physician notification has occurred as ordered on the POC. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved for 4 consecutive weeks. Random monitoring will continue ongoing.</p> <p>DON is responsible for implementing the corrective action</p>		

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G 164	<p>Continued From page 21</p> <p>weight on the POC was above the weights that were obtained during the nursing visits. She stated the POC should have been adjusted for the lower weights.</p> <p>The agency did not follow Patient #3's POC orders to contact her physician with results of her weight which was below established parameters.</p> <p>3. Patient #2 was a 72 year old male admitted to the agency on 12/22/14, for services related to an open wound on his knee. Additional diagnoses included HTN and asthma. He received SN, PT and OT services. His record, including the POC, for the certification period 12/22/15 to 2/19/15, was reviewed.</p> <p>Patient #2's SOC comprehensive asesment dated 12/22/14, signed by the RN Case Manager, included a pain assessment using a scale of 0-10, with 10 being the worst pain. The RN Case Manager documented "patient states his pain is at an eight to ten, he is only taking tylenol, recommended that he ask his doctor for a stronger pain medication." There was no documentation the RN contacted Patient #2's physician to communicate his severe pain, or request orders to address his pain.</p> <p>Subsequent SN visit notes documented Patient #2's reported pain as follows:</p> <ul style="list-style-type: none"> - 12/24/14 Pain level 8 reported - 12/31/14 Pain level 7 reported - 1/05/15 Pain level 8 reported <p>Patient #2's record did not include documentation his physician was notified of his reported pain.</p>	G 164			

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G 164	Continued From page 22 During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #2's record and confirmed his physician should have been notified of his continued complaints of pain.	G 164			
G 173	Patient #2's physician was not notified of his elevated level of pain. 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients' POCs were revised to ensure their medical and nursing needs were met, for 1 of 12 patients (#12), who received SN care and whose records were reviewed. This resulted in incomplete POCs and a lack of education provided relevant to patient needs, and had the potential to result in negative patient outcomes. Findings include: Patient #12 was a 53 year old female admitted to the agency on 5/22/15, for services related to acute heart failure. Additional diagnoses included CHF, CAD, insulin dependent diabetes and kidney failure. Her record, including the POC, for the certification period 5/22/15 to 7/20/15, was reviewed. Patient #12's POC included sliding scale insulin (dosage based on BG level as measured by a BG monitor) to be taken 3 times a day. The sliding scale insulin order stated for each BG increase of	G 173	An occurrence report has been submitted for patient # 12. Further visits with patient # 12 have demonstrated DM education, patient compliance, and MD notification with associated orders from MD for elevated blood glucose readings In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policy 2.1.007 Plan of Care and 2.1.017 Coordination of Care, 2.1.020 Vital Signs, 2.1.021 Diabetic Skin Care were reviewed with staff. The requirement is for the case manager to revise the POC as needed to reflect changes in the patient condition. Any abnormal findings, VS outside established parameters should be conveyed to the MD and the POC amended.	7/16/15 7/9/15	

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G 173	<p>Continued From page 23</p> <p>10 mg/dl over 170, an additional unit of Insulin should be added to 7 units. For example, 10 units would be taken for a BG of 200, and 20 units would be taken for a BG of 300.</p> <p>Patient #12's record included a SOC assessment completed on 5/22/15, and signed by the RN Case Manager. The assessment documented Patient #12 stated her fasting BG level was 548. The American Diabetes Association website, accessed 6/15/15, stated a normal fasting BG for a diabetic adult is less than 126 mg/dl. The SOC assessment did not document additional BG readings, or whether she was taking Insulin 3 times a day per her sliding scale orders. The visit note did not document an assessment of Patient #12's ability to calculate the correct dosage of Insulin and manage her sliding scale. Additionally, the visit note did not document patient education related to using her BG monitor or calculating an insulin dose based on her BG results.</p> <p>Patient #12's second and third SN visits were documented on 6/26/15, and 5/29/15, by the RN Case Manager. The visit notes did not document Patient #12's BG readings at the time of the visits, or between SN visits. Additionally, they did not document Patient #12's compliance with her sliding scale orders, or education related to sliding scale insulin administration.</p> <p>During an interview on 6/11/15 at 10:00 AM, the RN Case Manager reviewed Patient #12's record. She confirmed the visit notes did not document Patient #12's BG readings or compliance with her insulin regimen. Additionally, she confirmed there was no documentation of education related to BG monitoring or sliding scale insulin.</p>	G 173	<p>This includes educational/training needs of the patient /caregiver not covered in the original POC. Documentation should reflect compliance/non compliance and needs that were met/un-met to be addressed on subsequent visits.</p> <p>In a mandatory staff meeting 7/16/15 the Home Care Home Base Diabetes Problem Statement Pathway education will be provided to all Oasis clinicians and TL.</p> <p>Process Change:</p> <ol style="list-style-type: none"> Oasis clinicians to utilize the correct Home Care Home Base Problem Statement Pathway for Diabetes pertinent Oasis time points. Blood Glucose parameters will be added to the Home Care Home Base vital sign parameter pathway by the Oasis clinician. DON/TL to make pathway recommendations to the Oasis clinicians for correction. 	7/9/15	7/16/15	7/16/15

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G 173	Continued From page 24	G 173	Monitoring: Beginning 8/1/15, DON/TL will review 10 charts per month with a diagnosis of DM to verify the appropriate pathway and interventions were selected for the patient. The audit will verify that the clinician is assessing CBG's, patient's knowledge and level of compliance. The audit will be conducted for 3 months and until a greater than 94% compliance is achieved for 2 consecutive months. DON is responsible for implementing the corrective action.		
G 175	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. This STANDARD is not met as evidenced by: Based on medical record review, and staff interview, it was determined the agency failed to ensure the registered nurse evaluated patients to determine needed preventative or rehabilitative nursing measures for 2 of 12 patients (#2 and #12) whose records were reviewed. This resulted in a lack of preventative actions for patients with DM, CHF and anticoagulant therapy and significantly increased the potential for negative patient outcomes. Findings include: 1. Patient #2 was a 72 year old male admitted to the agency on 12/22/14, for services related to an open wound on his left knee. Additional diagnoses included HTN, and COPD. He received SN, PT and OT services. His record, including the POC, for the certification period 12/22/14 to 2/20/15, was reviewed. The National Institute of Health website, accessed 6/17/15, stated the presence of blood circulation to the wound is necessary for the healing process. Assessment of the patient's	G 175	G175 Occurrence reports have been submitted on patient #2 and #12. Subsequent visits to patient #12, since survey, have demonstrated correct assessment, education on diabetes and physician notification of findings has occurred. In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and descriptions were reviewed with staff.	7/16/15 7/9/15	

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G 175	<p>Continued From page 25</p> <p>circulatory flow to the wound site is encouraged to assist clinicians in determining appropriate Interventions.</p> <p>Circulatory flow to the leg is assessed by palpating pedal (foot) pulses, and assessing color and temperature of the extremity.</p> <p>Patient #2's POC included physician orders for wound care and goals that the wound status would improve as evidenced by measurable decrease in size and drainage of wound. His record included documentation of wound size and status over time. The The wound care assessment tool included measurements that documented the wound increased in size from 10.35 sq. cm. on 12/22/14, to 35 sq. cm. on 1/13/15. However, SN visits on 12/22/14, 12/24/14, 12/26/14, 12/31, 14, 1/02/15, 1/05/15, 1/13/15, 1/15/15, 1/16/15, 1/20/15, 1/22/15 and 1/24/15, did not include assessments of blood circulation in his left leg. There was no documentation of assessment of pedal pulses, color or temperature of his left leg.</p> <p>During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #2's record, including the wound care assessment tool and confirmed SN documentation of his wound status was indicative of a non-healing wound. In addition, she confirmed assessment and documentation of pedal pulses or other means of determining blood circulation to the wound were not present.</p> <p>Patient #2's record documented he was admitted to the hospital on 1/28/15 for an above the knee amputation of the left leg, due to peripheral vascular disease, a condition that causes decreased blood flow to the legs and feet.</p>	G 175	<p>The requirement is for the case manager to do a thorough evaluation and capture all needed interventions to discuss with the MD and to be reflected in the POC. Specifically:</p> <ol style="list-style-type: none"> 1. If a wound is non healing, include nutrition/hydration, circulation, environment, patient positioning etc in your evaluations. 2. If a diabetic has CBG readings unusually high or low, include intake, Medication compliance, education etc in your evaluations. <p>In a mandatory staff meeting 7/16/15 Home Care Home Base disease management problem statement pathways education will be reviewed. Oasis clinician and TL education on choosing the correct Problem statement pathways related to the primary and associated diagnosis. Best practice reference material in Mosby's via LHC connect will be utilized in assessment education to be provided to staff.</p>	7/9/15	7/16/15

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G 175	<p>Continued From page 26</p> <p>Patient #2's circulatory status was not comprehensively assessed to determine its effect on wound healing.</p> <p>2. Patient #12 was a 53 year old female admitted to the agency on 5/22/15, for services related to acute heart failure. Additional diagnoses included CHF, CAD, insulin dependent diabetes and kidney failure. Her record, including the POC, for the certification period 5/22/15 through 7/20/15, was reviewed.</p> <p>Patient #12's POC stated "SKILLED NURSE TO INSTRUCT ON ALL MEDICATIONS (INCLUDING OTC AND SUPPLEMENTS) INCLUDING HOW TO MONITOR EFFECTIVENESS OF DRUG THERAPY AND DRUG REACTIONS AND SIDE EFFECTS AND HOW TO REPORT PROBLEMS TO APPROPRIATE CARE PROVIDER".</p> <p>Patient #12's POC included sliding scale insulin (dosage based on BG level as measured by a BG monitor) to be taken 3 times a day. The sliding scale insulin order stated for each BG increase of 10 mg/dl over 170, an additional unit of insulin should be added to 7 units. For example, 10 units would be taken for a BG of 200, and 20 units would be taken for a BG of 300.</p> <p>Patient #12's record included a SOC assessment completed on 5/22/15, and signed by the RN Case Manager. The assessment documented Patient #12 stated her fasting BG level was 548. The American Diabetes Association website, accessed 6/15/15, stated a normal fasting BG for a diabetic adult is less than 126 mg/dl. The SOC assessment did not document additional BG</p>	G 175	<p>Process Change:</p> <ol style="list-style-type: none"> Oasis clinician will choose the correct Home Care Home Base problem statement pathways in areas that can impact the primary diagnosis. DON/TL to monitor each POC for associated problem statement pathways and make correction recommendations to the Oasis clinician. <p>Monitoring:</p> <ol style="list-style-type: none"> Beginning 8/1/15, DON/TL will review 100% of POC weekly to ensure correct problem statement pathway recommendations are made and included in the POC. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved for 4 consecutive weeks. Beginning 8/1/15, DON/TL will review 6 visit notes weekly for 8 weeks and until 94% compliance for 4 consecutive weeks is achieved in documentation of assessment, documentation and physician notification of findings outside of disease process parameters. 	7/16/15	

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G 175	Continued From page 27 readings, or whether she was taking insulin 3 times a day per her sliding scale orders. The visit note did not document an assessment of Patient #12's ability to calculate the correct dosage of insulin and manage her sliding scale. Additionally, the visit note did not document patient education related to using her BG monitor or calculating an insulin dose based on her BG results. Patient #12's second and third SN visits were documented on 5/26/15 and 5/29/15, by the RN Case Manager. The visit notes did not document Patient #12's BG readings at the time of the visits, or between SN visits. Additionally, they did not document Patient #12's compliance with her sliding scale orders, or education related to sliding scale insulin administration. During an interview on 6/11/15 at 10:00 AM, the RN Case Manager reviewed Patient #12's record. She confirmed the visit notes did not document Patient #12's BG readings or compliance with her insulin regimen. Additionally, she confirmed there was no documentation of education related to BG monitoring or sliding scale insulin. The RN Case Manager failed to assess Patient #12's BG levels or her compliance with sliding scale insulin orders. Additionally, she failed to provide patient education related to BG monitoring and sliding scale insulin.	G 175	DON is responsible for implementing corrective action.		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In	G 236	Occurrence reports have been submitted on patients' #1, #3, #4, #6, #9, #10, #11, and #12. All MDSBAR orders have been signed by physicians.	7/16/15	

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G 236	<p>Continued From page 28</p> <p>addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure complete and accurate documentation for 8 of 12 patients (#1, #3, #4, #6, #9, #10, #11, and #12) whose records reviewed. This had the potential to interfere with clarity, coordination, and safety of care. Findings include:</p> <p>1. Patient #1 was an 82 year old male, admitted to the agency on 1/11/15. He received SN and PT services related to an infection in his blood stream, irregular heart beat, and lymphoma. His records, including the POC, for the certification period 1/11/15 to 3/11/15, were reviewed.</p> <p>Patient #1's SOC was 1/11/15, a Sunday. The RN that performed the SOC documented Patient #1's physician was contacted and interim orders were received.</p> <p>During an interview on 6/11/15 at 2:35 PM, the DON reviewed Patient #1's record and stated the nursing staff had been instructed to perform the SOC assessment and then "Interim Orders" faxed to the physician to be signed. The POC was developed by the admitting RN, after review by the Clinical Lead and coders. The POC was then faxed to the physician for signature. The DON stated that as Patient #1 was admitted to</p>	G 236	<p>In a mandatory staff meeting 6/17/15 and with individual counseling as needed, the standard and description was reviewed with staff. The LHC policies 2.1.008 Physicians Orders and 2.1.001 Admission Process physician orders were reviewed. All staff educated on the need for accuracy of documentation in the patient record.</p> <p>Process Change:</p> <ol style="list-style-type: none"> Effective 6/17/15, all orders after evaluation must be obtained verbally from the MD or his designee before care is initiated or visits made. The POC must reflect the communication and direction given from the MD. All MDSBAR/written communications with the MD will be restricted to "for your information" quality needs. Staff will review documentation for errors prior to syncing visits in Home Care Home Base. Staff will follow Home Care Home Base problem statement pathways in their routine documentation. 	6/17/15 6/17/15	

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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 236	<p>Continued From page 29</p> <p>home health services on a Sunday, she was certain the physician was not contacted as documented in his record.</p> <p>Patient #1's record included documentation in the visit notes dated 1/14/15 and 1/22/15, that he was not taking an anticoagulant. However, his medication record documented Pradaxa 75mg, twice daily, which was an anti-coagulant.</p> <p>During an interview on 6/11/15 at 2:35 PM, the DON reviewed Patient #1's record and stated the RN documented he was not taking an anti-coagulant, and should have responded with a "yes" answer.</p> <p>In a visit note dated 1/22/15, the RN answered "No" to the query "Does the patient report any falls since the last skilled visit?" However, in the narrative section of the visit note, the RN documented Patient #1 fell on 1/19/15, and went to an urgent care center to be evaluated.</p> <p>During an interview on 6/11/15 at 2:35 PM, the DON reviewed Patient #1's record and confirmed that the RN documented Patient #1 did not have any falls, then documented he fell on 1/19/15. She stated the no response to a fall was probably an error on the part of the RN.</p> <p>Patient #1's record included inaccurate documentation.</p> <p>2. Patient #3 was an 85 year old female admitted to the agency for nursing and therapy services on 5/17/15, following a short hospitalization after a heart attack, cardiac catheterization, and stent placement. Additional diagnoses included UTI, and GERD. Her record, including the POC for</p>	G 236	<p>Monitoring :</p> <p>1. Beginning 6/17/15, the DON/TL will review 100% of all SOC to view that appropriate verbal orders were obtained following the initial evaluations. This will be completed by viewing the documentation and VSOC date. The review will be conducted for 8 weeks and until 100% compliance is achieved for 4 consecutive weeks.</p> <p>2. Beginning 8/1/15, the DON/TL will review 6 visit notes per week to verify accuracy of documentation. These visit note reviews will be conducted for 8 weeks and until greater than 94% compliance is achieved for 4 consecutive weeks.</p> <p>DON is responsible for implementing corrective action.</p>		

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G 236	<p>Continued From page 30 the certification period 5/17/15 to 7/15/15, was reviewed.</p> <p>Patient #3's PT POC included a statement "The licensed professional completing the Physical Therapy evaluation attests that verbal orders were received on 5/18/15, received from Dr. [Patient #3's physician's name]."</p> <p>During an interview on 6/11/15 beginning at 8:00 AM, the Physical Therapist reviewed Patient #3's record. She confirmed she conducted a therapy evaluation on 6/18/16. She stated she did not receive verbal orders, and she did not enter the above attestation on the POC.</p> <p>During an interview on 6/11/15 beginning at 1:30 PM, the Clinical Lead reviewed Patient #3's record and stated she entered the attestation statement noted on the PT POC after the PT evaluation was completed. She confirmed the attestation statement was inaccurate.</p> <p>Patient #3's record did not include complete and accurate information.</p> <p>3. Patient #10 was an 81 year old female who was admitted to the agency on 6/02/15 for SN and PT services related to a fractured pelvis. Additional diagnoses included HTN, and COPD. Her record, including the POC for the certification period 6/02/15 to 7/31/15, was reviewed.</p> <p>Patient #10's PT POC included a statement "The licensed professional completing the Physical Therapy evaluation attests that verbal orders were received on 6/04/15, received from Dr. [Patient #10's physician's name]."</p>	G 236		

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G 236	<p>Continued From page 31</p> <p>During an interview on 6/11/15 beginning at 8:00 AM, the Physical Therapist reviewed Patient #10's record. She confirmed she conducted the therapy evaluation on 6/04/15. She stated she did not receive verbal orders, and she did not enter the above attestation on the POC.</p> <p>During an interview on 6/11/15 beginning at 1:30 PM, the Clinical Lead reviewed Patient #10's record and stated she entered the attestation statement noted on the POC after the PT evaluation was completed. She confirmed the attestation statement was inaccurate.</p> <p>Patient #10's record did not include accurate information.</p> <p>4. Patient #6 was a 72 year old female who was admitted to the agency on 5/19/15, for SN and PT services following a short hospitalization after abdominal surgery. Additional diagnoses included GERD, depression, and degenerative arthritis. Her records, including the POC, for the certification period 5/19/15 to 7/17/15, were reviewed.</p> <p>Patient #6's PT POC included a statement "The licensed professional completing the Physical Therapy evaluation attests that verbal orders were received on 5/20/15, received from Dr. [Patient #3's physician's name]."</p> <p>During an interview on 6/11/15 beginning at 8:00 AM, the Physical Therapist reviewed Patient #6's record. She confirmed she conducted a therapy evaluation on 5/20/15. She stated she did not receive verbal orders, and she did not enter the above attestation on the POC.</p>	G 236			

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G 236	<p>Continued From page 32</p> <p>During an interview on 6/11/15 beginning at 1:30 PM, the Clinical Lead reviewed Patient #6's record and stated she entered the attestation statement noted on the POC after the PT evaluation was completed. She confirmed the attestation statement was inaccurate.</p> <p>Patient #6's record was not accurate.</p> <p>5. Patient #4 was an 83 year old female admitted to the agency on 5/15/15, following hospitalization for an acute MI. Additional diagnoses included CAD and CHF. She received SN, PT and OT services. Her record, including the POC, for the certification period 5/15/15 to 7/13/15, was reviewed.</p> <p>Patient #4's record included a PT evaluation, completed on 5/15/15, and signed by the Physical Therapist. Patient #4's POC stated "the licensed professional completing the physical therapy evaluation attests that orders were received on 5/15/15."</p> <p>During an interview on 6/11/15 at 2:30 PM, the DON and the Clinical Lead reviewed the POC for Patient #4, including the statement attesting the therapist contacted the physician for orders. The DON and the Clinical Lead confirmed the therapist had "not spoken with the the physician because the physicians here prefer we fax them an MD SBAR for orders and we wait for it to come back."</p> <p>The POC for Patients #4 included inaccurate information related to physician contact for approval of the POC.</p> <p>6. Patient #9 was a 71 year old male admitted to</p>	G 236			

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G 236	<p>Continued From page 33</p> <p>the agency on 5/27/15, for care related to the after effects of a CVA. Additional diagnoses included HPN, CAD and aphasia (impaired speech). He received PT services. His record, including the POC, for the certification period 5/27/15 to 7/72/15, was reviewed.</p> <p>Patient # 9's record included a SOC assessment completed on 5/27/15, and signed by the Physical Therapist. Patient #9's POC stated "the licensed professional completing the physical therapy evaluation attests that orders were received on 5/27/15."</p> <p>During an interview on 6/11/15 at 2:30 PM, the DON and the Clinical Lead reviewed the POC for Patient #9, including the statement attesting the therapist contacted the physician for orders. The DON and the Clinical Lead confirmed the therapist had "not spoken with the the physician because the physicians here prefer we fax them an MD SBAR for orders and we wait for it to come back."</p> <p>The POC for Patients #9 included inaccurate information related to physician contact for approval of the POC.</p> <p>7. Patient #12 was a 53 year old female admitted to the agency on 5/22/15, for services related to acute heart failure. Additional diagnoses included CHF, CAD, insulin dependent diabetes and kidney failure. Her record, including the POC, for the certification period 5/22/15 to 7/20/15, was reviewed.</p> <p>Patient #12's record included a PT evaluation, completed on 5/28/15, and signed by the Physical Therapist. Patient #12's POC stated "the</p>	G 236			

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G 236	<p>Continued From page 34</p> <p>licensed professional completing the physical therapy evaluation attests that orders were received on 5/28/15."</p> <p>Patient #12's record included an OT evaluation, completed on 5/28/15, and signed by the Occupational Therapist. Patient #12's POC stated "the licensed professional completing the occupational therapy evaluation attests that orders were received on 5/28/15."</p> <p>During an interview on 6/11/15 at 2:30 PM, the DON and the Clinical Lead reviewed the POC for Patient #12, including the statement attesting the therapist contacted the physician for orders. The DON and the Clinical Lead confirmed the therapist had "not spoken with the the physician because the physicians here prefer we fax them an MD SBAR for orders and we wait for it to come back."</p> <p>The POC for Patients #12 included inaccurate information related to physician contact for approval of the POC.</p> <p>8. Patient #11 was a 78 year old male admitted to the agency on 5/11/15 for Physical Therapy services related to weakness and back pain. Additional diagnoses included COPD, chronic pain, CHF, and pneumonia. His record, including the POC, for the certification period 5/11/15 to 7/09/15, was reviewed.</p> <p>Patient #11's POC included "amputation precautions" under safety measure. However, Patient #11 was not an amputee.</p> <p>During an interview on 6/11/15 beginning at 8:00 AM, the Physical Therapist reviewed Patient #11's</p>	G 236			

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G 322	<p>Continued From page 36</p> <p>diagnosis, however, her hospital discharge summary included information that she was admitted to the hospital with a diagnosis of acute myocardial infarction and had a cardiac catheterization. She was discharged from the hospital on 5/16/15. Her H&P dated 5/13/15 stated she had no prior history of cardiac problems, and did not contain any documentation related to a coronary artery vessel graft.</p> <p>During an interview on 6/11/15 at 9:25 AM, the RN Case Manager reviewed Patient #3's record and confirmed the information on the SOC assessment and POC related to coronary artery vessel graft was incorrect.</p> <p>During an interview on 6/11/15 at 1:00 PM, the DON stated she had further information, that the diagnosis of coronary artery vessel graft was an error by the coders after the SOC was performed.</p> <p>Patient #3's OASIS data did not accurately reflect her diagnosis.</p> <p>2. Patient #10 was an 81 year old female who was admitted to the agency on 6/02/15 for SN and PT services related to a fractured pelvis. Additional diagnoses included HTN, and COPD. Her record, including the POC, for the certification period 6/02/15 to 7/31/15, was reviewed.</p> <p>Patient #10's OASIS item M2020 "MANAGEMENT OF ORAL MEDICATIONS" was answered "3-UNABLE TO TAKE MEDICATION UNLESS ADMINISTERED BY ANOTHER PERSON." The assessment stated Patient #10 lived alone, and there was no documentation stating she received assistance with her medications.</p>	G 322	<p>3. Individual nurse involved in Patient #12 was educated on correct way to fill out OASIS M2020 and M2030.</p> <p>Process Change:</p> <ol style="list-style-type: none"> All Oasis clinicians will be provided a list of commonly used ICD-9 codes and then the ICD-10 commonly used codes during the coding transition. Oasis clinician/TL to redirect incorrect coding back to the coding department for correction. Oasis clinician will review and validate Oasis answers prior to syncing visit for review. Recommendations for corrections will be directed to Oasis clinician by the DON/TL. DON/TL will do remedial Oasis education ongoing with clinicians that have Oasis data errors in repeated areas TL will monitor Strategic Healthcare Programs (SHP) alerts daily to identify Oasis inaccuracies. 	7/9/15 7/16/15	

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G 322	<p>Continued From page 37</p> <p>During an interview on 6/11/15 at 10:00 AM, the RN Case Manager reviewed Patient #10's record. She stated OASIS item M2020 did not accurately reflect Patient #10's status at her SOC. The RN stated she had been instructed to answer item M2020 with "3-UNABLE TO TAKE MEDICATION UNLESS ADMINISTERED BY ANOTHER PERSON" at SOC, so the assessment completed at the time of discharge would indicate an improvement in the patient's ability to manage medications.</p> <p>The agency did not ensure OASIS data accurately reflected the patient's status at the time of the assessment.</p> <p>3. Patient #12 was a 53 year old female admitted to the agency on 5/22/15, for services related to acute heart failure. Additional diagnoses included CHF, CAD, insulin dependent diabetes and kidney failure. Her record, including the POC, for the certification period 5/22/15 to 7/20/15, was reviewed.</p> <p>Patient #12's POC included sliding scale insulin (dosage based on BG level as measured by a BG monitor) to be taken 3 times a day. The sliding scale insulin order stated for each BG increase of 10 mg/dl over 170, an additional unit of insulin should be added to 7 units. For example, 10 units would be taken for a BG of 200, and 20 units would be taken for a BG of 300.</p> <p>Patient #12's record included a SOC OASIS assessment completed on 5/22/15, and signed by the RN Case Manager. The assessment documented Patient #12 stated her BG was 548. It did not document additional BG readings, or</p>	G 322	<p>Monitoring:</p> <p>Beginning 8/1/15, DON/TL will review 10 charts per month to verify Oasis accuracy. The audit will be conducted form 3 months and until a greater than 94% compliance is achieved for 2 consecutive months</p> <p>DON is responsible for implementing corrective action.</p>		

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G 322	<p>Continued From page 38</p> <p>whether she had taken insulin per her sliding scale orders. There was no documentation related to Patient #12's ability to manage her sliding scale insulin.</p> <p>Patient #12's OASIS item M2020 "MANAGEMENT OF ORAL MEDICATIONS" was answered "3-UNABLE TO TAKE MEDICATION UNLESS ADMINISTERED BY ANOTHER PERSON." OASIS item M2030 "MANAGEMENT OF INJECTABLE MEDICATIONS" was answered "2-ABLE TO TAKE MEDICATION(S) AT THE CORRECT TIMES IF GIVEN REMINDERS BY ANOTHER PERSON BASED ON THE FREQUENCY OF THE INJECTION." The assessment stated Patient #12 lived alone, and there was no documentation stating she received assistance with her medications.</p> <p>During an interview on 6/11/15 at 10:00 AM, Patient #12's RN Case Manager reviewed her record. She stated OASIS items M2020 and M2030 did not accurately reflect Patient #12's status at her SOC. The RN stated she was instructed to answer item M2020 with "3-UNABLE TO TAKE MEDICATION UNLESS ADMINISTERED BY ANOTHER PERSON" at SOC, so the assessment completed at the time of discharge would indicate an improvement in the patient's ability to manage medications.</p> <p>The agency OASIS data did not accurately reflect Patient #12's status at the time of the assessment.</p>	G 322		
G 331	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT</p> <p>A registered nurse must conduct an initial assessment visit to determine the immediate care</p>	G 331	<p>Occurrence reports have been completed on patients #2, #4, and #8</p>	7/16/15

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G 331	<p>Continued From page 39 and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included a thorough examination of identified items of concern for 3 of 12 patients, (#2, #4 and #8) who received admission assessments and whose records were reviewed. This failure placed patients' at risk of negative outcomes. Findings include:</p> <p>1. Patient #2 was a 72 year old male admitted to the agency on 12/22/14, for services related to an open wound on his knee. Additional diagnoses included HTN and COPD. He received SN, PT and OT services. His record, including the POC, for the certification period 12/22/14 to 2/20/15, was reviewed.</p> <p>Patient #2's record included a SOC assessment, completed by the RN Case Manager and signed on 12/22/14. It stated a pain assessment was completed, using a 0-10 pain scale, with 10 being the worst pain. The assessment stated "PATIENT RATES PAIN AT ZERO ON PAIN SCALE 1-10." The assessment also stated Patient #2's pain was assessed and it indicated severe pain, all of the time. The narrative section of the note stated Patient #2 reported pain of 8-10, on a 0-10 scale.</p> <p>During an interview on 6/11/15 at 1:40 PM, the DON reviewed Patient #2's SOC assessment and confirmed the information related to pain was</p>	G 331	<p>The physician and record have been updated to reflect the skin assessment of patient #4 and the rectal prolapsed diagnosis and risk of increased bleeding for patient #8.</p> <p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policy 2.1.003 Patient Assessment, were reviewed with staff.</p> <p>Specifically:</p> <p>1. Reports of pain outside the established parameters must be communicated to the MD. Any unrelieved pain or reported pain level of 7 or greater should be reported to documentation of why it was not report.</p> <p>2. The requirement is for the case manager to perform to a thorough evaluation and capture all needed interventions to discuss with the MD and to be reflected in the POC. The LPN/PTA is to contact the case manager of issues or coordination of care after every appropriate visit. No one is to document "care coordinated" in the visit note if no communication occurred.</p>	7/16/15	7/9/15

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G 331	<p>Continued From page 40</p> <p>inconsistent and did not accurately describe his level of pain.</p> <p>Patient #2's SOC comprehensive assessment did not clearly identify his level of pain.</p> <p>2. Patient #4 was an 83 year old female admitted to the agency on 5/15/15, following hospitalization for an acute MI. Additional diagnoses included CAD and CHF. She received SN, PT and OT services. Her record, including the POC, for the certification period 5/15/15 to 7/13/15, was reviewed.</p> <p>Patient #4's record included a SOC Admission assessment completed by the RN Case Manager, dated 5/15/15. It stated the "patient has no pressure ulcers or no stageable pressure ulcers."</p> <p>Patient #4's record included a Visit Note Report completed by the LPN, dated 5/19/15. The note stated Patient #4 reported having a sore on her buttocks. The note stated it was getting better and she did not mention it to the RN during the SOC visit.</p> <p>During an interview on 6/11/15 at 9:25 AM, the RN Case Manager stated Patient #4 did not report a sore on her buttocks during the SOC visit. She confirmed she did not complete a comprehensive skin assessment, and stated "we usually just look at arms".</p> <p>During an interview on 6/11/15 at 2:05 PM, the DON reviewed Patient #4's record and confirmed the SOC assessment did not include a comprehensive skin assessment.</p>	G 331	<p>Process Change:</p> <ol style="list-style-type: none"> All Oasis clinicians to review assessment data and POC prior to syncing visit. DON/TL will review assessment data and POC for accuracy. DON/TL to make assessment change recommendations to Oasis clinician. <p>Monitoring: Beginning 8/1/15, the DON/TL will review 100% of admissions from the previous week to verify accuracy of the initial assessment. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved for 4 consecutive weeks.</p> <p>DON is responsible for implementing the corrective action.</p>	7/16/15	

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G 331	<p>Continued From page 41</p> <p>A comprehensive skin assessment was not completed during Patient #4's SOC assessment.</p> <p>3. Patient #8 was an 83 year old female admitted to the agency on 5/09/15, for services related to a CVA. Additional diagnosis included CHF, atrial fibrillation, CAD, dysphagia, and depressive disorder. She received SN, PT, OT and ST services. Her record, including the POC, for the certification period 5/09/15 to 7/07/15, was reviewed.</p> <p>Patient #8's record included two physician H & Ps, dated 4/15/15 and 4/17/15, completed during her hospitalization, and provided to the agency at the time of referral. The H & Ps stated Patient #8 had a diagnosis of rectal prolapse (a condition in which the rectum drops out of its normal location and pushes through the anal opening.) Johns Hopkins Medicine website, accessed on 6/17/15, identified pain and rectal bleeding as common symptoms with rectal prolapse. In addition, in the H & P dated 4/15/15, the physician stated "the patient is at risk for bleeding and need for transfusion due to blood thinner."</p> <p>Patient #8's record included a SOC assessment completed on 5/09/15, and signed by the RN Case Manager. The SOC assessment did not identify Patient #8's history of rectal prolapse, or include an assessment related to symptoms of rectal prolapse.</p> <p>Patient #8's drug regimen review, completed during the SOC assessment included 2 anticoagulants (medications that thin the blood and increase the risk of bleeding) taken concurrently. The SOC assessment failed to identify Patient #8's potential increased risk of</p>	G 331		
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G 331	Continued From page 42 bleeding associated with the rectal prolapse while taking anticoagulants. In addition, Patient #8's POC did not include her diagnosis of rectal prolapse and related interventions. During an interview on 6/11/15 at 1:55 PM, the DON and the Clinical Lead reviewed Patient #8's record. They confirmed the SOC assessment performed by the RN Case Manager on 5/09/15, did not include the patient's history of rectal prolapse. Additionally, they confirmed Patient #8's POC did not include rectal prolapse and interventions related to it.	G 331		
G 337	The registered nurse did not identify an existing high risk diagnosis in a patient on anticoagulation therapy and initiate appropriate nursing interventions. 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 review of medical records, observation, staff interview and patient/family interview it was determined the agency failed to ensure a comprehensive drug regimen review was completed for 7 of 12 patients, (#3, #4, #6, #8, #9, #11, and #12) whose records were reviewed. This resulted in the increased potential for patients to experience adverse events related to medications. Findings include:	G 337	Occurrence report has been done on patients' #3, #4, #6, #8, #9, #11, and #12. These patients have had a full medication reconciliation completed and the MD has been notified of current medications in the home. In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policies 2.1.002 Patient Assessment, 2.1.007 Plan of Care, 10.007 High Risk Medications, 10.008 Monitoring Medications and The Joint Commission (TJC) NPSG #3 Medication Management were reviewed with staff.	7/16/15 7/9/15

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G 337	Continued From page 43 1. Patient #3 was an 85 year old female, admitted to the agency for nursing and therapy services on 5/17/15, following a short hospitalization after a heart attack and cardiac catheterization. Additional diagnoses included UTI and GERD. Her record, including the POC, for the certification period 5/17/15 to 7/15/15, was reviewed. A home visit was conducted on 6/08/15 beginning at 12:15 PM to observe the LPN as she provided care. Interviews were also conducted with Patient #3 and her family. Medications were reviewed and compared with Patient #3's POC and medication record provided by the agency. Discrepancies were noted as follows: -The POC included Brillinta 90 mg, 2 tabs daily, Patient #3's daughter stated Patient #3 was not taking the medication. She stated the medication was over \$250.00 more than Plavix, so she was taking Plavix instead. - The POC included Docusate 100 mg, 1 tab twice daily. Patient #3's daughter stated Patient #3 stopped taking the medication shortly after her discharge from the hospital. - The POC included Pantoprazole 40 mg, 1 tab daily. Patient #3's daughter stated Patient #3 stopped taking the medication shortly after her discharge from the hospital. During the home visit additional medications were observed in the home that Patient #3 was taking, however they were not included on her POC. - Strauss Heartdrops, 0.75 ml, 3 times daily.	G 337	Specific focus areas are: 1. Visually inspecting medication bottles and comparing to the medication list. 2. Getting copies of the MAR (at ALFs) for comparison. 3. Looking around the home as needed for unlisted medications. 4. Education of the patient/ caregiver on all types of medications that need reviewed i.e. eye drops, supplements, ointments. Process Change; 1. The LHC Medication questionnaire will be placed in each patient's admission folder. 2. All clinicians will review the LHC Medication questionnaire at each visit to serve as a prompter and for consistency about medications. 3. Clinicians will request a copy of the ALF medication list at each visit to verify home health agency list is correct.	7/9/15	7/16/15

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G 337	<p>Continued From page 44</p> <p>- Emergen C Vitamin C, 1000 mg powder, 3 times daily with the above heartdrops.</p> <p>- Plavix 75 mg, 1 tab daily.</p> <p>During an interview on 6/11/15 beginning at 8:45 AM, the LPN that provided care for Patient #3 during the home visit confirmed the medication discrepancies that were found. She stated Patient #3 and her family did not disclose the information regarding the medication changes during previous visits.</p> <p>Patient #3's POC was not current and accurate to include all her medications.</p> <p>2. Patient #11 was a 78 year old male, admitted to the agency on 5/11/15 for physical therapy services related to weakness and back pain. Additional diagnoses included COPD, chronic pain, CHF, and pneumonia. His record, including the POC, for the certification period 5/11/15 to 7/09/15, was reviewed.</p> <p>Patient #11's hospital referral information, dated 5/06/15 and received by the agency 5/06/15, documented his medications included Carvedilol 6.25 mg twice daily. His POC documented the dose as 12.5 mg twice daily, which was double the dose ordered on his hospital discharge instructions.</p> <p>Patient #11's referral information and hospital record documented his medications included Prednisone. The discharge instructions noted Patient #11 was to taper the Prednisone from 30 mg daily for 3 days, then 20 mg for 3 days, then continue with 10 mg daily. Patient #11's POC documented the dose as 20 mg daily, and did not</p>	G 337	<p>4. DON/TL to compare Hospital Discharge medication list with the home health agency medication list.</p> <p>5. Physician to be notified by DON/TL of discrepancies found that have not been addressed prior by the field clinician.</p> <p>Monitoring:</p> <p>Beginning 8/1/15, DON/TL will make 10 home visits per month to review medications and verify that medication reconciliation is occurring and that medications in the home match the agency medication list. The review will be conducted for 3 months and until greater than 90% compliance is achieved for 2 consecutive months.</p> <p>DON is responsible for implementing the corrective action.</p>	7/16/15

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G 337	<p>Continued From page 45</p> <p>Include the tapering of the medications as detailed in the discharge instructions.</p> <p><i>The Physical Therapist completed a MD SBAR communication note which was sent to Patient #11's physician, dated 5/12/15, and was returned signed by the physician on 5/12/15. The Physical Therapist documented on the note "Medication discrepancies found in home include Carvedilol- Patient taking 12.5 mg BID per home medication, hospital record states 6.25 mg BID. Prednisone- Patient taking 20 mg daily, hospital record lists tapering dose to 10 mg daily, wife manages medications."</i></p> <p>The note to the physician was followed by a line which was checked, followed by the typed statement "Agree with above request."</p> <p>During an interview on 6/11/15 beginning at 8:00 AM, the Physical Therapist reviewed Patient #11's record and confirmed the medications listed on his POC did not reflect the discharge orders. The Physical Therapist reviewed the MD SBAR communication note that was sent to the physician, and confirmed the check mark beside the statement "Agree with above request" was not a clarification of the medication discrepancies.</p> <p>Patient #11's medications were not sufficiently reconciled.</p> <p>3. Patient #6 was a 72 year old female who was admitted to the agency on 5/19/15, for SN and PT services following a short hospitalization after abdominal surgery. Additional diagnoses included GERD, Depression, and degenerative arthritis. Her records, including the POC, for the certification period 5/19/15 to 7/17/15, were</p>	G 337			

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G 337	<p>Continued From page 46 reviewed.</p> <p>A home visit was conducted on 6/10/15 at 12:30 PM to observe the RN as she provided wound care for Patient #6.</p> <p>Medications were reviewed with Patient #6, and compared with her current medication list provided by the agency. The following discrepancies were noted:</p> <ul style="list-style-type: none"> - Aspirin 81 mg 1 tablet daily, Patient #6 stated she took this on a daily basis, however, her POC noted she was to discontinue taking it as of 5/19/15. - Vitamin D, 2 tablets daily, Patient #6 stated she took the medication daily, however it was not included on the POC. - Multivitamins, 1 daily, Patient #6 stated she took the medication daily, however, it was not included on the POC. <p>During an interview on 6/11/15 beginning at 12:45 PM, Patient #6's RN Case Manager reviewed her record and confirmed Patient #6 was taking the medications and they were not included on her POC.</p> <p>Patient #6's POC and medication record were not accurate and current.</p> <p>4. Patient #12 was a 53 year old female admitted to the agency on 5/22/15, for services related to acute heart failure. Additional diagnoses included CHF, CAD, insulin dependent diabetes and kidney failure. Her record, including the POC, for the certification period 5/15/15 to 7/13/15, was</p>	G 337			

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G 337	<p>Continued From page 47 reviewed.</p> <p>Patient #12's POC included sliding scale insulin (dosage based on BG level as measured by a BG monitor) to be taken 3 times a day. The sliding scale insulin order stated for each BG increase of 10 mg/dl over 170, an additional unit of insulin should be added to 7 units. For example, 10 units would be taken for a BG of 200, and 20 units would be taken for a BG of 300.</p> <p>Patient #12's record included a SOC assessment completed on 5/22/15, and signed by the RN Case Manager. The assessment documented Patient #12 stated her fasting BG level was 548. The American Diabetes Association website, accessed 6/15/15, stated a normal fasting BG for a diabetic adult is less than 126 mg/dl. The SOC assessment did not document additional BG readings, or whether she was taking insulin 3 times a day per her sliding scale orders. The visit note did not document an assessment of Patient #12's ability to calculate the correct dosage of insulin and manage her sliding scale. Additionally, the visit note did not document patient education related to using her BG monitor or calculating an insulin dose based on her BG results.</p> <p>Patient #12's second and third SN visits were documented on 5/26/15 and 5/29/15, by the RN Case Manager. The visit notes did not document Patient #12's BG readings at the time of the visits, or between SN visits. Additionally, they did not document Patient #12's compliance with her sliding scale orders, or education related to sliding scale insulin administration.</p> <p>Patient #12's SOC assessment completed on</p>	G 337			

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G 337	<p>Continued From page 48</p> <p>5/22/15, and signed by the RN Case Manager, documented a complete drug regimen review identified potential clinically significant medication issues, and stated her physician was contacted within 1 day to resolve her medication issues. However, Patient #12's record did not document communication with her physician regarding medication issues.</p> <p>During an interview on 6/11/15 at 10:00 AM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #12's physician following her SOC assessment to report or resolve the medication inconsistencies.</p> <p>The agency failed to ensure Patient #12's physician was contacted to resolve potentially significant medication issues.</p> <p>5. Patient #8 was an 83 year old female admitted to the agency on 5/09/15, for services related to a CVA. Additional diagnosis included CHF, atrial fibrillation, CAD, dysphagia, and depressive disorder. She received SN, PT, OT and ST services. Her record, including the POC for the certification period 5/09/15 to 7/07/15, was reviewed.</p> <p>Patient #8's POC, signed by her physician, included "SN to instruct on all medications (including supplements) including how to monitor effectiveness of drug therapy and drug reactions and side effects."</p> <p>Patient #8's record included a SN visit note dated 6/04/2015 that stated there were "no medication changes since the last SN visit and "the patient is compliant with the medication regimen."</p>	G 337		
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G 337	<p>Continued From page 49</p> <p>a. Patient #8's POC included Aspirin Low Dose Oral, 81 mg, 1 tab, daily, effective 5/09/2015. Aspirin prevents blood cells from sticking together to form clots, therefore increasing the risk of bleeding.</p> <p>Patient #8's record included a Client Medication Record. Her record stated a review of medications was performed by the RN Case Manager on 5/09/15, however, Aspirin was not included on her Client Medication Record. The review of medications did not identify her increased risk of bleeding related to concurrent use of Aspirin and Eliquis. (The website for Eliquis, an anticoagulant, included safety information regarding a higher risk of bleeding when taken with other medicines that increase the chance of bleeding, e.g. aspirin).</p> <p>Patient #8's record included an On Call Note on 5/10/15 at 9:00 AM. The RN Case Manager's On Call Note stated the "client's daughter called to report client had spent evening in the ER D/T rectal bleeding and prolapse."</p> <p>During an interview on 6/11/2015 at 1:55 PM, the DON and Clinical Lead reviewed Patient #8's record and confirmed the physician order for Aspirin at the SOC did not appear on the Client Medication Record. Additionally, they confirmed the drug regimen review by the RN Case Manager at the SOC failed to identify potentially significant medication issues.</p> <p>In addition, they confirmed the SN visits on 5/14/15, 5/21/15 and 5/28/15 did not document medication changes were made on the Client Medication Record.</p>	G 337			

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G 337	<p>Continued From page 50</p> <p>b. Patient #8's Client Medication Record included Atenolol oral 25 mg 1 tab 2 times daily ordered on her POC on 5/09/15 and signed by the physician. In addition, the records include a Physician Verbal Order dated 6/04/15, which instructed to discontinue Atenolol. The Client Medication Record dated 6/11/15 did not state Atenolol was discontinued.</p> <p>During an interview on 6/11/15 at 1:55 PM, the DON and Clinical Lead reviewed Patient #8's record and confirmed there was a physician order to discontinue Atenolol dated 6/04/15 at 11:38 AM and that the Client Medication Record dated 6/11/15 did not reflect the change in medication regimen discontinuing atenolol. In addition, the DON and the Clinical Lead confirmed the SN visit note on 6/04/2015 at 11:38 AM, stated there were "no medication changes since the last SN visit and "the patient is compliant with the medication regimen."</p> <p>The agency failed to include in Patient #8's comprehensive assessment a review of all medications she was taking and failed to identify potential adverse effects, significant drug interactions and duplicate drug therapy.</p> <p>6. Patient #4 was an 83 year old female admitted to the agency on 5/15/15, following hospitalization for an acute MI. Additional diagnoses included CAD and CHF. She received SN, PT and OT services. Her record, including the POC, for the certification period 5/15/15 to 7/13/15, was reviewed.</p> <p>The Physical Therapist was observed as she provided services to Patient #4 during a home visit on 6/09/2015 at 3:00 PM. The Physical</p>	G 337			

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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)	(X6) COMPLETION DATE	
G 337	<p>Continued From page 51</p> <p>Therapist asked her if there had been any medication changes. She responded she had a new eye ointment and provided the medication to the Physical Therapist. The Physical Therapist did not ask to visualize her other medications.</p> <p>During an interview with Patient #4 immediately after the departure of the Physical Therapist, her medications were reviewed. They included Diazepam 5 mg 1 tab to be taken every 12 hours PRN. Diazepam was not documented on Patient #4's Client Medication Record. She stated she took the Diazepam for anxiety a few times a month.</p> <p>During an interview on 6/11/15 at 2:05 PM, the DON reviewed Patient #4's record and confirmed the Client Medication Record had not been updated to reflect Patient #4 was taking Diazepam.</p> <p>The agency failed to include in Patient #4's comprehensive assessment a review of all medications she was taking.</p> <p>7. Patient #9 was a 71 year old male admitted to the agency on 5/27/15, for care related to the after effects of a CVA. Additional diagnoses included HTN, CAD and aphasia (impaired speech). He received PT services. His record, including the POC, for the certification period 5/27/15 to 7/25/15, was reviewed.</p> <p>Patient #9's POC included a Client Medication Report that stated he was to take Valproic Acid 250 mg, 2 tabs in AM and at noon, and 3 tabs at bedtime.</p> <p>The PTA was observed as he provided services</p>	G 337			

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

PRINTED: 08/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2015
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2428 NORTH MERRITT CREEK LOOP COEUR D'ALENE, ID 83814		
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G 337	<p>Continued From page 52</p> <p>during a home visit on 6/09/15 at 5:00 PM. Patient #9 resided in an Assisted Living Facility (ALF). After the PTA completed the visit, he spoke with the owner of the facility regarding Patient #9's progress towards goals. However, he did not review Patient #9's medications.</p> <p>After the PTA exited, the facility owner provided Patient #9's ALF Medication Record to the surveyors. The record documented a change in his medication regimen on 6/03/15. The ALF Medication Record documented Valproic Acid 250 mg 3 capsules in the morning, 2 capsules at noon and 3 capsules at bedtime. The facility owner confirmed the medication dosage change was made by the visiting Nurse Practitioner on 6/03/15.</p> <p>During an interview on 6/11/15 at 2:05 PM, the DON reviewed Patient #9's record and confirmed the Client Medication Record had not been updated to reflect the change to his medication regimen.</p> <p>The agency failed to ensure Patient #9's record included an accurate list of all medications he was taking.</p>	G 337			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2015
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2426 NORTH MERRITT CREEK LOOP COEUR D'ALENE, ID 83814		
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure recertification survey of your home health agency on 6/08/15 through 6/12/15. The surveyors conducting the survey were: Susan Costa RN, HFS, Team Lead Nancy Bax RN, HFS Dennis Kelly RN, HFS Acronyms used in this report include: RN - Registered Nurse SOC - Start of Care	N 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JUL 10 2015</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: I. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143 as it relates to the failure of the agency to effectively coordinate patient care.	N 062		See attached
N 093	03.07024. SK. NSG. SERV. N093 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	N 093		See Attached

Bureau of Facility Standards

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

Vickie Doshaw

TITLE

DDN

(X6) DATE

7/10/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2015
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N 093	Continued From page 1 registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G331 as it relates to the failure of the agency to ensure assessments identified patients' needs and that all needs were addressed.	N 093		
N 094	03.07024. SK. NSG. SERV. N094 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G173 as it relates to the failure of the agency to ensure the patients' needs were identified during the SOC comprehensive assessment.	N 094	N094 An occurrence report has been submitted for patient # 12. Further visits with patient # 12 have demonstrated DM education, patient compliance, and MD notification with associated orders from MD for elevated blood glucose readings In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policy 2.1.007 Plan of Care and 2.1.017 Coordination of Care, 2.1.020 Vital Signs, 2.1.021 Diabetic Skin Care were reviewed with staff. The requirement is for the case manager to revise the POC as needed to reflect changes in the patient condition. Any abnormal findings, VS outside established parameters should be conveyed to the MD and the POC amended. This includes educational/training needs of the patient /caregiver not covered in the original POC. Documentation should reflect compliance/non-compliance and needs that were met/un-met to be addressed on subsequent visits. In a mandatory staff meeting 7/16/15 the Home Care Home Base Diabetes Problem Statement Pathway education will be provided to all Oasis clinicians and TL. Process Change: 1. Oasis clinicians to utilize the correct Home Care Home Base Problem Statement Pathway for Diabetes pertinent Oasis time 2. Blood Glucose parameters will be added to the Home Care Home Base vital sign parameter pathway by the Oasis clinician. 3. DON/TL to make pathway recommendations to the Oasis clinician for completion.	7/16/15 7/9/15 7/16/15 7/16/15
N 096	03.07024. SK. NSG. SERV. N096 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the	N 096	Monitoring: Beginning 8/1/15, DON/TL will review 10 charts per month with a diagnosis of DM to verify the appropriate pathway and interventions were selected for the patient. The audit will verify that the clinician is assessing CBG's, patient's knowledge and level of compliance. The audit will be conducted for 3 months and until a greater than 94% compliance is achieved for 2 consecutive months.	

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N 096	Continued From page 2 following: d. Initiates appropriate preventive and rehabilitative nursing procedures; This Rule is not met as evidenced by: Refer to G175 as it relates to the failure of the agency to ensure the RN initiated appropriate nursing interventions.	N 096	See attached	
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	see attached	
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:	N 153	see attached	

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N 163	Continued From page 3 Refer to G159 as it relates to the failure of the agency to ensure the plan of care covered all pertinent diagnoses.	N 153		
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164 as it relates to the failure of the agency to ensure professional staff promptly alerted the physician to any changes that suggested a need to alter the plan of care.	N 172	See Attached	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337 as it relates to the failure of the agency to ensure agency staff check all medications a patient may be taking to identify possible ineffective side effects, drug allergies,	N 173	see Attached	

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N 173	Continued From page 4 and contraindicated medication and promptly report any problems to the physician.	N 173		
N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to G236 as it relates to the failure of the agency to ensure a clinical record was maintained in accordance with accepted professional standards for all patients.	N 174	See Attached	

<p>G143 N 093</p>	<p>An occurrence report has been submitted on patient #4 regarding care coordination.</p> <p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC Policy 2.1.017 Coordination of Care was reviewed with staff.</p> <p>Process Change:</p> <ol style="list-style-type: none"> 1. A process Changes has been implemented requiring all LPNs and PTAs to contact the Case Manager for a verbal report when a change in status or symptoms are identified or reported. <p>Ongoing monitoring: Beginning 8/1/15, 2 visit notes per week for each LPN and PTA will be reviewed for evidence of care coordination. The review will be conducted by the DON/TL for 8 weeks and until a greater than 94% compliance is reached for 4 consecutive weeks.</p> <p>DON is responsible for implementing corrective action.</p>	<p>7/16/15</p> <p>7/9/15</p> <p>7/9/15</p>		
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<p>G331 N 093</p>	<p>Occurrence reports have been completed on patients #2, #4, and #8. The physician and record have been updated to reflect the skin assessment of patient #4 and the rectal prolapsed diagnosis and risk of increased bleeding for patient #8.</p> <p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policy 2.1.003 Patient Assessment, were reviewed with staff.</p> <p>Specifically:</p> <ol style="list-style-type: none"> 1. Reports of pain outside the established parameters must be communicated to the MD. Any unrelieved pain or reported pain level of 7 or greater should be reported to documentation of why it was not report. 2. The requirement is for the case manager to perform a thorough evaluation and capture all needed interventions to discuss with the MD and to be reflected in the POC. The LPN/PTA is to contact the case manager of issues or coordination of care after every appropriate visit. No one is to document "care coordinated" in the visit note if no communication occurred. 	<p>7/9/15</p> <p>7/9/15</p>	<p>Process Change:</p> <ol style="list-style-type: none"> 1. All Oasis clinicians to review assessment data and POC prior to syncing visit. 2. DON/TL will review assessment data and POC for accuracy. 3. DON/TL to make assessment change recommendations to Oasis clinician. <p>Monitoring: Beginning 8/1/15, the DON/TL will review 100% of admissions from the previous week to verify accuracy of the initial assessment. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved for 4 consecutive weeks.</p>	<p>7/16/15</p>
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<p>G175 N 096</p>	<p>Occurrence reports have been submitted on patient #2 and #12. Subsequent visits to patient #12, since survey, have demonstrated correct assessment, education on diabetes and physician notification of findings has occurred.</p> <p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and descriptions were reviewed with staff. The requirement is for the case manager to do a thorough evaluation and capture all needed interventions to discuss with the MD and to be reflected in the POC. Specifically:</p> <ol style="list-style-type: none"> 1. If a wound is non healing, include nutrition/hydration, circulation, environment, patient positioning etc in your evaluations. 2. If a diabetic has CBG readings unusually high or low, include intake. Medication compliance, education etc in your evaluations. <p>In a mandatory staff meeting 7/16/15 Home Care Home Base disease management problem statement pathways education will be reviewed. Oasis clinician and TL education on choosing the correct Problem statement pathways related to the primary and associated diagnosis. Best practice reference material in Mosby's via LHC connect will be utilized in assessment education to be provided to staff.</p> <p>Process Change:</p> <ol style="list-style-type: none"> 1. Oasis clinician will choose the correct Home Care Home Base problem statement pathways in areas that can impact the primary diagnosis. 2. DON/TL to monitor each POC for associated problem statement pathways and make correction recommendations to the Oasis clinician. 	<p>7/16/15</p> <p>7/9/15</p> <p>7/16/15</p> <p>7/16/15</p>	<p>Monitoring:</p> <ol style="list-style-type: none"> 1. Beginning 8/1/15, DON/TL will review 100% of POC weekly to ensure correct problem statement pathway recommendations are made and included in the POC. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved for 4 consecutive weeks. 2. Beginning 8/1/15, DON/TL will review 6 visit notes weekly for 8 weeks and until 94% compliance for 4 consecutive weeks is achieved in documentation of assessment, documentation and physician notification of findings outside of disease process parameters. <p>DON is responsible for implementing corrective action..</p>	
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<p>G158 N 152</p>	<p>An occurrence report has been submitted on patients' #2, #4, #12 for each individual item identified in the deficient report.</p> <p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC Policy 2.1.002 Patient Assessment, Initial and Reassessment, 2.1.007 Plan of Care, 2.1.008 Physician Orders were reviewed with staff with the focus on the following:</p> <ol style="list-style-type: none"> 1. All add on discipline evaluations are to be completed within 5 days of referral. 2. All care implemented must have a written or verbal order before initiation. 3. Any orders obtained must be complete and thorough, to include multiple wounds sites and site specific orders as needed. 4. All orders must be implemented as specifically ordered. 5. All visit frequency must be accomplished as ordered or evidence of physician notification of missed visit must be evident in the record. <p>Process Change:</p> <p>Add on Evaluations-</p> <ol style="list-style-type: none"> 1. The DON/TL (who input the referrals) will schedule all add on disciplines within 5 days of referral. 2. If an add on evaluation is unable to be done in the 5 days, the agency will contact the physician and refer the patient to another provider who can meet the patient needs. 	<p>7/16/15</p> <p>7/9/15</p> <p>7/16/15</p>	<p>Weights not performed:</p> <ol style="list-style-type: none"> 1. Oasis clinician will document weight parameters within the Home Care Home Base vital sign parameters pathway at SOC/ROC/RECERT. 2. Oasis clinician to put in a point care alert for each visit to designate that a weight or other vital sign must be documented. <p>Care without orders:</p> <ol style="list-style-type: none"> 1. Physician/TL/DON will be contacted with any changes in patient status. 2. Verbal orders will be obtained and reduced to writing prior to delivery of care. <p>Visit frequency:</p> <ol style="list-style-type: none"> 1. Missed visit notification will be faxed to the physician by the office manager/assistant when scheduled visits are unable to be completed as ordered and affect the plan of care. <p>Monitoring beginning 8/1/15:</p> <ol style="list-style-type: none"> 1. Evals: DON/TL will review 100% of MSW evals to verify they have been scheduled and performed within 5 days. The audit will be conducted for 3 months and until 100% compliance is achieved for 2 consecutive months. 2. Weekly, TL will review 3 visit notes to verify that weights have been performed as ordered. The review will be conducted for 8 weeks and until greater than 94% compliance has been achieved for 4 consecutive weeks. 3. Care without orders: DON/TL to review 6 visit notes per week for evidence that care has not been provided without orders. The review will continue for 8 weeks and until the findings are greater than 94% compliance for 4 consecutive weeks. <p>DON is responsible for implementing the corrective action</p>	<p>7/16/16</p> <p>7/16/15</p> <p>7/16/15</p>
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<p>G159 N 153</p>	<p>An occurrence report has been submitted on patients' #1, #2, #8, and #11 for deficiencies identified in the report.</p> <p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policy 2.1.007 Plan of Care, 2.1.008 Physicians Orders, and TJC NPSG #15-Oxygen Safety were reviewed with staff with the focus on the following:</p> <ol style="list-style-type: none"> 1. All appropriate and applicable diagnoses and associated codes should be included in the POC. 2. All applicable DME and equipment should be included in the POC in locator 14. 3. All orders received on a referral or ROC must be included in the POC. 4. All Oasis clinicians have been provided a list of commonly used ICD-9 codes and will be presented a list of the mostly commonly used ICD-10 codes during the transition. <p>Process Change:</p> <ol style="list-style-type: none"> 1. DON/TL will review H & P, Oasis, add on evaluations, and the POC to review all possible diagnosis and DME that may impact the POC. 2. DON/TL will make recommended revisions to the plan of care for the clinician to approve. 	<p>7/16/15</p> <p>7/9/15</p> <p>7/16/15</p>	<p>Monitoring: Beginning 8/1/15, DON/TL will review 100% of plans of care and documentation weekly to verify that all pertinent diagnosis(es) and Durable Medical Equipment have been included. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved to identify clinicians needing further education. Monitoring will be ongoing.</p> <p>DON is responsible for implementing the corrective action.</p>	
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<p>G164 N172</p>	<p>Occurrence reports have been submitted on patients' #1, and #2, and #3. The physician has been notified of patient #3 weight changes.</p> <p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policies 2.1.002 Patient Assessment, Initial and Reassessment, 2.1.007 Plan of Care, 2.1.008 Physicians Orders, 2.1.011 Pain Assessment, 2.1.020 Vital Signs were reviewed with staff. The requirements are that ongoing notification of patient changes will be reported to the physician as these changes occur. The POC will include individual parameters for physician notification.</p> <p>Specifically:</p> <ol style="list-style-type: none"> 1. Any weight gain/loss outside established parameters must be communicated to the MD. Parameters should be modified in the POC as ordered or appropriate. Parameters should be flexible to reflect the visit schedule and applicable to the diagnosis. 2. Reports of pain outside the established parameters must be communicated to the MD. Any unrelieved pain or reported pain level of 7 or greater should be reported or documentation of why it was not reported. 	<p>7/16/15</p> <p>7/9/15</p>	<p>Process Change:</p> <ol style="list-style-type: none"> 1. Physician ordered weight and pain parameters will be entered into the Vital Sign parameter pathway in Home Care Home Base by all Oasis clinicians. 2. DON/TL will verify the weight and pain parameters are entered and are evident on the POC and in Home Care Home Base correctly. 3. Clinician will notify the physician when ordered VS are unable to be obtained. <p>Monitoring:</p> <p>Beginning 8/1/15, the DON/TL will review 100% of SOC and 6 charts weekly to ensure all parameters are being entered and followed and physician notification has occurred as ordered on the POC. The review will be conducted for 8 weeks and until a greater than 94% compliance is achieved for 4 consecutive weeks. Random monitoring will continue ongoing.</p> <p>DON is responsible for implementing the corrective action</p>	<p>7/16/15</p>
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<p>G337 N 173</p>	<p>Occurrence report has been done on patients' #3, #4, #6, #8, #9, #11, and #12. These patients have had a full medication reconciliation completed and the MD has been notified of current medications in the home.</p>	<p>7/16/15</p>	<p>3. Clinicians will request a copy of the ALF medication list at each visit to verify home health agency list is correct.</p>	
	<p>In a mandatory staff meeting 7/9/15 and individual counseling as needed, the standard and LHC policies 2.1.002 Patient Assessment, 2.1.007 Plan of Care, 10.007 High Risk Medications, 10.008 Monitoring Medications and The Joint Commission (TJC) NPSG #3 Medication Management were reviewed with staff.</p> <p>Specific focus areas are:</p> <ol style="list-style-type: none"> 1. Visually inspecting medication bottles and comparing to the medication list. 2. Getting copies of the MAR (at ALFs) for comparison. 3. Looking around the home as needed for nlisted medications. 4. Education of the patient/caregiver on all types of medications that need reviewed i.e. eye drops, supplements, ointments. 	<p>7/9/15</p>	<p>4. DON/TL to compare Hospital Discharge medication list with the home health agency medication list.</p> <p>5. Physician to be notified by DON/TL of discrepancies found that have not been addressed prior by the field clinician.</p> <p>Monitoring:</p> <p>Beginning 8/1/15, DON/TL will make 10 home visits per month to review medications and verify that medication reconciliation is occurring and that medications in the home match the agency medication list. The review will be conducted for 3 months and until greater than 90% compliance is achieved for 2 consecutive months.</p> <p>DON is responsible for implementing the corrective action.</p>	
	<p>Process Change;</p> <ol style="list-style-type: none"> 1. The LHC Medication questionnaire will be placed in each patient's admission folder. 2. All clinicians will review the LHC Medication questionnaire at each visit to serve as a prompter and for consistency about medications. 	<p>7/16/15</p>		

<p>G236 N174</p>	<p>Occurrence reports have been submitted on patients' #1, #3, #4, #6, #9, #10, #11, and #12. All MDSBAR orders have been signed by physicians.</p> <p>In a mandatory staff meeting 6/17/15 and with individual counseling as needed, the standard and description was reviewed with staff. The LHC policies 2.1.008 Physicians Orders and 2.1.001 Admission Process physician orders were reviewed. All staff educated on the need for accuracy of documentation in the patient record.</p> <p>Process Change:</p> <ol style="list-style-type: none"> 1. Effective 6/17/15, all orders after evaluation must be obtained verbally from the MD or his designee before care is initiated or visits made. The POC must reflect the communication and direction given from the MD. All MDSBAR/written communications with the MD will be restricted to "for your information" quality needs. 2. Staff will review documentation for errors prior to syncing visits in Home Care Home Base. 3. Staff will follow Home Care Home Base problem statement pathways in their routine documentation. 	<p>7/16/15</p> <p>6/17/15</p> <p>6/17/15</p>	<p>Monitoring :</p> <ol style="list-style-type: none"> 1. Beginning 6/17/15, the DON/TL will review 100% of all SOC to view that appropriate verbal orders were obtained following the initial evaluations. This will be completed by viewing the documentation and VSOC date. The review will be conducted for 8 weeks and until 100% compliance is achieved for 4 consecutive weeks. 2. Beginning 8/1/15, the DON/TL will review 6 visit notes per week to verify accuracy of documentation. These visit note reviews will be conducted for 8 weeks and until greater than 94% compliance is achieved for 4 consecutive weeks. <p>DON is responsible for implementing corrective action.</p>	
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