



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T. – Chief  
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**CERTIFIED MAIL: 7012 3050 0001 2125 5662**

October 2, 2015

Merrilee Stevenson, Administrator  
Idaho Home Health & Hospice  
222 Shoshone Street East  
Twin Falls ID 83301

RE: Idaho Home Health & Hospice, Provider #137014

Dear Ms. Stevenson:

Based on the survey completed at Idaho Home Health & Hospice, on September 18, 2015, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA)

**Conditions of Participation:**

- **Compliance W/ Fed, State, Local Laws (42 CFR 484.12)**
- **Acceptance of Patients, POC, Med Super (42 CFR 484.18)**
- **Skilled Nursing Services (42 CFR 484.30)**
- **Comprehensive Assessment of Patients (42 CFR 484.55)**

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

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Idaho Home Health & Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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

An acceptable Plan of Correction contains the following elements:

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

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **October 14, 2015**. It is recommended your Credible Allegation of Correction for each Condition of Participation and related standard level deficiencies show compliance on or about **November 2, 2015**, 45 days from survey exit. We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

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

Consistent with the provisions of 42 CFR 488, Alternative Sanctions for Home Health Agencies, the following remedies will be recommended to the Centers for Medicare/Medicaid (CMS) Region X Office:

- Termination effective March 18, 2016 (6 months from the survey exit date) if compliance with all Conditions of Participation is not achieved, [42 CFR 488.865]
- Civil Monetary Penalty [42 CFR 488.820(b)]

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

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

In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal dispute resolution (IDR) process. To be given such an opportunity, you are required to send your written request and all

Merrilee Stevenson, Administrator  
October 2, 2015  
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required information as directed in the attached document. This request must be received by **October 14, 2015**. If your request for IDR is received after **October 14, 2015**, the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting (Refer to page 6 of the attached IDR Guidelines).

We urge you to begin correction immediately.

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

Sincerely,



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

SC/pmt

Enclosures

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



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

PRINTED: 10/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/18/2015
NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE STREET EAST TWIN FALLS, ID 83301	
(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 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was completed at Idaho Home Health and Hospice 9/14/15 though 9/18/15. Immediate jeopardy to patients' health and safety was identified during the survey (refer to G121). The Immediate jeopardy was abated prior to the survey exit conference.</p> <p>The surveyors conducting the recertification were:</p> <p>Nancy Bax RN, BSN, HFS Team Lead Dennis Kelly, RN, BSN, HFS Laura Thompson, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ABD - large gauze pad ADL - Activities of Daily Living ALF - Assisted Living Facility AMD - Antimicrobial Dressing Bid - 2 times a day BP - Blood Pressure CHF - Congestive Heart Failure CKD - Chronic Kidney Disease cm - centimeters COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DM - Diabetes Mellitus DME - Durable Medical Equipment EMR - Electronic Medical Record GERD - Gastro Esophageal Reflux Disorder HHA - Home Health Aide HTN - Hypertension IV - Intravenous lpm - liters per minute LPN - Licensed Practical Nurse mg - milligrams mg/dl - milligrams per deciliter</p>	G 000		

RECEIVED  
OCT 22 2015  
FACILITY STANDARDS

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

*Dennis Kelly* DON 10/21/15

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 mm/hg - millimeters of mercury MSW - Masters of Social Work NC - Nasal Cannula NPWT - Negative Pressure Wound Therapy NT - Nutritional Therapy OASIS - Outcome and Assessment Information Set OT - Occupational Therapy PICC - Peripherally Inserted Central Catheter POC - Plan of Care prn - as needed Pt - Patient PT - Physical Therapy PT/INR - Prottime/International Ratio PVD - Peripheral Vascular Disease RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy UTI - Urinary Tract Infection VAC - Vacuum Assisted Closure WOCN - Wound Ostomy Continence Nurse	G 000		
G 117	484.12 COMPLIANCE W/ FED, STATE, LOCAL LAWS  This CONDITION is not met as evidenced by: Based on observation, review of medical records and agency policies and procedures, and staff and patient interview, it was determined the agency failed to ensure staff complied with accepted standards of practice related to infection control and wound care. The cumulative effect of these systemic negative practices resulted in the failure of the agency to provide safe and effective wound care to protect patients	G 117	Refer to G121	

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G 117	Continued From page 2 from wound infections. This resulted in serious and immediate threat to the health and safety of 2 patients. Findings include:  Refer to G121 as it relates to the agency's failure to follow accepted standards of practice for wound care. This failure placed Patient #2 and Patient #4 in immediate jeopardy of serious harm, impairment or death.	G 117		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD  The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.  This STANDARD is not met as evidenced by: Based on observation, review of medical records and agency policies and procedures, and patient and staff interview, it was determined the agency failed to ensure staff complied with accepted standards of practice related to infection control and wound care for 2 of 2 patients (#2 and #4) whose wound care was observed. This failure placed Patient #2 and Patient #4 in immediate jeopardy of serious harm, impairment or death; and created the potential to introduce or facilitate the spread of infection in other patients, resulting in serious negative outcomes. Findings include:  1. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was	G 121	An occurrence report was entered into the online system for patient #2 and patient #4 identified in this deficient practice. Physician for patient #2 contacted and new wound care orders obtained. Patient #4 no longer on services. Clinician (LPN) identified in deficient practice was removed from administering wound care to patients immediately. Clinician will take the Infection Control course on LHC Connect with passing rate of 90% by 9/18/15. In addition, clinician will be required to complete education by WOCN which will include review of wound care basics, wound care products, wound care dressing changes, and infection control measures when performing wound care. Clinician will be observed by DON or designee via co-visits x 3 to ensure wound care is being provided as ordered and standards of care are implemented as advised by the WOCN prior to administering any further wound care independently and ongoing as per monitoring indicated below.  100% LPNs and RNs were required to complete the Infection Control course on the LHC online education forum with a passing rate of 90% or better. Any clinician that did not complete education or pass with a minimum of 90% was removed from providing visits until further education, and competency demonstrated. WOCN educated 100% of LPNs and RNs on the following: wound care basics, wound care products, dressing changes, and infection control measures when performing dressing changes.  100% of wound care patients were identified in each branch and an observation visit was conducted by DON/designee to verify wound care provided per order, appropriate wound care supplies available, and utilized, and infection control measures implemented per standards of care. Any clinician identified to be deficient in practice will be removed from administering wound care until further education, competency demonstrated, and additional observation visits made x 3 with 100% compliance.  100% of RNs and LPNs were educated and observed on bag technique and proper hand hygiene by DON or designee	9/17/15 9/17/16 9/17/15  10/2/15 10/2/15 9/25/15 10/2/15

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G 121	Continued From page 3 reviewed.  The agency's policy 2.2.001, revised 9/01/14, titled Wound Assessment, Documentation, and Photography, stated "Upon initial visit and subsequently as indicated below, all wounds will be assessed with appropriate documentation within the medical record. Wound Location and Description ID Tools are initiated on all patients with wounds at the time of admit or upon development of a wound."  a. Patient #2's record included a SOC comprehensive assessment completed on 4/17/15, and signed by his RN Case Manager. The assessment included a section to document pressure ulcers. It included:  - "CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT STAGE III: FULL THICKNESS TISSUE LOSS." The assessment stated Patient #2 had 2 Stage III pressure ulcers.  - "CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT STAGE IV: FULL THICKNESS TISSUE LOSS WITH VISIBLE BONE, TENDON OR MUSCLE." The assessment stated Patient #2 had 2 Stage IV pressure ulcers.  The SOC assessment stated Patient #2 had 2 Stage III and 2 Stage IV pressure ulcers. It did not include the location or a description of the pressure ulcers, but stated "SEE WOUND ASSESSMENT TOOL."  Patient #2's record included a "Wound Assessment Tool Report" that documented wound assessments from 4/17/15 to 8/14/15,	G 121	100% of RNs and LPNs were educated on Home Care Home Base (HCHB) supply order process by DON. Supplies available in each location will be reviewed to ensure adequacy. Ongoing, the Office Manager will be responsible to review supplies in each branch utilizing the PAR form monthly to ensure proper supply availability.  The LHC Integration Team provided education to 100% of RNs and LPNs on the following: * correct documentation of wounds within the HCHB system * Integumentary Command Center (ICC) * Team Leader (TL) review process to ensure consistency of documentation within assessment to subsequent visits, completeness of wound documentation, accuracy of wound documentation, and orders implemented appropriately * care coordination among disciplines involved in patient's care and physician  DON/designee to educate all staff on the following policies and procedures: * 2.1.007 Plan of Care * 2.1.008 Physicians Orders * 2.1.017 Coordination of Care From Admit Through Discharge * 8.004 Hand Hygiene * 8.005 Standard Precautions  The following process changes will be implemented to prevent recurrence of the deficient practice: All wound care orders will be reviewed with TL prior to care performed to verify most current order. All supplies will be verified upon entering home prior to initiation of visit. Clinicians will order supplies within HCHB system and will be shipped directly to patient or agency (in situations where home delivery not practical). All wounds will be entered in to the ICC. Any changes in patient's condition will be verbally communicated to the TL with documentation to support appropriate follow up. TL will perform the review process of reviewing 3 clinician notes per week per clinician to ensure care performed as ordered and care coordination occurred when warranted. Beginning 10/12/15, DON/designee will observe 1 wound visit per clinician (RN and LPN) per week to ensure care is performed as ordered by physician and standards of care implemented. The observation visits will be conducted until 100% compliance achieved x 4 consecutive weeks. Beginning 10/12/15, DON/designee will complete a record review of 3 wound care notes per clinician (RN and LPN) per week to verify documentation of care provided is consistent with wound care orders and infection control measures documented appropriately. The review will continue x 8 weeks and until 100% compliance achieved x 4 consecutive weeks. The DON is responsible for implementing the plan of correction.	10/2/15  10/6/15  10/6/15  10/10/15  Date of completion 10/30/15

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G 121	<p>Continued From page 4</p> <p>when a new wound assessment tool was implemented. The report documented 4 wounds. However, it was incomplete and/or did not match the SOC assessment, as follows:</p> <p>i. The report documented a Stage III pressure ulcer on Patient #2's right hip. The entry on the SOC date 4/17/15, did not include wound assessment or measurements of the right hip wound.</p> <p>The first assessment of his right hip wound was documented on the wound report on 4/20/15. The wound was described as a pressure ulcer, stage III, and stated the wound bed was a "3." The wound report legend described a "3" as "Full thickness skin loss involving damage or necrosis of SQ [subcutaneous] tissue; may extend down to but not through underlying fascia; &amp;/or mixed partial or full-thickness &amp;/or tissue layers, obscured by granulation tissue." The report documented undermining of less than 2 cm, and a scant amount of serosanguineous drainage.</p> <p>The first measurements of Patient #2's right hip wound were documented on 4/27/15, 10 days after Patient #2's SOC. The measurements were 6 cm long by 12 cm wide by 0.5 cm deep.</p> <p>ii. The report documented a Stage IV pressure ulcer on Patient #2's scrotum. The entry on the SOC date 4/17/15, did not include wound assessment or measurements of the scrotal wound.</p> <p>The first assessment of Patient #2's scrotal wound was documented on the wound report on 4/20/15. The wound was described as a pressure ulcer, Stage IV, and stated the wound</p>	G 121			

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G 121	<p>Continued From page 5</p> <p>bed was also a "3." The report documented undermining of less than 2 cm, and a scant amount of serosanguineous drainage.</p> <p>The first measurements of Patient #2's scrotal wound were documented on 4/27/15, 10 days after Patient #2's SOC. The measurements were 6.5 cm long by 3 cm wide by 3.2 cm deep.</p> <p>iii. The report documented a Stage III pressure ulcer on the coccyx. However, the first entry on the wound report for the coccyx wound was dated 5/27/15, 40 days after Patient #2's SOC. No assessment or measurement of the wound was documented at the SOC.</p> <p>The first assessment of Patient #2's coccyx wound was documented on the wound report on 5/27/15. The wound was described as a pressure ulcer, Stage III, and stated the wound bed was also a "3." The report documented no undermining, and a small amount of drainage.</p> <p>The first measurements of Patient #2's coccyx wound were documented on 5/27/15. The measurements were 5.5 cm long by 3.5 cm wide by 0.1 cm deep.</p> <p>iv. The report documented a Stage II pressure ulcer on the right heel. However, the first entry on the wound report for the heel wound was dated 6/15/15, 59 days after Patient #2's SOC. No assessment or measurement of the wound was documented at the SOC.</p> <p>The first measurement and assessment of Patient #2's right heel wound was documented on the wound report on 6/15/15. The wound was described as a pressure ulcer, Stage II. The</p>	G 121		

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G 121	<p>Continued From page 6</p> <p>wound bed was not described. The measurements were 1.5 cm long by 0.3 cm wide by 0.2 cm deep.</p> <p>An assessment of Patient #2's right heel wound was documented on the wound report on 6/22/15. It described the wound bed as a "3."</p> <p>Patient #2's SOC assessment completed on 4/17/15, documented 2 Stage III and 2 Stage IV pressure ulcers. However, his "Wound Assessment Tool Report" documented 1 Stage III and 1 Stage IV pressure ulcer on 4/17/15. An additional Stage III pressure ulcer was documented on 5/27/15. An additional Stage II pressure ulcer was documented on 6/15/15. The status of Patient #2's pressure ulcers at the time of his admission was not documented.</p> <p>b. Patient #2's POC for the certification period 4/17/15 to 6/15/15, included an order for SN visits 3 times a week for 8 weeks. Additionally, it included the following wound care orders "Three times weekly on [sic] hip and scrotum and weekly on heel and coccyx and weekly right lower heel and coccyx may apply skin prep or barrier cream to peri-wound pm. Apply doroderm [sic] dressing/foam hydrofiber and secure with tape and or tegaderm. Apply 4x4 saturated with solution to the coccyx and scrotum teh [sic] cover with abd [large gauze pad] and secure in place with tape."</p> <p>The order was unclear. It included wound care to 5 wounds (hip, scrotum, coccyx, heel and right lower heel). However, only 4 wounds were documented in Patient #1's record. The order did not specify the type of solution to be used to saturate the 4x4 dressings. Additionally, the</p>	G 121		

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G 121	<p>Continued From page 7</p> <p>wound care order for the coccyx wound was not clear. The order stated to apply Duoderm (an occlusive dressing) to the coccyx, and also stated to apply a 4x4 saturated with solution, cover with a gauze pad and secure in place with tape.</p> <p>c. Patient #2's record included a note dated 4/29/15, and signed by a certified WOCN (Wound Ostomy and Continence Nurse). The note stated the WOCN evaluated Patient #2. Her findings and recommendations included the following:</p> <p>i. The WOCN note stated "The orders are for Acetic acid and gauze to be changed daily. Since the agency cannot go out daily to change the dressings, and the patient does not have any able willing caregiver and is unable to change the dressing himself the dressings are only changed 3 times a week. This is a problem with the existing orders as gauze needs to be changed daily or it will colonize with bacteria. A better choice of treatment if the physician is insisting on gauze is to use AMD gauze which is treated with an antimicrobial agent and can be left on for up to 72 hours...If the physician is agreeable to changing the wound care orders, depending on the culture you can pack the wound with either an alginate or a silver alginate (if infected) and cover with a foam."</p> <p>Wound Care Essentials Practice Principles, 2nd edition, 2008, published by Lippincott, Williams and Wilkers, states "Even if moistened with saline, gauze doesn't create an optimal moist healing environment. Gauze impedes healing, increases the risk of infection, requires numerous dressing changes, and is a substandard of care..."</p>	G 121			

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G 121	<p>Continued From page 8</p> <p>ii. The WOCN note stated "A more thorough cleaning of the wound needs to be done. The scrotal ulcer has lots of wrinkles and crevices where bacteria can hide. Suggest using a syringe and aggressively irrigating the area with the dressing changes."</p> <p>Patient #2's record included a physician order request dated 5/06/15, and signed by the RN Branch Manager. The request included the WOCN's evaluation and recommendations, and stated "May we implement her recommendations, obtain a wound culture with full set of labs to evaluate nutrition, change dressing to a wet/dry with an antimicrobial gauze from dally to three times a week...?" The order request did not include irrigation of Patient #2's wounds as recommended by the WOCN. The order request was signed by Patient #2's physician on 5/06/15.</p> <p>Patient #2's record included POCs for the certification periods 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15. Both POCs included orders to apply 4x4 antimicrobial dressings to his right hip and scrotal wounds. The orders did not specify wet/dry dressings and did not include irrigation of the wounds as recommended by the WOCN.</p> <p>A visit was made to Patient #2's home on 9/16/15 at 11:00 AM, to observe an SN visit. Patient #2 was a paraplegic who used a wheelchair for ambulation. He had a suprapubic catheter for bladder drainage, and a colostomy. He stated he cared for both independently. He lived alone in a mobile home, and had no outside assistance with housekeeping. Patient #2 stated he had a handicapped accessible van, was able to drive, and did his own grocery shopping.</p>	G 121			

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G 121	<p>Continued From page 9</p> <p>Upon arrival to the home, Patient #2 was in his wheelchair. The RN completed vital signs and asked him to lay in his bed for his wound care. Patient #2 transferred himself to his bed and rolled to his left side. His fleece pants were noted to be saturated with drainage from his wounds. A foul odor was noted.</p> <p>The RN Case Manager donned gloves and removed saturated dressings from Patient #2's right hip and coccyx. After changing gloves, he used wound cleanser and gauze to clean the wounds. The RN Case Manager was noted to apply several plain 4x4 gauze dressings to 1 wound on Patient #2's right hip. He used one plain 4x4 gauze dressing to pack the undermining of the other hip wound, then covered it with several plain 4x4 gauze dressings. He then used 1 plain 4x4 gauze dressing to pack Patient #2's scrotal wound, and covered it with several plain 4x4 gauze dressings. He covered the 3 wounds with an ABD pad. After the dressings were secured with tape, the RN Case Manager assisted Patient #2 to pull up his pants that were saturated with wound drainage. He did not offer to assist Patient #2 to change his pants. The RN Case Manager removed the dressing from Patient #2's right heel, cleansed the wound with wound cleanser and gauze, then applied a plain gauze 4x4 dressing and secured it with tape. After the dressing changes were completed, Patient #2 transferred back to his wheelchair.</p> <p>Wound care supplies were observed in Patient #2's bedroom, including plain 4x4 gauze, wound cleanser and tape. However, no antimicrobial gauze was noted.</p>	G 121			

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G 121	<p>Continued From page 10</p> <p>During an interview following the SN visit, on 9/16/15 at 12:10 PM, the RN Case Manager stated he used the antimicrobial gauze for a while, but it got too expensive so he went back to using plain gauze.</p> <p>During an interview on 9/16/15 at 3:15 PM, the RN Branch Manager provided invoices for antimicrobial gauze ordered for Patient #2. The invoices documented antimicrobial gauze was ordered for Patient #2 on 5/07/15, and 6/05/15. The RN Branch Manager confirmed no antimicrobial gauze was ordered for Patient #2 after 6/05/15. She stated the antimicrobial gauze was not available from the agency's vendor and had to be ordered from another supplier. She stated the RN Case Manager was to let her know when he needed an additional supply of the gauze. The RN Branch Manager confirmed Patient #2's wound care order was for antimicrobial gauze. Additionally, she confirmed his wounds were currently being packed and/or covered with plain gauze every Monday, Wednesday and Friday.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his wound care order for antimicrobial gauze was not being followed. He estimated he ran out of antimicrobial gauze around the middle of August, at the time of Patient #2's most recent recertification. He stated he talked to the RN Branch Manager about ordering more antimicrobial gauze, and stated it was expensive. Additionally, he stated the wound healing had stagnated and he wanted to see what would happen if he went back to plain gauze, instead of the antimicrobial gauze. The RN Case Manager confirmed he had not irrigated Patient</p>	G 121		

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G 121	<p>Continued From page 11</p> <p>#2's wounds as advised by the WOCN.</p> <p>Patient #2's SOC comprehensive assessment completed on 4/17/15, documented 2 stage III pressure ulcers and 2 stage IV pressure ulcers.</p> <p>Patient #2's record included a "Wound Record Report" dated 9/14/15, and signed by the RN Case Manager. The report documented 3 stage IV and 1 stage III pressure ulcer, indicating a decline in the status of his wounds.</p> <p>iii. The WOCN note stated "Due to the length of time that the wounds have been open, I would request a culture of the area. Depending on the results of the culture, a better decision can be made about the dressings that can be used for treatment."</p> <p>Patient #2's record included results of wound cultures from his hip and scrotal wounds. The cultures were collected on 5/08/15, 9 days after the WOCN requested the cultures. The results showed moderate growth of greater than 3 organisms. However, there was no documentation stating the results of the culture were shared with Patient #2's physician or the WOCN.</p> <p>During an interview on 9/16/15 at 2:20 PM, the RN Branch Manager confirmed the wound culture results were not sent to Patient #2's physician or the WOCN. She confirmed there was no documentation of a conversation with his physician or WOCN regarding the culture results, or implementation of new wound care orders based on the culture results.</p> <p>iv. The WOCN note stated "The decubiti</p>	G 121			

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G 121	<p>Continued From page 12</p> <p>[pressure ulcer] over the right hip is caused by pressure from sitting. The Roho [a pressure relieving cushion comprised of soft, flexible, interconnected air cells] that the patient is using is not relieving the pressure. It appears to be deflating with a small amount of pressure and the patient is bottoming out onto a metal base on the wheelchair. The Roho needs to be assessed and either replaced or repaired so that the patient does not have any further pressure causing the ulcer to be open."</p> <p>Patient #2's record did not include documentation stating his Roho cushion was repaired or replaced. Additionally, there was no documentation stating he was educated regarding the importance of pressure relief for wound healing.</p> <p>During an interview on 9/16/15 at 2:20 PM, the RN Branch Manager stated Patient #2 refused an OT visit to evaluate for a new pressure relieving cushion, and stated he was not able to pay the 10-20% co-pay necessary to purchase a new cushion. The RN Branch Manager confirmed no additional measures were implemented to obtain a new cushion or to educate Patient #2 regarding the importance of pressure relief for wound healing.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager stated a medical supply company was contacted by the agency to evaluate Patient #2 for a new Roho cushion. He confirmed Patient #2 did not receive a new cushion. Additionally, he confirmed no additional measure were taken to assist Patient #2 to obtain a new cushion, or to educate him regarding the importance of pressure relief to assist in wound</p>	G 121			

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G 121	<p>Continued From page 13 healing.</p> <p>Patient #2 was admitted to home health services on 4/17/15, for wound care to 4 pressure ulcers. He was evaluated by a wound care specialist, who was a certified WOCN. The WOCN stated the plain gauze used in his wound care placed him at risk for wound infection due to potential colonization of bacteria. She recommended changes in his wound care protocol, including antimicrobial gauze and wound irrigation, to decrease the risk of infection. Additionally, she recommended wound cultures and a new cushion for his wheelchair to decrease pressure and allow for wound healing.</p> <p>The agency obtained physician orders for antimicrobial gauze. However, failed to obtain orders to irrigate Patient #2's wounds. Approximately 3 months after Patient #2's evaluation by the wound specialist, the agency unilaterally made a decision to stop using the antimicrobial gauze. Patient #2's wounds were then packed with plain gauze, which the wound specialist identified as a risk for infection due to colonization of bacteria. The agency obtained a culture of Patient #2's wounds. However, they did not share the results with his physician or the wound specialist, to determine if additional measures were necessary to address a current infection, or the risk of infection. Additionally, the agency did not take measures to assist Patient #2 in obtaining a pressure relieving cushion for his wheelchair.</p> <p>Patient #2 was admitted to the agency with extensive, severe wounds. His initial assessment, including the status of his wounds at the time of admission, and wound care orders,</p>	G 121			

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G 121	<p>Continued From page 14</p> <p>were not clearly documented. The recommendations of the wound specialist were not implemented and/or sustained. The combination of these lapses in care placed Patient #2 in immediate jeopardy of serious harm or death due to wound infection.</p> <p>2. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential hypertension, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's record included a Wound Assessment Tool Report that included measurements of two wounds as follows:</p> <ul style="list-style-type: none"> <li>- Wound #1 was documented by the RN on 9/09/15, as a stage 1 pressure ulcer and measured 3 cm in length by 2 cm in width by 3 cm deep with undermining and serosanguineous drainage.</li> <li>- Wound #2 was documented by the RN on 9/09/15, as a surgical incision and measured 3 cm in length by 2.8 cm in width by 0.2 cm in depth with undermining and serosanguineous drainage.</li> </ul> <p>Patient #4's POC wound care orders dated, 9/12/15, stated "skilled nurse to cleanse wound with wound wash and gauze [sic] prepare periwound area with skin prep. Fill entire cavity with black VAC foam, in tunnelled/undermined areas apply black VAC foam, cover with transparent drape and apply tubing. Apply negative pressure device [wound VAC] at 125</p>	G 121			

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G 121	<p>Continued From page 15</p> <p>mm/hg continuous, dressing to be changed every Mon Wed and Fri. May use the following protocol as an alternate dressing as needed for periwound maceration/breakdown, pump failure or other complications saturated gauze cover with ABD and secure with tape. Instruct patient/caregiver on troubleshooting techniques and canister changes; instruct on signs/symptoms of wound infection."</p> <p>The website of the manufacturer of the negative pressure wound therapy (NPWT) device was accessed 9/23/15. It stated the use of a wound VAC was a therapeutic technique using a vacuum dressing to promote healing and reducing infections in chronic wounds.</p> <p>During an interview with the LPN on 9/16/15 at 2:35 PM, she stated that training in use of the NPWT device was provided by the manufacturer of the device. The NPWT manufacturer's website, accessed 9/21/15, contained cautions to avoid cross contamination of wound(s) with surfaces that may contain pathogens that inhibit wound healing or introduce infection(s) to the wound.</p> <p>The Journal of the American Medical Association website was accessed on 9/21/15. It listed complications of wound infections, including the following:</p> <ul style="list-style-type: none"> <li>- Death of surrounding tissue, including muscle, connective tissue, or bones,</li> <li>- Spread of the infection to the bloodstream, involving other organs</li> <li>- Septic shock, a critical illness involving the whole body, which may require intensive care and life support and lead to multiple organ failure or death</li> </ul>	G 121		

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G 121	<p>Continued From page 16</p> <p>An agency policy number 6.012 titled "Standards for Nursing Care and Practice (LVN/LPN), dated 6/01/06 and revised 9/01/14, was reviewed. It stated "the LPN/LVN shall implement measures to prevent exposure to infectious pathogens and communicable diseases." The policy also stated "the LPN/LVN shall collaborate with members of the health care team in the interest of the client's health care."</p> <p>Patient #4's SOG OASIS Admission note, dated 3/16/15, listed functional documentation as follows:</p> <ul style="list-style-type: none"> <li>- "Decreased Strength"</li> <li>- "Someone must assist the patient to groom self"</li> <li>- "Someone must help the patient put on upper body clothing"</li> <li>- "Someone must help patient put on undergarments, slacks, socks or nylons, and shoes"</li> <li>- "Requires presence of another person throughout the bath for assistance or supervision"</li> <li>- "Unable to get to and from the toilet"</li> <li>- "Someone must help the patient to maintain toileting hygiene and/or adjust clothing"</li> <li>- "Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations"</li> </ul> <p>Patient #4's SOG OASIS Assessment note, dated 3/16/15, included a Braden Risk Assessment (a standardized tool for predicting pressure sore risks) that was scored at 16 (at risk). Braden Risk Assessment questions responses were as follows:</p> <ul style="list-style-type: none"> <li>- "Responds to verbal commands but cannot always communicate discomfort or need to be turned, or has some sensory impairment which</li> </ul>	G 121		

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G 121	<p>Continued From page 17 . limits ability to feel pain or discomfort in 1 or 2 extremities"</p> <ul style="list-style-type: none"> <li>- "Skin is occasionally moist, requiring an extra linen change approximately once a day"</li> <li>- "Spends majority of day in bed or chair"</li> <li>- "Rarely eats a complete meal and generally eats only about 1/2 of any food offered"</li> <li>- "Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against the sheets ..."</li> </ul> <p>A visit was made to Patient #4's home on 9/16/15 beginning at 1:00 PM.</p> <p>Patient #4 lived in a small apartment with her son. She was in bed in a back bedroom with her pet dog in her bed. She appeared weak as evidenced by difficulty in turning in her bed. She used a side table and a rolling walker next to her bed to assist her to turn and exhibited facial grimacing as she moved. Patient #4 was observed using a walker to ambulate to her kitchen. She was unsteady with a shuffling gait and moved slowly. Patient #4 exhibited gaunt facial features.</p> <p>Her floor included a throw rug beside her bed . which folded under her feet as she walked. Patient #4 was unable to bend over to straighten the rug and asked the LPN to straighten it for her. She was noted to use a bedside phone to communicate with her son who was on a couch in the next room.</p> <p>There were signs of a fire in her kitchen as</p>	G 121			

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G 121	<p>Continued From page 18</p> <p>evidenced by scorch marks to her stove, walls and microwave. Patient #4 stated it had occurred a day or so before.</p> <p>The LPN was observed performing wound care on 9/16/15.</p> <p>a. The following infection control breeches were observed during the visit.</p> <p>i. Patient #4 informed the LPN the wound vac device had been leaking. Her pants, brief and disposable underpad were visibly wet where the device had lost the seal necessary to create a vacuum and wound drainage had leaked out. The LPN asked Patient #4 to stand, lower her pants and brief and return to the bed. The LPN did not remove or replace the wet disposable underpad and the patient laid down on the soiled pad, as instructed by the LPN.</p> <p>ii. The LPN instructed Patient #4 to roll on her right side, donned gloves, removed the wound dressings and discarded them. She irrigated the two wounds with normal saline and started to prepare new dressings. Patient #4 rolled on to her back and her two open wounds came into contact with the soiled disposable underpad. The LPN did not clean the wounds and area surrounding the wounds after they came in contact with the soiled disposable underpad.</p> <p>iii. The LPN donned new gloves, opened a wound VAC dressing kit and set it directly on Patient #4's bed. Part of the kit was on the bed and part was on the soiled disposable underpad. The LPN removed drape material and foam material from the kit and trimmed the items to fit the wound area. She laid the items down on the</p>	G 121			

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G 121	<p>Continued From page 19</p> <p>kit packaging with parts of the foam in contact with the patient's sheets and part in contact with the soiled disposable underpad.</p> <p>iv. The LPN removed wound prep pads from her nursing bag and laid them on the bed, contaminating the outside of the prep pad packages. She used her gloved hands to pick up the contaminated prep pad packages, contaminating her gloves. She removed the prep pads with contaminated gloves, contaminating the prep pads. She used the contaminated prep pads to wipe the area immediately surrounding each wound.</p> <p>v. The LPN asked Patient #4 if she had another disposable underpad. She replied there may be another but she was not sure. She stated they are expensive so she could not buy too many. She instructed the LPN to look around. The LPN located Patient #4's disposable underpad next to boxes on the floor and placed it on top of the soiled disposable underpad. The LPN did not remove the soiled underpad.</p> <p>vi. The LPN did not change or offer to assist Patient #4 to change her wet pants or wet brief after wound care was completed. She told Patient #4 she was finished with wound care and requested Patient #4 to accompany her to the kitchen to review medications. Patient #4 exhibited difficulty standing independently and used furniture and a rolling walker to provide assistance to stand. She exhibited facial grimacing as she stood. She extended her right hand to a side table to steady herself as she used her left hand to pull up her wet brief and wet pants. She then extended her left hand to a rolling walker to steady herself as she used her</p>	G 121			

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G 121	<p>Continued From page 20</p> <p>right hand to pull up the right side of her wet brief and wet pants.</p> <p>During an interview on 9/17/15 at 11:30 AM, the LPN confirmed she heard Patient #4 report the wound VAC device was leaking. She confirmed the disposable underpad was wet and she did not replace it prior to beginning wound care. The LPN confirmed the agency did not supply Patient #4 disposable underpads and that she used the wound care supply package, placed on the bed, as a barrier to prevent wound contamination.</p> <p>During the interview, the LPN stated she was not aware Patient #4 had laid on the soiled underpad and that her uncovered wounds came in contact with significantly contaminated surfaces. She also confirmed she was unaware she had any breaches in infection control when she prepared the new dressings or when she handled the contaminated prep pads.</p> <p>The LPN failed to practice accepted professional standards of infection control when she performed wound care on Patient #4's two chronic wounds.</p> <p>b. Patient #4's record included a physician's order dated 8/21/15 for wound care which was to be continued in the 9/12/15 to 11/10/15 certification period. The physician's order stated "continue (sic) vac changes M, W, F, dust sponge liberally with wound healing powder".</p> <p>During the home visit on 9/16/15, the LPN did not apply "wound healing powder" as was indicated in a physician's order.</p> <p>The LPN was interviewed on 9/17/15 at 11:30</p>	G 121			

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G 121	<p>Continued From page 21</p> <p>AM. She confirmed she forgot to apply the wound healing powder.</p> <p>c. During the home visit on 9/16/15 Patient #4 reported problems to the LPN, as follows:</p> <ul style="list-style-type: none"> <li>- Patient #4 reported the wound vac device had leaked and drainage from the wound soaked through clothing to the bed.</li> <li>- Patient #4 complained of pain from shingles. Her POCs, dated 7/14/15 and 9/12/15, did not include the diagnosis of shingles.</li> <li>- Patient #4 reported she was out of oxycodone (a medication for severe pain). Her POC included oxycodone-acetaminophen oral 10-325mg, 1-2 tab, every 6 hours/PRN for pain.</li> <li>- Patient #4 reported a fire had occurred in her kitchen. Her stove and microwave had burned and had not been repaired.</li> </ul> <p>During an interview on 9/17/15 at 11:30 AM, the LPN stated she had called the office after her home visit to Patient #4 on 9/16/15. She stated she reported to the DON she had forgotten to apply wound healing powder to the wound. However, she stated she did not report the wound VAC device had leaked, the patient complained of pain from shingles and the patient reported she was out of oxycodone (a pain medication). She also stated she did not report the fire in Patient #4's kitchen that indicated a significant safety issue existed.</p> <p>The LPN stated she had not documented the SN visit made on 9/16/15, but that she intended to enter an order to discontinue the oxycodone</p>	G 121		

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G 121	<p>Continued From page 22</p> <p>because Patient #4 stated she had not taken it. She stated she did not know if Patient #4 did not take the oxycodone because it did not provide relief from pain or because she was out of the medication. She stated she did not call the physician to collaborate on Patient #4's condition and POC and did not obtain physician orders to discontinue the oxycodone.</p> <p>The RN Branch Manager and the DON were present during the interview with the LPN on 9/17/15 at 11:30 AM. They confirmed the LPN did not report concerns from her 9/16/15 visit to Patient #4 as follows: leakage from the wound VAC, the report of shingles (a diagnosis not on her POCs), the report of pain from her shingles and the report of a fire in her home.</p> <p>The LPN did not collaborate with Patient #4's health care team on significant changes in her condition and significant safety events that occurred in her home.</p> <p>Patient #4 was a frail 88 year old with documented limited functional abilities, compromised nutritional intake, increasingly complicated wound care to deteriorating wounds and living in an environment with safety issues known to the agency.</p> <p>The LPN was observed providing wound care in an unsafe manner inconsistent with accepted professional standards that increased Patient #4's risk for further complications and infections.</p> <p>The LPN neglected to provide care or assistance with ADLs previously identified and documented as functional limitations. Failure to receive care and assistance increased Patient #4's risk for</p>	G 121		

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G 121	<p>Continued From page 23 further injury.</p> <p>Patient #4's healthcare team neglected to coordinate aspects of her care related to a safe living environment and her ability to receive nutritional intake therefore, she was at a higher risk for decline.</p> <p>Patient #4's frail condition, evidence of decline, environmental risks and inappropriate care provided by the agency placed Patient #4 at imminent risk for serious injury, harm, and death.</p> <p>Note: The facility was notified of the findings related to the immediate jeopardy on 9/17/15, beginning at 12:25 PM. A Plan of Correction was reviewed and accepted on 9/18/15 at 1:50 PM.</p> <p>The Plan of Correction included the following immediate actions, verified through physician orders, SN visit notes, and Infection Control course results:</p> <ul style="list-style-type: none"> <li>- The physicians of Patients #2 and #4 were notified of lapses in infection control practices on 9/17/15.</li> <li>- New wound care orders were obtained for Patient #2, and an SN visit was made on 9/17/15, to implement the new orders.</li> <li>- An SN visit was made to Patient #4 on 9/17/15.</li> <li>- The clinicians identified in the deficient practices completed an Infection Control course with at least 90% accuracy on 9/18/15.</li> <li>- The clinicians identified in the deficient practices were removed from all wound care visits, pending education by the WOCN, and observation by the DON or designee on 3 wound care visits prior to completing wound care independently.</li> </ul>	G 121			

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G 121	Continued From page 24  The Plan of Correction included the following actions to be completed by 9/25/15  - 100% of the agency's wound care patients identified, observation visit made by DON or designee on each patient to verify wound care performed as ordered, appropriate supplies used and infection control measures demonstrated.	G 121		
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 medical record review and patient and staff interview, it was determined the agency failed to ensure care coordination between disciplines for 3 of 13 patients (#1, #4, and #13) who received services from more than 1 discipline and whose records were reviewed. As a result, the quality, safety and continuity of patient care, was compromised. Findings include:  1. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential HTN, peripheral vascular disease and urinary incontinence. She received SN services.	G 143	An occurrence report will be entered for patients #1, 4, and 13 identified in the deficient practice.  100% RN, LPNs, and therapists were educated on reporting pertinent findings from patient visits to supervising RN, physician, other organizations, or other disciplines involved in care. Policy 2.1.0.17 Coordination of Care From Admit Through Discharge was utilized in outlining expectations. Coordination of care will be implemented by all disciplines providing care to ensure continuity of care from admit through discharge.  A new process will be implemented in which any change in patients condition or pertinent findings will be reported to the TL verbally with documentation to support appropriate follow-up.  Beginning 10/12/15, DON/designee will complete a record review of 3 notes per clinician per week to verify any pertinent findings or changes were reported and communicated appropriately. The review will be conducted x 8 weeks and until 100% compliance achieved x 4 consecutive weeks.  The DON is responsible for implementing the plan of correction.	10/16/15  10/16/15  10/30/15  Date of completion 10/30/15

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G 143	<p>Continued From page 25</p> <p>Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15 and 9/12/15 to 11/10/15, were reviewed.</p> <p>A visit was made to Patient #4's home on 9/16/15, beginning at 1:00 PM. The LPN was observed performing wound care using wound VAC.</p> <p>During the home visit on 9/16/15 Patient #4 reported problems to the LPN. However, the LPN did not report or collaborate with members of the health care team Patient #4's concerns as follows:</p> <ul style="list-style-type: none"> <li>- Patient #4 reported the wound VAC device had leaked and drainage from the wound soaked through clothing to the bed.</li> <li>- Patient #4 complained of pain from shingles. Her POC did not include the diagnosis of shingles.</li> <li>- Patient #4 reported she was out of Oxycodone. Her POC included Oxycodone-Acetaminophen oral 10-325mg, 1-2 tab, every 6 hours PRN for pain.</li> <li>- Patient #4 reported a fire had occurred in her kitchen. Her stove and microwave had burned and had not been repaired.</li> </ul> <p>During an interview on 9/17/15 at 11:30 AM, the LPN stated she called the office after her home visit to Patient #4 on 9/16/15. She stated she reported to the DON she forgot to apply wound healing powder to the wound. However, she stated she did not report the wound VAC device had leaked, the patient complained of pain from shingles and the patient reported she was out of</p>	G 143		

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G 143	<p>Continued From page 26</p> <p>Oxycodone. She also stated she did not report the fire in Patient #4's kitchen and that a significant safety issue existed.</p> <p>The LPN stated she had not documented the visit on 9/16/15, in the EMR. She stated she intended to enter an order to discontinue the Oxycodone. The LPN stated she did not call the physician and did not obtain physician orders to discontinue the Oxycodone.</p> <p>The RN Branch Manager and the DON were present during the interview with the LPN on 9/17/15 at 11:30 AM. They confirmed the LPN did not report concerns from her 9/16/15, visit to Patient #4 as follows: the wound VAC leaked, the report of shingles (a diagnosis not on her POC), report of pain related to shingles and the report of a fire in her home.</p> <p>The LPN did not collaborate with Patient #4's health care team on significant changes in her condition and significant safety events that occurred in her home.</p> <p>2. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC, for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>Patient #1's record included a PT visit note completed on 9/08/15, and signed by the Physical Therapist. The note stated Patient #1 was discharged from PT services on that date.</p> <p>A visit was made to Patient #1's home on 9/15/15</p>	G 143		

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G 143	<p>Continued From page 27</p> <p>at 1:00 PM, to observe an SN visit. During the visit, the RN Case Manager asked Patient #1 if he was still receiving PT services. Patient #1 stated the Physician Therapist discharged him from PT services the previous week.</p> <p>During a phone interview on 9/18/15 at 10:50 AM, the RN Case Manager confirmed the Physical Therapist did not communicate with her regarding Patient #1's discharge from PT services.</p> <p>Patient #1's discharge from PT services was not communicated to his RN Case Manager.</p> <p>3. Patient #13 was an 86 year old female admitted to the agency on 7/25/15, for SN, OT, and HHA services related to fracture of the sacrum. Additional diagnoses included rheumatoid arthritis, osteoporosis, osteoarthritis of the pelvis, and history of falls. Her record, including the POC, for the certification period 7/25/15 to 9/22/15, was reviewed.</p> <p>Patient #13's record included an OT evaluation dated 7/29/15, and signed by the Occupational Therapist. The evaluation documented Patient #13's heart rate was 110 and her pain level was 9/10. According to the Mayo Clinic website, accessed 9/22/15, a normal resting heart rate for adults was 60 to 100. Heart rates outside of this range may indicate an underlying problem.</p> <p>The Occupational Therapist documented she spoke with the HHA and RN Case Manager after the visit. She documented discussing Patient #13's POC. There was no documentation Patient #13's increased heart rate or pain level were discussed. Additionally, the visit note did not include documentation Patient #13's physician or</p>	G 143			

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G 143	Continued From page 28 Physical Therapist were notified of her increased heart rate or high pain level.	G 143			
G 144	<p>During an interview on 9/18/15 at 9:40 AM, the DON reviewed the record and confirmed Patient #13's heart rate was elevated and she reported a high pain level. She confirmed there was no documentation by the Occupational Therapist these were reported to the RN Case Manager. The DON confirmed there was no documentation the Physical Therapist and Patient #13's physician were informed of the abnormal vital signs.</p> <p>Patient #13's care and status were not communicated between disciplines.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records, it was determined the agency failed to ensure care coordination between disciplines was documented for 1 of 13 patients (Patient #7) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include:</p> <p>Patient #7 was a 70 year old male admitted to the agency on 6/15/15, for SN, PT, and OT services</p>	G 144	<p>An occurrence report will be entered for patients #1, 4, and 13 identified in the deficient practice.</p> <p>100% RN, LPNs, and therapists were educated on reporting pertinent findings from patient visits to supervising RN, physician, other organizations, or other disciplines involved in care. Policy 2.1.017 Coordination of Care From Admit Through Discharge was utilized in outlining expectations. Coordination of care will be implemented by all disciplines providing care to ensure continuity of care from admit through discharge.</p> <p>A new process will be implemented in which any change in patients condition or pertinent findings will be reported to the TL verbally with documentation to support appropriate follow-up.</p> <p>Beginning 10/12/15, DON/designee will complete a record review of 3 notes per clinician per week to verify any pertinent findings or changes to include but not limited to pain level and current pain relief measures, were reported and communicated appropriately. The review will be conducted x 8 weeks and until 100% compliance achieved x 4 consecutive weeks.</p> <p>The DON is responsible for implementing the plan of correction.</p>	10/16/15 10/16/15 10/30/15 Date of completion 10/30/15	

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G 144	<p>Continued From page 29</p> <p>related to chronic airway obstruction. Additional diagnoses included abnormal gait, HTN, chronic pain, dysphagia, coronary atherosclerosis, general muscle weakness, supplemental oxygen, history of falls, and long term medication use. His record, including the POCs, for the certification periods 6/15/15 to 8/13/15 and 8/14/15 and 10/12/15, were reviewed.</p> <p>Patient #7's record included a resumption of care assessment, dated 9/11/15, signed by the RN Team Lead. The assessment documented Patient #7 had pain which was 9 out of 10, on a 1 to 10 pain scale, and was not relieved with pain control measures. Additionally, the assessment documented the pain interfered with Patient #7's appetite.</p> <p>The RN Team Lead documented Patient #7 was encouraged to take the pain medication Tramadol as ordered. No other interventions were documented for pain relief. However, under the medication review section of the assessment the RN Team Lead documented she instructed Patient #7 about Morphine.</p> <p>The RN Team Lead documented she spoke with the RN Case Manager about Patient #7's status and his medications. There was no documentation she spoke with the Physical Therapist, Occupational Therapist, or physician regarding his high pain level and his pain medication, which was not relieving his pain.</p> <p>During an interview on 9/17/15 at 4:25 PM, the RN Team Lead reviewed the record. She confirmed she did not speak with the Occupational Therapist or Physical Therapist. The RN Team Lead stated she did speak with</p>	G 144		

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G 144	Continued From page 30 Patient #7's physician to discuss his pain level and medications. She confirmed this was not documented in the record.	G 144		
G 156	Patient #7's record did not include documentation care was coordinated with his physician. 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION Is not met as evidenced by: Based on medical record review, policy review, observations during home visits and staff and patient interview, it was determined the agency failed to ensure patient needs were met, care was provided in accordance with patients' POCs, the POCs included all pertinent information, physicians were consulted to approve POCs, the physician was notified of changes in patients' conditions, and treatments were administered as ordered by the physician. This resulted in unmet patient needs, and care provided without physician authorization. Findings include:  1. Refer to G158 as it relates to the agency's failure to ensure care was provided in accordance with POCs.  2. Refer to G159 as it relates to the agency's failure to ensure the POC included all pertinent diagnoses, types of services and equipment required.  3. Refer to G160 as it relates to the agency's failure to consult physicians to approve POCs following evaluation visits.	G 156	Refer to G158, G159, G160, G164, G165	

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G 156	Continued From page 31	G 156			
G 158	<p>4. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs.</p> <p>5. Refer to G165 as it relates to the agency's failure to ensure treatments were administered only as ordered by the physician.</p> <p>The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on observation, medical record review, and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 7 of 16 patients (#2, #4, #5, #11, #13, #14, and #15) whose records were reviewed. This resulted in omissions of care and unmet patient needs. Findings include:</p> <p>1. Patient #11 was a 67 year old female admitted to the agency on 5/27/15, for services related to CHF. Additional diagnoses included aortic valve disorder and chronic kidney disease. Her record, including the POC, for the certification periods 5/27/15 to 7/25/15, and 7/26/15 to 9/23/15, was reviewed.</p>	G 158	<p>An occurrence report will be entered for patients #2, 4, 5, 11, 13, 14, and 15 identified in this deficient practice.</p> <p>Physician notification will occur for patients #2, 4, 5, 11, 13, 14, and 15 for not following plan of care.</p> <p>Current weight will be obtained for patient #11 and physician notified.</p> <p>Patients #4, 5, 13, and 15 are no longer on service.</p> <p>100% of clinicians will be educated by the DON/Designee on the following policies and procedures:</p> <p>2.1.008 Physician Orders 2.1.007 Plan of Care</p> <p>Education will focus on obtaining orders prior to care, following physician orders on all care provided, following ordered frequency when visits scheduled, and interpretation of Plan of Care within HCHB.</p> <p>Communication will occur between RN supervisor and physician for refusal of any ordered services with documentation to support.</p> <p>The field clinician will be responsible to review current orders prior to implementation of patient visit. All wound care orders will be reviewed with TL prior to care to verify most current order.</p> <p>Beginning 10/12/15, the DON/Designee will complete a record review of 3 notes per clinician per week to verify care is provided per physician orders, care coordination occurred, and plan of care complete and accurate. The review will be conducted x 8 weeks and until 100% compliance achieved x 4 consecutive weeks.</p> <p>The DON is responsible for implementing the plan of correction.</p>	<p>10/16/15</p> <p>10/16/15</p> <p>10/16/15</p> <p>10/30/15</p> <p>Date of completion 10/30/15</p>	

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G 158	<p>Continued From page 32</p> <p>a. The National Institutes for Health website, accessed 9/22/15, included a patient education guide for congestive heart failure. It stated heart failure is a condition where the heart is not able to pump blood at a normal rate, resulting in excess fluid in the rest of the body. It stated one of the first signs of heart failure is sudden weight gain due to the accumulation of fluid.</p> <p>Patient #11's POC for the certification period 7/26/15 to 9/23/15, included an order to notify her physician for a weight greater than 285 pounds. Her weight at the start of her certification period was documented as 282.4 pounds. Patient #11 experienced a 17.6 pound weight gain over 20 days (7/26/15 - 8/15/15), as follows:</p> <ul style="list-style-type: none"> <li>- 8/12/15 289.4 pounds</li> <li>- 8/13/15 291.8 pounds</li> <li>- 8/14/15 294.4 pounds</li> <li>- 8/15/15 300 pounds</li> </ul> <p>Her record did not include documentation of physician notification of her weight gain.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed it did not state her physician was notified of her weight gain.</p> <p>The agency failed to notify Patient #11's physician of her weight gain, as ordered on the POC.</p> <p>b. Patient #11 was admitted to the agency following a hospitalization for CHF. Her record included a referral order from the discharging hospital. The order included SN visit frequency no less than daily for the first 3 days.</p>	G 158			

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G 158	<p>Continued From page 33</p> <p>Patient #11's record included a SOC comprehensive assessment completed on 5/27/15, and signed by the RN Case Manager. The next 2 SN visits were documented on 5/29/15 and 6/01/15. No SN visit was documented on 5/28/15.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed she did not receive daily visits for 3 days as ordered by the referring physician.</p> <p>c. Patient #11's record included a physician's order for SN visits 5 times a week for 1 week, effective 8/23/15. However, her record included 4 SN visits for the week of 8/23/15, dated 8/23/15, 8/24/15, 8/25/15, and 8/28/15</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed 5 SN visits were ordered, and 4 SN visits were completed during the week of 8/23/15.</p> <p>Patient #11's SN visits were not provided as ordered by her physician.</p> <p>d. Patient #11's record included a Physician Verbal Order dated 9/02/15, and signed by the RN Case Manager. The order was to obtain blood tests as ordered by a Physician Assistant. The order was signed by Patient #11's physician on 9/04/15.</p> <p>Patient #11's record included a SN visit note dated 9/02/15, and signed by the RN Case Manager. The note documented the blood tests were obtained as ordered by the Physician</p>	G 158			

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G 158	<p>Continued From page 34 Assistant.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed the order for the blood tests was obtained from a Physician Assistant. He stated he did not verify the order with Patient #11's physician, and confirmed the blood tests were obtained prior to approval by her physician.</p> <p>The agency failed to obtain a physician's order for Patient #11's blood tests.</p> <p>e. Patient #11's record included a Physician Verbal Order for a HHA to assist with personal care twice weekly, effective 8/09/15. However, the first HHA visit documented was dated 8/18/15, 9 days later. Patient #11 did not receive HHA visits during the week of 8/09/15.</p> <p>During an interview on 9/17/15 at 4:30 PM, the RN Branch Manager reviewed Patient #11's record and confirmed she did not receive HHA visits during the week of 8/09/15. She stated Patient #11 refused the visits, and confirmed there was no documentation of her refusal and her physician was not notified.</p> <p>Patient #11's HHA visits were not provided as ordered by her physician.</p> <p>2. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.</p>	G 158			

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G 158	<p>Continued From page 35</p> <p>Patient #2's record included a SOC comprehensive assessment completed on 4/17/15, signed by his RN Case Manager. The assessment noted Patient #2 had 2 Stage III pressure ulcers and 2 Stage IV pressure ulcers.</p> <p>The POC for the certification period 8/15/15 to 10/13/15, included an order for dressing changes 3 times a week. The order included 4x4 antimicrobial gauze to be applied to his hip and scrotum.</p> <p>A visit was made to Patient #2's home on 9/16/15 at 11:00 AM, to observe an SN visit. During the visit, the RN Case Manager provided wound care to 2 wounds on his hip, 1 wound on his scrotum and 1 wound on his right heel. The RN Case Manager was noted to apply plain 4x4 gauze dressings to Patient #2's 4 wounds. Wound care supplies were present in his bedroom. However, no antimicrobial gauze was noted.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his wound care order for antimicrobial gauze was not being followed. He stated he began using plain gauze instead of antimicrobial gauze at the beginning of the current certification period, 8/15/15.</p> <p>Patient #2's wound care was not provided as ordered on his POC.</p> <p>3. Patient #5 was a 60 year old male admitted to the agency on 8/14/15, for care related to diastolic heart failure. Additional diagnoses included COPD, DM type II, ulcer of his left foot, cellulitis, peripheral vascular disease,</p>	G 158		

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G 158	<p>Continued From page 36</p> <p>polyneuropathy, essential HTN, depressive disorder, and muscle weakness. He received SN, PT, OT, HHA, and NT services. His record, including the POC, for the certification period 8/14/15 to 10/12/15, was reviewed.</p> <p>Patient #5's POC included the order "SN to provide instructions related to heart failure, including but not limited to definition of heart failure, measures to prevent heart failure, and signs and symptoms of heart failure, and possible complications of heart failure. For weight gain of 3 LBS overnight or 5 LBS over one week notify MD."</p> <p>Patient #5's record included nursing notes dated 8/26/15 and 8/28/15. In the nursing note dated 8/26/15, the RN documented 175 pounds as Patient #5's weight. In the nursing note dated 8/28/15, the RN documented 182 pounds as Patient #5's weight, an increase of 7 pounds in 2 days.</p> <p>The SN visit note dated 8/28/15, included a section titled "Care Coordination." The RN documented care coordination occurred with "supervisor, patient, family caregiver, HHA and physician" and that the subject discussed was "wound care." The RN note did not state his 7 pound weight gain was reported.</p> <p>During an interview with the DON on 9/16/15, she reviewed Patient #5's nursing notes. She confirmed Patient #5's weight gain was not reported to the physician as ordered in his POC.</p> <p>The agency did not alert the physician of Patient #5's weight gain, as indicated in his POC.</p>	G 158			

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G 158	<p>Continued From page 37</p> <p>4. Patient #14 was a 75 year old female admitted to the agency on 1/19/15, for services related to hyposmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal). Additional diagnoses included HTN, diastolic heart failure and CHF. Her record, including the POC, for the certification period 1/19/15 to 3/19/15, was reviewed.</p> <p>Patient #14's record included a Physician Verbal Order, dated 3/05/15, and signed by the RN Branch Manager. The order included SN visits 2 times a week for 1 week, then 1 time a week for 2 weeks.</p> <p>Patient #14's record included an additional Physician Verbal Order also dated 3/05/15, and signed by the RN Case Manager. The order included SN visits 3 times a week for 1 week, then 4 times a week for 1 week, then 1 time a week for 1 week.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #14's record and confirmed the 2 orders conflicted and stated he did not know which order was to be followed.</p> <p>Patient #14's record included conflicting orders for SN frequency.</p> <p>5. Patient #15 was a 61 year old male admitted to the agency on 8/10/15, for services related to insulin dependent DM. Additional diagnoses included a foot ulcer, CHF and Parkinson's disease. He received SN, PT, HHA and MSW services. His record, including the POC, for the certification period 8/10/15 to 10/08/15, was reviewed.</p>	G 158			

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G 158	<p>Continued From page 38</p> <p>Patient #15's POC included an order to fill his medication planner device every visit. However, SN visit notes dated 8/10/15 and 9/01/15, did not state his medication planner was filled. Therefore, his medications were not set up for his use during week 1 and week 4 of his certification period.</p> <p>During an interview on 9/17/15 at 3:05 PM, the RN Branch Manager reviewed Patient #15's record and confirmed his medication planner was not filled as ordered on his POC.</p> <p>Patient #15's medications were not set up in a planner device as ordered on his POC.</p> <p>6. Patient #13 was an 86 year old female admitted to the agency on 7/25/15, for SN, OT, and HHA services related to fracture of the sacrum. Additional diagnoses included rheumatoid arthritis, osteoporosis, osteoarthritis of the pelvis, and history of falls. Her record, including the POC, for the certification period 7/25/15 to 9/22/15, was reviewed.</p> <p>Patient #13's record included orders for a HHA to assist with personal care twice weekly, effective 7/26/15. The HHA did not make visits the first 2 weeks of service due to Patient #13's refusal of service. There were 4 missed HHA visits documented for the first 2 weeks of the certification period. However, the physician was not notified of Patient #13's refusals for a HHA until 8/13/15, her fourth week of service.</p> <p>During an interview on 9/18/15 at 9:40 AM, the DON reviewed Patient #13's record and confirmed she did not receive HHA visits during her first two weeks of service. She stated Patient</p>	G 158			

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G 158	<p>Continued From page 39</p> <p>#13 refused the visits and her physician was notified during the second week, 7/31/15. She confirmed this was not documented in the record.</p> <p>Patient #13's HHA visits were not provided as ordered by her physician.</p> <p>7. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential HTN, PVD and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's record included a physician's order dated 8/21/15 for wound care. The physician's orders stated "continue (sic) vac changes M, W, F, dust sponge liberally with wound healing powder".</p> <p>Patient #4's record included SN notes that did not conform with the physician order dated 8/21/15, as follows:</p> <ul style="list-style-type: none"> <li>- A SN note dated 8/24/15, was completed by the RN. It did not include use of wound healing powder.</li> <li>- A SN note dated 8/26/15, was completed by the LPN. It did not include use of wound healing powder.</li> <li>- A SN note dated 9/02/15, was completed by the LPN. It did not include use of wound healing powder.</li> <li>- A SN note dated 9/04/15, was completed by the LPN. It did not include use of wound healing</li> </ul>	G 158			

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G 158	Continued From page 40 powder.  - A SN note dated 9/06/15, was completed by the RN. It did not include use of wound healing powder.  A visit was made to Patient #4's home on 9/16/15 beginning at 1:00 PM. The LPN was observed performing wound care. During the visit the LPN did not apply "wound healing powder" as was indicated in a physician's order dated 8/21/15.  The LPN was interviewed on 9/17/15 at 11:30 AM. She confirmed she forgot to apply the wound healing powder.  Patient #4's wound care was not provided as ordered on her POC.	G 158			
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.  This STANDARD is not met as evidenced by: Based on record review, observation, patient/caregiver interview, and staff interview, it was determined the agency failed to ensure POCs covered all pertinent information for 9 of 16 patients (#1, #4, #5, #6, #8, #10, #12, #13, and	G 159	An occurrence report will be entered for patients #1, 4,5,6,8,10,12,13, and 16 identified in the deficient practice. For patient #1, physician will be contacted to obtain correct dosage for sliding scale insulin and ASA. Medication list will be updated. For patient #6, physician will be contacted to obtain pulse ox parameters and plan of care updated accordingly to include utilization of equipment in home. For patient #10, physician will be notified of missed visits/altered frequency and orders obtained for CBG parameters and DM care. Plan of care will be updated to include equipment utilized in home. For patient #16, physician will be contacted for complete wound care order. Patients #4, 5,8,12, and 13 are no longer on services.  DON/designee will educate 100% of RN's and LPN's to review components of a plan of care. Policy 2.1.007 Plan of Care and 2.1.008 Physician Orders was utilized for education. The Integration Team educated all clinicians on proper documentation within HCHB according to physician orders. An identified knowledge deficit contributing to the deficient practice of exclusion of supplies/equipment utilized in the home was addressed with all field staff by the Integration Team. A demonstration of where this information is to be documented within HCHB was performed by the Integration Team.	10/16/15 10/12/15  10/16/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/18/2015
NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE STREET EAST TWIN FALLS, ID 83301	
(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 41</p> <p>#16) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include:</p> <p>1. Patient #8 was a 39 year old male admitted to the agency on 8/27/15, for SN and PT services related to pneumonia. Additional diagnoses included cellulitis and abscess of buttock, HTN, dislocated right shoulder, vertebrae fracture, PICC line, and history of falls. His record, including the POC, for the certification period 8/27/15 to 10/25/15, was reviewed.</p> <p>Patient #8's record documented he had a Jackson-Pratt (JP) drain in his right groin for drainage from a wound on his right gluteal area. The JP drain was a tube, connected to a suction bulb, which was inserted into the wound to prevent the collection of fluid.</p> <p>Patient #8's POC included orders for wound care to his right groin. The order stated the JP drain site was to be cleansed with normal saline and betadine, then covered with a transparent dressing. However, the order did not include how often the wound care was to be performed by the SN.</p> <p>The referral order, dated 8/26/15, stated the JP drain site was to be changed every 2 days. However, the SN visit orders on the POC did not follow the referral orders. The POC included orders for SN visits 1 time a week for 1 week, 2 times a week for 1 week, and 1 time every other week for 2 weeks. There was no documentation in Patient #13's record to explain why the frequency on the referral orders was not included on the POC.</p>	G 159	<p>The admitting clinician will be responsible to obtain individualized parameters for all patients with a diagnosis of DM and CHF, orders for pulse ox. Pain parameters will be included for all patients. TL will be responsible to review 100% plans of care to ensure parameters obtained, assessment reflective of physician orders, plan of care consistent with referral orders, complete orders, and equipment/supplies included.</p> <p>Beginning 10/12/15, DON/designee will audit 100% plans of care weekly to verify information on plan of care is complete and accurate. Review will be conducted weekly x 8 weeks and until 100% compliance achieved x 4 consecutive weeks.</p> <p>The DON is responsible for implementing the plan of correction.</p>	10/30/15  Date of completion 10/30/15

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G 159	<p>Continued From page 42</p> <p>During an interview on 9/17/15 at 3:40 PM, the RN Case Manager reviewed the record and confirmed the wound care order on the POC did not include how often the dressing was to be changed. He stated he believed the wound cleaning and dressing changes were to be done twice daily. The RN Case Manager stated he was unaware the referral order stated the wound care was to be done every 2 days.</p> <p>Patient #8's POC did not include all necessary information related to his care.</p> <p>2. Patient #10 was an 82 year old male admitted to the agency on 5/07/15, for SN, PT, and HHA services related to CHF. Additional diagnoses included ankle fracture, cardiomyopathies, atrial fibrillation, DM, CKD, therapeutic drug monitoring and long term use of anticoagulants, rotator cuff injury, and history of falls. His record, including the POCs, for the certification periods 5/07/15 to 7/05/15 and 9/04/15 to 11/02/15, were reviewed.</p> <p>a. Patient #10's record included a referral order, dated 5/06/15. The order stated Patient #10 was to have home health visits 3 times a week to assess vital signs and fluid overload related to his admission diagnosis of CHF. Additionally, the referral order stated SN visits were to be no less than daily for the first 3 days following admission, then 3 times a week for 2 weeks, and 2 times a week for 2 weeks.</p> <p>The POC, dated 5/07/15, ordered SN visits for 1 time the first week, 3 times a week for 1 week, 2 times a week for 2 weeks, then 1 time a week for 5 weeks. The referral orders were not followed on Patient #10's POC for SN visits. There was no documentation in the record why the referral</p>	G 159			

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G 159	<p>Continued From page 43 orders were not followed.</p> <p>During an interview on 9/17/15 at 10:40 AM, the RN Case Manager confirmed the SN visit orders on the POC. He stated he was unaware of the referral orders specifying the frequency of visits from the referring facility for assessment of vital signs and fluid overload.</p> <p>During an interview on 9/17/15 at 10:40 AM, the DON stated the referral orders were not followed because Patient #10 had went back to the hospital within the first 2 days of admission to the agency. She stated the agency had received new orders from his physician, which they had followed, after his hospital visit. The new physician orders were not received as of 9/18/15.</p> <p>Patient #10's referral orders were not followed for SN visits related to his admission diagnosis of CHF.</p> <p>b. Patient #10's record included an SOC comprehensive assessment dated 5/07/15, and signed by the RN Case Manager. The assessment documented Patient #10 was checking his blood sugar levels according to physician orders and his blood sugar levels were within "Patient Specific Parameters." There was no documentation in the assessment what Patient #10's blood sugar level was or how frequently he checked them.</p> <p>Patient #10's POCs did not include orders or interventions for checking his blood sugar levels. Additionally, there were no parameters for blood sugar levels included on his POC.</p> <p>During an interview on 9/17/15 at 10:40 AM, the</p>	G 159		

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G 159	<p>Continued From page 44</p> <p>RN Case Manager confirmed Patient #10 was checking his blood sugar levels. He confirmed there were no orders or interventions related to checking blood sugar levels or parameters for when to notify the physician on Patient #10's POC.</p> <p>Patient #10's POC did not include orders related to his DM.</p> <p>c. A visit was conducted on 9/15/15 beginning at 12:30 PM, to Patient #10's home for observation of a PT visit. While in the home it was noted Patient #10 had 2 wheelchairs. However, Patient #10's POCs did not include the wheelchairs.</p> <p>During an interview on 9/17/15 at 10:40 AM, the RN Case Manager confirmed the wheelchairs were not included on Patient #10's POCs.</p> <p>Patient #10's POCs did not include all equipment used in the home.</p> <p>3. Patient #13 was an 86 year old female admitted to the agency on 7/25/15, for SN, OT, and HHA services related to fracture of the sacrum. Additional diagnoses included rheumatoid arthritis, osteoporosis, osteoarthritis of the pelvis, and history of falls. Her record, including the POC, for the certification period 7/25/15 to 9/22/15, was reviewed.</p> <p>a. Patient #13's record included a SOC comprehensive assessment dated 7/25/15, and signed by the RN Case Manager. The assessment included a nutritional screen to identify risk factors for malnutrition. The RN Case Manager documented Patient #13 had a poor appetite and her pain decreased her</p>	G 159			

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G 159	<p>Continued From page 45</p> <p>appetite. Additionally, risk factors identified for Patient #13 included chewing or swallowing problems, eating fewer than 2 meals per day, and taking 3 or more medications.</p> <p>The nutritional screen identified Patient #13 was identified for high nutritional risk. The assessment documented as part of the plan for Patient #13's high nutritional risk the clinician was to provide nutritional education as appropriate based on the physician's or dietician's recommendations.</p> <p>Patient #13's POC did not include a referral to a dietician or interventions related to Patient #13's high risk status for malnutrition.</p> <p>During an interview on 9/18/15 at 9:40 AM, the DON reviewed the record and confirmed Patient #13 was identified as a high risk for malnutrition. She stated the agency had a Registered Dietician available for consultation and did not know why Patient #13 was not referred to the dietician.</p> <p>b. The SOC comprehensive assessment documented Patient #13 was using a rolling walker and elevated toilet seat in her home. APT evaluation, dated 8/04/15, documented the DME in Patient #13's home included a rolling walker and a tub chair. Patient #13's POC did not include an elevated toilet seat or tub chair.</p> <p>During an interview on 9/18/15 at 9:40 AM, the DON reviewed the record. She confirmed the elevated toilet seat and tub chair were not included on the POC.</p> <p>Patient #13's POC did not include all services needed or all equipment used in the home.</p>	G 159			

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G 169	<p>Continued From page 46</p> <p>4. Patient #16 was an 87 year old male admitted to the agency on 9/05/15, for SN, PT, and ST services related to Parkinson's disease. Additional diagnoses included prostate cancer, coronary atherosclerosis, cardiac pacemaker, convulsions, macular degeneration, hypothyroidism, high cholesterol, GERD, HTN, and supplemental oxygen. His record, including the POC, for the certification period 9/05/15 to 11/03/15, was reviewed.</p> <p>The "Orders" section of Patient #16's POC stated "Skilled nurse to perform/instruct/reinforce patient/caregiver procedure of wound care to left shin twice weekly." However, the SN visit frequency on the POC was 1 time a week for 5 weeks and 1 time a week every 2 weeks for 4 weeks. The POC included conflicting information. Additionally, the POC did not indicate who was to perform wound care on the days the SN did not visit.</p> <p>During an interview on 9/17/15 at 8:40 AM, the RN Case Manager reviewed the record and confirmed the wound care order on the POC was for twice weekly. He stated he was unaware wound care was to be performed twice a week.</p> <p>Patient #16's POC did not include information necessary to ensure his needs were met.</p> <p>5. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential HTN, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15 and</p>	G 169			

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G 159	<p>Continued From page 47 9/12/15 to 11/10/15, were reviewed.</p> <p>a. A review of Patient #4's record included referral documents, dated 3/13/15, sent from a rehabilitation facility to the agency. The documents included an admission record that listed herpes zoster (shingles) in her list of diagnoses.</p> <p>A review of Patient #4's POC did not include shingles on her list of pertinent diagnoses.</p> <p>A visit was made to Patient #4's home on 9/16/15 beginning at 1:00 PM. The LPN was observed performing wound care. During the home visit Patient #4 reported pain related to shingles to the LPN.</p> <p>During an interview with the LPN on 9/16/15 at 2:35 PM, after the home visit, she stated she was unaware the patient had shingles.</p> <p>During an interview with the RN Branch Manager on 9/17/2015 at 3:30 PM, she confirmed the agency had referral documentation dated 3/13/15 that included shingles as a diagnosis for Patient #4. She also stated Patient #4's POC did not include shingles on her pertinent diagnoses list.</p> <p>The agency did not ensure all pertinent diagnoses were included in the POC.</p> <p>b. A review of agency policy 2.1.011 titled "Provision of Care, Treatment and Services" dated 5/01/99 and revised 12/01/13 was reviewed. The policy stated "a score of 7 or greater on any of the pain assessment tools ... is indicative of severe pain." The policy also stated "standards indicate that once the presence of</p>	G 159		

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G 159	<p>Continued From page 48</p> <p>pain has been assessed, the appropriate intervention ordered on the Plan of Care will be initiated. If there is no appropriate intervention ordered, the clinician will notify the physician and obtain orders."</p> <p>Patient #4's POC included a physician order for SN to "monitor pain and instruct/reinforce patient [sic] regarding pharmacologic and non pharmacologic and other pain control measures". However, the POC did not include pain parameters stating what the SN was to report, including score on a pain assessment tool.</p> <p>Patient #4's visit notes documented pain rated at a 7 or above as follows:</p> <ul style="list-style-type: none"> <li>- SN visit notes dated 7/16/15, 7/18/15, 7/19/15, 7/20/15, 7/25/15, 8/19/15, 8/24/15, and 9/02/15, documented Patient #4's pain at 7. Her severe pain was not reported to her physician.</li> <li>- RN visit note dated 9/07/15, documented Patient #4's pain at 8. Her severe pain was not reported to her physician.</li> </ul> <p>During an interview with the DON on 9/16/15 at 10:45 AM, she reviewed Patient #4's medical record. She confirmed her POC did not include parameters for reporting pain and that the physician was not notified of Patient #4's severe pain. The DON stated because pain parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated severe pain.</p> <p>Patient #4's POC did not include parameters for reporting her pain.</p>	G 159			

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G 159	<p>Continued From page 49</p> <p>c. Patient #4's POC included utilization of a wound VAC device for wound care on Mondays, Wednesdays and Fridays. However, her POC did not include a wound VAC device to perform the prescribed wound care.</p> <p>During an interview with the DON on 9/16/15 at 10:45 AM, she confirmed Patient #4's POC did not include a wound care device in the equipment required on her POC.</p> <p>Patient #4's POC was not developed and updated to meet her needs.</p> <p>d. A physician verbal order dated 8/21/15 stated: "PATIENT TO CONTINUE VAC CHANGES M,W,F, DUST SPONGE LIBERALLY WITH WOUND HEALING POWDER."</p> <p>Patient #4's POC for the certification period beginning 9/12/15, did not include use of wound healing powder as stated in the physician order dated 8/21/15. The order was erroneously left off the POC for the certification period beginning 9/12/15. This was confirmed by the DON during an interview on 9/16/15 at 10:45 AM.</p> <p>Patient #4's POC for the certification period that began 9/12/15, did not include all information necessary for her care.</p> <p>6. Patient #5 was a 60 year old male admitted to the agency on 8/14/15, for care related to diastolic heart failure. Additional diagnoses included COPD, DM type II, ulcer of his left foot, cellulitis, peripheral vascular disease, polyneuropathy, essential HTN, depressive disorder and muscle weakness. He received SN, PT, OT HHA and NT services. His record,</p>	G 159			

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G 159	<p>Continued From page 50 including the POC, for the certification period 8/14/15 to 10/12/15, was reviewed.</p> <p>a. Patient #5's POC included a physician order for the SN to "monitor pain and instruct/reinforce patient [sic] regarding pharmacologic and non pharmacologic and other pain control measures". The POC did not include pain parameters that stated what the SN was to report.</p> <p>Patient #5's visit notes documented pain rated at a 7 or above as follows:</p> <ul style="list-style-type: none"> <li>- A PT visit note dated 8/18/15, documented Patient #5's pain at 7. His severe pain was not reported to his physician.</li> <li>- An SN visit note dated 8/20/15, documented Patient #5's pain at 8. His severe pain was not reported to his physician.</li> <li>- An SN visit note dated 8/26/15, documented Patient #5's pain at 8. His severe pain was not reported to his physician.</li> <li>- An SN visit note dated 9/03/15 documented Patient #5's pain at 7. His severe pain was not reported to his physician.</li> </ul> <p>During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #5's medical record. She confirmed his POC did not include parameters for reporting pain and that the physician was not called for Patient #5's severe pain. The DON stated because pain parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated severe pain. The DON stated the RN that documented the notes was no longer</p>	G 159			

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G 159	<p>Continued From page 51 employed by the agency and unavailable for interview.</p> <p>The agency did not include parameters for reporting Patient #5's pain.</p> <p>b. Patient #5's POC also included the diabetes medications Metformin 500 mg BID and Insulin Detemir subcutaneous, 5 units daily.</p> <p>The Diabetic Health Center website, accessed 9/23/15, stated target blood glucose levels for individuals with diabetes ranged from 70-100. Unmanaged elevated blood glucose levels listed complications to eyes, kidneys and nerves. In addition, it stated diabetes doubled the risk for heart disease and stroke.</p> <p>Patient #5's POC included a physician order for SN to "instruct on diabetes to include disease process, signs and symptoms of exacerbation, complications, and management, skin care/footcare, administration of insulin, and blood glucose testing." His POC did not include blood glucose parameters to report to the physician.</p> <p>A review of Patient #5's visit notes documented blood glucose levels as follows:</p> <ul style="list-style-type: none"> <li>- A SN visit note dated 8/14/15, documented Patient #5's blood glucose level was 288. His elevated blood glucose level was not reported to his physician.</li> <li>- A SN visit note dated 8/28/15, documented Patient #5's blood glucose level was 200. His elevated blood glucose level was not reported to his physician.</li> </ul>	G 159			

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G 159	<p>Continued From page 52</p> <p>During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #5's medical record. She confirmed his POC did not include parameters for reporting elevated blood glucose levels and the physician was not notified for Patient #5's elevated blood glucose levels. The DON stated because blood glucose level parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated elevated blood glucose.</p> <p>c. Patient #5's SOC assessment, dated 8/14/15 included a walker, a wheelchair and a CPAP device in the home. His POC, however, did not include a walker, a wheelchair or a CPAP device in the equipment required list.</p> <p>During an interview with the DON on 9/16/15 at 10:45 AM, she confirmed Patient #5's record did not include a walker, a wheelchair or a CPAP device in his equipment required list in his POC.</p> <p>The agency did not include a comprehensive list of equipment required in Patient #5's POC.</p> <p>7. Patient #6 was a 73 year old female admitted to the agency on 5/02/15, for care related to a pressure ulcer. Additional diagnoses included DM type II, coronary atherosclerosis, essential HTN and muscle weakness. She received SN and PT services. Her record, including the POC, for the certification period 8/30/15 to 10/28/15, was reviewed.</p> <p>a. Patient #6's POC included an order for SN "to obtain O2 sat [saturation] on room air via pulse oximeter prn with decline in respiratory status. Report the following pulse oximeter parameters to physician". However, the orders and the POC</p>	G 159			

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G 159	<p>Continued From page 54</p> <p>and oxygen in her home. Her POC dated 2/13/15, however, did not include a walker, a wheelchair, an elevated toilet seat, a hospital bed or oxygen on the equipment required list.</p> <p>The DON was interviewed on 9/16/15 at 10:45 AM. She confirmed Patient #12's record did not include a walker, a wheelchair, an elevated toilet seat, a hospital bed or oxygen on her equipment required list in his POC.</p> <p>Patient #12's POC did not include a comprehensive list of equipment she required.</p> <p>b. Patient #12's POC dated 2/13/15, was reviewed. It included an order that stated "SN to perform/instruct/reinforce patient/caregiver procedure of wound care to bilateral ankles ... apply MEDIHONEY to wund [sic] base ...". Her POC did not include MEDIHONEY on her medication list or on her DME/SUPPLIES list.</p> <p>The Dermasciences (manufacturer of MEDIHONEY) website, accessed on 9/24/15, stated MEDIHONEY is "medical grade honey offering versatility and effectiveness for managing challenging wounds and helping with removal of necrotic tissue."</p> <p>During an interview with the DON on 9/16/15 at 10:45 AM, she confirmed Patient #12's record did not include MEDIHONEY on her POC medication list or DME/SUPPLIES list. She stated she did not remember if the agency ever listed MEDIHONEY on a patient's POC. She stated she was uncertain whether to list it on the medication list or DME/SUPPLIES list.</p> <p>Patient #12's POC was not comprehensive.</p>	G 159			

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G 159	<p>Continued From page 55</p> <p>9. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC, for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>a. Patient #1's POC included Humalog insulin to be taken 3 times a day per sliding scale (dosage based on his blood glucose level as measured by a blood glucose monitor). However, his POC and medication profile, did not include the amount of insulin to be taken.</p> <p>Patient #1's record included referral information from the discharging hospital. The referral information included discharge medication orders, dated 8/29/15. The orders stated Patient #1 should start taking Aspirin 81 mg daily, 1 week after his hospital discharge (9/05/15). However, Patient #1's POC medication profile, printed on 9/14/15, did not include Aspirin.</p> <p>During an interview on 9/17/15 at 3:30 PM, the RN Branch Manager reviewed Patient #1's record and confirmed his POC and medication profile did not include the dosages for his sliding scale insulin, or the Aspirin ordered by the referring physician.</p> <p>b. Patient #1's POC documented no equipment or supplies were required for his care. However, his POC included orders to instruct him on administration of insulin and blood glucose testing.</p> <p>A visit was made to Patient #1's home on 9/15/15</p>	G 159			

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G 159	Continued From page 56 at 1:00 PM, to observe an SN visit. During the visit, a blood glucose monitor, test strips and insulin syringes were observed. Patient #1 stated he used the monitor to test his blood glucose level 2 to 3 times a day, and stated his son gave him insulin injections 2 to 3 times a day.  During an interview on 9/17/15 at 3:30 PM, the RN Branch Manager reviewed Patient #1's record and confirmed his POC did not include his blood glucose monitor, test strips and insulin syringes.  Patient #1's POC did not include all equipment and supplies used in his care.	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 2 of 16 patients (#2 and #14) whose records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include:  1. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was	G 160	An occurrence report will be entered for patients #2 and 14 identified in the deficient practice.  100% of clinicians responsible for completing initial assessments will be educated by the DON/designee utilizing the Verbal Order Process Job Aid. Each clinician will be able to verbally state correct process of obtaining approval/verbal orders prior to implementation of plan of care.  All visits made prior to obtaining physician orders will be non-billed services.  Upon completion of initial assessment or recertification, clinician will contact physician via phone to obtain orders for plan of care based on finding from assessment. Subsequent visits will not be scheduled until verbal order obtained.  Beginning 10/12/15, DON/designee will review 100% recerts/admissions resumption of care weekly to verify verbal order obtained and documented. Review will be conducted x 8 weeks and until 100% compliance x 4 consecutive weeks.  The DON is responsible for implementing the plan of correction.	10/18/15  10/16/15  10/30/15  10/30/15    Date of completion 10/30/15	

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G 160	<p>Continued From page 57 reviewed.</p> <p>Patient #2's record included a recertification comprehensive assessment for the certification period 8/15/15 to 10/13/15, completed on 8/10/15, and signed by his RN Case Manager. Patient #2's record did not include documentation of communication with his physician to obtain orders for the new certification period. A POC for the certification period was signed by his physician on 9/03/15. However, SN visits were completed on 8/17/15, 8/19/15, 8/21/15, 8/24/15, 8/26/15, 8/28/15, 8/31/15, and 9/02/15, prior to physician approval of the POC.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed there was no documentation of physician contact to obtain approval of the POC. He stated he may have called the physician's office and left a message. However, he confirmed he did not speak to Patient #2's physician regarding the POC for the new certification period.</p> <p>Patient #2's physician was not consulted to approve his POC for the new certification period.</p> <p>2. Patient #14 was a 75 year old female admitted to the agency on 1/19/15, for services related to hyposmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal). Additional diagnoses included HTN, diastolic heart failure and CHF. Her record, including the POC, for the certification period 1/19/15 to 3/19/15, was reviewed.</p> <p>Patient #14's record included a SOC comprehensive assessment completed on</p>	G 160			

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G 160	Continued From page 58 1/19/15, and signed by the RN Case Manager. The assessment documented communication with Patient #14's physician. However, it did not document the date of the contact, or physician approval of the POC. Patient #14's POC was signed by her physician on 1/30/15. However, a SN visit was provided on 1/27/15, prior to physician approval of her POC.  During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #14's record and confirmed there was no documentation of physician approval of her POC prior to 1/30/15. He stated he may have called the physician's office and left a message, but did not receive a return call to approve the POC.	G 160		
G 164	Patient #14's physician was not consulted to approve her POC. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on review of clinical records, policy review, and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 5 of 16 patients (#2, #4, #5, #11, and #13) whose records were reviewed. This resulted in missed opportunities for the physician to alter patients' POCs to meet their needs. Findings include:	G 164	An occurrence report was completed for patients #2,4,5,11, and 13 identified in the deficient practice. For patient #2, physician will be contacted to obtain blood pressure parameters and plan of care updated. For patient #11 an accurate weight will be obtained and physician notified. Patient #5 is no longer on service.  The Integration Team provided education to Team Leaders on the following: • TL daily job responsibilities • TL Workflow Tasks • TL Administrative Tasks including periodic review of plan of care  TL will follow appropriate workflow as outlined in LHC Team Leader Workflow Organization Tip Sheet. 100% plans of care will be reviewed by TL for verification of appropriate components in plan of care. TL will perform a review of 3 notes per clinician weekly to verify coordination of care occurring and orders are carried out appropriately.  Beginning 10/12/15, DON/designee will review 3 notes per clinician per week to verify coordination of care is evident and care provided according to physician orders. Review will be conducted weekly x 8 weeks and until 100% compliance achieved for 4 consecutive weeks.  The DON is responsible for implementing the plan of correction.	10/18/15  10/9/15  10/30/15  Date of completion 10/30/15

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G 164	<p>Continued From page 59</p> <p>1. Patient #13 was an 86 year old female admitted to the agency on 7/25/15, for SN, OT, and HHA services related to fracture of the sacrum. Additional diagnoses included rheumatoid arthritis, osteoporosis, osteoarthritis of the pelvis, and history of falls. Her record, including the POC, for the certification period 7/25/15 to 9/22/15, was reviewed.</p> <p>a. An SN visit note dated 8/07/15, signed by the RN Case Manager, documented Patient #13's heart rate was 110. Additionally, under the cardiovascular assessment section the RN Case Manager documented Patient #13 had "fainting/dizziness." The visit note did not include documentation of further assessment or interventions related to Patient #13's cardiovascular status.</p> <p>The RN Case Manager documented she coordinated care with the Supervisor, HHA, and OT regarding the POC. There was no documentation the RN Case Manager informed Patient #13's physician of her increased heart rate, dizziness, or fainting.</p> <p>During an interview on 9/18/15 at 9:40 AM, the DON reviewed the record and confirmed the cardiovascular assessment findings documented. She confirmed there was no documentation Patient #13's physician was notified of her changed status.</p> <p>b. Patient #13's record included an OT evaluation dated 7/29/15, and signed by the Occupational Therapist. The evaluation documented Patient #13's heart rate was 110 and her pain level was 9 out of 10. According to the</p>	G 164			

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G 164	<p>Continued From page 60</p> <p>Mayo Clinic website, accessed 9/22/15, a normal resting heart rate for adults was 60 to 100. Heart rates outside of this range may indicate an underlying problem.</p> <p>The Occupational Therapist documented she spoke with the HHA and RN Case Manager after the visit. She documented discussing Patient #13's POC. There was no documentation Patient #13's increased heart rate or pain level were discussed. Additionally, the visit note did not include documentation Patient #13's physician was notified of her increased heart rate or high pain level.</p> <p>During an interview on 9/18/15 at 9:40 AM, the DON reviewed the record and confirmed Patient #13's heart rate was elevated and she reported a high pain level. She confirmed there was no documentation by the Occupational Therapist these were reported to Patient #13's physician.</p> <p>A review of agency policy 2.1.011 titled "Provision of Care, Treatment and Services" dated 5/01/99 and revised 12/01/13 was reviewed. The policy stated "a score of 7 or greater on any of the pain assessment tools ... is indicative of severe pain." The policy also stated "standards indicate that once the presence of pain has been assessed, the appropriate intervention ordered on the Plan of Care will be initiated. If there is no appropriate intervention ordered, the clinician will notify the physician and obtain orders." This policy was not followed.</p> <p>Patient #13's physician was not informed of changes in her status.</p> <p>2. Patient #5 was a 60 year old male admitted to</p>	G 164			

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G 164	<p>Continued From page 61</p> <p>the agency on 8/14/15, for care related to diastolic heart failure. Additional diagnoses included COPD, DM type II, ulcer of his left foot, cellulitis, peripheral vascular disease, polyneuropathy, essential HTN, depressive disorder, and muscle weakness. He received SN, PT, OT, HHA, and NT services. His record, including the POC, for the certification period 8/14/15 to 10/12/15, was reviewed.</p> <p>a. Patient #5's POC included the order "SN to provide instructions related to heart failure, including but not limited to definition of heart failure, measures to prevent heart failure, and signs and symptoms of heart failure, and possible complications of heart failure. For weight gain of 3 LBS overnight or 5 LBS over one week notify MD."</p> <p>Patient #5's record included nursing notes dated 8/26/15 and 8/28/15. In the nursing note dated 8/26/15, the RN documented 176 pounds as Patient #5's weight. In the nursing note dated 8/28/15, the RN documented 182 pounds as Patient #5's weight, an increase of 7 pounds in 2 days.</p> <p>The SN visit note dated 8/28/15, included a section titled "Care Coordination." The RN documented care coordination occurred with "supervisor, patient, family caregiver, HHA and physician" and that the subject discussed was "wound care." The RN note did not state his 7 pound weight gain was reported.</p> <p>During an interview with the DON on 9/16/15, she reviewed Patient #5's nursing notes. She confirmed Patient #5's weight gain was not reported to the physician as ordered in his POC.</p>	G 164			

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G 164	<p>Continued From page 62</p> <p>The agency did not alert the physician to a change in Patient #5's condition.</p> <p>b. A review of Patient #5's POC dated 8/14/15, and signed by his physician, was made. His POC included the medications tramadol 50 mg, 1 every 6 hours/PRN for pain and neurontin 100 mg, 1 tablet daily.</p> <p>His POC included a physician order "SN to monitor pain and instruct/reinforce patient [sic] regarding pharmacologic and non pharmacologic and other pain control measures". The POC did not include pain parameters that stated what the SN was to report.</p> <p>A review of Patient #5's visit notes, pain rated at a 7 or above was documented as follows:</p> <ul style="list-style-type: none"> <li>- PT visit note dated 8/18/15 documented Patient #5's pain at 7. His severe pain was not reported to his physician</li> <li>- RN visit note dated 8/20/15 documented Patient #5's pain at 8. His severe pain was not reported to his physician</li> <li>- RN visit note dated 8/26/15 documented Patient #5's pain at 8. His severe pain was not reported to his physician.</li> <li>- RN visit note dated 9/03/15 documented Patient #5's pain at 7. His severe pain was not reported to his physician.</li> </ul> <p>During an interview with the DON on 9/16/15 at 10:45 AM, she reviewed Patient #5's medical record. The DON stated the RN that documented</p>	G 164			

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G 164	<p>Continued From page 63</p> <p>the notes was no longer employed by the agency and unavailable for interview. She confirmed his POC did not include parameters for reporting pain and that the physician was not called for Patient #5's severe pain. The DON stated that because pain parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated severe pain.</p> <p>The agency did not alert Patient #5's physician of his severe pain.</p> <p>5. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential HTN, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15 and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's POC for the certification period 7/14/15 to 9/11/15, included the medications gabapentin 300 mg 3 times daily for pain and NORCO 5-325 mg 1-2 tablets by mouth, every 6 hours/PRN for pain. Her POC for the certification period 9/12/15 to 11/10/15, included an additional pain medication, oxycodone 10-325, 1-2 tablets by mouth every 6 hours/PRN.</p> <p>Her POC included a physician order "SN to monitor pain and instruct/reinforce patient [sic] regarding pharmacologic and non pharmacologic and other pain control measures". The POC did not include pain parameters that stated what the SN was to report.</p> <p>A review of Patient #4's visit notes, pain rated at a 7 or above was documented as follows:</p>	G 164		

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NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE STREET EAST TWIN FALLS, ID 83301		
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G 164	<p>Continued From page 64</p> <p>- SN visit notes dated 7/16/15, 7/18/15, 7/19/15, 7/20/15, 7/25/15, 8/19/15, 8/24/15, and 9/02/15, documented Patient #4's pain at 7. Her severe pain was not reported to her physician.</p> <p>- An SN visit note dated 9/07/15 documented Patient #4's pain at 8. Her severe pain was not reported to her physician.</p> <p>During an interview with the DON on 9/16/15 at 10:45 AM, she reviewed Patient #4's medical record. She confirmed her POC did not include parameters for reporting pain and that the physician was not called for Patient #4's severe pain. The DON stated that because pain parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated severe pain.</p> <p>The agency did not alert Patient #4's physician of her severe pain.</p> <p>4. Patient #11 was a 67 year old female admitted to the agency on 5/27/15, for services related to CHF. Additional diagnoses included aortic valve disorder and chronic kidney disease. Her record, including the POC, for the certification period 7/26/15 to 9/23/15, was reviewed.</p> <p>The National Institutes for Health website, accessed 9/22/15, included a patient education guide for congestive heart failure. It stated heart failure is a condition where the heart is not able to pump blood at a normal rate, resulting in excess fluid in the rest of the body. It stated one of the first signs of heart failure is sudden weight gain due to the accumulation of fluid."</p>	G 164			

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G 164	<p>Continued From page 65</p> <p>Patient #11's POC for the certification period 7/26/15 to 9/23/15, included an order to notify her physician for a weight greater than 285 pounds. Her weight at the start of her certification period was documented as 282.4 pounds. Patient #11 experienced a 17.6 pound weight gain over 20 days (7/26/15 - 8/15/15), as follows:</p> <ul style="list-style-type: none"> <li>- 8/12/15 289.4 pounds</li> <li>- 8/13/15 291.8 pounds</li> <li>- 8/14/15 294.4 pounds</li> <li>- 8/15/15 300 pounds</li> </ul> <p>Her record did not include documentation of physician notification of her weight gain.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed it did not state her physician was notified of her weight gain.</p> <p>The agency failed to notify Patient #11's physician of her weight gain.</p> <p>5. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.</p> <p>Patient #2's record included a SN visit note dated 8/17/15, and signed by his RN Case Manager. The note documented a BP reading of 160/101. The American Heart Association website, accessed on 9/22/15, defines hypertension as greater than 140/90. There was no</p>	G 164			

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G 164	Continued From page 66 documentation stating Patient #2's physician was notified of his elevated BP.	G 164			
G 165	<p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his physician was not notified of his elevated BP.</p> <p>The agency failed to notify Patient #2's physician of his elevated BP.</p> <p><b>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</b></p> <p>Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the agency failed to ensure physician orders were obtained/clarified prior to the provision of wound care for 3 of 8 patients (#2, #4, and #11) who received wound care and whose records were reviewed. This resulted in wound care orders not being followed, and had the potential to negatively impact patient safety. Findings include:</p> <p>1. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.</p> <p>Patient #2's record included a SOC</p>	G 165	<p>An occurrence report was entered for patients #2, 4, and 11 identified in the deficient practice.</p> <p>100% of clinicians will be educated by the DON/designee on the following policies and procedures:</p> <ul style="list-style-type: none"> <li>* 2.1.008 Physician Orders</li> <li>* 2.1.007 Plan of Care</li> </ul> <p>Education will focus on obtaining orders prior to care, following physician orders on all care provided, following ordered frequency when visits scheduled, and interpretation of Plan of Care within HCHB. Communication will occur between RN supervisor and physician for refusal of any ordered services with documentation to support.</p> <p>The field clinician will be responsible to review current orders prior to implementation of patient visit. All wound care orders will be reviewed with TL prior to care to verify most current order.</p> <p>Beginning 10/12/15, the DON/designee will complete a record review of 8 notes per clinician per week to verify care is provided per physician orders, care coordination occurred, and plan of care complete and accurate. The review will be conducted x 8 weeks and until 100% compliance achieved x 4 consecutive weeks.</p> <p>The DON is responsible for implementing the plan of correction</p>	<p>10/16/15</p> <p>10/16/15</p> <p>10/30/15</p> <p>Date of completion 10/30/15</p>	

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G 165	<p>Continued From page 67</p> <p>comprehensive assessment completed on 4/17/15, signed by his RN Case Manager. The assessment noted Patient #2 had 2 Stage II pressure ulcers and 2 Stage III pressure ulcers.</p> <p>Patient #2's POC for the certification period 8/15/15 to 10/13/15, included an order for dressing changes 3 times a week. The order included 4x4 antimicrobial gauze to be applied to his hip and scrotum.</p> <p>A visit was made to Patient #2's home on 9/16/15 at 11:00 AM, to observe an SN visit. During the visit, the RN Case Manager provided wound care to 2 wounds on his hip, 1 wound on his scrotum and 1 wound on his right heel. The RN Case Manager was noted to apply plain 4x4 gauze dressings to Patient #2's 4 wounds. Wound care supplies were present in his bedroom. However, no antimicrobial gauze was noted.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his wound care order for antimicrobial gauze was not being followed. He stated he began using plain gauze instead of antimicrobial gauze at the beginning of the current certification period, 8/15/15.</p> <p>Patient #2's wound care was not provided as ordered by his physician.</p> <p>2. Patient #11 was a 67 year old female admitted to the agency on 5/27/15, for services related to CHF. Additional diagnoses included aortic valve disorder and chronic kidney disease. Her record, including the POC, for the certification period 7/26/15 to 9/23/15, was reviewed.</p>	G 165			

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G 165	<p>Continued From page 68</p> <p>a. Patient #11's POC for the certification period 7/26/15 to 9/23/15, included an order for care of her lower leg wounds. It stated "Wound care to bilateral lower extremities once a week. Cleanse with saline and gauze. Apply dual stage wrap, then top with Unaboot [sic] calamine wrap for moisture..." Unnaboots are compression bandage kits that can be left in place for 7 days.</p> <p>Patient #11's record included an SN visit note dated 7/31/15, and signed by the RN Case Manager. The note stated Patient #11's lower extremities were cleansed with saline, then rewrapped with dual stage wraps. The note did not document application of Unnaboot calamine wraps.</p> <p>Patient #11's record included an SN visit note dated 8/07/15, and signed by the RN Case Manager. The note stated Patient #11's lower extremities were wrapped with dual stage wraps. The note did not document application of Unnaboot calamine wraps.</p> <p>During an Interview on 8/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed Unnaboot calamine wraps were not applied as ordered by her physician. The RN Case Manager stated he did not remember seeing an order for Unnaboots.</p> <p>b. Patient #11's record included a Physician Verbal Order dated 8/11/15, and signed by the RN Branch Manager. It was signed by the physician on 8/13/15. The order stated to wrap her legs with gauze dampened with Minnesota solution (antibiotic solution), then cover with dry gauze.</p>	G 165			

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G 165	<p>Continued From page 69</p> <p>Patient #11's record included an SN visit note dated 8/21/15, and signed by the RN Case Manager. The note stated Medihoney (a medical-grade honey product for the management of wounds and burns) was applied to her lower leg wound. However, there was no physician order for Medihoney.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed Medihoney was applied without a physician's order. He stated he did not obtain an order because he did not know if it would work.</p> <p>c. Patient #11's record included a Physician Verbal Order dated 8/28/15, and signed by the RN Case Manager. The new wound order included the application of tubigrips for compression, following cleansing and wrapping of her legs. Tubigrips are compression bandages used to control edema (swelling caused by excess fluid trapped in the tissues).</p> <p>Patient #11's record included an SN visit note dated 8/30/15, and signed by an RN. The note stated her legs were cleansed and wrapped, then the dressings were secured with ace wraps. The note did not document tubigrips were applied.</p> <p>Patient #11's record included SN visit notes dated 8/31/15, 9/02/15, and 9/04/15 and signed by the RN Case Manager. The note stated her legs were cleansed and wrapped, then the dressings were secured with ace wraps. The note did not document tubigrips were applied.</p> <p>Patient #11's record included an SN visit note dated 9/07/15 and signed by the RN Case Manager. The note stated the wound care nurse</p>	G 165			

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G 165	<p>Continued From page 70</p> <p>at the wound clinic was contacted due to extensive drainage and redness of Patient #11's lower legs. The note stated the wound to her left foot had worsened due to extensive edema.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed ace wraps were applied instead of tubigrips. He stated the agency did not obtain the tubigrips, and used ace wraps in their place.</p> <p>Patient #11's wound care was not provided as ordered by her physician.</p> <p>3. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential HTN, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15 and 9/12/15 to 11/10/15, were reviewed.</p> <p>A physician verbal order dated 8/21/15 stated: "PATIENT TO CONTINUE VAC CHANGES M,W,F, DUST SPONGE LIBERALLY WITH WOUND HEALING POWDER."</p> <p>Patient #4's record included SN notes that did not conform with the physician order dated 8/21/15, as follows:</p> <ul style="list-style-type: none"> <li>- A SN note dated 8/24/15, was completed by the RN. It did not include use of wound healing powder.</li> <li>- A SN note dated 8/26/15, was completed by the LPN. It did not include use of wound healing powder.</li> </ul>	G 165			

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G 165	Continued From page 71  - A SN note dated 9/02/15, was completed by the LPN. It did not include use of wound healing powder.  - A SN note dated 9/04/15, was completed by the LPN. It did not include use of wound healing powder.  - A SN note dated 9/06/15, was completed by the RN. It did not include use of wound healing powder.  During an interview on 9/16/15 at 10:45 AM, the DON reviewed the physician order dated 8/21/15, and confirmed the order to use wound care powder in the wound care orders. She reviewed Patient #4's SN notes dated 8/24/15, 8/28/15, 9/02/15, 9/04/15 and 9/06/15 and confirmed the SN interventions did not include use of wound care powder as ordered by the physician.	G 165			
G 168	484.30 SKILLED NURSING SERVICES  This CONDITION is not met as evidenced by: Based on record review, policy review, observation, patient/caregiver interview and staff interview, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the plan of care and consistent with patients' needs, and failed to ensure patients received comprehensive assessments. This negatively impacted quality, coordination, and safety of patient care. Findings include:	G 168	Refer to G170, G173, G174, G175, G176, G177, G182		

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G 108	Continued From page 72  1. Refer to G170 as it relates to a failure of the agency to ensure skilled nursing services were furnished in accordance with the POC.  2. Refer to G173 as it relates to the failure of the agency to ensure nursing staff developed and updated POCs to meet patients' medical and nursing needs.  3. Refer to G174 as it relates to the failure of the agency to ensure a registered nurse provided specialized and substantial nursing services consistent with the agency's policies and procedures, and current standards of practice.  4. Refer to G175 as it relates to the failure of the agency to ensure a registered nurse initiated appropriate preventive and rehabilitative nursing procedures.  5. Refer to G176 as it relates to the failure of the agency to ensure nurses prepared clinical notes that accurately described the patient's condition, and informed the physician of changes in the patient's condition and needs.  6. Refer to G177 as it relates to the failure of the agency to ensure a registered nurse counseled the patient and family in meeting nursing and related needs.  7. Refer to G182 as it relates to the failure of the agency to ensure a licensed practical nurse prepared equipment and materials, and provided treatment using aseptic technique.  The cumulative effects of these negative practices seriously impeded the ability of the	G 168			

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G 168	Continued From page 73 agency to provide services of adequate quality. 484.30 SKILLED NURSING SERVICES  The HHA furnishes skilled nursing services in accordance with the plan of care.  This STANDARD is not met as evidenced by: Based on review of medical records, observation, and staff interview, it was determined the agency failed to ensure SN services were provided in accordance with POCs for 6 of 16 patients (#2, #4, #5, #11, #14, and #15) who received SN services and whose records were reviewed. This resulted in patients not receiving SN visits as ordered or care as ordered related to pressure ulcers and medications. Findings include:  1. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.  Patient #2's record included a SOC comprehensive assessment completed on 4/17/15, signed by his RN Case Manager. The assessment noted Patient #2 had 2 Stage III pressure ulcers and 2 Stage IV pressure ulcers.  The POC for the certification period 8/15/15 to 10/13/15, included an order for dressing changes 3 times a week. The order included 4x4 antimicrobial gauze to be applied to his hip and	G 168		
G 170		G 170	An occurrence report will be entered for patients #2, 4, 5, 11, 14, and 15 identified in the deficient practice.  DON/designee to educate all staff on the following policies and procedures: • 2.1.007 Plan of Care • 2.1.008 Physicians Orders • 2.1.017 Coordination of Care From Admit Through Discharge Staff instructed that orders will be reviewed prior to implementing care. All orders to be obtained prior to rendering care.  To prevent recurrence of this deficient practice, any changes in patient's condition will be verbally communicated to the TL with documentation to support appropriate follow-up. The TL will be responsible to conduct reviews of each clinician's notes to verify care is being provided per physician orders.  Beginning 10/12/15, DON/designee will complete a review of 3 clinical notes of each clinician to verify clinician provided care per physician orders and care coordination occurring. Review will be conducted x 8 weeks and until 100% compliance achieved x 4 consecutive weeks. The DON is responsible for implementing the plan of correction.	10/10/15  10/16/15  10/30/15  Date of completion 10/30/15

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G 170	<p>Continued From page 74 scrotum.</p> <p>A visit was made to Patient #2's home on 9/16/15 at 11:00 AM, to observe an SN visit. During the visit, the RN Case Manager provided wound care to 2 wounds on his hip, 1 wound on his scrotum and 1 wound on his right heel. The RN Case Manager was noted to apply plain 4x4 gauze dressings to Patient #2's 4 wounds. Wound care supplies were present in his bedroom. However, no antimicrobial gauze was noted.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his wound care order for antimicrobial gauze was not being followed. He stated he began using plain gauze instead of antimicrobial gauze at the beginning of the current certification period, 8/16/15.</p> <p>Patient #2's wound care was not provided as ordered on his POC.</p> <p>2. Patient #11 was a 67 year old female admitted to the agency on 5/27/15, for services related to CHF. Additional diagnoses included aortic valve disorder and chronic kidney disease. Her record, including the POC, for the certification period 7/26/15 to 9/23/15, was reviewed.</p> <p>a. The National Institutes for Health website, accessed 9/22/15, included a patient education guide for congestive heart failure. It stated heart failure is a condition where the heart is not able to pump blood at a normal rate, resulting in excess fluid in the rest of the body. It stated one of the first signs of heart failure is sudden weight gain due to the accumulation of fluid.</p>	G 170		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/18/2015
NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE STREET EAST TWIN FALLS, ID 83301		
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G 170	<p>Continued From page 75</p> <p>Patient #11's POC for the certification period 7/26/15 to 9/23/15, included an order to notify her physician for a weight greater than 285 pounds. Her weight at the start of her certification period was documented as 282.4 pounds. Patient #11 experienced a 17.6 pound weight gain over 20 days (7/26/15 - 8/15/15), as follows:</p> <ul style="list-style-type: none"> <li>- 8/12/15 289.4 pounds</li> <li>- 8/13/15 291.8 pounds</li> <li>- 8/14/15 294.4 pounds</li> <li>- 8/15/15 300 pounds</li> </ul> <p>Her record did not include documentation of physician notification of her weight gain.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed it did not state her physician was notified of her weight gain.</p> <p>The agency failed to notify Patient #11's physician of her weight gain as stated in her POC.</p> <p>b. Patient #11 was admitted to the agency following a hospitalization for CHF. Her record included a referral order from the discharging hospital. The order included SN visit frequency no less than daily for the first 3 days.</p> <p>Patient #11's record included a SOC comprehensive assessment completed on 5/27/15, and signed by the RN Case Manager. The next 2 SN visits were documented on 5/29/15, and 6/01/15. No SN visit was documented on 5/28/15, her second day of service.</p> <p>During an interview on 9/17/15 at 9:20 AM, the</p>	G 170			

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G 170	<p>Continued From page 76</p> <p>RN Case Manager reviewed Patient #11's record and confirmed she did not receive daily visits for 3 days as ordered by the referring physician.</p> <p>c. Patient #11's record included a physician's order for SN visits 5 times a week for 1 week, effective 8/23/15. However, her record included 4 SN visits for the week of 8/23/15, dated 8/23/15, 8/24/15, 8/25/15, and 8/28/15</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed 5 SN visits were ordered, and 4 SN visits were completed during the week of 8/23/15.</p> <p>Patient #11's SN visits were not provided as ordered by her physician.</p> <p>d. Patient #11's record included a Physician Verbal Order dated 9/02/15, and signed by the RN Case Manager. The order was to obtain blood tests as ordered by a Physician Assistant. The order was signed by Patient #11's physician on 9/04/15.</p> <p>Patient #11's record included an SN visit note dated 9/02/15, and signed by the RN Case Manager. The note documented the blood tests were obtained as ordered by the Physician Assistant.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed the order for the blood tests was obtained from a Physician Assistant. He stated he did not verify the order with Patient #11's physician, and confirmed the blood tests were obtained prior to approval by her physician.</p>	G 170			

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G 170	<p>Continued From page 77</p> <p>Patient #11's RN Case Manager completed blood tests without a Physician's order.</p> <p>e. Patient #11's POC for the certification period 7/28/15 to 9/23/15, included an order for care of her lower leg wounds. It stated " Wound care to bilateral lower extremities once a week. Cleanse with saline and gauze. Apply dual stage wrap, then top with Unaboot [sic] calamine wrap for moisture..." Unnaboots are compression bandage kits that can be left in place for 7 days.</p> <p>Patient #11's record included an SN visit note dated 7/31/15, and signed by the RN Case Manager. The note stated Patient #11's lower extremities were cleansed with saline, then rewrapped with dual stage wraps. The note did not document application of Unnaboot calamine wraps.</p> <p>Patient #11's record included an SN visit note dated 8/07/15, and signed by the RN Case Manager. The note stated Patient #11's lower extremities were wrapped with dual stage wraps. The note did not document application of Unnaboot calamine wraps.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed Unnaboot calamine wraps were not applied as ordered by her physician. The RN Case Manager stated he did not remember seeing an order for Unnaboots.</p> <p>f. Patient #11's record included a Physician Verbal Order dated 8/11/15, and signed by the RN Branch Manager. It was signed by the physician on 8/13/15. The order stated to wrap</p>	G 170			

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G 170	<p>Continued From page 78</p> <p>her legs with gauze dampened with Minnesota solution (antibiotic solution), then cover with dry gauze.</p> <p>Patient #11's record included an SN visit note dated 8/21/15, and signed by the RN Case Manager. The note stated Medihoney (a medical-grade honey product for the management of wounds and burns) was applied to her lower leg wound. However, there was no physician order for Medihoney.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed Medihoney was applied without a physician's order. He stated he didn't obtain an order because he didn't know if it would work.</p> <p>g. Patient #11's record included a Physician Verbal Order dated 8/28/15, and signed by the RN Case Manager. The new wound order included the application of tubigrips for compression, following cleansing and wrapping of her legs. Tubigrips are compression bandages used to control edema (swelling caused by excess fluid trapped in the tissues).</p> <p>Patient #11's record included SN visit notes dated 8/30/15, 8/31/15, 9/02/15, and 9/04/15 and signed by the RN Case Manager. The notes stated her legs were cleansed and wrapped, then the dressings were secured with ace wraps. The notes did not document tubigrips were applied.</p> <p>Patient #11's record included an SN visit note dated 9/07/15 and signed by the RN Case Manager. The note stated the wound care nurse at the wound clinic was contacted due to extensive drainage and redness of Patient #11's</p>	G 170			

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G 170	<p>Continued From page 79</p> <p>lower legs. The note stated the wound to her left foot had worsened due to extensive edema.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed ace wraps were applied instead of tubigrips. He stated the agency did not obtain the tubigrips, and used ace wraps in their place. The RN Case Manager confirmed Patient #11's physician was not consulted regarding the use of ace wraps instead of tubigrips.</p> <p>Patient #11's wound care was not provided as ordered by her physician.</p> <p>3. Patient #5 was a 60 year old male admitted to the agency on 8/14/15, for care related to diastolic heart failure. Additional diagnoses included COPD, DM type II, ulcer of his left foot, cellulitis, peripheral vascular disease, polyneuropathy, essential HTN, depressive disorder, and muscle weakness. He received SN, PT, OT, HHA, and NT services. His record, including the POC, for the certification period 8/14/15 to 10/12/15, was reviewed.</p> <p>Patient #5's POC included the order "SN to provide instructions related to heart failure, including but not limited to definition of heart failure, measures to prevent heart failure, and signs and symptoms of heart failure, and possible complications of heart failure. For weight gain of 3 LBS overnight or 5 LBS over one week notify MD."</p> <p>Patient #5's record included nursing notes dated 8/26/15 and 8/28/15. In the nursing note dated 8/26/15, the RN documented 175 pounds as Patient #5's weight. In the nursing note dated</p>	G 170			

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G 170	<p>Continued From page 80</p> <p>8/28/15, the RN documented 182 pounds as Patient #5's weight, an increase of 7 pounds in 2 days.</p> <p>The SN visit note dated 8/28/15, included a section titled "Care Coordination." The RN documented care coordination occurred with "supervisor, patient, family caregiver, HHA and physician" and that the subject discussed was "wound care." The RN note did not state his 7 pound weight gain was reported.</p> <p>During an interview with the DON on 9/16/15, she reviewed Patient #5's nursing notes. She confirmed Patient #5's weight gain was not reported to the physician as ordered in his POC.</p> <p>The agency did not alert the physician of Patient #5's weight gain, as indicated in his POC.</p> <p>4. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential HTN, PVD and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's record included a physician's order dated 8/21/15 for wound care. The physician's orders stated "continue (sic) vac changes M, W, F, dust sponge liberally with wound healing powder".</p> <p>Patient #4's record included SN notes that did not conform with the physician order dated 8/21/15, as follows:</p> <p>- A SN note dated 8/24/15, was completed by the</p>	G 170		

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G 170	<p>Continued From page 81</p> <p>RN. It did not include use of wound healing powder.</p> <p>- A SN note dated 8/26/15, was completed by the LPN. It did not include use of wound healing powder.</p> <p>- A SN note dated 9/02/15, was completed by the LPN. It did not include use of wound healing powder.</p> <p>- A SN note dated 9/04/15, was completed by the LPN. It did not include use of wound healing powder.</p> <p>- A SN note dated 9/06/15, was completed by the RN. It did not include use of wound healing powder.</p> <p>5. Patient #14 was a 75 year old female admitted to the agency on 1/19/15, for services related to hyposmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal). Additional diagnoses included HTN, diastolic heart failure and CHF. Her record, including the POC, for the certification period 1/19/15 to 3/19/15, was reviewed.</p> <p>Patient #14's record included a Physician Verbal Order dated 3/05/15, and signed by the RN Branch Manager. The order included SN visits 2 times a week for 1 week, then 1 time a week for 2 weeks.</p> <p>Patient #14's record included an additional Physician Verbal Order, also dated 3/05/15, and signed by the RN Case Manager. The order included SN visits 3 times a week for 1 week, then 4 times a week for 1 week, then 1 time a</p>	G 170			

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G 170	Continued From page 82 week for 1 week.  During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #14's record and confirmed the 2 orders conflicted and stated he did not know which order was to be followed.  Patient #14's record included conflicting orders for SN frequency.  6. Patient #15 was a 61 year old male admitted to the agency on 8/10/15, for services related to Insulin dependent DM. Additional diagnoses included a foot ulcer, CHF and Parkinson's disease. He received SN, PT, HHA and MSW services. His record, including the POCs, for the certification period 8/10/15 to 10/08/15, was reviewed.  Patient #15's POC included an order to fill his medication planner device every visit. However, SN visit notes dated 8/10/15, and 9/01/15, did not slate his medication planner was filled. Therefore, his medications were not set up for his use during week 1 and week 4 of his certification period.  During an interview on 9/17/15 at 3:05 PM, the RN Branch Manager reviewed Patient #15's record and confirmed his medication planner was not filled as ordered on his POC.  Patient #15's medications were not set up in a planner device as ordered on his POC.	G 170			
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse initiates the plan of care and	G 173	Occurrence report entered for patients #1, 4,5,6,8,10,13,16 identified in the deficient practice.	10/16/15	

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G 173	<p>Continued From page 83 necessary revisions.</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation, policy review, and staff interview, it was determined the agency failed to ensure patients' POCs were initiated and revised to ensure their medical and nursing needs were met, for 8 of 16 patients (#1, #4, #5, #6, #8, #10, #13, and #16), whose records were reviewed. This resulted in incomplete POCs and a lack of assessment and patient/caregiver education relevant to patient needs, and had the potential to result in negative patient outcomes. Findings include:</p> <p>1. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC, for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>Patient #1's record included referral information from the discharging hospital. The referral information stated Patient #1 was a newly diagnosed diabetic. He was admitted to the hospital on 8/25/15, with a blood glucose level of 589 mg/dl (The American Diabetes Association website, accessed 9/22/15, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl.) He was discharged from the hospital on 8/29/15, with orders for blood glucose testing and insulin administration. The discharge information stated Patient #1 required home health services for education related to DM and insulin administration.</p>	G 173	<p>For patient #16, physician will be contacted for complete wound care orders and plan of care updated to include who will perform wound care on days skilled nurse not present. For patient #6, physician will be contacted for pulse ox parameters. Patients #4, 5, 8, and 13 are no longer on service.</p> <p>100% clinicians will be educated by the DON/designee on the following: 2.1.008 Physician Orders 2.1.007 Plan of Care</p> <p>Education will focus on obtaining complete orders prior to care, following physician orders on all care provided, following ordered frequency when scheduling visits, and interpretation of plan of care within HCHB.</p> <p>All clinicians were instructed on reviewing plan of care and documentation within HCHB by Integration Team.</p> <p>The field clinician will be responsible to review current orders prior to implementation of patient visit. All wound care orders will be reviewed with TL prior to care to verify most current order. RN will obtain order for parameters on all patients with a diagnosis of DM and CHF. Patients will ordered pulse ox will have established parameters. All patients will have pain parameters. For any patient receiving wound care from caregiver, SN to document education and return demonstration with evidence of competency from caregiver.</p> <p>Beginning 10/12/15, 3 clinical notes will be reviewed per week per clinician by the DON/designee. Review will be conducted to verify care provided per physician orders and appropriate notification to physician, if applicable. Review will also determine accuracy and completeness of plan of care. Review will be conducted x 8 weeks and until compliance 100% for 4 consecutive weeks. The DON is responsible for implementing the plan of correction.</p>	<p>10/12/15</p> <p>10/16/15</p> <p>10/16/15</p> <p>10/30/15</p> <p>Date of completion 10/30/15</p>	

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G 173	<p>Continued From page 84</p> <p>Patient #1's record included a SOC comprehensive assessment completed on 9/01/15, and signed by the RN Case Manager. The assessment stated Patient #1 was at risk for rehospitalization and front loading of visits (increased visits at the beginning of his care episode) would be implemented to prevent rehospitalization.</p> <p>Patient #1's record included a POC for the certification period 9/01/15 to 10/30/15, signed by the RN Case Manager. The POC included an order for SN visits 1 time a week for 5 weeks, then every other week for 4 weeks. The order did not include front loaded SN visits.</p> <p>During an interview on 9/17/15 at 3:30 PM, the RN Branch Manager reviewed Patient #1's record and stated he required additional SN visits at the beginning of his care episode for education related to blood glucose testing and insulin administration, and to decrease his risk of rehospitalization. She confirmed his SN visits were not front loaded as indicated to meet his needs.</p> <p>Patient #1's RN Case Manager failed to initiate a POC to meet his needs related to DM education.</p> <p>2. Patient #8 was a 39 year old male admitted to the agency on 8/27/15, for SN and PT services related to pneumonia. Additional diagnoses included cellulitis and abscess of buttock, HTN, dislocated right shoulder, vertebrae fracture, PICC line, and history of falls. His record, including the POC, for the certification period 8/27/15 to 10/25/15, was reviewed.</p> <p>Patient #8's record stated he had a Jackson-Pratt</p>	G 173			

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G 173	<p>Continued From page 85</p> <p>(JP) drain in his right groin for drainage from a wound on his right gluteal (buttock) area. A JP drain is a tube, connected to a suction bulb, which was inserted into the wound to prevent the collection of fluid.</p> <p>Patient #8's POC included orders for SN visits 1 time a week for 1 week, 2 times a week for 1 week, and 1 time every other week for 2 weeks. His POC also included orders for wound care to his right groin. The order stated the JP drain site was to be cleansed with normal saline and Betadine, then covered with a transparent dressing. However, the order did not state how often the wound care was to be performed.</p> <p>Patient #8's record included a referral order for home health services, dated 8/26/15. The order stated the JP drain site dressing was to be changed every 2 days. However, his POC did not include orders for SN visits every 2 days. There was no documentation in Patient #8's stating who would complete his drain site care on the days the nurse did not make a visit. Additionally, Patient #8's record did not include documentation the SN instructed him how to clean the wound or change the dressing.</p> <p>During an interview on 9/17/15 at 3:40 PM, the RN Case Manager reviewed Patient #8's record and confirmed the wound care order on the POC did not include how often the dressing was to be changed. He stated he believed the wound cleaning and dressing changes were to be done twice daily. The RN Case Manager stated he was unaware the referral order stated the wound care was to be done every 2 days. He stated he instructed Patient #8's wife how to change clean the wound and change the dressing beginning the</p>	G 173			

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G 173	<p>Continued From page 86</p> <p>second visit. The RN Case Manager confirmed he did not consistently document teaching in the record.</p> <p>Patient #8's RN Case Manager failed to initiate a POC to meet his needs for management of his wound.</p> <p>3. Patient #10 was an 82 year old male admitted to the agency on 5/07/15, for SN, PT, and HHA services related to CHF. Additional diagnoses included ankle fracture, cardiomyopathies, atrial fibrillation, DM, CKD, therapeutic drug monitoring and long term use of anticoagulants, rotator cuff injury, and history of falls. His record, including the POCs, for the certification periods 5/07/15 to 7/06/15 and 9/04/15 to 11/02/15, was reviewed.</p> <p>a. Patient #10's record included a referral order, dated 5/06/15. The referral order stated SN visits were to be no less than daily for the first 3 days following admission, then 3 times a week for 2 weeks, and 2 times a week for 2 weeks, to assess Patient #10's vital signs and fluid overload related to his admission diagnosis of CHF.</p> <p>The POC, dated 5/07/15, ordered SN visits 1 time the first week, 3 times a week for 1 week, 2 times a week for 2 weeks, then 1 time a week for 5 weeks. The referral orders for SN visits were not followed on Patient #10's POC. There was no documentation in the record why the referral orders were not followed.</p> <p>During an interview on 9/17/15 at 10:40 AM, the RN Case Manager confirmed the SN visit orders on the POC. He stated he was unaware of the referral orders specifying the frequency of visits from the referring facility for assessment of vital</p>	G 173			

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G 173	<p>Continued From page 87 signs and fluid overload.</p> <p>During an interview on 9/17/15 at 10:40 AM, the DON stated the referral orders were not followed because Patient #10 went back to the hospital within the first 2 days of admssion to the agency. She stated the agency received new orders from his physician, which they followed, after his hospital visit. The new physician orders were not received as of the end of the survey.</p> <p>b. Patient #10's record included an SOC comprehensive assessment dated 5/07/15, and signed by the RN Case Manager. The assessment documented Patient #10 was checking his blood sugar levels according to physician orders and his blood sugar levels were within "Patient Specific Parameters." There was no documentation in the assessment what Patient #10's blood sugar level was or how frequently he checked them.</p> <p>Patient #10's POC did not include orders or interventions for checking his blood sugar levels. Additionally, there were no parameters for blood sugar levels included on his POC.</p> <p>During an interview on 9/17/15 at 10:40 AM, the RN Case Manager confirmed Patient #10 was checking his blood sugar levels. He confirmed there were no orders or interventions related to checking blood sugar levels or parameters for when to notify the physician on Patient #10's POC.</p> <p>Patient #10's RN Case Manager failed to initiate a POC which addressed his wound care needs and management of his DM.</p>	G 173			

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G 173	<p>Continued From page 88</p> <p>4. Patient #13 was an 86 year old female admitted to the agency on 7/25/15, for SN, OT, and HHA services related to fracture of the sacrum. Additional diagnoses included rheumatoid arthritis, osteoporosis, osteoarthritis of the pelvis, and history of falls. Her record, including the POC, for the certification period 7/25/15 to 9/22/15, was reviewed.</p> <p>Patient #13's record included an SOC comprehensive assessment dated 7/25/15, and signed by the RN Case Manager. The assessment included a nutritional screening to identify risk factors for malnutrition. The RN Case Manager documented Patient #13 had a poor appetite and her pain decreased her appetite. Additionally, risk factors identified for Patient #13 included chewing or swallowing problems, eating fewer than 2 meals per day, and taking 3 or more medications.</p> <p>The nutritional screen indicated Patient #13 was identified for high nutritional risk.</p> <p>The assessment documented as part of the plan for Patient #13's high nutritional risk the clinician was to provide nutritional education as appropriate based on the physician's or dietician's recommendations.</p> <p>Patient #13's POC did not include a referral to a dietician or interventions related to Patient #13's high risk status for malnutrition.</p> <p>During an interview on 9/18/15 at 9:40 AM, the DON reviewed the record and confirmed Patient #13 was identified as a high risk for malnutrition. She stated the agency had a Registered Dietician available for consultation and did not know why</p>	G 173			

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G 173	<p>Continued From page 89</p> <p>Patient #13 was not referred to the dietician.</p> <p>Patient #13's RN Case Manager failed to initiate a POC which addressed her high risk for malnutrition.</p> <p>5. Patient #16 was an 87 year old male admitted to the agency on 9/05/15, for SN, PT, and ST services related to Parkinson's disease. Additional diagnoses Included prostate cancer, coronary atherosclerosis, cardiac pacemaker, convulsions, macular degeneration, hypothyroidism, high cholesterol, GERD, HTN, and supplemental oxygen. His record, including the POC, for the certification period 9/05/15 to 11/03/15, was reviewed.</p> <p>The "Orders" section of Patient #16's POC stated "Skilled nurse to perform/instruct/reinforce patient/caregiver procedure of wound care to left shin twice weekly." However, the SN visit frequency on the POC was 1 time a week for 5 weeks and 1 time a week every 2 weeks for 4 weeks. The POC included conflicting information. Additionally, the POC did not indicate who was to perform wound care on the days the SN did not visit.</p> <p>During an interview on 9/17/15 at 8:40 AM, the RN Case Manager reviewed the record and confirmed the wound care order on the POC was for twice weekly. He stated he was unaware wound care was to be performed twice a week.</p> <p>The agency failed to ensure an RN initiated a POC for Patient #16 that clearly identified his needs and the frequency of services necessary to meet them.</p>	G 173		

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G 173	<p>Continued From page 90</p> <p>6. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential hypertension, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15 and 9/12/15 to 11/10/15, were reviewed.</p> <p>A review of agency policy 2.1.011 titled "Provision of Care, Treatment and Services" dated 5/01/99 and revised 12/01/13 was reviewed. The policy stated "a score of 7 or greater on any of the pain assessment tools ... is indicative of severe pain." The policy also stated "standards indicate that once the presence of pain has been assessed, the appropriate intervention ordered on the Plan of Care will be initiated. If there is no appropriate intervention ordered, the clinician will notify the physician and obtain orders."</p> <p>Patient #4's POCs included a physician order for SN to "monitor pain and instruct/reinforce patient [sic] regarding pharmacologic and non pharmacologic and other pain control measures". However, the POC did not include pain parameters stating what the SN was to report, including score on a pain assessment tool.</p> <p>Patient #4's visit notes documented pain rated at a 7 or above as follows:</p> <ul style="list-style-type: none"> <li>- SN visit notes dated 7/16/15, 7/18/15, 7/19/15, 7/20/15, 7/25/15, 8/19/15, 8/24/15, and 9/02/15, documented Patient #4's pain at 7. Her severe pain was not reported to her physician.</li> <li>- RN visit note dated 9/07/15, documented Patient #4's pain at 8. Her severe pain was not</li> </ul>	G 173			

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G 173	<p>Continued From page 91 reported to her physician.</p> <p>During an interview with the DON on 9/16/15 at 10:45 AM, she reviewed Patient #4's medical record. She confirmed her POC did not include parameters for reporting pain and that the physician was not notified of Patient #4's severe pain. The DON stated because pain parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated severe pain.</p> <p>Patient #4's POC did not include parameters for reporting her pain.</p> <p>7. Patient #5 was a 60 year old male admitted to the agency on 8/14/15, for care related to diastolic heart failure. Additional diagnoses included COPD, DM type II, ulcer of his left foot, cellulitis, peripheral vascular disease, polyneuropathy, essential HTN, depressive disorder and muscle weakness. He received SN, PT, OT HHA and NT services. His record, including the POC, for the certification period 8/14/15 to 10/12/15, was reviewed.</p> <p>a. Patient #5's POC included the pain medications Tramadol 50 mg, 1 every 6 hours/PRN for pain and Neurontin 100 mg, 1 tablet daily.</p> <p>Patient #5's POC included a physician order for the SN to "monitor pain and instruct/reinforce patient [sic] regarding pharmacologic and non pharmacologic and other pain control measures". The POC did not include pain parameters that stated what the SN was to report.</p> <p>Patient #5's visit notes documented pain rated at</p>	G 173		

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G 173	<p>Continued From page 92 a 7 or above as follows:</p> <ul style="list-style-type: none"> <li>- A PT visit note dated 8/18/15, documented Patient #5's pain at 7. His severe pain was not reported to his physician.</li> <li>- An SN visit note dated 8/20/15, documented Patient #5's pain at 8. His severe pain was not reported to his physician.</li> <li>- An SN visit note dated 8/26/15, documented Patient #5's pain at 8. His severe pain was not reported to his physician.</li> <li>- An SN visit note dated 9/03/15 documented Patient #5's pain at 7. His severe pain was not reported to his physician.</li> </ul> <p>During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #5's medical record. She confirmed his POC did not include parameters for reporting pain and that the physician was not called for Patient #5's severe pain. The DON stated because pain parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated severe pain. The DON stated the RN that documented the notes was no longer employed by the agency and unavailable for interview.</p> <p>-The agency did not include parameters for reporting Patient #5's pain.</p> <p>b. Patient #5's POC also included the diabetes medications Metformin 500 mg BID and Insulin Detemir subcutaneous, 5 units daily.</p> <p>The Diabetic Health Center website, accessed</p>	G 173			

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G 173	<p>Continued From page 93</p> <p>9/23/15, stated target blood glucose levels for individuals with diabetes ranged from 70-100. Unmanaged elevated blood glucose levels listed complications to eyes, kidneys and nerves. In addition, it stated diabetes doubled the risk for heart disease and stroke.</p> <p>Patient #5's POC included a physician order for SN to "Instruct on diabetes to include disease process, signs and symptoms of exacerbation, complications, and management, skin care/footcare, administration of insulin, and blood glucose testing." His POC did not include blood glucose parameters to report to the physician.</p> <p>A review of Patient #5's visit notes documented blood glucose levels as follows:</p> <ul style="list-style-type: none"> <li>- A SN visit note dated 8/14/15, documented Patient #5's blood glucose level was 288. His elevated blood glucose level was not reported to his physician.</li> <li>- A SN visit note dated 8/28/15, documented Patient #5's blood glucose level was 200. His elevated blood glucose level was not reported to his physician.</li> </ul> <p>During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #5's medical record. She confirmed his POC did not include parameters for reporting elevated blood glucose levels and the physician was not notified for Patient #5's elevated blood glucose levels. The DON stated because blood glucose level parameters were not specified on the POC, vital sign alerts did not occur when the clinician entered a value that indicated elevated blood glucose.</p>	G 173			

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G 173	Continued From page 94 8. Patient #6 was a 73 year old female admitted to the agency on 5/02/15, for care related to a pressure ulcer. Additional diagnoses included DM type II, coronary atherosclerosis, essential HTN and muscle weakness. She received SN and PT services. Her record, including the POC, for the certification period 8/30/15 to 10/28/15, was reviewed.  Patient #6's POC included an order for SN "to obtain O2 sat [saturation] on room air via pulse oximeter prn with decline in respiratory status. Report the following pulse oximeter parameters to physician". However, the orders and the POC did not include pulse oximeter parameters.  During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #6's medical record. She confirmed her POC did not include parameters for reporting pulse oximeter results and the physician had not been consulted to establish parameters. The DON stated because pulse oximeter parameters were not specified on the POC, vital sign alerts would not appear when the clinician entered a value that indicated low O2 sats.  Patient #6's POC did not include parameters for reporting pulse oximeter results.	G 173		
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse furnishes those services requiring substantial and specialized nursing skill.  This STANDARD is not met as evidenced by:	G 174	An online occurrence report was entered for patients #2,4,16 identified in the deficient practice.  100% LPNs and RNs were required to complete the Infection Control course on the LHC online education forum with a passing rate of 90% or better. Any clinician that did not complete education or pass with a minimum of 90% was removed from providing visits until further education, competency demonstrated, and additional observation visits x 3 with 100% compliance.	10/16/15  10/5/16

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G 174	<p>Continued From page 95</p> <p>Based on record review, policy review, observation, and staff interview, it was determined the agency failed to ensure specialized and substantial nursing services were provided consistent with the agency's policies and procedures and current standards of practice. These negative practices directly affected 3 of 8 patients (#2, #4 and #16), who were receiving wound care and whose records were reviewed. This resulted in the lack of appropriate nursing care for patients with wounds, and had the potential to result in patient harm. Findings include:</p> <p>1. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.</p> <p>The agency's policy 2.2.001, revised 9/01/14, titled Wound Assessment, Documentation, and Photography, stated "Upon initial visit and subsequently as indicated below, all wounds will be assessed with appropriate documentation within the medical record. Wound Location and Description ID Tools are initiated on all patients with wounds at the time of admit or upon development of a wound."</p> <p>a. Patient #2's record included an SOC comprehensive assessment completed on 4/17/15, and signed by his RN Case Manager. The assessment included a section to document pressure ulcers. It included:</p>	G 174	<p>WOCN will educate 100% of LPNs and RN on the following: wound care basics, wound care products, dressing changes, and infection control measures when performing dressing changes</p> <p>100% of wound care patients were identified in each branch and an observation visit was conducted by DON/designee to verify wound care provided per order, appropriate wound care supplies available, and utilized, and infection control measures implemented per standards of care. Any clinician identified to be deficient in practice will be removed from administering wound care until further education, competency demonstrated, and additional observation visits made x 3 with 100% compliance.</p> <p>100% of RNs and LPNs will be educated and observed on bag technique and proper hand hygiene by DON or designee.</p> <p>100% of RNs and LPNs were educated on Home Care Home Base(HCHB) supply order process by DON. Supplies available in each location will be reviewed to ensure adequacy. Ongoing, the Office Manager will be responsible to review supplies in each branch utilizing the PAR form monthly to ensure proper supply availability.</p> <p>The LHC Integration Team provided education to 100% of staff on the following:          - correct documentation of wounds within the HCHB system          - Integumentary Command Center (ICC)          - Team Leader (TL) review process to ensure consistency of documentation within assessment to subsequent visits, completeness of wound documentation, accuracy of wound documentation, and orders implemented appropriately          - care coordination among disciplines involved in patient's care and physician</p> <p>DON/designee to educate all staff on the following policies and procedures:          - 2.1.007 Plan of Care          - 2.1.008 Physicians Orders          - 2.1.017 Coordination of Care From Admit Through Discharge          - 8.004 Hand Hygiene          - 8.005 Standard Precautions</p> <p>The following process changes will be implemented to prevent recurrence of the deficient practice:          - All wound care orders will be reviewed with TL prior to care performed to verify most current order.          - Education will be provided to all clinicians on a quarterly basis on Infection Control measures for 12 months then biannually for 24 months.</p>	10/2/15 9/25/15 10/2/15 10/2/15 10/6/15 10/16/15 10/30/15

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G 174	<p>Continued From page 96</p> <p>- "CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT STAGE III: FULL THICKNESS TISSUE LOSS." The assessment stated Patient #2 had 2 Stage III pressure ulcers.</p> <p>- "CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT STAGE IV: FULL THICKNESS TISSUE LOSS WITH VISIBLE BONE, TENDON OR MUSCLE." The assessment stated Patient #2 had 2 Stage IV pressure ulcers.</p> <p>The SOC assessment stated Patient #2 had 2 Stage III and 2 Stage IV pressure ulcers. It did not include the location or a description of the pressure ulcers, but stated "SEE WOUND ASSESSMENT TOOL."</p> <p>Patient #2's record included a "Wound Assessment Tool Report" that documented wound assessments from 4/17/15 to 8/14/15, when a new wound assessment tool was implemented. The report documented 4 wounds. However, it was incomplete and/or did not match the SOC assessment, as follows:</p> <p>i. The report documented a Stage III pressure ulcer on the right hip. The entry on the SOC date 4/17/15, did not include wound assessment or measurements of the right hip wound. The first measurements were documented on 4/27/15, 10 days after his SOC.</p> <p>ii. The report documented a Stage IV pressure ulcer on the scrotum. The entry on the SOC date 4/17/15, did not include wound assessment or measurements of the scrotal wound. The first measurements were documented on 4/27/15, 10 days after his SOC.</p>	G 174	<p>All supplies will be verified upon entering home prior to initiation of visit. Clinicians will order supplies within HCHB system and will be shipped directly to patient or agency (in situations where home delivery not practical).</p> <p>All wounds will be entered in to the ICC.</p> <p>Any changes in patient's condition will be verbally communicated to the TL with documentation to support appropriate follow-up.</p> <p>TL will perform the review process of reviewing 3 clinician notes per week per clinician to ensure care performed as ordered and care coordination occurred when warranted.</p> <p>Beginning 10/12/15, DON/designee will observe 1 wound visit per clinician per week to ensure care is performed as ordered by physician and standards of care implemented. The observation visits will be conducted until 100% compliance achieved x 4 consecutive weeks.</p> <p>Beginning 10/12/15, DON/designee will complete a record review of 3 wound care notes per clinician per week to verify documentation of care provided is consistent with wound care orders and Infection Control measures documented appropriately. The review will continue x 8 weeks and until 100% compliance achieved x 4 consecutive weeks. The DON is responsible for implementing the plan of correction.</p>	10/30/15  Date of completion 10/30/15

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G 174	<p>Continued From page 97</p> <p>iii. The report documented a Stage III pressure ulcer on the coccyx. However, the first entry on the wound report for the coccyx wound was dated 5/27/15. No assessment or measurement of the wound was documented at the SOC.</p> <p>iv. The report documented a Stage II pressure ulcer on the right heel. However, the first entry on the wound report for the heel wound was dated 6/15/15. No assessment or measurement of the wound was documented at the SOC.</p> <p>The status of Patient #2's pressure ulcers at the time of his admission was unclear.</p> <p>b. Patient #2's POC, signed by his RN Case-Manager, included an order for SN visits 3 times a week for 8 weeks. Additionally, it included the following wound care orders "Three times weekly on [sic] hip and scrotum and weekly on heel and coccyx and weekly right lower heel and coccyx may apply skin prep or barrier cream to peri-wound prn. Apply doroderm [sic] dressing/foam hydrofiber and secure with tape and or tegaderm. Apply 4x4 saturated with solution to the coccyx and scrotum teh [sic] cover with abd [large gauze pad] and secure in place with tape."</p> <p>The order did not specify the type of solution to be used to saturate the 4x4 dressings. Additionally, the wound care order for the coccyx wound was not clear. The order stated to apply Duoderm (an occlusive dressing) to the coccyx, and also stated to apply 4x4 saturated with solution, cover with a gauze pad and secure in place with tape.</p>	G 174		

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G 174	<p>Continued From page 98</p> <p>c. Patient #2's record included a note dated 4/29/15, and signed by a WOCN (Wound and Ostomy Care Nurse). The note stated the WOCN evaluated Patient #2. Her findings and recommendations included the following:</p> <p>i. The WOCN note stated "The orders are for Acetic acid and gauze to be changed daily. Since the agency cannot go out daily to change the dressings, and the patient does not have any able willing caregiver and is unable to change the dressing himself the dressings are only changed 3 times a week. This is a problem with the existing orders as gauze needs to be changed daily or it will colonize with bacteria. A better choice of treatment if the physician is insisting on gauze is to use AMD gauze which is treated with an antimicrobial agent and can be left on for up to 72 hours...If the physician is agreeable to changing the wound care orders, depending on the culture you can pack the wound with either an alginate or a silver alginate (if infected) and cover with a foam."</p> <p>ii. The WOCN note stated "A more thorough cleaning of the wound needs to be done. The scrotal ulcer has lots of wrinkles and crevices where bacteria can hide. Suggest using a syringe and aggressively irrigating the area with the dressing changes.</p> <p>Patient #2's record included a physician order request dated 5/06/15, and signed by the RN Branch Manager. The request included the WOCN's evaluation and recommendations, and stated "May we implement her recommendations, obtain a wound culture with full set of labs to evaluate nutrition, change dressing to a wet/dry with an antimicrobial gauze from daily to three</p>	G 174		

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G 174	<p>Continued From page 99</p> <p>times a week...?" The request did not include irrigation of Patient #2's wounds as recommended by the WOCN. The order request was signed by Patient #2's physician on 5/06/15.</p> <p>Patient #2's record included POCs for the certification periods 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15. Both POCs included orders to apply 4x4 antimicrobial dressings to his hip and scrotal wounds. The orders did not specify wet/dry dressings and did not include irrigation of the wounds as recommended by the WOCN.</p> <p>A visit was made to Patient #2's home on 9/16/15 at 11:00 AM, to observe an SN visit. During the visit, the RN Case Manager provided wound care to 2 wounds on his hip, 1 wound on his scrotum and 1 wound on his right heel. The RN Case Manager was noted to apply plain 4x4 gauze dressings to Patient #2's 4 wounds. Wound care supplies were present in his bedroom. However, no antimicrobial gauze was noted.</p> <p>During an interview following the SN visit, on 9/16/15 at 12:10 PM, the RN Case Manager stated he used the antimicrobial gauze for a while, but it got too expensive so he went back to using plain gauze.</p> <p>During an interview on 9/16/15 at 3:15 PM, the RN Branch Manager confirmed Patient #2's wound care order was for antimicrobial gauze. Additionally, she confirmed his wounds were currently being packed and/or covered with plain gauze 3 times a week.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his wound care order for</p>	G 174			

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G 174	<p>Continued From page 100 antimicrobial gauze was not being followed.</p> <p>Patient #2's SOC comprehensive assessment completed on 4/17/15, documented 2 stage III pressure ulcers and 2 stage IV pressure ulcers.</p> <p>Patient #2's record included a "Wound Record Report" dated 9/14/15, and signed by the RN Case Manager. The report documented 3 stage IV and 1 stage III pressure ulcer, indicating a decline in the status of his wounds.</p> <p>Patient #2 was admitted to home health services on 4/17/15, for wound care to 4 pressure ulcers. He was evaluated by a wound care specialist, who stated the plain gauze used in his wound care placed him at risk for wound infection due to potential colonization of bacteria. She recommended changes in his wound care protocol, including antimicrobial gauze and wound irrigation, to decrease the risk of infection.</p> <p>The agency obtained physician orders for antimicrobial gauze. However, they failed to obtain orders to irrigate his wounds. Approximately 3 months after Patient #2's evaluation by the wound specialist, the agency stopped using the antimicrobial gauze. Patient #2's wounds were then packed with plain gauze, which the wound specialist identified as a risk for infection due to colonization of bacteria.</p> <p>The agency failed to ensure Patient #2's wound care was provided as ordered, within acceptable practice standards and per agency policies.</p> <p>2. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included</p>	G 174		

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G 174	<p>Continued From page 101</p> <p>essential HTN, PVD and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's record included a Wound Assessment Tool Report that included measurements of two wounds, as follows:</p> <ul style="list-style-type: none"> <li>- Wound #1 was documented by the RN on 9/09/15, as a stage 1 pressure ulcer and measured 3 cm in length by 2 cm in width by 3 cm deep with undermining and serosanguineous drainage.</li> <li>- Wound #2 was documented by the RN on 9/09/15, as a surgical incision and measured 3 cm in length by 2.8 cm in width by 0.2 cm in depth with undermining and serosanguineous drainage.</li> </ul> <p>Patient #4's POC for the certification period 9/12/15 to 11/10/15, stated "skilled nurse to cleanse wound with wound wash and gauze [sic] prepare periwound area with skin prep. Fill entire cavity with black VAC foam, in tunnelled/undermined areas apply black VAC foam, cover with transparent drape and apply tubing. Apply negative pressure device [wound VAC] at 125 mm/hg continuous, dressing to be changed every Mon Wed and Fri. May use the following protocol as an alternate dressing as needed for periwound maceration/breakdown, pump failure or other complications saturated gauze cover with ABD and secure with tape. Instruct patient/caregiver on troubleshooting techniques and canister changes; instruct on signs/symptoms of wound infection."</p> <p>The NPWT device manufacturer's website was</p>	G 174			

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G 174	<p>Continued From page 102</p> <p>accessed 9/23/15. It stated wound VAC therapy was a therapeutic technique using a vacuum dressing to promote healing and reduce infections in chronic wounds.</p> <p>In an interview with the LPN on 9/16/15 at 2:35 PM, she stated that training in use of NPWT was provided by the manufacturer of the device. The manufacturer's website, accessed 9/21/15, contained cautions to avoid cross contamination of wound(s) with surfaces that may contain pathogens that inhibit wound healing.</p> <p>The Journal of American Medical Association website was accessed on 9/21/15. It listed complications of wound infections, including the following:</p> <ul style="list-style-type: none"> <li>- Death of surrounding tissue, including muscle, connective tissue, or bones,</li> <li>- Spread of the infection to the bloodstream, involving other organs</li> <li>- Septic shock, a critical illness involving the whole body, which may require intensive care and life support and lead to multiple organ failure or death</li> </ul> <p>An agency policy number 6.012 titled "Standards for Nursing Care and Practice (LVN/LPN), dated 6/01/06 and revised 9/01/14, was reviewed. It stated "the LPN/LVN shall implement measures to prevent exposure to infectious pathogens and communicable diseases." The policy also stated "the LPN/LVN shall collaborate with members of the health care team in the interest of the client's health care."</p> <p>A visit was made to Patient #4's home on 9/16/15 beginning at 1:00 PM. The LPN was observed performing wound care.</p>	G 174			

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G 174	Continued From page 103  a. The following infection control breeches were observed during the visit.  i. Upon arrival to her home, Patient #4 was laying in bed. She informed the LPN the wound VAC device had been leaking. Her pants, brief and the disposable underpad on her bed were visibly wet where the device had lost the seal necessary to create a vacuum and wound drainage had leaked out. The LPN asked patient #4 to stand, lower her pants and brief and return to the bed. The LPN did not remove or replace the wet disposable underpad and the patient laid down on the soiled pad, as instructed by the LPN.  ii. The LPN instructed Patient #4 to roll on her right side, donned gloves, removed the wound dressings and discarded them. She irrigated the two wounds with normal saline and started to prepare new dressings. Patient #4 rolled on to her back and her two open wounds came into contact with the soiled disposable underpad. The LPN did not clean the wounds and area surrounding the wounds after they came in contact with the soiled disposable underpad.  iii. The LPN donned new gloves, opened a wound VAC dressing kit and set it directly on Patient #4's bed. Part of the kit was on the bed and part was on the soiled disposable underpad. The LPN removed drape material and foam material from the kit and trimmed the items to fit the wound area. She laid the items down on the kit packaging with parts of the foam in contact with the patient's sheets and part in contact with the soiled disposable underpad.  iv. The LPN removed wound prep pads from her	G 174			

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G 174	<p>Continued From page 104</p> <p>nursing bag and laid them on the bed contaminating the outside of the prep pad packages. She used her gloved hands to pick up the contaminated prep pad packages, contaminating her gloves. She removed the prep pads with contaminated gloves, contaminating the prep pads. She used the contaminated prep pads to wipe the area immediately surrounding each wound.</p> <p>v. The LPN asked Patient #4 if she had another disposable underpad. She replied there may be another but she wasn't sure. She stated they were expensive so she could not buy too many. She instructed the LPN to look around. The LPN located Patient #4's disposable underpad on the floor and placed it on top of the soiled disposable underpad on the bed. The LPN did not remove the soiled underpad.</p> <p>In an interview on 9/17/15 at 11:30 AM, the LPN confirmed she heard Patient #4 report the wound VAC device was leaking. She confirmed the disposable underpad was wet and she did not replace it prior to beginning wound care. The LPN confirmed the agency did not supply Patient #4 disposable underpads and that she used the wound care supply package, placed on the bed, as a barrier to prevent wound contamination.</p> <p>In the interview, the LPN stated she was not aware Patient #4 had laid on the soiled underpad and that her uncovered wounds came in contact with significantly contaminated surfaces. She also confirmed she was unaware she had any breaches in infection control when she prepared the new dressings or when she handled the contaminated prep pads.</p>	G 174			

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G 174	<p>Continued From page 105</p> <p>b. Patient #4's record included a physician's order dated 8/21/15 for wound care. The physician's orders stated "continue (sic) vac changes M, W, F, dust sponge liberally with wound healing powder".</p> <p>During the home visit on 9/16/15, the LPN did not apply "wound healing powder" as was indicated in a physician's order dated 8/27/15.</p> <p>The LPN was interviewed on 9/17/15 at 11:30 AM. She confirmed she forgot to apply the wound healing powder.</p> <p>An RN did not provide Patient #4's wound care and an RN did not ensure Patient #4's wound care was provided, as ordered, within acceptable practice standards for infection control.</p> <p>3. Patient #16 was an 87 year old male admitted to the agency on 9/05/15, for SN, PT, and ST services related to Parkinson's disease. Additional diagnoses included prostate cancer, coronary atherosclerosis, cardiac pacemaker, convulsions, macular degeneration, hypothyroidism, high cholesterol, GERD, HTN, and supplemental oxygen. His record, including the POC, for the certification period 9/05/15 to 11/03/15, was reviewed.</p> <p>Patient #16's record included an SOC comprehensive assessment, dated 9/05/15, and signed by the RN Case Manager. The assessment included documentation Patient #16 had bruising and wounds.</p> <p>A separate wound assessment form documented a third degree burn to Patient #16's left shin. There was no documentation of wound</p>	G 174		

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G 174	Continued From page 106 measurements or a description of the wound on the wound assessment form. The wound assessment documented the wound was not assessed and wound care was not provided because it was covered by a dressing. However, Patient #16's POC included an order for wound care to be performed twice weekly to the left shin.  During an interview on 9/17/15 at 8:40 AM, the RN Case Manager reviewed the record and confirmed he did not perform wound care at the SOC assessment visit. He stated he believed the wound dressing did not need to be changed since it had been done by the discharging facility 1 to 2 days prior. The RN Case Manager stated he did not bring wound supplies with him to the visit.	G 174			
G 176	The agency failed to ensure Patient #16 received appropriate care for his wound as ordered. <b>484.30(a) DUTIES OF THE REGISTERED NURSE</b>  The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.  This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure the RN prepared clinical notes that accurately described the patient's condition, and informed the physician of changes in the patient's condition and needs for 6 of 16 patients (#1, #2, #4, #11, #13, and #15) who received SN services and whose records were reviewed. This had the potential to result in unmet patient needs and	G 176	An online occurrence report was completed for patients #1, 2, 4, 11, 13, 15 identified in the deficient practice.  All clinical staff were educated by the Integration Team on the following: correct documentation of wounds within HCHB Integumentary Command Center documentation of clinical visit within HCHB to include medication administration, PICC assessment/care TL review process to ensure consistency of documentation within assessment to subsequent visits, completeness of wound documentation, accuracy of wound documentation, and orders implemented appropriately care coordination among disciplines involved in patient's care and physician  DON/designee to educate all staff on the following: 2.1.007 Plan of Care 2.1.008 Physicians Orders 2.1.017 Coordination of Care From Admit Through Discharge DON to reinforce prohibition of utilizing copy and paste feature to document education.	10/16/16 10/16/15 10/16/15	



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NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE STREET EAST TWIN FALLS, ID 83301		
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G 176	<p>Continued From page 108</p> <p>b. Patient #15's record included a Physician Verbal Order dated 8/19/15, for SN visits to administer an IV antibiotic through a PICC line, daily for 5 days.</p> <p>i. SN visit notes dated 8/19/15, and 8/20/15, documented administration of the antibiotic through Patient #15's PICC line. However, SN visit notes dated 8/20/15, 8/21/15, and 8/22/15 did not document administration of the IV antibiotic.</p> <p>ii. SN visit notes dated 8/19/15, 8/20/15, 8/20/15, 8/21/15, and 8/22/15, did not include documentation of an assessment of Patient #15's PICC line, including placement, patency or signs of infection.</p> <p>During an interview on 9/17/15 at 3:05 PM, the RN Branch Manager reviewed Patient #15's record. She stated the IV medication was administered as ordered. However, she confirmed 3 SN visit notes did not document the administration of the IV antibiotic. Additionally, she confirmed Patient #15's record did not include documentation of PICC line assessment during the 5 days he was receiving IV antibiotics.</p> <p>Patient #15's SN visit notes were not complete to include all pertinent information regarding his status and services received.</p> <p>c. Patient #15's record included an SOC comprehensive assessment dated 8/10/15, and signed by the RN Case Manager. The assessment included a section to document interventions provided during the visit. The interventions provided included patient/caregiver</p>	G 176			

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G 176	<p>Continued From page 109</p> <p>education on one of his medications, Bumetanide (a potent diuretic used to eliminate excess fluid from the body). The education provided to Patient #15 on Bumetanide, documented in the EMR by the RN was extensive, and filled almost one page of the electronic visit note. Parts of documented education provided to Patient #15 were not relevant, including the following:</p> <ul style="list-style-type: none"> <li>- Patient #15's POC included Bumetanide 2 mg, 1/2 to 1 tablet, 2 times a day. The documented education included "Take this medication by mouth as directed by your doctor, usually once or twice daily." It did not state Patient #15 was educated regarding his dosage, including how to determine whether to take 1/2 or .1 tablet.</li> <li>- Patient #15 lived in Idaho. The documented education stated "In Canada...you may report side effects to health Canada."</li> <li>- Patient #15 was a 61 year old male. The documented education included information related to pregnancy and breast feeding.</li> </ul> <p>SN visit notes completed on 8/21/15, 8/23/15, 8/22/15, 8/27/15, 9/01/15, and 9/10/15, and signed by the RN Case Manager, each included documentation of patient education on one of Patient #15's medications. Each note included the extensive information described above, and included information that was not relevant to Patient #15.</p> <p>During an interview on 9/17/15 at 3:05 PM, the RN Branch Manager reviewed the record and confirmed the documented medication education was not appropriate, and included information that was not relevant to Patient #15. She stated</p>	G 176			

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G 176	<p>Continued From page 110</p> <p>the RN Case Manager did not provide education on all the material documented, and confirmed it was not possible to determine what education was provided to Patient #15.</p> <p>Patient #15's SN visit notes did not clearly document patient education related to medications.</p> <p>2. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential hypertension, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's record included a Wound Assessment Tool Report that included measurements of two wounds as follows:</p> <ul style="list-style-type: none"> <li>- Wound #1 was documented by the RN on 9/09/15, as a stage 1 pressure ulcer and measured 3 cm in length by 2 cm in width by 3 cm deep with undermining and serosanguineous drainage.</li> <li>- Wound #2 was documented by the RN on 9/09/15, as a surgical incision and measured 3 cm in length by 2.8 cm in width by 0.2 cm in depth with undermining and serosanguineous drainage.</li> </ul> <p>Patient #4's medical record was reviewed. It included an order for wound care utilizing a wound VAC device effective 8/07/15.</p> <p>The NPWT device manufacturer's website was accessed 9/23/15. It stated the use of a wound</p>	G 176			

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G 176	<p>Continued From page 111</p> <p>VAC was a therapeutic technique using a vacuum dressing to promote healing and reduce infections in chronic wounds. It also stated the foam used in the wound VAC therapy must be replaced with each dressing change to reduce potential for wound infection.</p> <p>The Journal of American Medical Association website was accessed on 9/21/15. It listed complications of wound infections, including the following:</p> <ul style="list-style-type: none"> <li>- Death of surrounding tissue, including muscle, connective tissue, or bones,</li> <li>- Spread of the infection to the bloodstream, involving other organs</li> <li>- Septic shock, a critical illness involving the whole body, which may require intensive care and life support and lead to multiple organ failure or death</li> </ul> <p>An agency policy number 2.2.007 titled "Patient Care treatment and Services revised 9/01/14, was reviewed. It stated "the clinician will document the number of foam/sponge pieces placed in the wound bed and the number of foam/sponge pieces removed from the wound."</p> <p>a. Patient #4's SN visit notes were reviewed for the period 8/07/15 to 9/09/15. The SN notes did not include documentation of the number of foam/sponge pieces placed in the wound or removed from the wound, on the following dates:</p> <p>8/07/15 8/10/15 8/12/15 8/14/15 8/17/15 8/19/15</p>	G 176			

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G 176	<p>Continued From page 112</p> <p>8/24/15 8/25/15 8/26/15 8/28/15 8/31/15 9/02/15 9/04/15 9/06/15 9/07/15 9/09/15</p> <p>The DON was interviewed on 9/16/15 at 10:45. She reviewed Patient #4's medical record and confirmed it did not include accurate and complete wound care documentation.</p> <p>The agency did not ensure SN clinical notes were accurate and complete.</p> <p>b. Patient #4's record contained a Wound Assessment Tool Report. It consistently stated her wound #1 was a Stage 1 pressure ulcer, however it was consistently described as open, with undermining, tunnelling with serosanguineous drainage.</p> <p>The Wound Ostomy and Continence Nurses Society website was accessed on 9/24/15. It stated a Stage 1 Pressure Ulcer is defined as "Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area."</p> <p>The agency did not accurately describe Patient #4's wound #1 in her medical record.</p> <p>3. Patient #2 was a 59 year old male admitted to</p>	G 176			

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G 176	<p>Continued From page 113</p> <p>the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.</p> <p>a. Patient #2's record included a SN visit note dated 8/17/15, and signed by his RN Case Manager. The note documented a BP reading of 160/101. The American Heart Association website, accessed on 9/22/15, defines hypertension as greater than 140/90. There was no documentation stating Patient #2's physician was notified of his elevated BP.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his physician was not notified of his elevated BP.</p> <p>The agency failed to notify Patient #2's physician of his elevated BP.</p> <p>b. Patient #2's record included a SN visit note dated 8/21/15, and signed by his RN Case Manager. The note documented a PT/INR (a test used to assess the clotting ability of blood) was performed during the visit. However, his record did not include an order for the test, or results of the test.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and stated there was an error in the documentation, and a PT/INR was not performed.</p> <p>Patient #2's SN visit note dated 8/21/15, was not</p>	G 176			

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G 176	<p>Continued From page 114 accurate.</p> <p>4. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC, for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>Patient #1's record included referral information from the discharging hospital. The referral information stated Patient #1 was a newly diagnosed diabetic. He was admitted to the hospital on 8/25/15, with a blood glucose level of 589 mg/dl (The American Diabetes Association website, accessed 9/22/15, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl.) He was discharged from the hospital on 8/29/15, with orders for blood glucose testing and insulin administration.</p> <p>Patient #1's POC included an order to instruct him in administration of insulin and blood glucose testing.</p> <p>Patient #1's record included a SOC comprehensive assessment completed on 9/01/15, and signed by the RN Case Manager. The assessment did not document Patient #1's blood glucose level. Additionally, it did not state the RN assessed Patient #1's ability to check his blood glucose level or inject his insulin.</p> <p>During an interview on 9/17/15 at 3:30 PM, the RN Case Manager stated on her SOC visit she observed Patient #1 check his blood glucose level. She stated his son prepared his insulin, and she watched him inject the insulin. She</p>	G 176			

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G 176	<p>Continued From page 115 confirmed she did not document the observation.</p> <p>Patient #1's SOC visit note did not document observations made by the nurse during the visit.</p> <p>5. Patient #11 was a 67 year old female admitted to the agency on 5/27/15, for services related to CHF. Additional diagnoses included aortic valve disorder and chronic kidney disease. Her record, including the POC, for the certification period 7/26/15 to 9/23/15, was reviewed.</p> <p>The National Institutes for Health website, accessed 9/22/15, included a patient education guide for congestive heart failure. It stated heart failure is a condition where the heart is not able to pump blood at a normal rate, resulting in excess fluid in the rest of the body. It stated one of the first signs of heart failure is sudden weight gain due to the accumulation of fluid.</p> <p>Patient #11's POC for the certification period 7/26/15 to 9/23/15, included an order to notify her physician for a weight greater than 285 pounds. Her weight at the start of her certification period was documented as 282.4 pounds. Weight gain was documented as follows:</p> <ul style="list-style-type: none"> <li>- 8/12/15 289.4 pounds</li> <li>- 8/13/15 291.8 pounds</li> <li>- 8/14/15 294.4 pounds</li> <li>- 8/15/15 300 pounds</li> </ul> <p>Her record did not include documentation of physician notification of her weight gain.</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed it did not state her physician was</p>	G 176			

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G 176	Continued From page 116 notified of her weight gain.  The RN Case Manager failed to notify Patient #11's physician of her weight gain.  6. Patient #13 was an 86 year old female admitted to the agency on 7/25/15, for SN, OT, and HHA services related to fracture of the sacrum. Additional diagnoses included rheumatoid arthritis, osteoporosis, osteoarthritis of the pelvis, and history of falls. Her record, including the POC, for the certification period 7/25/15 to 9/22/15, was reviewed.  An SN visit note, dated 8/07/15, signed by the RN Case Manager, documented a supervisory visit of the HHA. The note stated the patient/family was not pleased with the care provided and there was no evidence of good rapport between Patient #13 and the HHA. However, missed HHA visit notes were documented on 7/28/15, 7/31/15, 8/04/15, and 8/07/15, due to Patient #13's refusal.  During an interview on 9/18/15 at 9:40 AM, the DON reviewed the record and confirmed the missed HHA visit notes. She confirmed no HHA visits were made prior to the supervisory visit documented on 8/07/15. The DON stated the RN Case Manager, who was no longer employed by the agency, was new to the agency and did not understand what a supervisory visit was.  The SN clinical notes were inaccurate for Patient #13.	G 176			
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE	G 177	An online occurrence report was entered for patients #1, 2, 11, 15 identified in the deficient practice.	10/16/15	

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G 177	<p>Continued From page 117</p> <p>The registered nurse counsels the patient and family in meeting nursing and related needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the agency failed to ensure the RN provided necessary instruction to patients or caregivers for 4 of 16 patients (#1, #2, #11, and #15) who received SN services and whose records were reviewed. This created the potential for patients to experience adverse outcomes. Findings include:</p> <p>1. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC, for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>Patient #1's record included referral information from the discharging hospital. The referral information stated Patient #1 was a newly diagnosed diabetic. He was admitted to the hospital on 8/25/15, with a blood glucose level of 589 mg/dl (The American Diabetes Association website, accessed 9/22/15, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl.) He was discharged from the hospital on 8/29/15, with orders for blood glucose testing and insulin administration. The discharge information stated Patient #1 required home health services for education related to DM and insulin administration.</p> <p>Patient #1's record included a SOC comprehensive assessment completed on</p>	G 177	<p>Education was provided to a1 RN and LPNs by Integration Team on appropriate documentation of education within HCHB. Included were examples regarding specific education on medication administration.</p> <p>DON/designee will reinforce documentation on disease processes, identification of knowledge deficits. All education provided to patient/caregiver will be documented each visit.</p> <p>RN TL will review 3 clinical notes per clinician to verify documentation is evident of education provided.</p> <p>Beginning 10/12/15, DON/designee will review 3 clinical notes per clinician per week to review documentation of education provided to patient and ensure appropriateness and per physician orders. Review will be conducted for 8 weeks and until 100% compliance achieved x 4 consecutive weeks.</p> <p>The DON is responsible for implementing the plan of correction.</p>	<p>10/6/15</p> <p>10/30/15</p> <p>10/30/15</p>	

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G 177	<p>Continued From page 118 9/01/15, and signed by the RN Case Manager. The assessment did not document the RN Case Manager educated Patient #1 or his caregiver regarding use of his blood glucose monitor, or insulin administration.</p> <p>During an interview on 9/17/15 at 3:30 PM, the RN Branch Manager reviewed Patient #1's record and confirmed there was no documentation stating the RN Case Manager provided education during her initial visit.</p> <p>The RN failed to provide appropriate patient/caregiver education.</p> <p>2. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.</p> <p>Patient #2's record included a note dated 4/29/15, and signed by a WOCN. The note stated "The decubiti [pressure ulcer] over the right hip is caused by pressure from sitting. The Roho [a pressure relieving cushion] that the patient is using is not relieving the pressure. It appears to be deflating with a small amount of pressure and the patient is bottoming out onto a metal base on the wheelchair. The Roho needs to be assessed and either replaced or repaired so that the patient does not have any further pressure causing the ulcer to be open."</p> <p>Patient #2's record did not include documentation stating his Roho cushion was repaired or</p>	G 177			

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G 177	<p>Continued From page 119</p> <p>replaced. Additionally, there was no documentation stating he was educated regarding the importance of pressure relief for wound healing.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager stated a medical supply company was contacted by the agency to evaluate Patient #2 for a new Roho cushion. He confirmed Patient #2 did not receive a new cushion. Additionally, he confirmed Patient #2 was not educated regarding the importance of pressure relief to assist in wound healing.</p> <p>The RN failed to educate Patient #2 regarding the importance of pressure relief for wound healing.</p> <p>3. Patient #11 was a 67 year old female admitted to the agency on 5/27/15, for services related to CHF. Additional diagnoses included aortic valve disorder and chronic kidney disease. Her record, including the POC, for the certification period 7/26/15 to 9/23/15, was reviewed.</p> <p>Patient #11's record included a Physician Verbal Order dated 8/11/15, and signed by the RN Branch Manager. The order included wound care to her legs 3 times a day, and stated "SN to teach caregiver to perform wound care when home health is not providing the wound care."</p> <p>No SN visit was documented on 8/11/15. Patient #11's record included an SN visit note dated 8/12/15, and signed by the RN Case Manager. The visit note documented wound care was completed. However, it did not document instruction was provided to Patient #11's caregiver as ordered.</p>	G 177			

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G 177	<p>Continued From page 120</p> <p>During an interview on 9/17/15 at 9:20 AM, the RN Case Manager reviewed Patient #11's record and confirmed there was no documentation her caregiver was educated to provide wound care.</p> <p>Patient #11's RN Case Manager failed to provide wound care instruction as ordered by her physician.</p> <p>4. Patient #15 was a 61 year old male admitted to the agency on 8/10/15, for services related to insulin dependent DM. Additional diagnoses included a foot ulcer, CHF and Parkinson's disease. He received SN, PT, HHA and MSW services. His record, including the POCs, for the certification period 8/10/15 to 10/08/15, was reviewed.</p> <p>Patient #15's POC included Bumetanide (a potent diuretic used to eliminate excess fluid from the body) 2 mg, 1/2 to 1 tablet, 2 times a day. The POC did not state how Patient #15 would determine whether to take 1/2 or 1 tablet.</p> <p>Patient #15's record included an SOC comprehensive assessment dated 8/10/15, and signed by the RN Case Manager. The assessment included a section to document interventions provided during the visit. The interventions provided during the SOC visit included patient/caregiver education on Bumetanide.</p> <p>The documented education included "Take this medication by mouth as directed by your doctor, usually once or twice daily." It did not state Patient #15 was educated regarding his dosage, including how to determine whether to take 1/2 or 1 tablet.</p>	G 177			

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G 177	Continued From page 121	G 177		
G 182	<p>During an interview on 9/17/15 at 3:05 PM, the RN Branch Manager reviewed the record and confirmed the RN Case Manager did not instruct Patient #15 regarding his Bumetanide dosage.</p> <p>Patient #15's RN Case Manager failed to provide education regarding his medication.</p> <p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE</p> <p>The licensed practical nurse prepares equipment and materials for treatments, observing aseptic technique as required.</p> <p>This STANDARD is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the agency failed to ensure the LPN observed aseptic technique while providing wound care for 1 of 1 patient (#4) who was observed having a wound VAC dressing change. This placed Patient #4 at risk of infection. Findings include:</p> <p>Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential hypertension, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's record included a Wound Assessment Tool Report that included measurements of two wounds as follows:</p>	G 182	<p>An online occurrence was completed for patient #4 identified in deficient practice. Patient #4 is no longer on service.</p> <p>Clinician involved in deficient practice will complete Infection Control course with 90% passing rate or better. Clinician will demonstrate competency with infection control measures in a simulated environment prior to performing wound care independently.</p> <p>Education to LPN provided by WOCN consisting of the following:  <ul style="list-style-type: none"> <li>• wound care basics</li> <li>• wound care products</li> <li>• wound care dressing changes</li> <li>• infection control measures when performing wound care</li> </ul> </p> <p>Clinician will be observed during a wound care visit by DON/designee x 3 to ensure wound care provided according to Infection control standards of care.</p> <p>Beginning 10/12/15, DON/designee will observe clinician performing wound care visit once per week for 8 weeks and until 100% competency achieved for 4 consecutive weeks.</p> <p>The DON is responsible for implementing the plan of correction.</p>	<p>9/17/15</p> <p>9/18/15</p> <p>02/1/16</p> <p>10/12/16</p> <p>10/30/15</p>

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G 182	<p>Continued From page 122</p> <p>Wound #1 was documented by the RN on 9/09/15 as a stage 1 pressure ulcer and measured 3 cm in length by 2 cm in width by 3 cm deep with undermining and serosanguineous drainage.</p> <p>Wound #2 was documented by the RN on 9/09/15 as a surgical incision and measured 3 cm in length by 2.8 cm in width by 0.2 cm in depth with undermining and serosanguineous drainage.</p> <p>In an interview with the LPN on 9/16/15 at 2:35 PM, she stated that training in use of the NPWT was provided by the manufacturer of the device. The manufacturers website, accessed 9/21/15, contained cautions to avoid cross contamination of wound(s) with surfaces that may contain pathogens that inhibit wound healing.</p> <p>Complications of wound infections listed on the JAMA website, under "wound infections" accessed 9/21/15, list the following potential complications: - Death of surrounding tissue, including muscle, connective tissue, or bones, - Spread of the infection to the bloodstream, involving other organs - Septic shock, a critical illness involving the whole body, which may require intensive care and life support and lead to multiple organ failure or death</p> <p>An agency policy number 6.012 titled "Standards for Nursing Care and Practice (LVN/LPN), dated 6/01/06 and revised 9/01/14, was reviewed. It stated "the LPN/LVN shall implement measures to prevent exposure to infectious pathogens and communicable diseases." The policy also stated "the LPN/LVN shall collaborate with members of</p>	G 182			

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G 182	<p>Continued From page 123</p> <p>the health care team in the interest of the client's health care."</p> <p>A visit was made to Patient #4's home on 9/16/15 beginning at 1:00 PM. The LPN was observed performing wound care using NPWT (a therapeutic technique using a vacuum dressing to promote healing and reduce infections in chronic wounds).</p> <p>The following infection control breaches were observed during the visit.</p> <p>i. Upon arrival to her home, Patient #4 was laying in bed. She informed the LPN the wound VAC device had been leaking. Her pants, brief and the disposable underpad on her bed were visibly wet where the device had lost the seal necessary to create a vacuum and wound drainage had leaked out. The LPN asked patient #4 to stand, lower her pants and brief and return to the bed. The LPN did not remove or replace the wet disposable underpad and the patient laid down on the soiled pad, as instructed by the LPN.</p> <p>ii. The LPN instructed Patient #4 to roll on her right side, removed the wound dressings and discarded them. She irrigated the two wounds with normal saline and started to prepare new dressings. Patient #4 rolled on to her back and her two open wounds came into contact with the soiled disposable underpad. The LPN did not clean the wounds and area surrounding the wounds after they came in contact with the soiled disposable underpad.</p> <p>iii. The LPN opened a wound vac dressing kit and set it directly on the Patient #4's bed. Part of the kit was on the bed and part was on the soiled</p>	G 182			

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G 182	<p>Continued From page 124</p> <p>disposable underpad. The LPN removed drape material and foam material from the kit and trimmed the items to fit the wound area. She laid the items down on the kit packaging with parts of the foam in contact with the patient's sheets and part in contact with the soiled disposable underpad.</p> <p>iv. The LPN removed wound prep pads from her nursing bag and laid them on the bed and contaminated the outside of the package. She used her gloved hands to pick up the contaminated prep pad packages, and contaminated her gloves. She removed the prep pads with contaminated gloves, and contaminated the prep pads. She used the contaminated prep pads to wipe the area immediately surrounding each wound.</p> <p>v. The LPN asked Patient #4 if she had another disposable underpad. She replied there may be another but she wasn't sure. She stated they are expensive so she could not buy too many. She instructed the LPN to look around. The LPN located Patient #4's disposable underpad next to boxes on the floor and placed it on top of the soiled disposable underpad. The LPN did not remove the soiled underpad.</p> <p>In an interview on 9/17/15 at 11:30 AM, the LPN confirmed she heard Patient #4 report the wound vac device was leaking. She confirmed the disposable underpad was wet and she had not replaced it prior to beginning wound care. The LPN confirmed the agency did not supply Patient #4 disposable underpads and that she used the wound care supply package, placed on the bed, as a barrier.</p>	G 182			

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G 182	Continued From page 125 In the interview, the LPN stated she was not aware Patient #4 had laid on the soiled underpad and that her uncovered wounds came in contact with significantly contaminated surfaces. She also confirmed she was unaware she had any breaches in infection control when she prepared the new dressings or when she handled the contaminated prep pads.	G 182		
G 186	The LPN failed to follow aseptic technique when she performed wound care on Patient #4's two chronic wounds. 484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)  This STANDARD is not met as evidenced by: Based on record review, home visit observation, patient and therapist communication during a home visit, and staff interview, it was determined the agency failed to ensure the Occupational Therapist assisted the physician in developing or revising the plan of care to meet the patients' needs for 2 of 5 patients (#1 and #3) who received OT services and whose records were reviewed. This resulted in a lack of services and equipment necessary to meet patients' needs. Findings include:  1. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC,	G 186	An online occurrence was entered for patients #1 and 3 identified in the deficient practice.  100% of therapists will be educated on developing a plan of care to meet the needs of the patient by DON/designee. DON will review LHC policy 2.1.007 Plan of Care. Therapists will also be educated on documentation within HCHB and appropriate locator to document supplies utilized in home. All supplies identified as a need by the therapist will be communicated to the TL for appropriate follow up. DON/designee reinforced roles and responsibilities of therapists as well as expectations of job performance.  A full-time Occupational Therapist (OT) was hired to ensure adequate time and patient care provided for Idaho Home Health patients requiring Occupational Therapy services.  Beginning 10/12/15, DON/designee will review 3 OT notes per week to ensure care is provided as ordered by physician, patient's needs are being met and OT performing per LHC Group job expectations. Review will be conducted for 8 weeks and until 100% compliance achieved for 4 consecutive weeks. The DON is responsible for implementing the plan of correction.	10/16/15  10/16/15  10/1/15  10/30/15

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G 186	<p>Continued From page 126 for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>Patient #1's record included an OT evaluation completed on 9/05/15, and signed by the Occupational Therapist. The evaluation stated the Occupational Therapist was in Patient #1's home for 18 minutes. The OT evaluation documented Patient #1's vision was declining, affecting his performance with ADLs, and with insulin administration. The evaluation stated he would benefit from magnification products for increased clarity. The evaluation also documented Patient #1 had deformity of his fingers related to progressive arthritis.</p> <p>Patient #1's OT evaluation identified issues with vision and finger dexterity that affected his ability to administer insulin. It stated he would benefit from magnification products. However, the evaluation stated no further OT visits would be made. There was no documentation stating why additional OT visits were not scheduled to address his identified challenges.</p> <p>During an interview on 9/17/15 at 3:30 PM, the RN Branch Manager reviewed Patient #1's record and stated she expected therapy evaluations to take more than 18 minutes. Additionally, she confirmed the evaluation did not state why further visits would not be made to address his visual and dexterity issues.</p> <p>During an interview on 9/18/15 at 9:20 AM, the Occupational Therapist confirmed he did not document the reason no additional OT visits were planned. He was unable to recall specific information regarding the visit. He stated his schedule was busy as he had a full time job in</p>	G 186		

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G 186	<p>Continued From page 127</p> <p>addition to working as needed for the home health agency. He stated it was difficult to do visits in the evening after working all day at his other job.</p> <p>The Occupational Therapist did not develop a POC to meet Patient #1's needs.</p> <p>2. Patient #3 was a 74 year old female admitted to the agency on 8/17/15, for care related to essential HTN. Additional diagnoses included muscle weakness, UTI, bacteremia, DM type II, polyneuropathy and osteoarthritis. She received SN, PT and OT services. Her record, including the POC, for the certification period 8/17/15 to 10/15/15, was reviewed.</p> <p>Patient #3's POC dated 8/17/15, and signed by her physician on 9/09/15, included OT orders. The OT orders included "provide patient/caregiver with ADL training."</p> <p>A visit was made to Patient #3's home on 9/15/15 beginning at 3:35 PM, to observe an OT visit. Patient #3 had a hard cast on her dominant hand. Patient #3 asked the Occupational Therapist for the status on providing her with a "toileting device," which he had ordered on a previous visit "a week or two ago." The therapist stated he did not know the status and checked his email for a response from the agency. He informed Patient #3 he had not received an approval or a response from the agency.</p> <p>OT visit notes dated 8/29/15, 9/03/15, and 9/05/15 did not include documentation of ordering a toileting device for Patient #3. No OT visits were made between 9/05/15 and 9/15/15.</p>	G 186			

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G 186	Continued From page 128  During an interview on 9/15/15 at 4:25 PM, the Occupational Therapist stated he would have to follow up on the order. He stated he could not recall which device he had ordered.  During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #3's record. She confirmed Patient #3's medical record did not include evidence that a toileting device was ordered for Patient #3 by the Occupational Therapist or by the agency.  The Occupational Therapist did not provide equipment to meet Patient #3's needs.	G 186		
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 addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.  This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure medical records contained timely, complete, and accurate documentation for 3 of 16 patients (#4, #7, and #8) whose records were reviewed. This resulted in a lack of clarity regarding patients' care and health status.	G 236	An online occurrence report was completed for patients #4,7,8 identified in the deficient practice.  100% staff educated by Integration Team on the following: * documentation within HCHB to include all locators of plan of care and appropriate information to be included * TL review process to ensure consistency of documentation within assessment to subsequent visits, completeness of wound documentation, accuracy of wound documentation, and orders implemented appropriately * care coordination among disciplines involved in patient's care and physician  DON to reinforce properly utilizing copy and paste feature for documentation in the electronic medical record to ensure appropriate and individualized care.  TL will perform reviews weekly of 3 notes per clinician to verify documentation is accurate and complete.  Beginning 10/12/15, DON/designee will review 3 clinician notes per week per clinician to ensure documentation is consistent with plan of care and physician orders, and is representative of care provided. Review will be conducted for eight weeks and until 100% compliance achieved for 4 consecutive weeks.  The DON is responsible for implementing the plan of correction	10/18/15  10/01/15  10/30/15  10/19/15  10/30/16

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G 236	<p>Continued From page 129</p> <p>Findings include:</p> <p>1. Patient #7 was a 70 year old male admitted to the agency on 8/15/15, for SN, PT, and OT services related to chronic airway obstruction. Additional diagnoses included abnormal gait, HTN, chronic pain, dysphagia, coronary atherosclerosis, general muscle weakness, supplemental oxygen, history of falls, and long term medication use. His record, including the POCs, for the certification periods 8/15/15 to 8/13/15 and 8/14/15 and 10/12/15, were reviewed.</p> <p>Patient #7's record included a resumption of care assessment, dated 9/11/15, signed by the RN Team Lead.</p> <p>a. The assessment documented Patient #7 had hemoptysis (coughing up of blood). However, the RN Team Lead documented the color of the sputum was yellow.</p> <p>b. The assessment documented Patient #7 was instructed on the high risk medication Morphine. However, his medication list did not include Morphine.</p> <p>During an interview on 9/17/15 at 4:25 PM, the RN Team Lead stated Patient #7's sputum was gray. After reviewing the record she confirmed she documented the sputum was yellow and he was having hemoptysis. The RN Team Lead confirmed Patient #7 was taking Morphine but it was not included on his medication list.</p> <p>Patient #7's medical record did not include accurate information related to his respiratory status or medications.</p>	G 236		

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G 236	<p>Continued From page 130</p> <p>2. Patient #8 was a 39 year old male admitted to the agency on 8/27/15, for SN and PT services related to pneumonia. Additional diagnoses included cellulitis and abscess of buttock, HTN, dislocated right shoulder, vertebrae fracture, PICC line, and history of falls. His record, including the POC, for the certification period 8/27/15 to 10/26/15, was reviewed.</p> <p>Patient #8's medication list included an order for oxygen at 1 lpm via nasal cannula at bedtime. SN visit notes dated 8/27/15, 8/30/15, 9/02/15, and 9/10/15 documented Patient #8 was using 2 lpm of oxygen via nasal cannula intermittently. Additionally, the SN visit notes did not include documentation of when Patient #8 was using the oxygen.</p> <p>During an interview on 9/17/15 at 3:40 PM, the RN Case Manager reviewed the record and confirmed the order on the medication list for oxygen. He stated Patient #8 was using 1 lpm of oxygen in the home. The RN Case Manager stated he mistakenly documented 2 lpm in his visit notes.</p> <p>Patient #8's medical record did not include accurate information related to his medication.</p> <p>3. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential hypertension, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p>	G 236			

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G 236	<p>Continued From page 131</p> <p>Patient #4's medical record review included a review of SN note documentation and physicians orders. Evidence that the clinical record did not contain findings in accordance with acceptable professional standards were identified as follows:</p> <p>a. The Physician Verbal Order dated 8/07/15, signed by the physician on 8/12/15, stated:</p> <p>"Patient needs VAC change on Monday, Wednesday and Friday Patient has 2 wounds Scaral; 3.5 cm in diameter with undermining at 6 o'clock 2 cm and lessins at 8 o'clock to 1 cm, inferlor portion of wound is 1.5 cm deep LEFT OT" JAS PVER 3C, P[EMOMG AND JAS TIMME;OMG AT 6 O'CLOCK OF 7 CM AT 9 OCLOCK AND 5 CM AT 11 O'CLOCK The left it was opened further today in office and slyer nitrate sticks were used for hemostatsis [sic]"</p> <p>SN visit notes dated 8/07/15, 8/10/15, 8/31/15, and 9/09/15, included a section titled "PROVIDE AND INSTRUCT PATIENT / CAREGIVER WOUND CARE PER PHYSICIAN ORDER. DETAILS/COMMENTS:", which documented SN interventions verbatim as written in the physician order dated 8/07/15.</p> <p>During an interview on 9/16/15 at 10:45 AM, the DON reviewed the physician order dated 8/07/15, and confirmed the order was not legible. She reviewed Patient #4's SN notes dated 8/07/15, 8/10/15, 8/31/15 and 9/09/15, and confirmed the SN interventions contained content she was unable to decipher. The DON stated she could only guess the SN used a cut and paste feature in the EMR to document her wound care</p>	G 236		

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G 236	<p>Continued From page 132</p> <p>Interventions. She confirmed that she could not tell from the documentation what was done for the patient.</p> <p>b. A SN visit note dated 9/06/15 was reviewed. It included the following documentation of wound care interventions:</p> <p>- "Provide negative pressure wound therapy per physician orders. Details/comments: The one back on the patient's buttocks was altered from the previous wound vac placement due to the transparent drake rolling in the dressing being removed from the lower buttocks wound the wound was cleaned with when wash in gods then black foam was placed in the wound in the transparent drake was placed over the phone and 125 MG/HG was applied. [sic]"</p> <p>- "Provide and instruct patient / caregiver wound care per physician order. Details/comments: the one back to the bottom area was altered due to partial removal. The wound was cleaned with room cleaner in god black foam was placed in the moon and transparent drape was applied over the phone with 125 milliliters of mercury suction applied. [sic]"</p> <p>During an interview on 9/16/15 at 10:45 AM, the DON reviewed the physician order for wound care dated 8/21/15. She reviewed Patient #4's SN visit note dated 9/06/15, and confirmed the SN interventions contained content she was unable to decipher. The DON stated she could only guess the SN used a voice recognition feature in the EMR to document wound care interventions. She confirmed that she could not tell from the documentation what was done for the patient.</p>	G 236		

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G 236	<p>Continued From page 133</p> <p>Patient #4's medical record included documentation that was illegible.</p> <p>c. Patient #4's POCs dated 7/14/16 and 9/12/15, included "Skilled nurse to instruct on new and changed medications, those with assessed knowledge deficit, high risk medications and any applicable drug interactions."</p> <p>Patient #4's SN notes were reviewed. The content of the information included was inappropriate. Examples include, but were not limited to:</p> <ul style="list-style-type: none"> <li>- SN included instructions to "consult your doctor before breast-feeding" to an 89 year old patient.</li> <li>- SN included instructions to "report side effects to HEALTH CANADA at 1-866-234-2345"</li> <li>- SN included teaching of interactions with hormonal birth control.</li> <li>- SN included instructions to "tell the doctor right away if you notice any symptoms in your new born baby ..."</li> <li>- SN included instructions to "tell your doctor if you are pregnant or if plan to become pregnant..."</li> </ul> <p>SN visit notes completed on 7/14/15, 7/15/15, 7/16/15, 7/17/15, 7/20/15, 7/21/15, 7/25/15, 7/26/15, 7/30/15, 7/31/15, 8/07/15, 8/10/15, 8/24/15, 8/28/15, 8/31/15, and 9/09/15. Each note included information that was not relevant to Patient #4.</p> <p>During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #4's SN visit notes and</p>	G 236		

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G 236	Continued From page 134 confirmed the SN interventions contained content that was inappropriate to Patient #4's age and condition. The DON stated she could only guess that the SN used a cut and paste feature in the EMR to document SN interventions. She confirmed that she could not tell from the documentation what was done for the patient or what the patient understood.	G 236			
G 330	Patient #4's medical record did not accurately document patient education. <b>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS</b>  Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary  This CONDITION is not met as evidenced by: Based on medical record review, observation,	G 330	Refer to G331, G337, and G340		

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G 330	Continued From page 135 policy review, and staff interview, it was determined the agency failed to ensure comprehensive assessments accurately reflected patients' current health status and included a comprehensive medication review. These failures interfered with the delivery of safe and effective patient care. Findings include:  1. Refer to G331 as it relates to the failure of the agency to ensure comprehensive assessments completed at the SOC were thorough and accurately reflected the patient's health care status and needs.  2. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment included a thorough medication review to obtain a current list of patient medications, evaluate for drug interactions, and identify possible significant side effects.  3. Refer to G340 as it relates to the failure of the agency to ensure the resumption of care assessment included a thorough review which accurately reflected the patient's health care status and needs after a hospitalization.  The cumulative effect of these negative systemic practices significantly impeded the ability of the agency to provide quality care consistent with patients' needs.	G 330			
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT  A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including	G 331	An online occurrence was entered for patients #1, 2, 4, 15, 16 identified in the deficient practice.  For patient #1, a nutritional assessment will be completed and communicated to physician.  For patient #2, additional visit made for wound assessment, suprapubic catheter, and colostomy assessment and physician notified.	10/16/15 10/16/15 10/12/15	

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G 331	<p>Continued From page 136 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 including status of wounds, nutrition, pain, and cardiovascular assessment, for 5 of 10 patients, (#1, #2, #4, #15, and #16) whose admission assessments and records were reviewed. This failure placed patients at risk of negative outcomes. Findings include:</p> <p>1. Patient #2 was a 59 year old male admitted to the agency on 4/17/15, for services related to 4 pressure ulcers. Additional diagnoses included paraplegia and spinal cord injury. He received SN services. His record, including the POCs, for the certification periods 4/17/15 to 6/15/15, 6/16/15 to 8/14/15, and 8/15/15 to 10/13/15, was reviewed.</p> <p>a. The agency's policy 2.2.001, revised 9/01/14, titled Wound Assessment, Documentation, and Photography, stated "Upon initial visit and subsequently as indicated below, all wounds will be assessed with appropriate documentation within the medical record. Wound Location and Description ID Tools are initiated on all patients with wounds at the time of admit or upon development of a wound." This policy was not followed for Patient #2, as follows:</p> <p>Patient #2's record included a SOC comprehensive assessment completed on 4/17/15, and signed by his RN Case Manager. The assessment included a section to document pressure ulcers. It included:</p>	G 331	<p>For patient #16, additional visit made and assessment of wound status to include measurements and description of wound performed. Nutritional assessment performed and findings communicated to physician. Patients #4 and 15 are no longer on service.</p> <p>100% review of current Plans of Care will be reviewed by DON/designee to ensure adequate plan of care.</p> <p>DON/designee to educate all clinicians on LHC Policy Initial Assessments and Reassessments with focus on assessing all body systems and appropriate documentation.</p> <p>100% clinicians educated on documentation within HCHB by Integration Team on the following</p> <ul style="list-style-type: none"> <li>- correct documentation of wounds within the HCHB system</li> <li>- Integumentary Command Center (ICC)</li> <li>- Team Leader (TL) review process to ensure consistency of documentation within assessment to subsequent visits, completeness of wound documentation, accuracy of wound documentation, and orders implemented appropriately</li> <li>- care coordination among disciplines involved in patient's care and physician</li> </ul> <p>The following process changes will be implemented:</p> <ul style="list-style-type: none"> <li>- All assessments will be reviewed by TL for accuracy, completeness</li> <li>- TL will track any patients with identified need for nutritional follow-up based on assessment and wound care patients for appropriate documentation</li> </ul> <p>Beginning 10/12/15, DON/designee will review 3 assessments per week to ensure complete and accurate documentation within assessment. Review will be for 8 weeks and until 100% compliance achieved x 4 consecutive weeks.</p> <p>The DON is responsible for implementing the plan of correction.</p>	10/16/15 10/30/15 10/18/15 10/6/15 10/30/15 10/30/15	

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G 331	<p>Continued From page 137</p> <p>- "CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT STAGE III: FULL THICKNESS TISSUE LOSS." The assessment stated Patient #2 had 2 Stage III pressure ulcers.</p> <p>- "CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT STAGE IV: FULL THICKNESS TISSUE LOSS WITH VISIBLE BONE, TENDON OR MUSCLE." The assessment stated Patient #2 had 2 Stage IV pressure ulcers.</p> <p>The SOC assessment stated Patient #2 had 2 Stage III and 2 Stage IV pressure ulcers. It did not include the location or a description of the pressure ulcers, but stated "SEE WOUND ASSESSMENT TOOL."</p> <p>Patient #2's record included a "Wound Assessment Tool Report" that documented wound assessments from 4/17/15 to 8/14/15, when a new wound assessment tool was implemented. The report documented 4 wounds. However, it was incomplete and/or did not match the SOC assessment, as follows:</p> <p>i. The report documented a Stage III pressure ulcer on Patient #2's right hip. The entry on the SOC date 4/17/15, did not include wound assessment or measurements of the right hip wound.</p> <p>The first assessment of his right hip wound was documented on the wound report on 4/20/15. The wound was described as a pressure ulcer, stage III, and stated the wound bed was a "3." The wound report legend described a "3" as "Full thickness skin loss involving damage or necrosis</p>	G 331			

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G 331	<p>Continued From page 138</p> <p>of SQ [subcutaneous] tissue; may extend down to but not through underlying fascia; &amp;/or mixed partial or full-thickness &amp;/or tissue layers, obscured by granulation tissue." The report documented undermining of less than 2 cm, and a scant amount of serosanguineous drainage.</p> <p>The first measurements of Patient #2's right hip wound were documented on 4/27/15, 10 days after Patient #2's SOC. The measurements were 6 cm long by 12 cm wide by 0.5 cm deep.</p> <p>ii. The report documented a Stage IV pressure ulcer on Patient #2's scrotum. The entry on the SOC date 4/17/15, did not include wound assessment or measurements of the scrotal wound.</p> <p>The first assessment of Patient #2's scrotal wound was documented on the wound report on 4/20/15. The wound was described as a pressure ulcer, Stage IV, and stated the wound bed was also a "3." The report documented undermining of less than 2 cm, and a scant amount of serosanguineous drainage.</p> <p>The first measurements of Patient #2's scrotal wound were documented on 4/27/15, 10 days after Patient #2's SOC. The measurements were 6.5 cm long by 3 cm wide by 3.2 cm deep.</p> <p>iii. The report documented a Stage III pressure ulcer on the coccyx. However, the first entry on the wound report for the coccyx wound was dated 5/27/15, 40 days after Patient #2's SOC. No assessment or measurement of the wound was documented at the SOC.</p> <p>The first assessment of Patient #2's coccyx</p>	G 331			

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G 331	<p>Continued From page 139</p> <p>wound was documented on the wound report on 5/27/15. The wound was described as a pressure ulcer, Stage III, and stated the wound bed was also a "3." The report documented no undermining, and a small amount of drainage.</p> <p>The first measurements of Patient #2's coccyx wound were documented on 5/27/15. The measurements were 5.5 cm long by 3.5 cm wide by 0.1 cm deep.</p> <p>iv. The report documented a Stage II pressure ulcer on the right heel. However, the first entry on the wound report for the heel wound was dated 6/15/15, 59 days after Patient #2's SOC. No assessment or measurement of the wound was documented at the SOC.</p> <p>The first measurement and assessment of Patient #2's right heel wound was documented on the wound report on 6/15/15. The wound was described as a pressure ulcer, Stage II. The wound bed was not described. The measurements were 1.5 cm long by 0.3 cm wide by 0.2 cm deep.</p> <p>An assessment of Patient #2's right heel wound was documented on the wound report on 6/22/15. It described the wound bed as a "3."</p> <p>Patient #2's SOC assessment completed on 4/17/15, documented 2 Stage III and 2 Stage IV pressure ulcers. However, his "Wound Assosment Tool Report" documented 1 Stage III and 1 Stage IV pressure ulcer on 4/17/15. An additional Stage III pressure ulcer was documented on 5/27/15. An additional Stage II pressure ulcer was documented on 6/15/15. The status of Patient #2's pressure ulcers at the time</p>	G 331		

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G 331	<p>Continued From page 140 of his admission was not documented.</p> <p>b. Patient #2's SOC assessment also stated he had a colostomy and a suprapubic catheter in his abdomen to drain urine from his bladder. However, his SOC assessment did not include an assessment of his colostomy or suprapubic catheter, and did not document how they were managed.</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager reviewed Patient #2's record and confirmed his SOC assessment did not include an assessment of his colostomy or suprapubic catheter</p> <p>Patient #2's SOC assessment was not comprehensive to determine his needs.</p> <p>2. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC, for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>Patient #1's record included referral information from the discharging hospital. The referral information stated Patient #1 reported loss of appetite and a weight loss of 20 to 30 pounds over the last several months.</p> <p>Patient #1's record included a SOC comprehensive assessment completed on 9/01/15, and signed by the RN Case Manager. The assessment included a nutritional screen, and stated no major risk factors related to nutrition were present. Other nutrition risk factors</p>	G 331			

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G 331	<p>Continued From page 141</p> <p>documented were special diet and more than 3 medications. The assessment stated his nutritional risk level was low. The assessment did not include his significant weight loss prior to his hospital admission.</p> <p>During an interview on 9/17/15 at 3:30 PM, the RN Branch Manager reviewed Patient #1's record and confirmed his nutritional status related to his weight loss was not assessed during his SOC comprehensive assessment.</p> <p>Patient #1's SOC assessment was not comprehensive to determine his needs related to nutrition.</p> <p>3. Patient #15 was a 61 year old male admitted to the agency on 8/10/15, for services related to insulin dependent DM. Additional diagnoses included a foot ulcer, CHF and Parkinson's disease. He received SN, PT, HHA and MSW services. His record, including the POCs, for the certification period 8/10/15 to 10/08/15, was reviewed.</p> <p>Patient #15's record included a PT evaluation dated 8/12/15, and signed by the Physical Therapist. The note stated Patient #15 had an ulcer on his right foot, which affected his ambulation and weight bearing status. The note stated he had received IV antibiotics and hyperbaric therapy for the ulcer, prior to his home health admission.</p> <p>Patient #15's record included an SOC comprehensive assessment completed on 8/10/15, and signed by the RN Case-Manager. The SOC visit note did not include an assessment of his foot ulcer, or state how the</p>	G 331			

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G 331	<p>Continued From page 142 ulcer was being cared for.</p> <p>During an interview on 9/17/15 at 3:05 PM, the RN Branch Manager reviewed Patient #15's record and confirmed the SOC comprehensive assessment did not include documentation of his foot ulcer.</p> <p>Patient #15's SOC assessment was not comprehensive to describe his status and determine his needs.</p> <p>4. Patient #16 was an 87 year old male admitted to the agency on 9/05/15, for SN, PT, and ST services related to Parkinson's disease. Additional diagnoses included prostate cancer, coronary atherosclerosis, cardiac pacemaker, convulsions, macular degeneration, hypothyroidism, high cholesterol, GERD, HTN, and supplemental oxygen. His record, including the POC, for the certification period 9/05/15 to 11/03/15, was reviewed.</p> <p>Patient #16's record included an SOC comprehensive assessment, dated 9/05/15, and signed by the RN Case Manager. The SOC was not comprehensive as follows:</p> <p>a. The assessment included documentation Patient #16 had bruising and wounds. A separate wound assessment form documented a third degree burn to Patient #16's left shin. There was no documentation of wound measurements or a description of the wound on the wound assessment form. The wound assessment documented the wound was not assessed and wound care was not provided because it was covered by a dressing.</p>	G 331			

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G 331	<p>Continued From page 143</p> <p>b. The assessment stated Patient #16 had no problems with his mouth or throat. However, as part of the nutritional screen the RN Case Manager documented Patient #16 had problems chewing or swallowing.</p> <p>c. Patient #16 had a cardiac pacemaker. The assessment stated it was unknown what type of pacemaker and the rate of the pacemaker.</p> <p>During an interview on 9/17/15 at 8:40 AM, the RN Case Manager stated he was unaware of mouth or throat problems for Patient #16, or if he had a pacemaker. After reviewing the record he confirmed he documented there were problems with chewing or swallowing and Patient #16 had a pacemaker. The RN Case Manager confirmed he did not assess Patient #16's wound during the visit.</p> <p>Patient #16's assessment was not comprehensive to his needs for nutrition, wound care, or cardiovascular problems.</p> <p>5. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential hypertension, peripheral vascular disease and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15, and 9/12/15 to 11/10/15, were reviewed.</p> <p>Patient #4's POC dated 3/16/15, was reviewed. It documented a pressure ulcer as her primary diagnosis.</p> <p>Patient #4's record included an SOC comprehensive assessment dated 3/16/15, and</p>	G 331			

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G 331	Continued From page 144 signed by the RN Case Manager. It stated "patient has no pressure ulcers."  During an interview on 9/16/15 at 10:45 AM, the DON reviewed Patient #4's POCs dated 7/14/15 and 9/12/15, and confirmed the pressure ulcer as her primary diagnosis. She also reviewed Patient #4's SOC comprehensive assessment dated 3/16/15. She confirmed it stated Patient #4 had no pressure ulcers. The DON stated she could not explain the discrepancy.	G 331			
G 337	484.65(c) DRUG REGIMEN REVIEW  The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.  This STANDARD is not met as evidenced by: Based on record review, observation, policy review, and patient and staff interview, it was determined the facility failed to ensure a comprehensive drug regimen review for 7 of 16 patients (#1, #4, #7, #8, #14, #15, and #16) whose records were reviewed. This failure had the potential to affect all patients under the care of the agency, and place them at risk for adverse events, duplicative drug therapy, or negative drug interactions. Findings include:  A policy, number 10.008 "Monitoring Medications," stated "A drug regimen review will	G 337	An online occurrence was completed for patients #1, 4, 7, 8, 14, 15, 16 identified in deficient practice. Medication lists were updated for all patients and a current list was sent to physician.  DON/designee to educate 100% of skilled clinicians on Policy 10.008 Monitoring Medications to review expectations of medication reconciliation at each visit.  A process will be implemented in which patient's medications will be visually inspected at each visit. The medication questionnaire form will be utilized by 100% of skilled clinicians at each visit to provide consistency when inquiring about medications, to include all prescription and over the counter medications.  Beginning 10/12/15, 1 observation visit per clinician per week will be conducted by DON/designee to review medications in home and compare to agency medication list. Observation visits will be conducted until 100% compliance achieved for 4 consecutive weeks. The DON is responsible for implementing the plan of correction.	10/16/15  10/16/15  10/30/15  10/30/15	

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G 337	<p>Continued From page 145</p> <p>be performed on all patients in conjunction with all comprehensive assessments. Additionally, all clinicians will participate in medication review and reconciliation throughout the episode. For patients receiving skilled nursing and therapy services, the skilled nurse is responsible for medication review and reconciliation throughout the episode." This policy was not followed. Examples include:</p> <p>1. Patient #16 was an 87 year old male admitted to the agency on 9/05/15, for SN, PT, and ST services related to Parkinson's disease. Additional diagnoses included prostate cancer, coronary atherosclerosis, cardiac pacemaker, convulsions, macular degeneration, hypothyroidism, high cholesterol, GERD, HTN, and supplemental oxygen. His record, including the POC, for the certification period 9/05/15 to 11/03/15, was reviewed.</p> <p>A visit was conducted at the ALF Patient #16 resided in on 9/16/15 beginning at 2:00 PM, for observation of a ST visit. Patient #16 was asked about his medications. He stated the ALF staff was responsible for giving him his prescribed medications. Patient #16's medication list was requested from the ALF staff.</p> <p>The medication list was dated 9/05/15 to 10/04/15. The medication list included Patient #16's routine medications, as well as medications he took as needed. The medication list from the ALF had 11 medications which were not included on Patient #16's POC. Examples included:</p> <ul style="list-style-type: none"> <li>- Celexa 10 mg daily</li> <li>- Flomax 0.4 mg daily</li> </ul>	G 337			

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G 337	<p>Continued From page 146</p> <ul style="list-style-type: none"> <li>- Levothyroxine 75 mcg daily</li> <li>- Lipitor 10 mg daily</li> <li>- Micro K 20 mEq three times daily</li> <li>- Mirapex 1 mg three times daily</li> <li>- Multivitamin daily</li> <li>- Senemet 25/250 three times daily</li> <li>- Whey Protein Powder twice daily</li> <li>- Norco 10/325 mg as needed every 8 hours</li> <li>- Tessalon Perles 100mg as needed every 6 hours</li> </ul> <p>During an interview on 9/17/15 at 8:40 AM, the RN Case Manager reviewed the record and confirmed the medications on the POC did not include all the medications Patient #16 was taking. He stated he copied the medication list that was included with Patient #16's referral orders from the receiving facility. The RN Case Manager confirmed he did not reconcile the medication lists between the ALF and the referral orders.</p> <p>Patient #16's RN Case Manager failed to include all of his medications on his medication list and perform a comprehensive medication reconciliation.</p> <p>2. Patient #8 was a 39 year old male admitted to the agency on 8/27/15, for SN and PT services related to pneumonia. Additional diagnoses</p>	G 337		

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G 337	<p>Continued From page 147</p> <p>included cellulitis and abscess of buttock, HTN, dislocated right shoulder, vertebrae fracture, PICC line, and history of falls. His record, including the POC, for the certification period 8/27/15 to 10/25/15, was reviewed.</p> <p>An SOC comprehensive assessment dated 8/27/15, signed by the RN Case Manager, documented no problems were found during the medication review for Patient #8. However, the RN Case Manager documented Patient #8's physician was informed of the medication problems within 1 calendar day.</p> <p>Patient #8's record included a Client Coordination Note Report, dated 8/30/15, signed by the RN Case Manager, which documented a moderate medication interaction between Levaquin (an antibiotic) and an oral multivitamin.</p> <p>During an interview on 9/17/15 at 3:40 PM, the RN Case Manager reviewed the record and confirmed he documented no problems were found during the medication review. He confirmed the coordination note which documented an interaction between 2 of Patient #8's medications. The RN Case Manager stated he believed the question on the SOC assessment referred to whether Patient #8 had all of his prescribed medications and whether he was taking them as prescribed. He did not believe medication interactions were related to the comprehensive review.</p> <p>The agency failed to ensure Patient #8's medication review was comprehensive.</p> <p>3. Patient #7 was a 70 year old male admitted to the agency on 6/15/15, for SN, PT, and OT</p>	G 337			

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G 337	<p>Continued From page 148</p> <p>services related to chronic airway obstruction. Additional diagnoses included abnormal gait, HTN, chronic pain, dysphagia, coronary atherosclerosis, general muscle weakness, supplemental oxygen, history of falls, and long term medication use. His record, including the POCs, for the certification periods 8/15/15 to 8/13/15 and 8/14/15 and 10/12/15, were reviewed.</p> <p>Patient #7's record included an ROC assessment, dated 9/11/15, and signed by the RN Team Leader. Under the section "Medications" the RN Team Leader documented she instructed Patient #7 regarding special precautions for a high risk medication. The RN Team Leader documented the medication she instructed Patient #7 on was Morphine.</p> <p>Patient #7's medication list did not include Morphine.</p> <p>During an interview on 9/17/15 at 4:25 PM, the RN Team Leader reviewed the record and confirmed she had instructed Patient #7 about the Morphine. She confirmed Morphine was not included on his medication list.</p> <p>Patient #7's medication list was not comprehensive to include all of his medications.</p> <p>The agency's policy 2.1.008, titled Physician Orders, revised 2/01/15, included the following:</p> <p>- "Orders containing medication must be entered into the software system or written legibly in ink and at a minimum include: a. Name of medication, dose, dilution, frequency, route..."</p>	G 337			

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G 337	<p>Continued From page 149</p> <p>- "Range orders: Orders shall detail which dose or dosing intervals over a prescribed range, depending on the specific situation or patients' status."</p> <p>4. Patient #1 was a 76 year old male admitted to the agency on 9/01/15, for services related to insulin dependent DM. Additional diagnoses included muscle weakness. He received SN, PT and OT services. His record, including the POC, for the certification period 9/01/15 to 10/30/15, was reviewed.</p> <p>a. Patient #1's POC included Humalog insulin to be taken 3 times a day per sliding scale (dosage based on his blood glucose level as measured by a blood glucose monitor). However, his POC and medication profile, did not include the amount of insulin to be taken.</p> <p>b. Patient #1's record included a SOC comprehensive assessment completed on 9/01/15, and signed by the RN Case Manager. The assessment stated a drug regimen review was completed and no problems were identified. However, Patient #1's record included a report documenting a moderate level interaction between his Hydrochlorothiazide and his insulin.</p> <p>c. Patient #1's record included referral information from the discharging hospital. The referral information included discharge medication orders, dated 8/29/15. The orders stated Patient #1 should start taking Aspirin 81 mg daily, 1 week after his hospital discharge (9/05/15). However, Patient #1's medication profile printed on 9/14/15, did not include Aspirin.</p> <p>During an interview on 9/17/15 at 3:30 PM, the</p>	G 337			

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G 337	<p>Continued From page 150</p> <p>RN Branch Manager reviewed Patient #1's record and confirmed his POC and medication profile did not include the dosages for his sliding scale insulin, or the Aspirin ordered by the referring physician. Additionally, she confirmed a medication interaction was identified and was not documented on the SOC assessment.</p> <p>Patient #1's medication interaction was not identified during his SOC visit and his medication profile was not accurate to reflect his current medications, including dosages.</p> <p>5. Patient #15 was a 61 year old male admitted to the agency on 8/10/15, for services related to insulin dependent DM. Additional diagnoses included a foot ulcer, CHF and Parkinson's disease. He received SN, PT, HHA and MSW services. His record, including the POCs, for the certification period 8/10/15 to 10/08/15, was reviewed.</p> <p>a. Patient #15's POC included Humalog Insulin to be taken "per sliding scale, as directed." His POC and medication profile did not include the amount of insulin to be taken, or how often it should be taken.</p> <p>b. Patient #15's record included a SOC comprehensive assessment completed on 8/10/15, and signed by the RN Case Manager. The assessment stated a completed drug regimen review was completed and no problems were identified. However, Patient #15's record included a report documenting 2 severe level interactions between Xarelto (blood thinner) and Aspirin, and between Spironolactone (for HTN) and Potassium.</p>	G 337			

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G 337	<p>Continued From page 151</p> <p>During an interview on 9/17/15 at 3:05 PM, the RN Branch Manager reviewed Patient #15's record and confirmed his POC and medication profile did not include the amount of insulin to be taken per sliding scale, or how often it should be taken. Additionally, she confirmed medication interactions were identified but were not documented on the SOC assessment.</p> <p>Patient #15's medication interaction was not identified during his SOC visit and his medication profile was not accurate to reflect his current medications, including frequency and dosages.</p> <p>6. Patient #14 was a 75 year old female admitted to the agency on 1/19/15, for services related to hyposmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal). Additional diagnoses included HTN, diastolic heart failure and CHF. Her record, including the POC, for the certification period 1/19/15 to 3/19/15, was reviewed.</p> <p>a. Patient #14's record included a SOC comprehensive assessment completed on 1/19/15, and signed by the RN Case Manager. The assessment stated a drug regimen review was completed and no problems were identified. However, Patient #14's record included a report documenting 2 severe level interactions between Coumadin (blood thinner) and Levothyroxine (thyroid medication), and between Coumadin and Duloxetine (antidepressant).</p> <p>During an interview on 9/17/15 at 9:50 AM, the RN Case Manager stated medication interaction reports were available in the electronic medical record after the patient's medications were entered. However, he stated he did not enter</p>	G 337		

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G 337	<p>Continued From page 152</p> <p>medications into the system during the SOC visit because it took too much time. He stated the medications were often entered by someone in the office. The interactions were printed and sent to the patient's physician. He stated he was not aware of the interactions.</p> <p>Patient #14's medication interactions were not identified as part of her SOC assessment.</p> <p>7. Patient #4 was an 88 year old female admitted to the agency on 3/16/15, for care related to a pressure ulcer. Additional diagnoses included essential HTN, PVD and urinary incontinence. She received SN services. Her record, including the POCs, for the certification periods 7/14/15 to 9/11/15 and 9/12/15 to 11/10/15, were reviewed.</p> <p>a. Patient #4's POC dated 9/12/15, was reviewed. It included oxycodone-acetaminophen 10-325 mg, 1-2 tab, every 6 hours/PRN for pain.</p> <p>A visit was made to Patient #4's home on 9/16/15, beginning at 1:00 PM. She reported to the LPN she was out of oxycodone.</p> <p>During an interview on 9/17/15 at 11:30 AM, the LPN stated she called the office after her home visit to Patient #4 on 9/16/15. However, she stated she did not report the patient complained of pain from shingles and the patient reported she was out of oxycodone.</p> <p>The LPN stated she did not document the visit but intended to enter an order to discontinue the oxycodone. She stated she did not call the physician and did not obtain physician orders to discontinue the oxycodone.</p>	G 337		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/18/2015
NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE STREET EAST TWIN FALLS, ID 83301		
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G 337	<p>Continued From page 153</p> <p>The RN Branch Manager and the DON were present during the interview with the LPN on 9/17/15 at 11:30 AM. They confirmed the LPN did not report that Patient #4 told her she had pain from her shingles or that she was out of oxycodone.</p> <p>The LPN did not accurately review Patient #4's medication profile and did not identify the adverse effect of increased pain because she did not have prescribed pain medications in her home.</p> <p>b. Patient #4's POC dated 7/14/15, was reviewed. It included orders that stated "SN to perform wound care ...apply saturated gauze with Minnesota Solution [compounded antibiotic solution]..."</p> <p>The agency policy 2.1.008 was reviewed. It stated "orders for compounding ... shall be detailed in specific dose and frequency to be administered."</p> <p>Patient #4's POC dated 7/14/15, did not include Minnesota Solution in the medication list. In addition, it did not include Minnesota Solution in the DME/Supplies list.</p> <p>During an interview on 9/16/15 at 10:45, the DON stated she thought Minnesota Solution was a compounded solution of 3 antibiotics, but she was not sure. She was unable to state what drugs were compounded or in what doses. The DON also confirmed the compounded medication was not included in Patient #4's medication list.</p> <p>The DON confirmed the agency was unable to identify any potential side effects, drug reactions, side effects, drug interactions or duplicate drug</p>	G 337			

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G 337	Continued From page 154 therapy to Patient #4 because the specific drugs compounded were not known.	G 337			
G 340	The agency did not ensure Patient #4's medication list was complete or accurate. 484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT  The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the comprehensive assessment was updated and revised following the patient's return home from a hospital admission for 1 of 2 patients (Patient #7) whose care was resumed after a hospitalization and whose records were reviewed. This resulted in an assessment that was not sufficiently comprehensive to meet the patient's needs, and had the potential to result in adverse patient outcomes. Findings include:  Patient #7 was a 70 year old male admitted to the agency on 6/15/15, for SN, PT, and OT services related to chronic airway obstruction. Additional diagnoses included abnormal gait, HTN, chronic pain, dysphagia, coronary atherosclerosis, general muscle weakness, supplemental oxygen, history of falls, and long term medication use. His record, including the POCs, for the certification periods 6/15/15 to 8/13/15 and 8/14/15 and 10/12/15, were reviewed.	G 340	An online occurrence report was completed for patient #7 identified in the deficient practice. Patient #7 is no longer on service. DON/designee educated all clinicians on Initial Assessment and Reassessment policy with focus on appropriate follow-up of condition related to recent hospitalization. A new process will be implemented requiring TL to review 100% Resumption of Care assessments to verify assessment of body system is thorough related to recent hospitalization. Beginning 10/12/15, DON/designee will review 100% Resumptions of Care weekly to ensure appropriate follow-up on systems affected by recent hospitalization. Review will be conducted for 8 weeks and until 100% compliance achieved for 4 consecutive weeks. The DON is responsible for implementing the corrective action.	10/16/15 10/16/15 10/30/15 10/30/15	

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G 340	<p>Continued From page 155</p> <p>Patient #7's record included a transfer summary, dated 9/09/15, and signed by the RN Case Manager. It stated Patient #7 was admitted to the hospital for an injury caused by a fall.</p> <p>Patient #7's record included a resumption of care assessment, dated 9/11/15, after his discharge from the hospital. The assessment documented Patient #7 was treated for hypertension during his inpatient stay. Additionally, the assessment included documentation Patient #7 had a cardiac arrhythmia, atrial fibrillation.</p> <p>The National Institutes of Health website, accessed 9/24/15, stated atrial fibrillation is where the heart has rapid, disorganized electrical signals which causes the heart to beat rapidly and contract irregularly. Atrial fibrillation may cause chest pain and fainting. It also increases the risk of stroke and may cause heart failure.</p> <p>The assessment did not document whether Patient #7 was experiencing chest pain, fainting, dizziness, or edema. Additionally, there was no documentation of heart sounds.</p> <p>During an interview on 9/17/15 at 4:25 PM, the RN Team Lead reviewed Patient #7's record. She confirmed there was no documentation of his heart sounds or whether he had edema or had episodes of dizziness or fainting.</p> <p>The agency did not ensure Patient #7's comprehensive assessment was updated following his hospitalization.</p>	G 340			

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NAME OF PROVIDER OR SUPPLIER  IDAHO HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 222 SHOSHONE STREET EAST TWIN FALLS, ID 83301
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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>A licensure survey was completed at Idaho Home Health and Hospice 9/14/15 though 9/18/15. Immediate jeopardy to patients' health and safety was identified during the survey. The immediate jeopardy was abated prior to the survey exit conference.</p> <p>The surveyors conducting the recertification were:</p> <p>Nancy Bax RN, BSN, HFS Team Lead Dennis Kelly, RN, BSN, HFS Laura Thompson, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ABD - large gauze pad ADL - Activities of Daily Living ALF - Assisted Living Facility AMD - Antimicrobial Dressing Bid - 2 times a day BP - Blood Pressure CHF - Congestive Heart Failure CKD - Chronic Kidney Disease cm - centimeters COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DM - Diabetes Mellitus DME - Durable Medical Equipment EMR - Electronic Medical Record GERD - Gastro Esophageal Reflux Disorder HHA - Home Health Aide HTN - Hypertension IV - Intravenous lpm - liters per minute LPN - Licensed Practical Nurse mg - milligrams mg/dl - milligrams per deciliter mm/hg - millimeters of mercury MSW - Masters of Social Work</p>	N 000	<p>RECEIVED OCT 22 2015 FACILITY STANDARDS</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marilyn Davenport</i>	TITLE <i>10-21-15</i>	(X6) DATE
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N 000	Continued From page 1  NC - Nasal Cannula NPWT - Negative Pressure Wound Therapy NT - Nutritional Therapy OASIS - Outcome and Assessment Information Set OT - Occupational Therapy PICC - Peripherally Inserted Central Catheter POC - Plan of Care prn - as needed Pt - Patient PT - Physical Therapy PT/INR - Protine/International Ratio PVD - Peripheral Vascular Disease RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy UTI - Urinary Tract Infection VAC - Vacuum Assisted Closure WOCN - Wound Ostomy Continence Nurse	N 000		
N 062	03.07021. ADMINISTRATOR  N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:  i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur.  This Rule is not met as evidenced by: Refer to G143 and G144	N 062	Refer to G143 and G144	
N 091	03.07024. SK.NSG.SERV.	N 091	Refer to G170	

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N 091	Continued From page 2  N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care.  This Rule is not met as evidenced by: Refer to G170	N 091		
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 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	N 093	Refer to G331	
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:	N 094	Refer to G173	

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N 094	Continued From page 3 Refer to G173	N 094		
N 095	03.07024. SK. NSG. SERV.  N095 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  c. Provides those services requiring substantial and specialized nursing skill;  This Rule is not met as evidenced by: Refer to G174	N 095	Refer to G174	
N 097	03.07024. SK. NSG. SERV.  N097 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:  e. Prepares clinical and progress notes, and summaries of care;  This Rule is not met as evidenced by: Refer to G176	N 097	Refer to G176	
N 098	03.07024. SK. NSG. SERV.	N 098	Refer to G176	

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N 098	Continued From page 4  N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  f. Informs the physician and other personnel of changes in the patient's condition and needs;  This Rule Is not met as evidenced by: Refer to G176	N 098		
N 099	03.07024.SK. NSG. SERV.  N099 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  g. Counsels the patient and family in meeting nursing and related needs;  This Rule Is not met as evidenced by: Refer to G177	N 099	Refer to G177	
N 105	03.07024. SK. NSG. SERV.  N105 02. Licensed Practical Nurse. A licensed practical nurse perform the following:  c. Prepares equipment and	N 105	Refer to G182	

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N 105	Continued From page 5  materials for treatments observing aseptic technique as required;  This Rule is not met as evidenced by: Refer to G182	N 105		
N 124	03.07025.01.THERAPY SERV.  N124 01. Qualified Therapist. A qualified therapist duties include the following:  a. Assists in developing the plan of care and revising it when necessary;  This Rule is not met as evidenced by: Refer to G186	N 124	Refer to G186	
N 152	03.07030.01.PLAN OF CARE  N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  This Rule is not met as evidenced by: Refer to G158	N 152	Refer to G158	
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	N 163	Refer to G159	

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N 153	Continued From page 6 services for that patient. Care follows the written plan of care and includes:  a. All pertinent diagnoses;  This Rule is not met as evidenced by: Refer to G159	N 163		
N 155	03.07030. PLAN OF CARE  N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  c. Types of services and equipment required;  This Rule is not met as evidenced by: Refer to G159	N 155	Refer to G159	
N 156	03.07030.PLAN OF CARE.  N156 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:  d. Frequency of visits;  This Rule is not met as evidenced by: Refer to G159	N 156	Refer to G159	

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N 170	03.07030.04.PLAN OF CARE  N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine.  This Rule is not met as evidenced by: Refer to G160	N 170	Refer to G160	
N 172	03.07030.06.PLAN OF CARE  N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This Rule is not met as evidenced by: Refer to G164	N 172	Refer to G164	
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:	N 173	Refer to G165 and G337	

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N 173	Continued From page 8 Refer to G165 and G337	N 173			
N 176	03.07031.CLINICAL REC.  N176 02. Contents. Clinical records must include:  b. Assessments by appropriate personnel.  This Rule is not met as evidenced by: Refer to G236	N-176	Refer to G236		