



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  
BUREAU OF FACILITY STANDARDS  
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January 26, 2016

Shannon Stephenson, Administrator  
Gentiva Health Services CdA  
1230 Northwood Court Suite B  
Coeur d'Alene, ID 83814

RE: Gentiva Health Services CdA, Provider #137112

Dear Ms. Stephenson:

This is to advise you of the findings of the Medicare/Licensure survey at Gentiva Health Services CdA, which was concluded on January 8, 2016.

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

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

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

Shannon Stephenson, Administrator  
January 26, 2016  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **February 8, 2016**, and keep a copy for your records.

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

Sincerely,



on behalf of

NANCY BAX  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

NB/pmt  
Enclosures



Sylvia Creswell, Co-Supervisor  
Non-Long Term Care Section  
Bureau of Facility Standards  
P.O. Box 83720  
3232 Elder Street  
Boise, ID 83720-0009

RECEIVED  
FEB 10 2016  
FACILITY STANDARDS

February 9, 2016

Dear Sylvia,

Attached please find our plan of correction following our recertification survey. You will also find attached missed visit notes that relate to G code 158, patient #12.

We appreciate your time and patience as we prepared this plan. As you know we take these deficiencies very seriously and want to ensure we have a through plan of correction in place. The plan will be sent to you via email and the hard copy sent overnight express mail.

Sincerely

A handwritten signature in black ink, appearing to read "Shannon Stephenson MSN, BA".

Shannon Stephenson RN,BSN,MSN  
Branch Director  
Gentiva® Health Services, Inc. An Affiliate of Kindred at Home  
1230 Northwood Ctr Ct Suite C, Coeur d'Alene, ID 83814

Main office# 208-667-5470  
Tel: 208-667-5470 x238, Cell # 208-215-1529 Fax: 208-765-3873

[shannon.stephenson@gentiva.com](mailto:shannon.stephenson@gentiva.com)  
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/08/2016
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES CDA			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 NORTHWOOD CENTER CT, SUITE C COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare Recertification survey of your agency from 1/04/16 to 1/08/16. The surveyors conducting the survey were:</p> <p>Nancy Bax, RN, BSN, HFS, Team Leader Susan Costa, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>APS - Adult Protective Services CKD - Chronic Kidney Disease CHF - Congestive Heart Failure cm - centimeter DM - Diabetes Mellitus ED - Emergency Department HH - Home Health HTN - Hypertension INR - International Normalized Ratio LPN - Licensed Practical Nurse MCP - Manager of Clinical Practice MD - Medical Doctor mg - milligrams mg/dl - milligrams per deciliter MSW - Medical Social Worker OASIS - Outcome and Assessment Information Set OT - Occupational Therapy Parkinson's disease- A disorder of the central nervous system that affects movement, often including tremors. PT - Physical Therapy PTA - Physical Therapy Assistant POC - Plan of Care RN - Registered Nurse SOC - Start of Care SN - Skilled Nurse, may be either RN or LPN</p>	G 000	<p><i>See Attached Plan of correction</i></p> <p><b>RECEIVED</b> <b>FEB 10 2016</b> <b>FACILITY STANDARDS</b></p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Shannon Stephenson MSN Branch Director* / *[Signature]* TITLE  
2/8/16 (X6) DATE

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

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G 158	<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 record review and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 6 of 16 patients (#4, #7, #12, #13, #14 and #15) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include:</p> <p>1. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>a. Patient #7's POC included an order to notify her physician of a weight gain of 3 pounds in 1 day. Her record included an SN SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated her weight was 190 pounds. Patient #7's record included a SN visit note dated 12/07/15, 3 days after her SOC. The visit note stated her weight was 200, a gain of 10 pounds in 3 days. There was no documentation in Patient #7's record stating her physician was notified of her weight gain.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and</p>	G 158			

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G 158	<p>Continued From page 2</p> <p>confirmed her physician was not notified of her weight gain as ordered.</p> <p>b. Patient #7's POC included an order to notify her physician of blood glucose levels greater than 200 mg/dl. Patient #7's record included SN visit notes which recorded blood glucose levels greater than 200, as follows:</p> <ul style="list-style-type: none"> <li>- 12/28/15 Blood glucose 233</li> <li>- 12/30/15 Blood glucose 228</li> <li>- 1/04/16 Blood glucose 228</li> </ul> <p>There was no documentation in Patient #7's record stating her physician was notified of her blood glucose levels greater than 200.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her physician was not notified of her elevated blood glucose levels.</p> <p>The agency failed to ensure Patient #7's physician was notified of her elevated blood glucose levels as ordered.</p> <p>c. Patient #7's record included an SN visit note dated 12/07/14, and signed by the RN Case Manager. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/07/15.</p> <p>Patient #7's record included an SN visit note dated 12/28/14, and signed by the LPN. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/28/15.</p>	G 158			

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G 158	<p>Continued From page 3</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed INR blood tests were completed on 12/07/15 and 12/28/15, without physician orders.</p> <p>Blood tests were completed on Patient #7 without a physician's order.</p> <p>2. Patient #13 was a 62 year old male admitted to the agency on 12/24/15, for services related to cellulitis and ulceration of his left leg. Additional diagnoses included neuropathy and atrial fibrillation. His record, including the POC, for the certification period 12/24/15 to 2/21/15, was reviewed.</p> <p>Patient #13's POC included an order for wound care to a wound on his left foot. His record included an SN visit note dated 1/02/16, signed by the LPN. The note stated wound care was provided to his left foot wound and left shin wound. Patient #13's record did not include a physician's order for wound care to his left shin.</p> <p>During an interview on 1/07/16 at 2:20 PM, the Branch Director reviewed Patient #13's record and confirmed there were no orders for wound care to his left shin.</p> <p>Wound care was provided to Patient #13 without a physician's order.</p> <p>3. Patient #15 was an 80 year old male admitted to the agency on 12/10/15, for services related to acute CHF. Additional diagnoses included CKD and insulin dependent DM. He received SN, PT, OT and MSW services. His record, including the POC, for the certification period 12/10/15 to</p>	G 158			

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G 158	<p>Continued From page 4 2/07/15, was reviewed.</p> <p>a. Patient #15's POC included an order to instruct him to weigh himself daily and record the results. Additionally, it included an order to report to his physician a weight variation of 3 pounds in 2 days, or 5 pounds in 1 week.</p> <p>Patient #15's record included an SOC comprehensive assessment dated 12/10/15, and signed by the RN Case Manager. The assessment included a weight of 188 pounds and stated it was reported, rather than an actual weight obtained during the assessment. There was no documentation stating the RN verified Patient #15 had a scale in his home, was able to safely step on the scale, and was able to accurately read his weight on the scale.</p> <p>Patient #15's record included an SN visit note dated 12/23/15, signed by the LPN. The visit note stated Patient #15 was educated on the importance of weighing himself daily and documenting his daily weight. However, the SN visit note did not include an actual or reported weight.</p> <p>Patient #15's record included an SN visit note dated 12/29/15, signed by the RN Case Manager. The note did not include an actual or reported weight. Patient #15's record did not include SN visit notes after 12/29/15.</p> <p>Patient #15's POC included SN goals. It stated "Patient/caregiver will verbalize/demonstrate knowledge of disease management for CHF, Recognize signs and symptoms of complications and symptoms to report..."</p>	G 158			

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G 158	<p>Continued From page 5</p> <p>Patient #15's record included a discharge summary dated 1/06/16, signed by the RN Case Manager. The note stated "Patient is knowledgeable of disease process and signs and symptoms to report to emergency management...Has met all skilled nursing goals."</p> <p>A visit was made to Patient #15's home on 1/07/15 at 11:00 AM, to observe an MSW visit. During the visit Patient #15 stated the nurse had completed her visits and would not return. When asked, Patient #15 stated he was not weighing himself daily, and did not remember being instructed by the nurses to record his weight daily or to notify his physician about a change in his weight.</p> <p>During an interview on 1/07/16 at 5:00 PM, the Branch Director reviewed Patient #15's record and confirmed Patient #15 was not assessed to determine his ability to weigh himself. Additionally, she confirmed his weight was not monitored on every SN visit.</p> <p>The SN failed to assess Patient #15 for weight gain and failed to ensure he was able to monitor his weight independently prior to discharge from SN services.</p> <p>b. Patient #15's POC included an order for SN visits 2 times a week for 2 weeks, effective Sunday, 12/13/15. His record included an SN missed visit note dated 12/15/15. No additional SN visit was documented for the week of 12/13/15.</p> <p>During an interview on 1/07/16 at 5:00 PM, the Branch Director reviewed Patient #15's record and confirmed 2 SN visits were ordered, and no</p>	G 158			

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G 158	<p>Continued From page 6</p> <p>SN visits were completed, for the week of 12/13/15. She confirmed Patient #15's record included documentation of 1 SN missed visit and stated it was unclear why a second SN visit was not made that week.</p> <p>The agency failed to ensure SN visits were completed as ordered.</p> <p>4. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers on his feet and coccyx. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>Patient #4's record included an order for daily SN visits during week 2 of his certification period (3/01/15 to 3/07/15). However, his record did not include documentation of an SN visit on 3/07/15. Additionally, his record did not include documentation his physician was notified of the missed visit.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed an SN visit was not completed on 3/07/15 as ordered. Additionally, she confirmed Patient #4's physician was not notified of the missed visit.</p> <p>Patient #4's SN visits were not completed as ordered by his physician.</p> <p>5. Patient #12 was an 84 year old female with a SOC of 10/20/15. She received SN services related to wound care. Additional diagnoses</p>	G 158			

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G 158	<p>Continued From page 7</p> <p>included dysphagia, dementia and stroke. Patient #12's record and POC for the certification period 12/19/15 to 2/16/16, was reviewed.</p> <p>Patient #12's POC included SN visits once weekly for 5 weeks, and Home Health Aide visits two times weekly for 5 weeks. However, no Home Health Aide visits were performed. Her record documented a missed Home Health Aide visit on 12/30/15.</p> <p>During an interview on 1/08/16 beginning at 8:25 AM, the MCP reviewed Patient #12's record and confirmed no Home Health Aide visits were performed. She was unable to find documentation in the record to determine why no visits had occurred.</p> <p>Patient #12 did not receive Home Health Aide visits as ordered on her POC.</p> <p>6. Patient #14 was a 74 year old female with a SOC of 12/16/15. She received SN, PT, and OT services related to a recent fall and multiple fractures. Additional diagnoses included diabetes, vertigo, hypertension and anemia. Her record, including the POC, for the period 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #14's POC included SN visits once a week for 1 week, then two times weekly for 4 weeks. In Week 3, (12/27/15 through 1/02/16,) Patient #14's record included 1 nursing visit on 12/30/15. There was no documentation in her record to indicate why the 2nd visit was not performed.</p> <p>Additionally, Patient #14's POC included Home Health Aide visits once weekly for 3 weeks, and</p>	G 158			

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G 158	Continued From page 8 twice weekly for 5 weeks. Week 2 of Patient #14's record (12/20/15 to 12/26/15) did not include documentation of a Home Health Aide visit, and there was no documentation in her record to indicate a why the visit was not performed.  During an interview on 1/07/16 beginning at 5:18 PM, the MCP reviewed Patient #14's record and confirmed the SN and the Home Health Aide missed visits. The MCP also confirmed there was no documentation of a missed visit.  Patient #14 did not receive SN and Home Health Aide visits 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 observation, patient interview, medical record review, and staff interview it was determined the agency failed to ensure the POC covered all appropriate items for 3 of 16 patients, (# 1, #6, and #8) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include:	G 159			

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G 159	<p>Continued From page 9</p> <p>1. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16, were reviewed.</p> <p>Patient #6's POC included wound care orders to cleanse her right lower leg with wound cleanser, apply silver alginate, and cover the wound with optifoam. Her POC did not include an ace wrap on the right lower leg, however, her record included documentation that during nursing visits between 11/11/15 and 1/07/16, 7 of the 17 SN visits, an ace wrap was applied.</p> <p>During a home visit on 1/07/16 beginning at 9:45 AM, the RN was observed to perform wound care. After wound care was completed, she applied an ace wrap on Patient #6's lower right leg and foot. Her POC did not include an ace wrap.</p> <p>During the observation of wound care, Patient #6 spoke with the RN about a large callus on a toe on her right foot. She stated she had to keep a cushion on the toe, and it caused pain when she walked. Patient #6 told the RN that she could have a pedicure and the callus could be removed during the pedicure. The RN did not provide instruction to Patient #6 regarding precautions and treatment of her painful callus.</p> <p>Nursing notes for the visit on 1/07/16 were reviewed. The notes did not include information related to Patient #6's callus, or evidence her physician was notified.</p>	G 159			

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G 159	<p>Continued From page 10</p> <p>During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed the POC did not include wrapping her foot and lower leg with an ace wrap. She confirmed the RN did not include documentation regarding the callus.</p> <p>Patient #6's POC was not comprehensive to include care for the callus on her foot, and use of an ace wrap.</p> <p>2. Patient #8 was a 66 year old female with a SOC of 8/27/15. She received SN services related to wound care. Additional diagnoses included gait disturbances, back pain, hypertension, CHF, depression and peripheral vascular disease. Her record and POC for the certification period 12/25/15 to 2/22/16, were reviewed.</p> <p>Patient #8's diagnoses included CHF, and her record indicated she used oxygen continuously. The National Institutes for Health website, accessed 1/12/16, 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 #8's POC did not include interventions and education related to her CHF.</p> <p>A home visit to observe care provided to Patient #8 by an LPN was conducted on 1/06/16 beginning at 9:30 AM. Patient #8 was wearing compression stockings on each leg. However,</p>	G 159			

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G 159	<p>Continued From page 11 compression stockings were not included on her POC.</p> <p>During an interview on 1/08/16 beginning at 7:45 AM, the MCP reviewed Patient #8's record and confirmed compression stockings were not included on her POC. Additionally, the MCP confirmed she did not see reference to weights or interventions related to CHF.</p> <p>Patient #8's POC was not comprehensive to include all relevant interventions.</p> <p>3. Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.</p> <p>Patient #1's POC included oxygen to be used as needed for shortness of breath. However, her POC did not include equipment to deliver her oxygen.</p> <p>Patient #1's POC included insulin to be taken 3 times a day, for a blood sugar greater than 150 mg/dl. However, her POC did not include supplies to administer her insulin, or a glucometer to test her blood sugar to determine the need for insulin.</p> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed her POC did not include all equipment and supplies needed for her care.</p> <p>Patient #1's POC was not comprehensive to</p>	G 159			

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G 159	Continued From page 12	G 159			
G 164	include all equipment and supplies needed for her care. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 3 of 16 patients ( #1, #3, and #9) whose records were reviewed. This resulted in missed opportunities for the physician to alter patients' POCs to meet their needs. Findings include:  1. Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.  a. Patient #1's record included a PT visit note dated 6/08/15, and signed by the Physical Therapist. The note stated the Physical Therapist observed Patient #1 filling her medication box. The note stated "...when patient went to refill boxes, she had trouble even opening boxes, and then made multiple mistakes re-filling boxes putting extra pills into days that still had pills remaining in them. Filling box is visually	G 164			

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G 164	<p>Continued From page 13</p> <p>challenging for patient..." There was no documentation Patient #1's physician was notified of her difficulty filling her medication box, and resultant risk of errors in taking her medications.</p> <p>b. Patient #1's record included a PT visit note dated 6/17/15, and signed by the PTA. The note stated Patient #1 reported she had a fall in the middle of the night, landing on her buttocks, and complained of soreness in her buttocks. The note stated Patient #1's fall was reported to the Physical Therapist. However, there was no documentation Patient #1's physician was notified of her fall.</p> <p>Patient #1's record included a PT visit note dated 6/23/15, and signed by the Physical Therapist. The note stated Patient #1 complained of soreness in her buttocks from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <p>Patient #1's record included a PT visit note dated 6/26/15, and signed by the Physical Therapist. The note stated Patient #1 reported her buttocks was still sore from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <p>Patient #1's record included a PT visit note dated 7/01/15, and signed by the Physical Therapist. The note stated Patient #1 complained of soreness in her buttocks from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <p>During an interview on 1/07/16 at 4:00 PM, the</p>	G 164			

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G 164	<p>Continued From page 14</p> <p>Branch Director reviewed Patient #1's record and confirmed there was no documentation stating her physician was notified of her fall and continued complaints of pain after the fall.</p> <p>2. Patient #3 was a 95 year old female with a SOC of 3/13/15. She received SN services related to wound care. Additional diagnoses included chronic pain, depression and abnormal gait. Patient #3's record and POC for the certification period 7/11/15 to 9/08/15, were reviewed.</p> <p>Patient #3's record included a nursing note dated 7/20/15. The note stated she had fallen sometime between the SN visit on 7/17/15 and the current visit date of 7/20/15. Her record did not include documentation of physician notification of the fall.</p> <p>The POC included nursing visits until 9/08/15, however Patient #3's record included a discharge assessment dated 7/22/15. Her record did not include documentation why home health services stopped. Additionally, Patient #3's record did not document her physician was notified of plans to discharge her before the ordered nursing visits were completed.</p> <p>During an interview on 1/07/16 beginning at 5:00 PM, the MCP reviewed Patient #3's record and confirmed there was no documentation of physician notification regarding her fall or intended discharge.</p> <p>The agency did not inform Patient #3's physician of her fall and early discharge.</p>	G 164			

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G 164	<p>Continued From page 15</p> <p>3. Patient #9 was an 86 year old male with a SOC of 12/24/15. He received SN, PT, OT and Home Health Aide services related to a fall which resulted in multiple fractures. Additional diagnoses included dementia and Parkinson's disease. His medical record and POC for the certification period 12/24/15 to 2/21/16, was reviewed.</p> <p>In a nursing visit note dated 1/06/16, the RN documented Patient #9's blood pressure was 98/60. His POC did not include parameters for alerting his physician of vital signs that were not within normal range. The visit note did not include a repeat assessment of the blood pressure.</p> <p>Patient #9's record included a "Case Communication Note," dated 1/06/16, addressed to the MCP and Patient #9's care team. The RN wrote that she reported to Patient #9's physician's agent that "...patient's son has stopped giving him his Parkinsons [sic] approximately one week ago."</p> <p>During an interview on 1/08/16 beginning at 8:45 AM, the MCP reviewed Patient #9's record and stated the note referred to Parkinson's disease medication. She confirmed the note did not state which medication was stopped by the son. She also confirmed the record did not indicate which medication the RN spoke with the physician's agent about.</p> <p>Patient #9's nurse did not specify which medication was stopped, and she did not notify his physician of abnormal vital signs.</p>	G 164			
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN	G 165			

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G 165	<p>Continued From page 16 ORDERS</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 medical record review and staff interview it was determined the agency failed to ensure drugs and treatments were administered only as ordered by the physician for 2 of 16 patients (#4 and #13) whose records were reviewed. This resulted in unauthorized treatments and had the potential to negatively impact the safety and quality of patient care. Findings include:</p> <p>1. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers on his feet and coccyx. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>a. Patient #4's POC included orders for wound care to his foot and coccyx wounds. The order stated to cleanse his wounds, apply silver alginate dressing, and cover with foam dressing, gauze wrap and tape.</p> <p>Patient #4's record included documentation of wound care provided during SN visits. SN visit notes stated antibiotic ointment was applied to his wounds. Examples include:</p> <p>-SN visit note dated 2/28/15, stated Triple Antibiotic ointment was applied to wounds.</p>	G 165			

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G 165	Continued From page 17  -SN visit note dated 3/01/15, stated Neosporin ointment was applied to wounds.  -SN visit note dated 3/02/15, stated Neosporin ointment was applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.  -SN visit note dated 3/03/15, stated Triple Antibiotic ointment and Neosporin ointment were applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.  -SN visit notes dated 3/05/15 and 3/06/15, stated Neosporin ointment was applied to all wounds.  -SN visit note dated 3/09/15, stated Neosporin ointment and Silvadene (a prescription medication to treat infection) were applied to all wounds.  Patient #4's wound care orders did not include the application of Triple Antibiotic ointment, Neosporin ointment, or Silvadene. Additionally, Patient #4's medication profile did not include Triple Antibiotic ointment, Neosporin ointment or Silvadene.  During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed Triple Antibiotic ointment, Neosporin ointment and Silvadene were applied to his wounds without a physician's order.  Patient #4's wound care was not provided as ordered by his physician.  b. Patient #4's record included an SN visit note dated 3/05/15, and signed by the LPN. The note	G 165			

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G 165	<p>Continued From page 18</p> <p>stated Patient #4 sustained a new wound on his left great toe. It stated the new wound was cleansed and Neosporin ointment and a Band-Aid were applied. Patient #4's record did not include a physician's order for care to his left great toe.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed wound care was completed to his left great toe without a physician's order.</p> <p>Wound care was provided to Patient #4 without a physician's order.</p> <p>3. Patient #13 was a 62 year old male admitted to the agency on 12/24/15, for services related to cellulitis and ulceration of his left leg. Additional diagnoses included neuropathy and atrial fibrillation. His record, including the POC, for the certification period 12/24/15 to 2/21/15, was reviewed.</p> <p>Patient #13's POC included an order for wound care to his left foot. His record included an SN visit note dated 1/02/16, signed by the LPN. The note stated wound care was provided to his left foot wound and left shin wound. Patient #13's record did not include physician's orders for wound care to his left shin.</p> <p>During an interview on 1/07/16 at 2:20 PM, the Branch Director reviewed Patient #13's record and confirmed there were no orders for wound care to his left shin.</p> <p>Wound care was provided to Patient #13 without a physician's order.</p>	G 165			
G 170	484.30 SKILLED NURSING SERVICES	G 170			

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G 170	<p>Continued From page 19</p> <p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure SN services were furnished in accordance with the plan of care for 3 of 12 patients (#4, #7, and #13) who received SN services and whose records were reviewed. This resulted in unauthorized treatments being performed and a lack of physician notification of changes in patients' conditions. Findings include:</p> <p>1. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers on his feet and coccyx. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>a. Patient #4's POC included orders for wound care to his foot and coccyx wounds. The order stated to cleanse his wounds, apply silver alginate dressing, and cover with foam dressing, gauze wrap and tape.</p> <p>Patient #4's record included documentation of wound care provided during SN visits. SN visit notes stated antibiotic ointment was applied to his wounds. Examples include:</p> <p>-SN visit note dated 2/28/15, stated Triple Antibiotic ointment was applied to wounds.</p>	G 170			

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G 170	<p>Continued From page 20</p> <p>-SN visit note dated 3/01/15, stated Neosporin ointment was applied to wounds.</p> <p>-SN visit note dated 3/02/15, stated Neosporin ointment was applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.</p> <p>-SN visit note dated 3/03/15, stated Triple Antibiotic ointment and Neosporin ointment were applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.</p> <p>-SN visit notes dated 3/05/15 and 3/06/15, stated Neosporin ointment was applied to all wounds.</p> <p>-SN visit note dated 3/09/15, stated Neosporin ointment and Silvadene (a prescription medication to treat infection) were applied to all wounds.</p> <p>Patient #4's wound care orders did not include the application of Triple Antibiotic ointment, Neosporin ointment, or Silvadene. Additionally, Patient #4's medication profile did not include Triple Antibiotic ointment, Neosporin ointment or Silvadene.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed Triple Antibiotic ointment, Neosporin ointment and Silvadene were applied to his wounds without a physician's order.</p> <p>b. Patient #4's record included an SN visit note dated 3/05/15, and signed by the LPN. The note stated Patient #4 sustained a new wound on his left great toe. It stated the new wound was cleansed and Neosporin ointment and a Band-Aid were applied. Patient #4's record did not include</p>	G 170			

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G 170	<p>Continued From page 21</p> <p>a physician's order for care to his left great toe.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed wound care was completed to his left great toe without a physician's order.</p> <p>c. Patient #4's record included an order for daily SN visits during week 2 of his certification period (3/01/15 to 3/07/15). However, his record did not include documentation of an SN visit on 3/07/15. Additionally, his record did not include documentation his physician was notified of the missed visit.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed an SN visit was not completed on 3/07/15 as ordered. Additionally, she confirmed Patient #4's physician was not notified of the missed visit.</p> <p>Patient #4's wound care and SN visits were not completed as ordered by his physician.</p> <p>2. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>a. The National Institutes for Health website, accessed 1/13/16, included a patient education guide for 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</p>	G 170			

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G 170	<p>Continued From page 22</p> <p>signs of heart failure is sudden weight gain due to the accumulation of fluid.</p> <p>Patient #7's POC included an order to notify her physician of a weight gain of 3 pounds in 1 day. Her record included a SN SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated her weight was 190 pounds. Patient #7's record included a SN visit note dated 12/07/15, 3 days after her SOC. The visit note stated her weight was 200, a gain of 10 pounds in 3 days. Patient #7's record did not state her physician was notified of her weight gain.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her physician was not notified of her weight gain as ordered.</p> <p>b. Patient #7's POC included an order to notify her physician of blood glucose levels greater than 200 mg/dl. Patient #7's record included SN visit notes which recorded blood glucose levels greater than 200, as follows:</p> <ul style="list-style-type: none"> <li>- 12/28/15 Blood glucose 233</li> <li>- 12/30/15 Blood glucose 228</li> <li>- 1/04/16 Blood glucose 228</li> </ul> <p>There was no documentation Patient #7's physician was notified of her blood glucose levels greater than 200.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her physician was not notified of her elevated blood glucose levels.</p>	G 170			

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G 170	<p>Continued From page 23</p> <p>The agency failed to ensure Patient #7's physician was notified of her elevated blood glucose levels as ordered.</p> <p>c. Patient #7's record included an SN visit note dated 12/07/14, and signed by the RN Case Manager. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/07/15.</p> <p>Patient #7's record included an SN visit note dated 12/28/14, and signed by the LPN. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/28/15.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed INR blood tests were completed on 12/07/15 and 12/28/15, without physician orders.</p> <p>Blood tests were completed on Patient #7 without a physician's order.</p> <p>3. Patient #13 was a 62 year old male admitted to the agency on 12/24/15, for services related to cellulitis and ulceration of his left leg. Additional diagnoses included neuropathy and atrial fibrillation. His record, including the POC, for the certification period 12/24/15 to 2/21/15, was reviewed.</p> <p>Patient #13's POC included an order for wound care to a wound on his left foot. His record included an SN visit note dated 1/02/16, signed by the LPN. The note stated wound care was provided to his left foot wound and left shin</p>	G 170			

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G 170	Continued From page 24 wound. Patient #13's record did not include a physician's order for wound care to his left shin.  During an interview on 1/07/16 at 2:20 PM, the Branch Director reviewed Patient #13's record and confirmed there were no orders for wound care to his left shin.	G 170			
G 175	The SN provided wound care to Patient #13 without a physician's order. <b>484.30(a) DUTIES OF THE REGISTERED NURSE</b>  The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.  This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview it was determined the agency failed to ensure the registered nurse effectively evaluated patients to determine needed preventative or rehabilitative nursing measures for 4 of 12 patients (#6, #7, #10, and #15) who received SN services and whose records were reviewed. Failure to properly identify and implement necessary precautions had the potential to place patients at risk for negative outcomes. Findings include:  The National Institutes for Health website, accessed 1/13/16, included a patient education guide for 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	G 175			

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G 175	<p>Continued From page 25</p> <p>the accumulation of fluid. Additionally, it stated shortness of breath is a common symptom of heart failure, due to decreased ability of the heart to effectively pump blood. Oxygen saturation levels can be measured to determine the oxygen level in the blood.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director stated she expected every patient with a diagnosis heart failure to be weighed during every SN visit.</p> <p>1. Patients with a diagnosis of heart failure were not assessed for symptoms of heart failure exacerbation. Examples include:</p> <p>a. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>i. Patient #7's POC included an order to instruct her to weigh herself daily and record the results. Additionally, it included an order to report to her physician a weight variation of 3 pounds in 1 day.</p> <p>Patient #7's record included an SN SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated her weight was 190 pounds. Patient #7's record included an SN visit note dated 12/07/15, 3 days after her SOC. The visit note stated her weight was 200, a gain of 10 pounds in 3 days. An SN visit note dated 12/10/15, stated her weight was 199 pounds. However, the next 2 SN visit notes, dated</p>	G 175			

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G 175	<p>Continued From page 26 12/14/15 and 12/16/15, did not include Patient #7's weight, to further monitor for weight gain related to her heart failure.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed Patient #7's weight was not monitored on every SN visit to assess for complications of heart failure.</p> <p>The SN failed to obtain Patient #7's weight to monitor her status related to heart failure.</p> <p>ii. Patient #7's POC included an order to obtain her oxygen saturation level on every SN visit, as needed for shortness of breath. Patient #7's SN visit notes dated 12/10/15, 12/14/15, 12/22/15, and 1/04/16 stated she was short of breath with moderate exertion. However, the notes did not include her oxygen saturation level.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her oxygen saturation level should have been obtained when she was noted to be short of breath.</p> <p>The SN failed to obtain Patient #7's oxygen saturation levels as ordered.</p> <p>b. Patient #15 was an 80 year old male admitted to the agency on 12/10/15, for services related to acute CHF. Additional diagnoses included CKD and insulin dependent DM. He received SN, PT, OT and MSW services. His record, including the POC, for the certification period 12/10/15 to 2/07/15, was reviewed.</p> <p>Patient #15's POC included an order to instruct</p>	G 175			

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G 175	<p>Continued From page 27</p> <p>him to weigh himself daily and record the results. Additionally, it included an order to report to his physician a weight variation of 3 pounds in 2 days, or 5 pounds in 1 week.</p> <p>Patient #15's record included an SOC comprehensive assessment dated 12/10/15, and signed by the RN Case Manager. The assessment included a weight of 188 pounds and stated it was reported, rather than an actual weight obtained during the assessment. There was no documentation stating the RN verified Patient #15 had a scale in his home, was able to safely step on the scale, and was able to accurately read his weight on the scale.</p> <p>Patient #15's record included an SN visit note dated 12/23/15, signed by the LPN. The visit note stated Patient #15 was educated on the importance of weighing himself daily and documenting his daily weight. However, the SN visit note did not include an actual or reported weight.</p> <p>Patient #15's record included an SN visit note dated 12/29/15, signed by the RN Case Manager. The note did not include an actual or reported weight. Patient #15's record did not include SN visit notes after 12/29/15.</p> <p>Patient #15's POC included SN goals. It stated "Patient/caregiver will verbalize/demonstrate knowledge of disease management for CHF, Recognize signs and symptoms of complications and symptoms to report..."</p> <p>Patient #15's record included a discharge summary dated 1/06/16, signed by the RN Case Manager. The note stated "Patient is</p>	G 175			

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G 175	<p>Continued From page 28</p> <p>knowledgeable of disease process and signs and symptoms to report to emergency management...Has met all skilled nursing goals."</p> <p>A visit was made to Patient #15's home on 1/07/15 at 11:00 AM, to observe an MSW visit. During the visit Patient #15 stated the nurse had completed her visits and would not return. When asked, Patient #15 stated he was not weighing himself daily, and did not remember being instructed by the nurses to record his weight daily or to notify his physician about a change in his weight.</p> <p>During an interview on 1/07/16 at 5:00 PM, the Branch Director reviewed Patient #15's record and confirmed Patient #15 was not assessed to determine his ability to weigh himself. Additionally, she confirmed his weight was not monitored on every SN visit.</p> <p>The SN failed to assess Patient #15 for weight gain and failed to ensure he was able to monitor his weight independently prior to discharge from SN services.</p> <p>2. Patients' wounds were not thoroughly assessed to determine healing or deterioration. Examples include:</p> <p>a. Patient #10 was an 88 year old male admitted to the agency on 7/01/15, for services related to a pressure ulcer on his heel. Additional diagnoses included CHF and CKD. He received SN and Home Health Aide services. His record, including the POCs, for the certification periods 10/29/15 to 12/27/15, and 12/28/15 to 2/25/15, was reviewed.</p> <p>The agency's policy 03-05 titled "Assessment"</p>	G 175			

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G 175	<p>Continued From page 29</p> <p>revised 12/14/15, stated "At least weekly, the wound(s) status will be observed and documented, including dimensions (L x W x D in cm), drainage amount and type, wound bed appearance and surrounding skin condition."</p> <p>Patient #10's POC included assessment of his heel wound.</p> <p>Patient #10's record included an SN visit note dated 12/11/15, and signed by the LPN. The visit note included an assessment of his left heel wound. It was described as a Stage 3 pressure ulcer, measuring 0.5 cm long by 0.4 cm wide. No depth was documented.</p> <p>Patient #10's record included an SN visit note dated 12/18/15, and signed by the LPN. The visit note included an assessment of his left heel wound. It was described as a Stage 4 pressure ulcer, measuring 0.8 cm long, 0.7 cm wide, and 0.2 cm deep. The "Care Coordination" section of the note had a check mark next to RN, indicating communication occurred, however, there was no documentation of what was discussed. It could not be determined if the RN was notified of the increased wound size and severity.</p> <p>A recertification comprehensive assessment was completed by the RN on 12/23/15. The assessment stated Patient #10's heel wound was a Stage 3 pressure ulcer. However, the assessment did not include wound measurements. SN visit notes dated 12/28/15, and 12/30/15, did not include measurements of his heel wound.</p> <p>An SN visit note dated 12/30/15, and signed by the LPN stated "Pt [patient] saw MD yesterday</p>	G 175			

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G 175	<p>Continued From page 30</p> <p>and was advised to start going back to wound clinic weekly for evaluation of r [right] heel wound. It cont [continues] to be painful and getting larger in size and depth. However, no wound measurements were documented in the 20 days between 12/18/15 and current date of 1/07/16.</p> <p>During an interview on 1/07/16 at 1:50 PM, the Branch Director reviewed Patient #10's record and confirmed the most recent wound measurements documented in his record were dated 12/18/15.</p> <p>The agency failed to ensure the SN monitored the status of Patient #10's wound.</p> <p>b. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16 was reviewed.</p> <p>Patient #6's POC included orders for SN visits twice weekly for 9 weeks. Wound measurements were not assessed on week 2 and week 4.</p> <p>During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed the wound measurements were not performed weekly as per the agency guidelines.</p> <p>Patient #6's wound measurements were not performed weekly.</p>	G 175			
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE	G 176			

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G 176	<p>Continued From page 31</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, policy review, and medical record review, it was determined the facility failed to ensure RNs appropriately prepared clinical notes, and coordinated care with the physician for 2 of 12 patients (#4, and #6) who received SN services and whose records were reviewed. These failures resulted in a lack of clarity as to the course of patient care, the physician who was managing care, and had the potential to negatively impact quality and coordination of patient care. Findings include:</p> <p>1. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>Patient #4's record included SN visit notes and Wound Assessment Addendums, that documented the status of his wounds throughout his certification period. However, the wound documentation lacked accuracy and consistency. Examples include:</p> <p>a. Patient #4's record included an SOC comprehensive assessment completed on 2/28/15, and signed by the RN. The assessment included a section to document the stage of</p>	G 176			

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G 176	<p>Continued From page 32 pressure ulcers, as follows:</p> <p>Stage 1 - Intact skin with non-blanchable redness of a localized area Stage 2 - Partial thickness loss of dermis presenting as a shallow open ulcer Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed Stage 4 - Full thickness tissue loss with visible bone, tendon, or muscle</p> <p>Patient #4's SOC comprehensive assessment, dated 2/28/15, and completed by the RN, documented he had 2 stage 2 pressure ulcers, 1 stage 3 pressure ulcer, and 1 stage 4 pressure ulcer, a total of 4 pressure ulcers. However, the wound assessment completed on 2/28/15, did not identify a Stage 4 pressure ulcer. The 4 ulcers were described as follows:</p> <p>Left heel - Diabetic ulcer (slow healing wound that occurs in people with diabetes, due to decreased circulation, not caused by pressure) Coccyx - Stage 3 pressure ulcer Left plantar - Stage 2 pressure ulcer Right plantar - Stage 2 pressure ulcer</p> <p>It was unclear whether the left heel wound was a Stage 4 pressure ulcer or a diabetic ulcer.</p> <p>b. Patient #4's left plantar wound was identified by the SN as follows:</p> <ul style="list-style-type: none"> <li>- SOC 2/28/15 - Stage 2</li> <li>- 3/16/15 - Stage 4</li> <li>- 3/24/15 - Stage 3</li> <li>- 4/01/15 - Stage 1</li> <li>- 4/06/15 - Stage 4</li> </ul>	G 176			

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G 176	<p>Continued From page 33 - 4/08/15 - Stage 2</p> <p>It was unclear whether the left plantar wound was a Stage 1, 2, 3, or 4.</p> <p>c. Patient #4's right plantar wound was identified by the SN as follows:</p> <ul style="list-style-type: none"> <li>- SOC 2/28/15 - Stage 2 pressure ulcer</li> <li>- 3/16/15 - Stage 3 pressure ulcer</li> <li>- 4/01/15 - Stage 2 pressure ulcer</li> <li>- 4/06/15 - Stage 3 pressure ulcer</li> <li>- 4/08/15 - Stage 2 pressure ulcer</li> </ul> <p>It was unclear whether the right plantar wound was a Stage 2 or 3 pressure ulcer.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and stated the documentation related to his wounds was unclear. She confirmed the description and staging of his ulcers did not accurately reflect the status of his wounds.</p> <p>The agency failed to ensure documentation completed by SNs accurately described the status of Patient #4's wounds.</p> <p>2. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16, were reviewed.</p> <p>Patient #6's record included a referral to home health from her family practice physician. After the initial SOC visit on 11/11/15, the RN</p>	G 176			

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G 176	Continued From page 34 documented she contacted the family practice physician to inform him of the SOC and to obtain verbal orders for the POC. However, the POC was sent to a different physician, a surgeon, for signature. The surgeon was the physician who signed the POC, not the referring physician who ordered HH services and gave verbal orders for the POC.  During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed the physician listed on the POC was not the referring physician and the physician who the RN notified after her SOC visit. She was unable to determine why the POC was sent to a different physician. During the interview, the MCP noted Patient #6's record referred to each of the 2 physicians, and stated it was confusing to know which physician was managing her care.	G 176			
G 177	Patient #6's record lacked clarity as to who was the managing physician for her care. <b>484.30(a) DUTIES OF THE REGISTERED NURSE</b>  The registered nurse counsels the patient and family in meeting nursing and related needs.  This STANDARD is not met as evidenced by: Based on record review, observation during a home visit, and patient and staff interview, it was determined the agency failed to ensure patients and/or caregivers were provided necessary instruction by nursing staff for 1 of 12 patients (#8) who received SN services and whose records were reviewed. This resulted in a failure to provide advance notice of patient discharge	G 177			

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G 177	Continued From page 35 and a failure to instruct a patient related to oxygen safety. Findings include:  Patient #8 was a 66 year old female with a SOC of 8/27/15. She received SN services related to wound care. Additional diagnoses included gait disturbances, back pain, hypertension, CHF, depression and peripheral vascular disease. Her record and POC for the certification period 12/25/15 to 2/22/16, were reviewed.  A home visit was conducted to observe Patient #8's care provided by an LPN on 1/06/16 beginning at 9:30 AM. Upon entry into the living room, next to the fireplace were 4 upright unsecured oxygen tanks. The LPN provided care to Patient #8 in the same room, within 10 feet from the fireplace, and upright unsecured oxygen tanks. She did not appear to recognize that the location of the oxygen tanks posed a danger to Patient #8 and her husband. After the LPN left the home, Patient #8's husband was asked by the surveyor about the unsecured oxygen tanks. He stated the tanks were full, and stated the holder for the tanks was in the car. He was cautioned to remove the oxygen tanks to another area, away from the fireplace, and not to store them upright. Patient #8 and her husband stated they did not receive storage instructions regarding the oxygen tanks by the agency staff.	G 177			
G 186	484.32 THERAPY SERVICES  The qualified therapist assists the physician in evaluating the patient's level of function, and	G 186			

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G 186	<p>Continued From page 36</p> <p>helps develop the plan of care (revising it as necessary.)</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure PT staff alerted the physician to changes in patient condition for 1 of 12 patients (#1) who received therapy services and whose records were reviewed. This had the potential to interfere with the physician's ability to evaluate the patient's level of care, and if needed, to alter the plan of care. Findings include:</p> <p>1. Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.</p> <p>a. Patient #1's record included a PT visit note dated 6/08/15, and signed by the Physical Therapist. The note stated the Physical Therapist observed Patient #1 filling her medication box. The note stated "...when patient went to refill boxes, she had trouble even opening boxes, and then made multiple mistakes re-filling boxes putting extra pills into days that still had pills remaining in them. Filling box is visually challenging for patient..."</p> <p>Patient #1's POC included Humalog insulin, to be taken 3 times a day for a blood sugar greater than 150 mg/dl. However, there was no documentation stating the Physical Therapist assessed Patient #1's ability to use a glucometer</p>	G 186			

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G 186	<p>Continued From page 37</p> <p>to test her blood sugar, or her ability to prepare and inject her insulin, due to her decreased vision.</p> <p>There was no documentation stating Patient #1's physician was notified of her difficulty filling her medication box, and resultant risk of errors in taking her medications, including her insulin.</p> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed the record and confirmed the Physical Therapist did not communicate with Patient #1's physician regarding the problem she had managing her medications.</p> <p>b. Patient #1's record included a PT visit note dated 6/17/15, and signed by the PTA. The note stated Patient #1 reported she had a fall in the middle of the night, landing on her buttocks, and complained of soreness in her buttocks. The note stated Patient #1's fall was reported to the Physical Therapist. However, there was no documentation Patient #1's physician was notified of her fall.</p> <p>Patient #1's record included a PT visit note dated 6/23/15, and signed by the Physical Therapist. The note stated Patient #1 complained of soreness in her buttocks from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <p>Patient #1's record included a PT visit note dated 6/26/15, and signed by the Physical Therapist. The note stated Patient #1 reported her buttocks was still sore from her recent fall. There was no documentation Patient #1's physician was notified</p>	G 186			

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G 186	Continued From page 38 of her fall and continued soreness.  Patient #1's record included a PT visit note dated 7/01/15, and signed by the Physical Therapist. The note stated Patient #1 complained of soreness in her buttocks from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.  During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed there was no documentation stating her physician was notified of her fall and continued complaints of pain after the fall.  The Physical Therapist did not communicate pertinent information to Patient #1's physician.	G 186			
G 187	484.32 THERAPY SERVICES  The qualified therapist prepares clinical and progress notes.  This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure the Physical Therapist recorded pertinent findings for 1 of 12 patients (#1) who received therapy services and whose records were reviewed. This resulted in omission of relevant information in a discharge summary. Findings include:  Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses	G 187			

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G 187	Continued From page 39 included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.  Patient #1's record included a PT visit note dated 6/17/15, and signed by the PTA. The note stated Patient #1 reported she had a fall in the middle of the night, landing on her buttocks, and complained of soreness in her buttocks.  Patient #1's record included a PT Discharge Summary Report, dated 7/10/15, and signed by the Physical Therapist. The report stated Patient #1 did not have any falls in the past month.  During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed the Discharge Summary was incorrect, and did not include the fall she reported on 6/17/15.  Patient #1's Discharge Summary, completed by the Physical Therapist, was not accurate.	G 187			
G 229	484.36(d)(2) SUPERVISION  The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.  This STANDARD is not met as evidenced by: Based on clinical record review and interview of staff, it was determined the agency failed to ensure on-site home health aide supervisory visits were conducted by an RN or qualified therapist at least every 2 weeks for 4 of 7 patients	G 229			

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G 229	<p>Continued From page 40 (#4, #7, #10, and #14), who received Home Health Aide services and whose records were reviewed. This had the potential to prevent the agency from identifying and correcting substandard care by Home Health Aides. Findings include:</p> <p>1. Patient #14 was a 74 year old female with a SOC of 12/16/15. She received SN, PT, OT and Home Health Aide services related to a recent fall and multiple fractures. Additional diagnoses included diabetes, vertigo, hypertension and anemia. Her record, including the POC, for the period 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #14's POC included Home Health Aide visits once weekly for 3 weeks, and twice weekly for 5 weeks. Her record documented 3 Home Health Aide visits were provided during the 4 weeks she was receiving services. The record did not include evidence of missed visit documentation. Visits completed by the Home Health Aide were documented as follows:</p> <ul style="list-style-type: none"> <li>- Once on week 1 as ordered (12/18/15).</li> <li>- Week 2 (12/20/15 to 12/26/15) no Home Health Aide visits were documented.</li> <li>- Week 3 (12/27/15 to 1/02/16) one Home Health Aide visit was documented on 12/31/15.</li> <li>- Week 4 (1/03/16 to 1/09/16) one Home Health Aide visit was documented on 1/04/16.</li> </ul> <p>Additionally, Patient #14's record did not include evidence of Home Health Aide supervision by an RN.</p>	G 229			

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G 229	<p>Continued From page 41</p> <p>During an interview on 1/07/15 beginning at 5:18 PM, the MCP reviewed Patient #14's record and confirmed there was no documentation of Home Health Aide supervision by an RN.</p> <p>Patient #14 received unsupervised Home Health Aide services.</p> <p>2. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>Patient #4's POC included an order for Home Health Aide visits 2 times a week. The first Home Health Aide visit was documented on 3/09/15. The first Home Health Aide supervisory visit, completed by an RN, was documented on 4/06/15, 26 days after Home Health Aide services were initiated.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed Home Health Aide supervisory visits were not completed every 14 days.</p> <p>The agency failed to ensure Patient #4 received on-site Home Health Aide supervisory visits no less frequently than every 2 weeks.</p> <p>3. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including</p>	G 229			

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G 229	<p>Continued From page 42</p> <p>the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>Patient #7's POC included an order for Home Health Aide visits 2 times a week. The first Home Health Aide visit was documented on 12/09/15. However, no Home Health Aide RN supervisory visits were documented as of 1/07/15, 28 days after Home Health Aide services were initiated.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed no Home Health Aide supervisory visits were documented.</p> <p>The agency failed to ensure Patient #7 received on-site Home Health Aide supervisory visits no less frequently than every 2 weeks.</p> <p>4. Patient #10 was an 88 year old male admitted to the agency on 7/01/15, for services related to a pressure ulcer on his heel. Additional diagnoses included CHF and CKD. He received SN and Home Health Aide services. His record, including the POCs, for the certification periods 10/29/15 to 12/27/15, and 12/28/15 to 2/25/15, was reviewed.</p> <p>Patient #10's POC for the certification period 10/29/15 to 12/27/15, included an order for Home Health Aide visits 2 times a week. Home Health Aide visits were documented 2 times a week from 11/02/15 to 12/21/15. However, no Home Health Aide supervisory visits were documented during the 60 day certification period.</p> <p>During an interview on 1/07/16 at 1:50 PM, the Branch Director reviewed Patient #10's record and confirmed no Home Health Aide supervisory visits were completed during the certification</p>	G 229			

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NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES CDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 NORTHWOOD CENTER CT, SUITE C COEUR D'ALENE, ID 83814</b>		
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G 229	Continued From page 43 period 10/29/15 to 12/27/15.	G 229			
G 322	<p>The agency failed to ensure Patient #10 received on-site Home Health Aide supervisory visits no less frequently than every 2 weeks.</p> <p>484.20(b) ACCURACY OF ENCODED OASIS DATA</p> <p>The encoded OASIS data must accurately reflect the patient's status at the time of assessment.</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 encoded OASIS data reflected the patient's status at the time of assessment for 4 of 16 patients whose records were reviewed (#1, #7, #10 and #13). This resulted in the reporting of inaccurate data. Findings include:</p> <p>1. Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.</p> <p>Patient #1's record included a discharge OASIS comprehensive assessment dated 7/10/15, and signed by the Physical Therapist. OASIS item M2300 stated Patient #1 used a hospital ED and was admitted to the hospital due to an injury caused by a fall, during the certification period 5/15/15 to 7/10/15. However, Patient #1's record did not include documentation of an ED visit or hospital admission.</p>	G 322			

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G 322	<p>Continued From page 44</p> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed she did not have an ED visit or hospitalization during the certification period.</p> <p>The agency failed to ensure Patient #1's discharge OASIS contained accurate information.</p> <p>2. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, following discharge from a rehabilitation facility, after a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>Patient #7's record included a discharge summary from the rehabilitation facility, dated 12/03/15. The summary stated she had a total hip arthroplasty on 8/28/15, more than 3 months prior to her HH admission. Additionally, the summary stated the incision to her left hip had healed without complications.</p> <p>Patient #7's record included a SOC OASIS comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. OASIS item M1340 stated Patient #7 had at least one surgical wound. OASIS item M1342 stated the status of the wound was early/partial granulation. Instant OASIS Answers 2015, a CMS-based reference for OASIS guidance, stated "For the purposes of determining the healing status, a surgical wound can be considered fully healed and not reportable as a current surgical wound approximately 30 days after complete epithelialization."</p> <p>During an interview on 1/07/16 at 4:30 PM, the</p>	G 322			

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G 322	<p>Continued From page 45</p> <p>Branch Director reviewed the record and stated Patient #7's healed incision line should not have been reported as a surgical wound on her SOC OASIS.</p> <p>Patient #7's OASIS was not accurate to reflect her status at the time of her SOC.</p> <p>3. Patient #10 was an 88 year old male admitted to the agency on 7/01/15, for services related to a pressure ulcer on his heel. Additional diagnoses included CHF and CKD. He received SN and Home Health Aide services. His record, including the POCs, for the certification periods 10/29/15 to 12/27/15, and 12/28/15 to 2/25/15, was reviewed.</p> <p>Patient #10's record included a Recertification OASIS assessment dated 12/23/15, and signed by the RN Case Manager. The assessment described 1 wound, on his left heel. The assessment stated 100% of his left heel wound was covered with a scab.</p> <p>OASIS item M1308 stated Patient #10 had 1 Stage 3 pressure ulcer. Instant OASIS Answers 2015, a CMS-based reference for OASIS guidance, provided guidance on pressure ulcer staging. It stated ulcers that can not be visualized due to the presence of a scab should be documented on the OASIS as "Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar."</p> <p>During an interview on 1/07/16 at 5:30 PM, the MCP reviewed Patient #10's record and confirmed the pressure ulcer on his left heel was unstageable at the time of his recertification OASIS.</p>	G 322			

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G 322	Continued From page 46 Patient #10's OASIS was not accurate to reflect his status at the time of his recertification assessment.  4. Patient #13 was a 62 year old male admitted to the agency on 12/24/15, for services related to cellulitis and ulceration of his left leg. Additional diagnoses included neuropathy and atrial fibrillation. His record, including the POC, for the certification period 12/24/15 to 2/21/15, was reviewed.  Patient #13's record included a physician order for HH services. The note stated "Anticipated discharge from acute care 12/23/15..." His record included an SOC OASIS assessment dated 12/24/15, and signed by the RN. OASIS item M1000 asks from which inpatient facility the patient was discharged in the last 14 days. It was answered "Patient was not discharged from an inpatient facility."  During an interview on 1/07/16 at 2:20 PM, the Branch Director reviewed Patient #13's record and confirmed OASIS item M1000 was answered incorrectly on his SOC OASIS.  Patient #10's OASIS was not accurate to reflect his status at the time of his SOC assessment.	G 322			
G 337	484.55(c) DRUG REGIMEN REVIEW  The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.	G 337			

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G 337	Continued From page 47  This STANDARD is not met as evidenced by: Based on review of medical records and agency policies, observations during home visits, and staff and patient interviews, it was determined the agency failed to ensure the comprehensive assessment included all medications the patient was taking, as well as a medication review to evaluate for drug interactions, identify significant side effects, and identify duplicative therapy and non-compliance with drug therapy for 6 of 8 patients, (#5, #6, #7, #8, #9, and #14) for whom home visits were completed. This resulted in the potential for patients to experience adverse outcomes related to medications. Findings include:  The agency's policy 03-05, titled "Assessment," revised 12/14/15, included a section titled "Review of Patients' Medications." It stated "At the time of the initial assessment and each subsequent assessment, prescription, over-the-counter drugs, and herbals the patient is taking will be evaluated. Review will include viewing the bottles and labels of the drugs the patient has; asking about other over-the counter medications the patient is taking..." Additionally, it stated "The agency will promptly notify the physician of any signs or symptoms of adverse side effects the patient is experiencing, any contraindicated drugs or drug combinations, and any other significant negative responses to the medications. Medications will be entered in the clinical record and will be updated as the agency becomes aware of changes in the prescribed medications." This policy was not followed. Examples include:  1. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, following discharge	G 337			

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G 337	<p>Continued From page 48</p> <p>from a rehabilitation facility, after a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>a. A visit was made to Patient #7's home on 1/06/16 at 1:45 PM, to observe an OT visit. During the visit by the surveyor Patient #7's medications were reviewed and compared to the medication profile in her HH record. The following discrepancies were noted:</p> <ul style="list-style-type: none"> <li>-Patient #7's medication profile included Senokot, a laxative. She stated she did not have Senokot in her home. Additionally, she stated she was having problems with diarrhea and did not need a laxative.</li> <li>- Patient #7 stated she was taking Lomotil for diarrhea. Lomotil was not included on her medication profile.</li> <li>- Patient #7's medication profile included Tramadol, a pain medication. She stated she had not taken Tramadol since she was in the rehabilitation facility, and did not have Tramadol in her home.</li> <li>- Patient #7's medication profile included Norco, a pain medication. She stated she had not taken Norco since she was in the rehabilitation facility, and did not have Norco in her home.</li> <li>- Patient #7 stated she took Tylenol as needed for pain. Her medication profile did not include Tylenol.</li> </ul>	G 337			

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G 337	<p>Continued From page 49</p> <ul style="list-style-type: none"> <li>- Patient #7's medication profile included Diltiazem CD, an antiarrhythmic, 240 mg daily. She stated she was taking 120 mg daily, as instructed by her physician.</li> <li>- Patient #7's medication profile included Atorvastatin, a cholesterol lowering medication. She stated she was given Atorvastatin while in the rehabilitation facility, but upon return to her home she resumed her Simvastatin, another cholesterol lowering medication, prescribed by her physician.</li> <li>- Patient #7's medication profile included Novolog insulin, 3 units daily with breakfast, 6 units daily with lunch, and 8 units daily with dinner. She stated that was how her insulin was administered at the rehabilitation facility. However, upon her return home she resumed her sliding scale insulin (insulin dosage determined by current blood glucose level as measure by a glucose testing device) as ordered by her physician. She stated she tested her blood glucose 4 times a day. Patient #7's medication profile did not include sliding scale insulin.</li> </ul> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed the record and confirmed Patient #7's medication profile was not accurate.</p> <p>Patient #7's medication profile was not accurate.</p> <p>b. Patient #7's record included an SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated 3 major drug interactions were identified during a review of her medications. Additionally, the assessment stated</p>	G 337			

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G 337	<p>Continued From page 50</p> <p>Patient #7's physician was contacted to resolve the significant medications issues. However, an SN visit note dated 12/10/15, signed by a different RN, stated "Dr. [name] is unavailable this week and has not responded to the medication issue order."</p> <p>Patient #7's record included a "Medication Issue Communication/Order" dated 12/06/15, and signed by the RN Case Manager. The form was not signed by Patient #7's physician as of 1/07/16.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed the record and confirmed Patient #7's major drug interactions were not resolved with her physician as of 1/07/16.</p> <p>The agency failed to ensure Patient #7's identified drug interactions were resolved with her physician.</p> <p>2. Patient #5 was a 67 year old female admitted to the agency on 1/04/16, following surgery to repair a fractured ankle. She received PT services. Her record, including the POC, for the certification period 1/04/16 to 3/03/16, was reviewed.</p> <p>A visit was made to Patient #5's home on 1/04/16 at 12:15 PM, to observe the SOC comprehensive assessment completed by the Physical Therapist. During the visit, the Physical Therapist copied Patient #5's medications from her hospital discharge information. He did not visualize her medications.</p> <p>During an interview on 1/07/16 at 2:10 PM, the</p>	G 337			

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G 337	<p>Continued From page 51</p> <p>Branch Director stated the agency's policy requires clinicians to view patients' medications during the SOC assessment. She confirmed the policy was not followed for Patient #5's SOC assessment.</p> <p>Patient #5's medications were not reviewed during her SOC comprehensive assessment.</p> <p>3. Patient #8 was a 66 year old female with a SOC of 8/27/15. She received SN services related to wound care. Additional diagnoses included gait disturbances, back pain, hypertension, CHF, depression and peripheral vascular disease. Her record and POC for the certification period 12/25/15 to 2/22/16, were reviewed.</p> <p>A home visit to observe LPN services for Patient #8 was conducted on 1/06/16 at 9:30 AM. The LPN, Patient #8 and the surveyor reviewed her medications in the home with the medication list and her POC. The following was noted:</p> <ul style="list-style-type: none"> <li>-Patient #8's medication list included the pain medications Norco and Hydrocodone. She told the LPN that she took another family member's oxycodone, as well as, her own pain medications. Patient #8 stated she took the oxycodone twice daily, and had been taking them since December.</li> <li>- Patient #8's POC specified Melatonin 3 mg 1 tablet daily, however, Patient #8 stated she did not take the medication.</li> </ul> <p>During an interview on 1/07/16 beginning at 7:45 AM, the MCP reviewed Patient #8's record and stated it was her third certification period, and medication non-compliance issues had occurred</p>	G 337			

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G 337	<p>Continued From page 52</p> <p>multiple times. She stated a referral to APS occurred, and it was recommended that Patient #8's pharmacy prepare her medications in bubble packs, but she refused.</p> <p>Patient #8's POC list of medications was not current when medications were reviewed in the home.</p> <p>4. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16, were reviewed.</p> <p>A home visit to observe nursing care provided to Patient #6, was conducted on 1/07/16, beginning at 9:45 AM. After the wound care was provided, her medications were reviewed with Patient #6, the RN, and the surveyor. The POC list of medications was not consistent with what was found in the home. Examples include:</p> <ul style="list-style-type: none"> <li>- The POC specified Gabapentin 100 mg 1 tablet every night. Patient #6 stated she took 2 each night, and had "always" taken 2.</li> <li>- Silvadene cream was not on the POC. However, Patient #6 stated she applied the cream under her right breast.</li> <li>- Iron tablets were not on the POC, however Patient #6 stated she took iron tablets daily.</li> <li>- Antidiarrheal tablets were not on the POC. However, Patient #6 stated she took them when she took antibiotics.</li> </ul>	G 337			

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G 337	<p>Continued From page 53</p> <p>- Patient #6's record included an SN visit note dated 11/27/15, which noted Patient #6 had 1 dose of Cipro left. Cipro (an antibiotic) was not on the POC. Her record did not include further entries about Cipro.</p> <p>During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed she did not see any evidence Patient #6 was on Cipro other than the entry by the LPN on 11/27/15. She confirmed the home visit medications that were reviewed with the RN differed from the POC.</p> <p>Patient #6's POC list of medications was not current when medications were reviewed in the home.</p> <p>5. Patient #9 was an 86 year old male with an SOC of 12/24/15. He received SN, PT, OT and Home Health Aide services related to a fall which resulted in multiple fractures. Additional diagnoses included dementia and Parkinson's disease. His medical record and POC for the certification period 12/24/15 to 2/21/16, were reviewed.</p> <p>A home visit to observe services provided to Patient #9 by the Home Health Aide was conducted on 1/06/15 at 1:00 PM. Patient #9's POC medication list and medications in the home were reviewed with his son and surveyor. Discrepancies were noted as follows:</p> <p>- Patient #9's POC specified Carbidopa/Levodopa 95 mg capsules, (2) twice daily. Patient #9's medication bottle in the home noted it was 47.5 mg, and his son stated he took 1 tablet twice</p>	G 337			

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

PRINTED: 01/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137112</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES CDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 NORTHWOOD CENTER CT, SUITE C COEUR D'ALENE, ID 83814</b>		
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G 337	<p>Continued From page 54</p> <p>daily. (The dose of the medication on Patient #9's medication list and POC was 4 times the amount he was actually taking.) According to Drugs.com, this medication is used to treat Parkinson's disease.</p> <p>Patient #9's record included a "Case Communication Note," dated 1/06/16, and was addressed to the MCP and Patient #9's care team. The RN wrote that she reported to Patient #9's physician's agent that "...patient's son has stopped giving him his Parkinsons [sic] approximately one week ago." The note to the care team was incorrect, as the only medication that was on his POC and in his home used for Parkinson's disease was Carbidopa/Levodopa, and he was taking the medication, however, in a lower dosage.</p> <p>- Patient #9's POC specified Flecainide Acetate 150 mg, 1/2 tablet twice daily. Patient #9's son stated he took 1/2 tablet once daily, for a daily dose of 75 mg.</p> <p>- Patient #9's POC specified Lisinopril 5 mg 1 tablet daily. Patient #9's son stated he did not take the medication after his hospitalization, as his father's blood pressure was low and he did not need it.</p> <p>- Patient #9's POC specified Rivastigmine Tartrate 1.5 mg, 1 daily. Patient #9's son stated he never filled the prescription. He stated it was for treatment of dementia, and he did not think it was needed.</p> <p>- The SOC assessment dated 12/24/15, documented Patient #9 took Tylenol every 6 hours as needed for hip pain, however, the</p>	G 337			

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G 337	<p>Continued From page 55</p> <p>medication was not included on the medication list or POC.</p> <p>During an interview on 1/08/16 beginning at 8:45 AM, the MCP reviewed Patient #9's record and confirmed the medications reviewed in the home did not match the POC.</p> <p>Patient #9's home medication regime was different from that on his POC.</p> <p>6. Patient #14 was a 74 year old female with a SOC of 12/16/15. She received SN, PT, and OT services related to a recent fall and multiple fractures. Additional diagnoses included diabetes, vertigo, hypertension and anemia. Her record, including the POC, for the certification period 12/16/15 to 2/13/16, was reviewed.</p> <p>A home visit to observe services provided to Patient #14 by the PTA was conducted on 1/06/15 at 10:00 AM. Patient #14's medication list and medications in the home were reviewed with her and the PTA. Discrepancies were noted as follows:</p> <ul style="list-style-type: none"> <li>- Patient #14's POC specified Metformin 750 mg twice daily, however, the container in the home, as well as, the hospital discharge orders specified 850 mg twice daily. Patient #14 stated she took 850 mg, one in the AM and one in the PM.</li> <li>- Patient #14's POC specified Hydroxyzine 10 mg, 4 times daily as needed for anxiety. The medication container in the home contained 50 mg tablets, to be taken 4 times daily as needed.</li> <li>- Patient #14's POC specified Coumadin 7.5 mg daily. Patient #14 stated she took 7.5 mg every</li> </ul>	G 337			

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G 337	Continued From page 56 day except Sunday, when she took only 5 mg.  During an interview on 1/07/16 beginning at 5:18 AM, the MCP reviewed Patient #14's record. She stated the agency clinicians were instructed to review medications and medication changes with each visit. She was unable to determine the reason the medications in Patient #14's home did not match her medication profile.  Patient #14's home medication regime was different from that on her POC.	G 337			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>OAS001016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/08/2016</b>
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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State Recertification survey of your agency from 1/04/16 to 1/08/16. The surveyors conducting the survey were:</p> <p>Nancy Bax, RN, BSN, HFS, Team Leader Susan Costa, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>CKD - Chronic Kidney Disease CHF - Congestive Heart Failure DM - Diabetes Mellitus HTN - Hypertension LPN - Licensed Practical Nurse MCP - Manager of Clinical Practice OT - Occupational Therapy PT - Physical Therapy POC - Plan of Care RN - Registered Nurse SOC - Start of Care SN - Skilled Nurse, may be either RN or LPN</p>	N 000	<p><i>See Attached Plan of Correction</i></p> <p><b>RECEIVED FEB 10 2016 FACILITY STANDARDS</b></p>	
N 091	<p>03.07024. SK.NSG.SERV.</p> <p>N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care.</p> <p>This Rule is not met as evidenced by: Refer to G 170</p>	N 091		
N 096	<p>03.07024. SK. NSG. SERV.</p> <p>N096 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that</p>	N 096		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Shannon Stephenson MSN Branch Director</i>	TITLE	(X6) DATE  <i>2/8/16</i>
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N 096	Continued From page 1  all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  d. Initiates appropriate preventive and rehabilitative nursing procedures;  This Rule is not met as evidenced by: Refer to G 175	N 096		
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 G 176	N 097		
N 098	03.07024. SK. NSG. SERV.  N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  f. Informs the physician and	N 098		

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N 098	Continued From page 2  other personnel of changes in the patient's condition and needs;  This Rule is not met as evidenced by: Refer to G 176	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 G 177	N 099		
N 102	03.07024.SK.NSG.SERV.  N102 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:  j. For patients receiving care from a licensed practical nurse, the registered nurse reviews the plan of care and nursing services received at least every two (2) weeks and documents this in the patient's	N 102		

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N 102	<p>Continued From page 3 medical record.</p> <p>This Rule is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure sufficient RN supervision of LPN skilled nursing services for 5 of 12 patients (#6, #7, #10, #11 and #14) who received SN services. This negatively impacted quality and coordination of patient care. Findings include:</p> <p>During the survey entrance conference on 1/04/16 beginning at 8:35 AM, the Branch Director stated when an LPN was providing SN visits, the RN completed a supervisory visit at a minimum of every 2 weeks. She stated the LPN supervision was documented on the first page of the SN visit note.</p> <p>The agency's policy 03-05, titled "Assessment," revised 12/14/15, stated "When assigning wound care to the LPN/LVN, the RN is responsible for reassessment visits at least every two weeks and more frequently as necessary based on the complexity of the wound or surgical incision, and patient's comorbidities."</p> <p>1. Patient #14 was a 74 year old female with a SOC of 12/16/15. She received SN, PT, and OT services related to a recent fall and multiple fractures. Additional diagnoses included diabetes, vertigo, hypertension and anemia. Her record and POC for the certification period 12/16/15 to 2/13/16, were reviewed.</p> <p>Patient #14's orders for SN services was for one visit the first week, and twice weekly for 4 weeks. Her record indicated she had a total of 5 nursing visits after her SOC. Four of the visits were by an</p>	N 102		
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N 102	<p>Continued From page 4</p> <p>LPN. The RN visit on 12/22/15, included information that a supervisory visit was performed, but there was no indication of who was supervised. Additionally, the LPN visit notes included documentation that supervisory visits were performed on each visit, however, it was unclear why an LPN was documenting supervision of herself.</p> <p>During an interview on 1/07/16 beginning at 5:18 PM, the MCP reviewed Patient #14's record and confirmed the LPN had documented supervisory visits of herself. She stated the LPN should not have marked that section in the nursing visit notes. The MCP confirmed that although the RN documented a supervisory visit, she did not indicate the LPN she was supervising.</p> <p>Patient #14's record lacked clarity as to the supervision of LPN's by the RN.</p> <p>2. Patient #11 was an 83 year old male with a SOC of 12/04/15. He received SN services related to multiple burns on his back. His record and certification for the period 12/04/15 to 2/01/16, were reviewed.</p> <p>Patient #11 had a total of 12 nursing visits during his certification period. He had two different LPN's that provided care for 7 of those visits. Supervisory visits by the RN were documented, however, the RN identified one LPN and not the other.</p> <p>During an interview on 1/07/16 beginning at 5:07 PM, the MCP reviewed Patient #11's record and stated the RN provided a supervisory visit on the LPN that is on her team. She was unable to determine why the other LPN was not included. Patient #11's RN did not sufficiently supervise the</p>	N 102		

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N 102	<p>Continued From page 5</p> <p>LPN's that provided his care.</p> <p>3. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16 were reviewed.</p> <p>Patient #6's POC included orders for SN visits twice weekly for 9 weeks. During the period of 12/03/15 to 12/24/15, she received 5 LPN visits and no RN visits. Wound measurements were not assessed on week 2 and week 4, which were both visits by an LPN. Additionally, the LPN visit on 12/10/15, was the first visit where an ace wrap was applied to her right lower leg after wound care was provided. Patient #6's record did not include an order for ace wraps.</p> <p>During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed the every 2 week supervision of Patient #6's wound and of the LPN was not performed.</p> <p>4. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>Patient #7's SN visits dated 12/16/15, 12/22/15, and 12/28/15 were provided by an LPN. No visits were provided by an RN from 12/16/15 to 12/28/15. Patient #7's record included an SN visit note dated 12/30/15, and signed by the RN. However, the note did not include documentation</p>	N 102		
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N 102	<p>Continued From page 6</p> <p>of an LPN supervisory visit. Patient #7's record did not include documented supervision of the LPN.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed the RN did not provide supervision of the LPN.</p> <p>The agency failed to ensure SN services were supervised by an RN.</p> <p>5. Patient #10 was an 88 year old male admitted to the agency on 7/01/15, for services related to a pressure ulcer on his heel. Additional diagnoses included CHF and CKD. He received SN and Home Health Aide services. His record, including the POCs, for the certification periods 10/29/15 to 12/27/15, and 12/28/15 to 2/25/15, was reviewed.</p> <p>Patient #10's POC for the certification periods 10/29/15 to 12/27/15, included an order for wound care to be provided 2 times a week by an SN. SN visits dated 11/05/15, 11/09/15, 11/13/15, 11/18/15, 11/20/15, 11/24/15, and 11/27/15 were provided by an LPN. No visits were provided by an RN from 11/05/15 to 11/27/15.</p> <p>An RN visit dated 11/02/15, included documentation of supervision of LPN services. The next RN visit was documented on 12/01/15, 27 days later.</p> <p>During an interview on 1/07/16 at 1:50 PM, the Branch Director reviewed the record and confirmed the RN did not reassess Patient #10's wound or supervise the LPN every 2 weeks as required by the agency's policy.</p> <p>The agency failed to ensure SN services were</p>	N 102		
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N 102	Continued From page 7 supervised by an RN.	N 102		
N 119	03.07024.04.SK.NSG.SERV.  N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days.  This Rule is not met as evidenced by: Refer to G 229	N 119		
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 G 124	N 124		
N 126	03.07025.THERAPY SERV.  N126 01. Qualified Therapist. A qualified therapist duties include the following:	N 126		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 126	Continued From page 8  c. Prepares clinical and progress notes, and summaries of care, and  This Rule is not met as evidenced by: Refer to G 126	N 126		
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 G 158	N 152		
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 G 159	N 155		
N 161	03.07030.PLAN OF CARE	N 161		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>OAS001016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/08/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES CDA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 NORTHWOOD CENTER CT, SUITE C COEUR D'ALENE, ID 83814</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 161	Continued From page 9  N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  i. Medication and treatment orders;  This Rule is not met as evidenced by: Refer to G 159	N 161		
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 G 164	N 172		
N 173	03.07030.07.PLAN OF CARE  N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check 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	N 173		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>OAS001016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/08/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES CDA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 NORTHWOOD CENTER CT, SUITE C COEUR D'ALENE, ID 83814</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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N 173	Continued From page 10  medication and promptly report any problems to the physician.  This Rule is not met as evidenced by: Refer to G 165 and G 337	N 173		
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Plan of Correction – Gentiva Health Services Provider # 137112  
 1/18/169Response to : Medicare/Licensure Survey – State of Idaho  
 State Survey Date: January 4, to January 8, 2016

*SSP/POD 2/9/16*

<b>Deficiency</b> Key: BD=Branch Director MCP=Manager of Clinical Practice MCPQA = Manager of Clinical Practice Quality Assurance CTC=Care Team Coordinator-scheduler LINK = electronic medical record system	<b>How the deficiency will be corrected</b>	<b>Who will be responsible for making the corrections</b>	<b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b>	<b>When the correction will be completed</b>
<b>G158 – 484.14 Acceptance of patients, POC, Med Supervision N152</b>  484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 6 of 16 patients (#4, #7, #12, #13, #14 and #15) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include:		Regional VP of Clinical and/or Director of Clinical operations, AVP, BD, MCP, MCPQA	Area/Regional/Agency leadership will have biweekly calls to assess compliance and adherence to plan of correction as well as trends for stated audits.	2/19/16
1. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.  a. Patient #7's POC included an order to notify her physician of a weight gain of 3 pounds in 1 day. Her record included an SN SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated her weight was 190 pounds. Patient #7's record included a SN visit note dated 12/07/15, 3 days after her SOC. The visit note stated her weight was 200, a gain of 10 pounds in 3 days. There was no documentation in Patient #7's record stating her physician was notified of her weight gain.  During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and	<ul style="list-style-type: none"> <li>Pt #7 MD notified of need for INR order to be signed on INR form, faxed for signature. Returned 1/13/16</li> </ul>	MCP, MCPQA, Branch Director	<ul style="list-style-type: none"> <li>Mandatory meeting for all clinicians and office staff to review findings (from state exit) – conducted 1/13/16  <i>(Discussed Wound policy and procedures, Standards of practice CHF, Supervisory visit policy and procedures, SOC initial assessment and documentations, exit interview and pending G code deficiencies, plan of correction from 1/13/16 forward, roles and responsibilities of each team member including leadership team)</i></li> <li>Team strongly advised regarding performing care on any patient without ensuring physician orders are in place</li> </ul>	1/13/16

<b>Deficiency</b> Key: BD=Branch Director MCP=Manager of Clinical Practice MCPQA = Manager of Clinical Practice Quality Assurance CTC=Care Team Coordinator-scheduler LINK = electronic medical record system	<b>How the deficiency will be corrected</b>	<b>Who will be responsible for making the corrections</b>	<b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b>	<b>When the correction will be completed</b>
<p><b>G158 and N152 continued</b></p> <p>confirmed her physician was not notified of her weight gain as ordered.</p> <p>b. Patient #7's POC included an order to notify her physician of blood glucose levels greater than 200 mg/dl. Patient #7's record included SN visit notes which recorded blood glucose levels greater than 200, as follows:</p> <ul style="list-style-type: none"> <li>- 12/28/15 Blood glucose 233</li> <li>- 12/30/15 Blood glucose 228</li> <li>- 1/04/16 Blood glucose 228</li> </ul> <p>There was no documentation in Patient #7's record stating her physician was notified of her blood glucose levels greater than 200.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her physician was not notified of her elevated blood glucose levels.</p> <p>The agency failed to ensure Patient #7's physician was notified of her elevated blood glucose levels as ordered.</p> <p>c. Patient #7's record included an SN visit note dated 12/07/14, and signed by the RN Case Manager. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/07/15.</p> <p>Patient #7's record included an SN visit note dated 12/28/14, and signed by the LPN. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/28/15.</p> <hr/> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed INR blood tests were completed on 12/07/15 and 12/28/15, without physician orders.</p> <p>Blood tests were completed on Patient #7 without a physician's order.</p>	<p>Pt #7 cont.</p>		<p>and those orders must be followed as written.</p> <ul style="list-style-type: none"> <li>• MCP performance coaching to clinicians not meeting standards of care</li> <li>• MCP will monitor notes for MD contact on v/s parameters via chart audits. 100% CHF charts, check Q week-monitor active patients with CHF in top 6 Dx</li> <li>• Mandatory Nurses meeting on 1/13/16- educated on having orders for all labs-use of point of care devices vs venipuncture</li> <li>• MCP monitor via online activity in Link when care provided without orders, clinician will be counseled regarding visits without orders</li> <li>• MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s or biometric values outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, and Therapy Team Lead and Branch director during quarterly chart review and with weekly final claims review. Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/13/16</p> <p>Beginning 1/20/16 and ongoing</p> <p>1/13/16</p> <p>1/13/16 and ongoing</p> <p>1/13/16 and ongoing</p>



<b>Deficiency</b> Key: BD=Branch Director MCP=Manager of Clinical Practice MCPQA = Manager of Clinical Practice Quality Assurance CTC=Care Team Coordinator-scheduler LINK = electronic medical record system	<b>How the deficiency will be corrected</b>	<b>Who will be responsible for making the corrections</b>	<b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b>	<b>When the correction will be completed</b>
<b>G158 and N152 continued</b>			or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with weekly final claims review. Non adherent staff will be coached via corrective counseling. <ul style="list-style-type: none"> <li>• MCP reviews orders for completeness and adherence via 100% wound chart audits q. 2 wks, in addition to 10% quarterly chart audits.</li> <li>• MCPQA doing 100% wnd audits and wnd case conferences Q2wks</li> <li>• MCP and CTC ensuring orders are in place via reports in LINK system weekly,</li> <li>• Team Case Conference moved to Q week beginning 2/17/116 to facilitate increased MCP,MCPQA oversight</li> <li>• MCP performance coaching to clinicians not meeting standards, Branch Director coaching to MCPQA and MCP that are not meeting performance standards</li> </ul>	1/13/16  1/18/16  1/13/16 and ongoing  2/5/16 and ongoing  1/13/18 and ongoing weekly  2/17/16 and then weekly  1/13/16 and prn

<b>Deficiency</b> Key: BD=Branch Director MCP=Manager of Clinical Practice MCPQA = Manager of Clinical Practice Quality Assurance CTC=Care Team Coordinator-scheduler LINK = electronic medical record system	<b>How the deficiency will be corrected</b>	<b>Who will be responsible for making the corrections</b>	<b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b>	<b>When the correction will be completed</b>
<b>G158 and N152 continued</b>				
<p>3. Patient #15 was an 80 year old male admitted to the agency on 12/10/15, for services related to acute CHF. Additional diagnoses included CKD and insulin dependent DM. He received SN, PT, OT and MSW services. His record, including the POC, for the certification period 12/10/15 to 2/07/16, was reviewed.</p> <p>a. Patient #15's POC included an order to instruct him to weigh himself daily and record the results. Additionally, it included an order to report to his physician a weight variation of 3 pounds in 2 days, or 5 pounds in 1 week.</p> <p>Patient #15's record included an SOC comprehensive assessment dated 12/10/15, and signed by the RN Case Manager. The assessment included a weight of 188 pounds and stated it was reported, rather than an actual weight obtained during the assessment. There was no documentation stating the RN verified Patient #15 had a scale in his home, was able to safely step on the scale, and was able to accurately read his weight on the scale.</p> <p>Patient #15's record included an SN visit note dated 12/23/15, signed by the LPN. The visit note stated Patient #15 was educated on the importance of weighing himself daily and documenting his daily weight. However, the SN visit note did not include an actual or reported weight.</p> <p>Patient #15's record included an SN visit note dated 12/29/15, signed by the RN Case Manager. The note did not include an actual or reported weight. Patient #15's record did not include SN visit notes after 12/29/15.</p> <p>Patient #15's POC included SN goals. It stated "Patient/caregiver will verbalize/demonstrate knowledge of disease management for CHF, Recognize signs and symptoms of complications and symptoms to report..."</p>	<p>Patient #15: SN services were discharged on 12/29 thus unable to correct for this patient. SN Discharge summary sent to MD on 1/6/16. Pt was d/c'd from agency 1/15/16, PT final agency discharge summary sent to MD on 1/21/16 prior to receiving final survey report.</p>	<p>MCP, MCPQA, branch director</p> <p>Clinician</p> <p>Clinician</p>	<ul style="list-style-type: none"> <li>Mandatory meeting for all clinicians and office staff to review findings (from state exit) – conducted 1/13/16 <i>(Discussed Wound policy and procedures, Standards of practice CHF, Supervisory visit policy and procedures, SOC initial assessment and documentations, exit interview and pending Gcode deficiencies, plan of correction from 1/13/16 forward, roles and responsibilities of each team member including leadership team)</i></li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.</li> <li>Vital Sign parameters or biometric values orders by MD or by the American Heart Association recommendations will be utilized, documented and reported to the MD if outside the normal parameters set in the POC.</li> </ul>	<p>1/13/16</p>

<p><b>Deficiency</b>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p><b>How the deficiency will be corrected</b></p>	<p><b>Who will be responsible for making the corrections</b></p>	<p><b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b></p>	<p><b>When the correction will be completed</b></p>
<p><b>G158 and N152 continued</b></p> <div style="border: 1px solid black; padding: 5px;"> <p>Patient #15's record included a discharge summary dated 1/06/16, signed by the RN Case Manager. The note stated "Patient is knowledgeable of disease process and signs and symptoms to report to emergency management...Has met all skilled nursing goals."</p> <p>A visit was made to Patient #15's home on 1/07/15 at 11:00 AM, to observe an MSW visit. During the visit Patient #15 stated the nurse had completed her visits and would not return. When asked, Patient #15 stated he was not weighing himself daily, and did not remember being instructed by the nurses to record his weight daily or to notify his physician about a change in his weight.</p> <p>During an interview on 1/07/16 at 5:00 PM, the Branch Director reviewed Patient #15's record and confirmed Patient #15 was not assessed to determine his ability to weigh himself. Additionally, she confirmed his weight was not monitored on every SN visit.</p> <p>The SN failed to assess Patient #15 for weight gain and failed to ensure he was able to monitor his weight independently prior to discharge from SN services.</p> </div> <p>b. Patient #15's POC included an order for SN visits 2 times a week for 2 weeks, effective Sunday, 12/13/15. His record included an SN missed visit note dated 12/15/15. No additional SN visit was documented for the week of 12/13/15.</p> <p>During an interview on 1/07/16 at 5:00 PM, the Branch Director reviewed Patient #15's record and confirmed 2 SN visits were ordered, and no</p>		<p>Clinician</p> <p>MCP/MCPQA BD</p>	<ul style="list-style-type: none"> <li>• Vital Signs or other biometric measures noted to be outside of these parameters will phoned to the MD at time of visit, before leaving the patients home</li> <li>• 100% audit Qweek x 1 month until 100% compliance then decrease to 50% audit x 2 months until 100% compliance then 10% quarterly audit for CHF</li> <li>• 100% CHF chart audits as well as weekly checks to ensure parameters are followed and abnormal values are reported to MD</li> <li>• MCP performance coaching to clinicians not meeting standards, Branch Director coaching to MCPQA and MCP that are not meeting performance standards</li> </ul>	<p>2/5/16 and ongoing</p> <p>2/5/16 and ongoing</p> <p>1/13/16 and prn</p>

<p><b>Deficiency</b>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p><b>How the deficiency will be corrected</b></p>	<p><b>Who will be responsible for making the corrections</b></p>	<p><b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b></p>	<p><b>When the correction will be completed</b></p>
<p><b>G158 and N152 continued</b></p> <p>SN visits were completed, for the week of 12/13/15. She confirmed Patient #15's record included documentation of 1 SN missed visit and stated it was unclear why a second SN visit was not made that week.</p> <p>The agency failed to ensure SN visits were completed as ordered.</p>	<p>See above</p>		<p>See above</p>	



<p><u>Deficiency</u>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice                      Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p>How the deficiency will be corrected</p>	<p>Who will be responsible for making the corrections</p>	<p>What will be done to prevent reoccurrence and how we will monitor for continued compliance</p>	<p>When the correction will be completed</p>
<p><b>G158 and N152 continued</b></p> <p>included dysphagia, dementia and stroke. Patient #12's record and POC for the certification period 12/19/15 to 2/16/16, was reviewed.</p> <p>Patient #12's POC included SN visits once weekly for 5 weeks, and Home Health Aide visits two times weekly for 5 weeks. However, no Home Health Aide visits were performed. Her record documented a missed Home Health Aide visit on 12/30/15.</p> <p>During an interview on 1/08/16 beginning at 8:25 AM, the MCP reviewed Patient #12's record and confirmed no Home Health Aide visits were performed. She was unable to find documentation in the record to determine why no visits had occurred.</p> <p>Patient #12 did not receive Home Health Aide visits as ordered on her POC.</p>				
	<p><b>See below for specific actions</b></p>			

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<p><b>G159 – 484.18(a) Plan of Care N155 and N161</b>                      484.18(a) PLAN OF CARE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, patient interview, medical record review, and staff interview it was determined the agency failed to ensure the POC covered all appropriate items for 3 of 16 patients, (# 1, #6, and #8) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include:</p>				<p>1/13/16</p> <p>1/13/16 and prn</p> <p>2/5/16</p> <p>2/5/16</p> <p>1/13/16</p> <p>2/17/16</p>

<p><u>Deficiency</u>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p>How the deficiency will be corrected</p>	<p>Who will be responsible for making the corrections</p>	<p>What will be done to prevent reoccurrence and how we will monitor for continued compliance</p>	<p>When the correction will be completed</p>
<p><b>G159 –N155 and N161 continued</b></p> <p>1. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16, were reviewed.</p> <p>Patient #6's POC included wound care orders to cleanse her right lower leg with wound cleanser, apply silver alginate, and cover the wound with optifoam. Her POC did not include an ace wrap on the right lower leg, however, her record included documentation that during nursing visits between 11/11/15 and 1/07/16, 7 of the 17 SN visits, an ace wrap was applied.</p> <p>During a home visit on 1/07/16 beginning at 9:45 AM, the RN was observed to perform wound care. After wound care was completed, she applied an ace wrap on Patient #6's lower right leg and foot. Her POC did not include an ace wrap.</p> <p>During the observation of wound care, Patient #6 spoke with the RN about a large callus on a toe on her right foot. She stated she had to keep a cushion on the toe, and it caused pain when she walked. Patient #6 told the RN that she could have a pedicure and the callus could be removed during the pedicure. The RN did not provide instruction to Patient #6 regarding precautions and treatment of her painful callus.</p> <p>Nursing notes for the visit on 1/07/16 were reviewed. The notes did not include information related to Patient #6's callus, or evidence her physician was notified.</p>	<p>Pt #6 order obtained for ace wrap immediately following survey exit order 1/11 requested, received back 2/1/16</p>	<p>MCP, MCPQA, Branch Director</p> <p>Clinician</p>	<ul style="list-style-type: none"> <li>Mandatory meeting for all clinicians and office staff to review findings (from state exit) – conducted 1/13/16  <i>(Discussed Wound policy and procedures, Standards of practice CHF, Supervisory visit policy and procedures, SOC initial assessment and documentations, exit interview and pending Gcode deficiencies, plan of correction from 1/13/16 forward, roles and responsibilities of each team member including leadership team)</i></li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.</li> <li>MCP reviews orders for completeness and adherence via 100% wound chart audits, 10% quarterly chart audits.</li> <li>MCPQA doing 100% wnd audits and wnd case conferences Q2wks</li> <li>MCP and CTC ensuring orders are in place via reports in LINK system</li> <li>Team Case Conference moved to Q week beginning 2/17/16 to</li> </ul>	<p>1/13/16</p> <p>1/13/16 1/18/16</p>

<b>Deficiency</b> Key: BD=Branch Director MCP=Manager of Clinical Practice MCPQA = Manager of Clinical Practice Quality Assurance CTC=Care Team Coordinator-scheduler LINK = electronic medical record system	<b>How the deficiency will be corrected</b>	<b>Who will be responsible for making the corrections</b>	<b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b>	<b>When the correction will be completed</b>
<b>G159 –N155 and N161 continued</b>			facilitate increased MCP,MCPQA oversight <ul style="list-style-type: none"> <li>• MCP performance coaching to clinicians not meeting standards, Branch Director coaching to MCPQA and MCP that are not meeting performance standards</li> </ul>	

<p><u>Deficiency</u>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p>How the deficiency will be corrected</p>	<p>Who will be responsible for making the corrections</p>	<p>What will be done to prevent reoccurrence and how we will monitor for continued compliance</p>	<p>When the correction will be completed</p>
<p><b>G159 –N155 and N161 continued</b></p> <p>Patient #8's diagnoses included CHF, and her record indicated she used oxygen continuously. The National Institutes for Health website, accessed 1/12/16, 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 #8's POC did not include interventions and education related to her CHF.</p> <p>A home visit to observe care provided to Patient #8 by an LPN was conducted on 1/06/16 beginning at 9:30 AM. Patient #8 was wearing compression stockings on each leg. However, compression stockings were not included on her POC.</p> <p>During an interview on 1/08/16 beginning at 7:45 AM, the MCP reviewed Patient #8's record and confirmed compression stockings were not included on her POC. Additionally, the MCP confirmed she did not see reference to weights or interventions related to CHF.</p> <p>Patient #8's POC was not comprehensive to include all relevant interventions.</p>	<p>Pt #8 1/8/16 order clarification requested regarding surveyor question regarding compression stockings. Pt had order for ace wraps bilat LE to secure wound dressings. SN requested MD to clarify ace wrap vs Tubi grips, order received back signed 1/19/16 for Tubi grips to BLE not compression stockings</p> <p>Pt #8 additionally WOCN consult requested 2/1/16 order returned signed 2/2/16</p>	<p>MCP, MCPQA                      Branch Dir</p> <p>Clinician</p>	<ul style="list-style-type: none"> <li>Mandatory meeting for all clinicians and office staff to review findings (from state exit) – conducted 1/13/16  <i>(Discussed Wound policy and procedures, Standards of practice CHF, Supervisory visit policy and procedures, SOC initial assessment and documentations, exit interview and pending Gcode deficiencies, plan of correction from 1/13/16 forward, roles and responsibilities of each team member including leadership team)</i></li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.</li> <li>100% audit Qweek x 1 month until 100% compliance then decrease to 50% audit x 2 months until 100% compliance then 10% quarterly audit for Wound once compliance achieved</li> <li>MCPQA doing 100% wnd audits and wnd case conferences Q2wks</li> <li>MCP and CTC ensuring orders are in place via reports in LINK system</li> </ul>	<p>1/13/16</p> <p>1/13/16 and prn</p> <p>2/5/16</p> <p>1/13/16</p>

<b>Deficiency</b> Key: BD=Branch Director MCP=Manager of Clinical Practice MCPQA = Manager of Clinical Practice Quality Assurance CTC=Care Team Coordinator-scheduler LINK = electronic medical record system	<b>How the deficiency will be corrected</b>	<b>Who will be responsible for making the corrections</b>	<b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b>	<b>When the correction will be completed</b>
G159 –N155 and N161 continued			<ul style="list-style-type: none"> <li>• Team Case Conference moved to Q week beginning 2/17/16 to facilitate increased MCP,MCPQA oversight</li> <li>• MCP performance coaching to clinicians not meeting standards, Branch Director coaching to MCPQA and MCP that are not meeting performance standards</li> </ul>	2/17/16  1/13/16
<p>3. Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.</p> <p>Patient #1's POC included oxygen to be used as needed for shortness of breath. However, her POC did not include equipment to deliver her oxygen.</p> <p>Patient #1's POC included insulin to be taken 3 times a day, for a blood sugar greater than 150 mg/dl. However, her POC did not include supplies to administer her insulin, or a glucometer to test her blood sugar to determine the need for insulin.</p> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed her POC did not include all equipment and supplies needed for her care.</p> <p>Patient #1's POC was not comprehensive to include all equipment and supplies needed for her care.</p>	<ul style="list-style-type: none"> <li>• Pt #1 d/c'd July 2015 unable to correct for this patient</li> </ul>	MCP, MCPQA, Branch Director  Clinician        Clinician        Clinician	<ul style="list-style-type: none"> <li>• 1/13/16 Team educated at mandatory meeting post survey</li> <li>• MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s or biometric values outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.</li> <li>• MD will be consistently notified of SCIC/falls/med issues related to no adherence or new medications noted</li> <li>• Vital Sign parameters or biometric</li> </ul>	1/13/16  1/13/16 and ongoing prn        1/13/16 and ongoing prn    1/13/16 and ongoing prn



<p><b>Deficiency</b>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p><b>How the deficiency will be corrected</b></p>	<p><b>Who will be responsible for making the corrections</b></p>	<p><b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b></p>	<p><b>When the correction will be completed</b></p>
<p><b>G164 484.18(b) Periodic Review of the Plan of Care N172</b></p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by:                      Based on review of clinical records and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 3 of 16 patients (#1, #3, and #9) whose records were reviewed. This resulted in missed opportunities for the physician to alter patients' POCs to meet their needs. Findings include:</p> <p>1. Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.</p> <p>a. Patient #1's record included a PT visit note dated 6/08/15, and signed by the Physical Therapist. The note stated the Physical Therapist observed Patient #1 filling her medication box. The note stated "...when patient went to refill boxes, she had trouble even opening boxes, and then made multiple mistakes re-filling boxes putting extra pills into days that still had pills remaining in them. Filling box is visually</p>	<p>Patient#1: d/c'd from services in July 2015 record could not be corrected</p>	<p>MCP, MCPQA</p> <p>Clinician</p> <p>Clinician</p> <p>Clinician</p>	<ul style="list-style-type: none"> <li>Mandatory team meeting held 1/3/16. Team educated that MCPQA will review medication records at oasis time points to ensure accuracy. MCP via soc/roc case conference, weekly team conference and d/c planning instructions will ensure patient is able to manage medications as clinical oversight over the team.</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>Non adherent staff will be coached via corrective counseling.</li> <li>Clinician will notify physician of change in condition at time of patient visit</li> <li>Every attempt will be made for accurate medication reconciliation. Med record will be reviewed by MCPQA and MCP at SOC with ongoing monitoring by clinician.</li> <li>Monitoring will occur via clinical record review by MCP, MCPQA, during SOC QA for initial reconciliation and a final review with weekly final claims review prior to claim release.</li> </ul>	<p>1/13/16</p> <p>1/13/16 and ongoing prn</p> <p>1/13/16 and prn</p> <p>1/13/16 and prn</p> <p>1/13/16 and ongoing</p> <p>1/13/16 and weekly ongoing</p>

<p><b>Deficiency</b>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p><b>How the deficiency will be corrected</b></p>	<p><b>Who will be responsible for making the corrections</b></p>	<p><b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b></p>	<p><b>When the correction will be completed</b></p>
<p><b>G164 and N172 continued</b></p> <hr/> <p>challenging for patient..." There was no documentation Patient #1's physician was notified of her difficulty filling her medication box, and resultant risk of errors in taking her medications.</p> <p>b. Patient #1's record included a PT visit note dated 6/17/15, and signed by the PTA. The note stated Patient #1 reported she had a fall in the middle of the night, landing on her buttocks, and complained of soreness in her buttocks. The note stated Patient #1's fall was reported to the Physical Therapist. However, there was no documentation Patient #1's physician was notified of her fall.</p> <p>Patient #1's record included a PT visit note dated 6/23/15, and signed by the Physical Therapist. The note stated Patient #1 complained of soreness in her buttocks from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <p>Patient #1's record included a PT visit note dated 6/26/15, and signed by the Physical Therapist. The note stated Patient #1 reported her buttocks was still sore from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <p>Patient #1's record included a PT visit note dated 7/01/15, and signed by the Physical Therapist. The note stated Patient #1 complained of soreness in her buttocks from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <hr/> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed there was no documentation stating her physician was notified of her fall and continued complaints of pain after the fall.</p>				

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<b>G164 and N172 continued</b>				
<p>2. Patient #3 was a 95 year old female with a SOC of 3/13/15. She received SN services related to wound care. Additional diagnoses included chronic pain, depression and abnormal gait. Patient #3's record and POC for the certification period 7/11/15 to 9/08/15, were reviewed.</p> <p>Patient #3's record included a nursing note dated 7/20/15. The note stated she had fallen sometime between the SN visit on 7/17/15 and the current visit date of 7/20/15. Her record did not include documentation of physician notification of the fall.</p> <p>The POC included nursing visits until 9/08/15, however Patient #3's record included a discharge assessment dated 7/22/15. Her record did not include documentation why home health services stopped. Additionally, Patient #3's record did not document her physician was notified of plans to discharge her before the ordered nursing visits were completed.</p> <p>During an interview on 1/07/16 beginning at 5:00 PM, the MCP reviewed Patient #3's record and confirmed there was no documentation of physician notification regarding her fall or intended discharge.</p> <p>The agency did not inform Patient #3's physician of her fall and early discharge.</p>	<ul style="list-style-type: none"> <li>Pt #3 d/c'd 7/22/15 unable to correct</li> </ul>	<p>MCP, MCPQA Branch Director</p> <p>Clinician</p> <p>MCP/BD MCP/MCPQA/BD</p> <p>MCP/MCPQA</p> <p>MCP/QA/CTC</p>	<ul style="list-style-type: none"> <li>Team case conferences moved to Qweek beginning 2/17/16 to facilitate d/c planning discussions</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with weekly final claims review prior to final claim release.</li> <li>Non adherent staff will be coached via corrective counseling.</li> <li>Team educated at mandatory meeting post survey exit 1/13/16 that Pts will be advised of the d/c plan of the HH agency and provided the proper CMS documentation such as the Notice of medicare non coverage in advance of their d/c.</li> <li>During weekly team meetings, upcoming discharges will be discussed and MCP will remind clinicians to notify MD prior to dc as well assigning clinician to give patient appropriate NOMNC or other MCR notices as necessary prior to dc.</li> <li>The dc summary will be faxed to MD upon patient's discharge from agency</li> </ul>	<p>2/5/16</p> <p>1/13/16 and prn</p> <p>1/13/16 and ongoing</p> <p>1/13/16</p> <p>1/13/16 and prn</p>

<p><b>Deficiency</b>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p><b>How the deficiency will be corrected</b></p>	<p><b>Who will be responsible for making the corrections</b></p>	<p><b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b></p>	<p><b>When the correction will be completed</b></p>
<p><b>G164 and N172 continued</b></p>				
<p>3. Patient #9 was an 86 year old male with a SOC of 12/24/15. He received SN, PT, OT and Home Health Aide services related to a fall which resulted in multiple fractures. Additional diagnoses included dementia and Parkinson's disease. His medical record and POC for the certification period 12/24/15 to 2/21/16, was reviewed.</p> <p>In a nursing visit note dated 1/06/16, the RN documented Patient #9's blood pressure was 98/60. His POC did not include parameters for alerting his physician of vital signs that were not within normal range. The visit note did not include a repeat assessment of the blood pressure.</p> <p>Patient #9's record included a "Case Communication Note," dated 1/06/16, addressed to the MCP and Patient #9's care team. The RN wrote that she reported to Patient #9's physician's agent that "...patient's son has stopped giving him his Parkinsons [sic] approximately one week ago."</p> <p>During an interview on 1/08/16 beginning at 8:45 AM, the MCP reviewed Patient #9's record and stated the note referred to Parkinson's disease medication. She confirmed the note did not state which medication was stopped by the son. She also confirmed the record did not indicate which medication the RN spoke with the physician's agent about.</p> <p>Patient #9's nurse did not specify which medication was stopped, and she did not notify his physician of abnormal vital signs.</p>	<ul style="list-style-type: none"> <li>Pt #9 sup visit done 1/6/16, 1/22/16, 1/25/16, 1/29/16 and 2/3/16 by RN and will continue per RN oversight of the HHA</li> </ul>	<p>MCP,MCPQA Branch Director</p> <p>Clinician</p> <p>Clinician</p> <p>Clinician</p> <p>Clinician</p> <p>MCP/MCPQA/BD</p>	<ul style="list-style-type: none"> <li>1/13/16 Team educated at mandatory meeting post survey see above</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.</li> <li>MD will be consistently notified of SCIC/falls/med issues related to no adherence or new medications noted</li> <li>Vital Sign parameters orders by MD or by the American Heart Association recommendations will be utilized, documented and reported to the MD if outside the normal parameters set in the POC</li> <li>Vital Signs noted to be outside of these parameters will phoned to the MD at time of visit, before leaving the patients home</li> <li>100% audit Qweek x 1 month until 100% compliance then decrease to</li> </ul>	<p>1/13/16</p>

<p><u>Deficiency</u>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice                      Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p>How the deficiency will be corrected</p>	<p>Who will be responsible for making the corrections</p>	<p>What will be done to prevent reoccurrence and how we will monitor for continued compliance</p>	<p>When the correction will be completed</p>
<p><b>G164 and N172 continued</b></p>			<p>50% audit x 2 months until 100% compliance then 10% quarterly audit for CHF</p> <ul style="list-style-type: none"> <li>• 100% CHF chart audits as well as weekly checks to ensure parameters are followed and abnormal values reported to MD</li> </ul>	
<p><b>G165 484.18(c) Conformance with Physician Orders and N173</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 medical record review and staff interview it was determined the agency failed to ensure drugs and treatments were administered only as ordered by the physician for 2 of 16 patients (#4 and #13) whose records were reviewed. This resulted in unauthorized treatments and had the potential to negatively impact the safety and quality of patient care.                      Findings include:</p>	<p>See below</p>			

<p><u>Deficiency</u>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p>How the deficiency will be corrected</p>	<p>Who will be responsible for making the corrections</p>	<p>What will be done to prevent reoccurrence and how we will monitor for continued compliance</p>	<p>When the correction will be completed</p>
<p><b>G165 and N173 continued</b></p> <p>1. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers on his feet and coccyx. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>a. Patient #4's POC included orders for wound care to his foot and coccyx wounds. The order stated to cleanse his wounds, apply silver alginate dressing, and cover with foam dressing, gauze wrap and tape.</p> <p>Patient #4's record included documentation of wound care provided during SN visits. SN visit notes stated antibiotic ointment was applied to his wounds. Examples include:</p> <p>-SN visit note dated 2/28/15, stated Triple Antibiotic ointment was applied to wounds.</p> <p>-SN visit note dated 3/01/15, stated Neosporin ointment was applied to wounds.</p> <p>-SN visit note dated 3/02/15, stated Neosporin ointment was applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.</p> <p>-SN visit note dated 3/03/15, stated Triple Antibiotic ointment and Neosporin ointment were applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.</p>	<ul style="list-style-type: none"> <li>Pt #4 d/c'd April 2015</li> </ul>	<p>MCP, MCPQA, Branch Director</p>	<ul style="list-style-type: none"> <li>1/13/16 Team educated at post survey mandatory meeting</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.</li> <li>MCP reviews orders for completeness and adherence via 100% wound chart audits, 10% quarterly chart audits.</li> <li>MCPQA doing 100% wound audits and wound case conferences Q2wks</li> <li>Clinician will notify physician of change in condition at time of patient visit</li> </ul>	<p>1/13/16</p>

<p><b>Deficiency</b>  <b>Key:</b>                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p><b>How the deficiency will be corrected</b></p>	<p><b>Who will be responsible for making the corrections</b></p>	<p><b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b></p>	<p><b>When the correction will be completed</b></p>
<p><b>G165 and N173 continued</b></p> <p>-SN visit note dated 3/03/15, stated Triple Antibiotic ointment and Neosporin ointment were applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.</p> <p>-SN visit notes dated 3/05/15 and 3/06/15, stated Neosporin ointment was applied to all wounds.</p> <p>-SN visit note dated 3/09/15, stated Neosporin ointment and Silvadene (a prescription medication to treat infection) were applied to all wounds.</p> <p>Patient #4's wound care orders did not include the application of Triple Antibiotic ointment, Neosporin ointment, or Silvadene. Additionally, Patient #4's medication profile did not include Triple Antibiotic ointment, Neosporin ointment or Silvadene.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed Triple Antibiotic ointment, Neosporin ointment and Silvadene were applied to his wounds without a physician's order.</p> <p>Patient #4's wound care was not provided as ordered by his physician.</p> <p>b. Patient #4's record included an SN visit note dated 3/05/15, and signed by the LPN. The note stated Patient #4 sustained a new wound on his left great toe. It stated the new wound was cleansed and Neosporin ointment and a Band-Aid were applied. Patient #4's record did not include a physician's order for care to his left great toe.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed wound care was completed to his left great toe without a physician's order.</p> <p>Wound care was provided to Patient #4 without a physician's order.</p>				



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G165 and N173 continued			Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.	
<b>G170 484.30 Skilled Nursing Services (N091)</b> The HHA furnishes skilled nursing services in accordance with the plan of care.  This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure SN services were furnished in accordance with the plan of care for 3 of 12 patients (#4, #7, and #13) who received SN services and whose records were reviewed. This resulted in unauthorized treatments being performed and a lack of physician notification of changes in patients' conditions. Findings include:	See below			



<p><b>Deficiency</b>  <b>Key:</b>  <b>BD=Branch Director</b>  <b>MCP=Manager of Clinical Practice</b>  <b>MCPQA = Manager of Clinical Practice Quality Assurance</b>  <b>CTC=Care Team Coordinator-scheduler</b>  <b>LINK = electronic medical record system</b></p>	<p><b>How the deficiency will be corrected</b></p>	<p><b>Who will be responsible for making the corrections</b></p>	<p><b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b></p>	<p><b>When the correction will be completed</b></p>
<p><b>G170 and N091 continued</b></p> <p>-SN visit note dated 3/02/15, stated Neosporin ointment was applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.</p> <p>-SN visit note dated 3/03/15, stated Triple Antibiotic ointment and Neosporin ointment were applied to foot wounds and Triple Antibiotic ointment was applied to coccyx wound.</p> <p>-SN visit notes dated 3/05/15 and 3/06/15, stated Neosporin ointment was applied to all wounds.</p> <p>-SN visit note dated 3/09/15, stated Neosporin ointment and Silvadene (a prescription medication to treat infection) were applied to all wounds.</p> <p>Patient #4's wound care orders did not include the application of Triple Antibiotic ointment, Neosporin ointment, or Silvadene. Additionally, Patient #4's medication profile did not include Triple Antibiotic ointment, Neosporin ointment or Silvadene.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed Triple Antibiotic ointment, Neosporin ointment and Silvadene were applied to his wounds without a physician's order.</p> <p>b. Patient #4's record included an SN visit note dated 3/05/15, and signed by the LPN. The note stated Patient #4 sustained a new wound on his left great toe. It stated the new wound was cleansed and Neosporin ointment and a Band-Aid were applied. Patient #4's record did not include a physician's order for care to his left great toe.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed wound care was completed to his left great toe without a physician's order.</p>			<p>.see above</p>	

<b>Deficiency</b> Key: BD=Branch Director MCP=Manager of Clinical Practice MCPQA = Manager of Clinical Practice Quality Assurance CTC=Care Team Coordinator-scheduler LINK = electronic medical record system	<b>How the deficiency will be corrected</b>	<b>Who will be responsible for making the corrections</b>	<b>What will be done to prevent reoccurrence and how we will monitor for continued compliance</b>	<b>When the correction will be completed</b>
<p><b>G170 and N091 continued</b></p> <p>c. Patient #4's record included an order for daily SN visits during week 2 of his certification period (3/01/15 to 3/07/15). However, his record did not include documentation of an SN visit on 3/07/15. Additionally, his record did not include documentation his physician was notified of the missed visit.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed an SN visit was not completed on 3/07/15 as ordered. Additionally, she confirmed Patient #4's physician was not notified of the missed visit.</p> <p>Patient #4's wound care and SN visits were not completed as ordered by his physician.</p>				
<p>2. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>a. The National Institutes for Health website, accessed 1/13/16, included a patient education guide for 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>	<ul style="list-style-type: none"> <li>• Pt #7 RN visit performed 1/4/16 , 1/14/16, 1/ 18/16 MD phoned on all 3 visits, though v/s within POT standards</li> <li>• Pt #7 1/1/4/16, d/c'd to outpatient 1/28 not homebound</li> <li>• Pt #7 RN visit BGL 155 1/14/16, Range since last visit 122-300</li> </ul>	<p>MCP, MCPQA, Branch Director</p> <p>Clinician</p> <p>Clinician</p> <p>Clinician</p>	<ul style="list-style-type: none"> <li>• MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s or biometric values outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>• CHF and Wound Zone tools to be utilized with all HF and wound patients</li> <li>• CHF patients will be educated using the Gentiva zone tools for tenants of care of CHF management</li> <li>• MD will be notified of SCIC</li> <li>• RN will ensure CHF teaching and disease mgmt goals are met based on tenants of CHF care utilized on Gentiva CHF zone tool and will communicate with MD if patient is not following recommendations for</li> </ul>	<p>1/18/16</p> <p>1/13/16 and prn</p> <p>1/13/16 and on going</p> <p>1/13/16 and prn</p> <p>1/13/16 and ongoing</p>

<p><u>Deficiency</u>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p>How the deficiency will be corrected</p>	<p>Who will be responsible for making the corrections</p>	<p>What will be done to prevent reoccurrence and how we will monitor for continued compliance</p>	<p>When the correction will be completed</p>
<p><b>G170 and N091 continued</b></p> <p>Patient #7's POC included an order to notify her physician of a weight gain of 3 pounds in 1 day. Her record included a SN SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated her weight was 190 pounds. Patient #7's record included a SN visit note dated 12/07/15, 3 days after her SOC. The visit note stated her weight was 200, a gain of 10 pounds in 3 days. Patient #7's record did not state her physician was notified of her weight gain.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her physician was not notified of her weight gain as ordered.</p> <p>b. Patient #7's POC included an order to notify her physician of blood glucose levels greater than 200 mg/dl. Patient #7's record included SN visit notes which recorded blood glucose levels greater than 200, as follows:</p> <ul style="list-style-type: none"> <li>- 12/28/15 Blood glucose 233</li> <li>- 12/30/15 Blood glucose 228</li> <li>- 1/04/16 Blood glucose 228</li> </ul> <p>There was no documentation Patient #7's physician was notified of her blood glucose levels greater than 200.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her physician was not notified of her elevated blood glucose levels.</p> <p>The agency failed to ensure Patient #7's physician was notified of her elevated blood glucose levels as ordered.</p>		<p>MCP/MCPQA</p> <p>Clinicians</p> <p>Clinicians</p> <p>Team Lead BD</p> <p>MCP/BD</p>	<p>disease management</p> <ul style="list-style-type: none"> <li>• 100% audit Qweek x 1 month until 100% compliance then decrease to 50% audit x 2 months until 100% compliance then 10% quarterly audit for CHF</li> <li>• Vital Sign and biometric parameters orders by MD or by the American Heart Association recommendations will be utilized, documented and reported to the MD if outside the normal parameters set in the POC</li> <li>• Vital Signs noted to be outside of these parameters will be phoned to the MD at time of visit to provide care, these include other know data such as BGL readings</li> <li>• In addition to above monitoring will Monitor for appropriate orders and notification will occur via 100 % clinical record review by MCP, MCPQA, at SOC/ROC and recertification QA process and Team Lead and Branch director during quarterly chart review and with weekly 10% final claims review prior to claim release.</li> <li>• Non adherent staff will have corrective counseling.</li> </ul>	<p>1/21/16 and ongoing</p> <p>1/13/16 and prn</p> <p>1/13/16 and prn</p> <p>1/18/16</p> <p>1/13/16 and prn</p>

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<p><b>G170 and N091 continued</b></p> <p>c. Patient #7's record included an SN visit note dated 12/07/14, and signed by the RN Case Manager. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/07/15.</p> <p>Patient #7's record included an SN visit note dated 12/28/14, and signed by the LPN. The note stated an INR blood test was completed during the visit. Patient #7's record did not include a physician's order for an INR blood test to be completed on 12/28/15.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed INR blood tests were completed on 12/07/15 and 12/28/15, without physician orders.</p> <p>Blood tests were completed on Patient #7 without a physician's order.</p>				
<p>3. Patient #13 was a 62 year old male admitted to the agency on 12/24/15, for services related to cellulitis and ulceration of his left leg. Additional diagnoses included neuropathy and atrial fibrillation. His record, including the POC, for the certification period 12/24/15 to 2/21/15, was reviewed.</p> <p>Patient #13's POC included an order for wound care to a wound on his left foot. His record included an SN visit note dated 1/02/16, signed by the LPN. The note stated wound care was provided to his left foot wound and left shin wound. Patient #13's record did not include a physician's order for wound care to his left shin.</p> <p>During an interview on 1/07/16 at 2:20 PM, the Branch Director reviewed Patient #13's record and confirmed there were no orders for wound care to his left shin.</p> <p>The SN provided wound care to Patient #13 without a physician's order.</p>	<ul style="list-style-type: none"> <li>Pt #13 order obtained for wound on shin 1/14/16</li> </ul>	<p>MCP, MCPQA                      Branch Director                      Nurse</p> <p>Nurse</p> <p>MCP/MCPQA</p>	<ul style="list-style-type: none"> <li>See above teaching and in services</li> <li>Wound care will be carried out specifically as spelled out on MD order</li> <li>Wound care will not be provided without proper orders in place</li> <li>100% audit Qweek x 1 month until 100% compliance then decrease to 50% audit x 2 months until 100% compliance then 10% quarterly audit for Wound</li> <li>MCPQA doing 100% wound audits and wound case conferences Q2wks</li> <li>MCP and CTC ensuring orders are in place via reports in LINK system including missed visit reports,</li> </ul>	<p>1/18/16</p> <p>2/5/16 and ongoing</p> <p>2/5/16</p> <p>1/18/16 and weekly</p>

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G170 and N091 continued		Clinician	supervisory visits, frequency expiring/order reports  • MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.	1/13/16 and prn

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<p><b>G175 484.30(a) Duties of the Registered Nurse (N096 and N098)</b></p> <p>The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>This STANDARD is not met as evidenced by:                      Based on medical record review, policy review, and staff interview it was determined the agency failed to ensure the registered nurse effectively evaluated patients to determine needed preventative or rehabilitative nursing measures for 4 of 12 patients (#6, #7, #10, and #15) who received SN services and whose records were reviewed. Failure to properly identify and implement necessary precautions had the potential to place patients at risk for negative outcomes. Findings include:</p> <p>The National Institutes for Health website, accessed 1/13/16, included a patient education guide for 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. Additionally, it stated shortness of breath is a common symptom of heart failure, due to decreased ability of the heart to effectively pump blood. Oxygen saturation levels can be measured to determine the oxygen level in the blood.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director stated she expected every patient with a diagnosis heart failure to be weighed during every SN visit.</p> <p>1. Patients with a diagnosis of heart failure were not assessed for symptoms of heart failure exacerbation. Examples include:</p>	<p>See below</p>	<p>See below</p>	<p>See below</p>	<p>See below</p>

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<p><b>G175 and N096 and N098 continued</b></p> <p>a. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>i. Patient #7's POC included an order to instruct her to weigh herself daily and record the results. Additionally, it included an order to report to her physician a weight variation of 3 pounds in 1 day.</p> <p>Patient #7's record included an SN SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated her weight was 190 pounds. Patient #7's record included an SN visit note dated 12/07/15, 3 days after her SOC. The visit note stated her weight was 200, a gain of 10 pounds in 3 days. An SN visit note dated 12/10/15, stated her weight was 199 pounds. However, the next 2 SN visit notes, dated 12/14/15 and 12/16/15, did not include Patient #7's weight, to further monitor for weight gain related to her heart failure.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed Patient #7's weight was not monitored on every SN visit to assess for complications of heart failure.</p> <p>The SN failed to obtain Patient #7's weight to monitor her status related to heart failure.</p> <p>ii. Patient #7's POC included an order to obtain her oxygen saturation level on every SN visit, as needed for shortness of breath. Patient #7's SN visit notes dated 12/10/15, 12/14/15, 12/22/15, and 1/04/16 stated she was short of breath with moderate exertion. However, the notes did not include her oxygen saturation level.</p>	<ul style="list-style-type: none"> <li>Pt #7 RN performed visit as followup to assess stability of condition 1/14/16</li> </ul>	<p>MCP, MCPQA, Branch Director</p> <p>Clinician RN</p> <p>MCP/MCPQA</p> <p>Clinician</p> <p>MCP/BD</p>	<ul style="list-style-type: none"> <li>CHF patients will be educated using the Gentiva zone tools for tenants of care of CHF management</li> <li>MD will be notified of SCIC</li> <li>RN will ensure CHF teaching and disease mgmt goals are met based on tenants of CHF care utilized on Gentiva CHF zone tool and will communicate with MD if patient is not following recommendations for disease management</li> <li>100% audit Qweek x 1 month until 100% compliance then decrease to 50% audit x 2 months until 100% compliance then 10% quarterly audit for CHF</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s or biometric values outside normal parameters or set parameters, falls, injuries, lack of stability of condition</li> <li>Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/13/16 and prn</p> <p>1/13/16 and prn</p> <p>2/5/16</p> <p>1/13/16 and prn</p>

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<p><b>G175 and N096 and N098 continued</b></p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed her oxygen saturation level should have been obtained when she was noted to be short of breath.</p> <p>The SN failed to obtain Patient #7's oxygen saturation levels as ordered.</p>				

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<b>G175, N096 and N098 continued</b>				

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<b>G175, N096 and N098 continued</b>				
<p>b. Patient #15 was an 80 year old male admitted to the agency on 12/10/15, for services related to acute CHF. Additional diagnoses included CKD and insulin dependent DM. He received SN, PT, OT and MSW services. His record, including the POC, for the certification period 12/10/15 to 2/07/16, was reviewed.</p> <p>Patient #15's POC included an order to instruct him to weigh himself daily and record the results. Additionally, it included an order to report to his physician a weight variation of 3 pounds in 2 days, or 5 pounds in 1 week.</p> <p>Patient #15's record included an SOC comprehensive assessment dated 12/10/15, and signed by the RN Case Manager. The assessment included a weight of 188 pounds and stated it was reported, rather than an actual weight obtained during the assessment. There was no documentation stating the RN verified Patient #15 had a scale in his home, was able to safely step on the scale, and was able to accurately read his weight on the scale.</p> <p>Patient #15's record included an SN visit note dated 12/23/15, signed by the LPN. The visit note stated Patient #15 was educated on the importance of weighing himself daily and documenting his daily weight. However, the SN visit note did not include an actual or reported weight.</p>	<ul style="list-style-type: none"> <li>• Pt #15 d/c'd 1/15/16 had not received survey results to correct error</li> <li>• Pt #15 SN d/c'd on 12/29/15</li> </ul>	<p>MCP, MCPQA, Branch Director</p> <p>Clinician Nurse</p> <p>MCP/QA/BD</p> <p>MCP</p> <p>Clinician</p>	<ul style="list-style-type: none"> <li>• CHF patients will be educated using the Gentiva zone tools for tenants of care of CHF management</li> <li>• MD will be notified of SCIC</li> <li>• RN will ensure CHF teaching and disease mgmt goals are met based on tenants of CHF care utilized on Gentiva CHF zone tool and will communicate with MD if patient is not following recommendations for disease management</li> <li>• 100% audit Qweek x 1 month until 100% compliance then decrease to 50% audit x 2 months until 100% compliance then 10% quarterly audit for CHF</li> <li>• 100% CHF chart audit by MCP, MCPQA ensure parameters in place on POT for CHF</li> <li>• MCP monitor use of zone tools and SCIC.</li> <li>• MCP review referrals for DX of CHF get order for nursing</li> <li>• CTC to utilize LINK reports weekly to ensure supervisory visits for LPNs are completed and will notify MCP for any variances</li> <li>• MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, iniuries. lack of stabilitv of</li> </ul>	<p>1/13/16</p> <p>1/13/16 and prn</p> <p>2/5/16 and ongoing until compliance reached</p> <p>2/5/16</p> <p>1/18/16 1/13/16 and ongoing</p> <p>1/18/16 and weekly thereafter</p> <p>1/13/16 and prn</p>

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<p><b>G175, N096 and N098 continued</b></p> <p>Patient #15's record included an SN visit note dated 12/29/15, signed by the RN Case Manager. The note did not include an actual or reported weight. Patient #15's record did not include SN visit notes after 12/29/15.</p> <p>Patient #15's POC included SN goals. It stated "Patient/caregiver will verbalize/demonstrate knowledge of disease management for CHF, Recognize signs and symptoms of complications and symptoms to report..."</p> <p>Patient #15's record included a discharge summary dated 1/06/16, signed by the RN Case Manager. The note stated "Patient is</p> <p>knowledgeable of disease process and signs and symptoms to report to emergency management...Has met all skilled nursing goals."</p> <p>A visit was made to Patient #15's home on 1/07/15 at 11:00 AM, to observe an MSW visit. During the visit Patient #15 stated the nurse had completed her visits and would not return. When asked, Patient #15 stated he was not weighing himself daily, and did not remember being instructed by the nurses to record his weight daily or to notify his physician about a change in his weight.</p> <p>During an interview on 1/07/16 at 5:00 PM, the Branch Director reviewed Patient #15's record and confirmed Patient #15 was not assessed to determine his ability to weigh himself. Additionally, she confirmed his weight was not monitored on every SN visit.</p> <p>The SN failed to assess Patient #15 for weight gain and failed to ensure he was able to monitor his weight independently prior to discharge from SN services.</p>			<p>condition.</p> <ul style="list-style-type: none"> <li>• Non adherent staff will be coached via corrective counseling.</li> </ul>	

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<p><b>G175, N096 and N098 continued</b></p> <p>2. Patients' wounds were not thoroughly assessed to determine healing or deterioration. Examples include:</p> <p>a. Patient #10 was an 88 year old male admitted to the agency on 7/01/15, for services related to a pressure ulcer on his heel. Additional diagnoses included CHF and CKD. He received SN and Home Health Aide services. His record, including the POCs, for the certification periods 10/29/15 to 12/27/15, and 12/28/15 to 2/25/15, was reviewed.</p> <p>The agency's policy 03-05 titled "Assessment" revised 12/14/15, stated "At least weekly, the wound(s) status will be observed and documented, including dimensions (L x W x D in cm), drainage amount and type, wound bed appearance and surrounding skin condition."</p> <p>Patient #10's POC included assessment of his heel wound.</p> <p>Patient #10's record included an SN visit note dated 12/11/15, and signed by the LPN. The visit note included an assessment of his left heel wound. It was described as a Stage 3 pressure ulcer, measuring 0.5 cm long by 0.4 cm wide. No depth was documented.</p> <p>Patient #10's record included an SN visit note dated 12/18/15, and signed by the LPN. The visit note included an assessment of his left heel wound. It was described as a Stage 4 pressure ulcer, measuring 0.8 cm long, 0.7 cm wide, and 0.2 cm deep. The "Care Coordination" section of the note had a check mark next to RN, indicating communication occurred, however, there was no documentation of what was discussed. It could not be determined if the RN was notified of the increased wound size and severity.</p>	<ul style="list-style-type: none"> <li>Pt #10 RN visit 1/11/16 wound measured, MCPQA wound conference with RN 1/18/16</li> </ul>	<p>MCP, MCPQA</p>	<p>See above for wound education</p> <ul style="list-style-type: none"> <li>RN oversight of wound minimum Q14 days if LPN assisting with Care</li> <li>RN to do the first visit of each week to ensure proper orders in place, measure the wound, LPN oversight.</li> <li>Wound zone tool utilized on all wound patients</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>100% audit Qweek x 1 month until 100% compliance then decrease to 50% audit x 2 months until 100% compliance then 10% quarterly audit for Wound</li> <li>Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/18/16 1/18/16</p> <p>1/18/16 and ongoing</p> <p>1/18/16 and ongoing prn 1/13/16 and prn</p> <p>2/5/16</p> <p>1/13/16 and prn</p>

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<p><b>G175, N096 and N098 continued</b>                      A recertification comprehensive assessment was completed by the RN on 12/23/15. The assessment stated Patient #10's heel wound was a Stage 3 pressure ulcer. However, the assessment did not include wound measurements. SN visit notes dated 12/28/15, and 12/30/15, did not include measurements of his heel wound.</p> <p>An SN visit note dated 12/30/15, and signed by the LPN stated "Pt [patient] saw MD yesterday and was advised to start going back to wound clinic weekly for evaluation of r [right] heel wound. It cont [continues] to be painful and getting larger in size and depth. However, no wound measurements were documented in the 20 days between 12/18/15 and current date of 1/07/16.</p> <p>During an interview on 1/07/16 at 1:50 PM, the Branch Director reviewed Patient #10's record and confirmed the most recent wound measurements documented in his record were dated 12/18/15.</p> <p>The agency failed to ensure the SN monitored the status of Patient #10's wound.</p>				
<p>b. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16 was reviewed.</p> <p>Patient #6's POC included orders for SN visits twice weekly for 9 weeks. Wound measurements were not assessed on week 2 and week 4.</p> <p>During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed the wound measurements were not performed weekly as per the agency guidelines.</p> <p>Patient #6's wound measurements were not performed weekly.</p>	<ul style="list-style-type: none"> <li>Pt #6 wound measured 1/11/16, wound conference with MCPQA on 1/12/16</li> </ul>	<p>MCP, MCPQA, Branch Director</p>	<ul style="list-style-type: none"> <li>.see above action items for wounds and weekly oversight of wounds</li> </ul>	<p>1/18/16</p>



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<p><b>G176 484.30 (a) Duties of the Registered Nurse (N097, N102)</b></p>			<p>in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition or wounds.</p> <ul style="list-style-type: none"> <li>• Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/13/16 and prn</p>
<p>During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed the physician listed on the POC was not the referring physician and the physician who the RN notified after her SOC visit. She was unable to determine why the POC was sent to a different physician. During the interview, the MCP noted Patient #6's record referred to each of the 2 physicians, and stated it was confusing to know which physician was managing her care.</p> <p>Patient #6's record lacked clarity as to who was the managing physician for her care.</p>				

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<p><b>G177 484.30(a) Duties of the Registered Nurse (N099)</b></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 record review, observation during a home visit, and patient and staff interview, it was determined the agency failed to ensure patients and/or caregivers were provided necessary instruction by nursing staff for 1 of 12 patients (#8) who received SN services and whose records were reviewed. This resulted in a failure to provide advance notice of patient discharge and a failure to instruct a patient related to oxygen safety. Findings include:</p> <p>A home visit was conducted to observe Patient #8's care provided by an LPN on 1/06/16 beginning at 9:30 AM. Upon entry into the living room, next to the fireplace were 4 upright unsecured oxygen tanks. The LPN provided care to Patient #8 in the same room, within 10 feet from the fireplace, and upright unsecured oxygen tanks. She did not appear to recognize that the location of the oxygen tanks posed a danger to Patient #8 and her husband. After the LPN left the home, Patient #8's husband was asked by the surveyor about the unsecured oxygen tanks. He stated the tanks were full, and stated the holder for the tanks was in the car. He was cautioned to remove the oxygen tanks to another area, away from the fireplace, and not to store them upright. Patient #8 and her husband stated they did not receive storage instructions regarding the oxygen tanks by the agency staff.</p> <p>Patient #8 did not receive teaching and reinforcement related to unsafe storage of oxygen tanks.</p>	<ul style="list-style-type: none"> <li>Pt #8 Surveyor advised of 02 safety hazard during her visit, also advised by RN 1/11—02 secured and away from fire.</li> </ul>	<p>MCP/QA/BD</p> <p>Clinicians</p> <p>MCP/QA/BD</p> <p>BD/MCPQA</p> <p>Clinician</p>	<ul style="list-style-type: none"> <li>Mandatory meeting held post survey 1/13/16:</li> <li>Oxygen signage handed out to staff including safety with 02 in service 1/13/16</li> <li>All staff will instruct on oxygen safety in home</li> <li>Red oxygen in use safety signs will be provided to the patient</li> <li>Staff will coordinate with the oxygen supply company to ensure proper storage racks are in place and in a safe area in the patient home</li> <li>MCP, MCPQA Branch Director ensure all staff understand importance of oxygen safety in the home</li> <li>Annual Skills fair re-education as follow up every October</li> <li>Quarterly QAPI meetings to review progress with survey action plan using the PDSA cycle</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch</li> </ul>	<p>1/13/16</p> <p>1/13/16</p> <p>1/13/16</p> <p>1/13/16 and prn</p> <p>October, 2016</p> <p>February 2016 July, Oct, 2016 etc</p> <p>1/13/16 and prn</p> <p>1/18/16</p>



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<p><b>G186 continued</b></p> <p>of her fall and continued soreness.</p> <p>Patient #1's record included a PT visit note dated 7/01/15, and signed by the Physical Therapist. The note stated Patient #1 complained of soreness in her buttocks from her recent fall. There was no documentation Patient #1's physician was notified of her fall and continued soreness.</p> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed there was no documentation stating her physician was notified of her fall and continued complaints of pain after the fall.</p> <p>The Physical Therapist did not communicate pertinent information to Patient #1's physician.</p>		<p>clinician</p> <p>MCP/BD</p>	<p>nursing needs</p> <ul style="list-style-type: none"> <li>• MCP will ensure reports of falls are logged and MD is notified and reflected in the documentation</li> <li>• MCP daily report of falls and report to MD, therapy team lead will investigate 100% chart audits related to injury</li> <li>• MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>• Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/18/16 and prn</p> <p>1/13/16 and prn</p>

<p><u>Deficiency</u>                      Key:                      BD=Branch Director                      MCP=Manager of Clinical Practice                      MCPQA = Manager of Clinical Practice Quality Assurance                      CTC=Care Team Coordinator-scheduler                      LINK = electronic medical record system</p>	<p>How the deficiency will be corrected</p>	<p>Who will be responsible for making the corrections</p>	<p>What will be done to prevent reoccurrence and how we will monitor for continued compliance</p>	<p>When the correction will be completed</p>
<p><b>G187 484.32 (N124 and N126) Therapy Services</b>                      The qualified therapist prepares clinical and progress notes.</p> <p>This STANDARD is not met as evidenced by:                      Based on medical record review and staff interview it was determined the agency failed to ensure the Physical Therapist recorded pertinent findings for 1 of 12 patients (#1) who received therapy services and whose records were reviewed. This resulted in omission of relevant information in a discharge summary. Findings include:</p> <p>Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.</p> <p>Patient #1's record included a PT visit note dated 6/17/15, and signed by the PTA. The note stated Patient #1 reported she had a fall in the middle of the night, landing on her buttocks, and complained of soreness in her buttocks.</p> <p>Patient #1's record included a PT Discharge Summary Report, dated 7/10/15, and signed by the Physical Therapist. The report stated Patient #1 did not have any falls in the past month.</p> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed the Discharge Summary was incorrect, and did not include the fall she reported on 6/17/15.</p> <p>Patient #1's Discharge Summary, completed by the Physical Therapist, was not accurate.</p>	<p>Pt #1 d/c'd 7/10/15 unable to correct record</p>	<p>MCP/Clinician</p> <p>CTC</p>	<ul style="list-style-type: none"> <li>• MCP will assure Clinical D/C summary will contain accurate information related to patients status and goals achieved while on service with Gentiva via case conference on all patients to be discharged.</li> <li>• D/C summary report will be faxed to the MD</li> <li>• MCP ensures d/c conference</li> <li>• MCPQA ensures summary is complete</li> <li>• Medical Records ensures d/c summary is faxed to MD</li> <li>• MCP ensures d/c case conferences occur with pending discharges</li> <li>• MCPQA ensures summary is sent to MD at time of final QA of the chart.</li> <li>• Medical records will utilize fax report in LINK to pool d/c summary faxes and faxes all one time a week.</li> </ul> <p>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</p> <p>Non adherent staff will receive corrective counseling.</p>	<p>1/13/16</p>

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<p><b>G229 484.36(d)(2) and N119</b>  <b>Supervision</b>                      The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on clinical record review and interview of staff, it was determined the agency failed to ensure on-site home health aide supervisory visits were conducted by an RN or qualified therapist at least every 2 weeks for 4 of 7 patients (#4, #7, #10, and #14), who received Home Health Aide services and whose records were reviewed. This had the potential to prevent the agency from identifying and correcting substandard care by Home Health Aides. Findings include:</p>	<ul style="list-style-type: none"> <li>Pt #14 sup visit done 1/13/16 LPN and HHA by the RN Case Mgr</li> </ul>	MCP, CTC	<ul style="list-style-type: none"> <li>HHA supervisory visits will be performed Q14days to ensure oversight of the HHA</li> <li>The primary nurse will be responsible for the HHA Supervisor visit</li> <li>Supervisory visit information will be complete in the documentation</li> <li>MCP is auditing charts weekly to ensure compliance</li> <li>CTC will utilize reports in LINK on supervisory visits to monitor and inform team and MCP CTC report every Thursday at standup to ensure standard is met</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition. Monitoring will occur via clinical record review by MCP, MCPQA, Therapy Team Lead and Branch director during quarterly chart review and with final claims review. Non adherent staff will be coached via corrective counseling.</li> </ul>	1/13/16
			See below	

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<p><b>G229 and N119 continued</b></p> <p>1. Patient #14 was a 74 year old female with a SOC of 12/16/15. She received SN, PT, OT and Home Health Aide services related to a recent fall and multiple fractures. Additional diagnoses included diabetes, vertigo, hypertension and anemia. Her record, including the POC, for the period 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #14's POC included Home Health Aide visits once weekly for 3 weeks, and twice weekly for 5 weeks. Her record documented 3 Home Health Aide visits were provided during the 4 weeks she was receiving services. The record did not include evidence of missed visit documentation. Visits completed by the Home Health Aide were documented as follows:</p> <ul style="list-style-type: none"> <li>- Once on week 1 as ordered (12/18/15).</li> <li>- Week 2 (12/20/15 to 12/26/15) no Home Health Aide visits were documented.</li> <li>- Week 3 (12/27/15 to 1/02/16) one Home Health Aide visit was documented on 12/31/15.</li> <li>- Week 4 (1/03/16 to 1/09/16) one Home Health Aide visit was documented on 1/04/16.</li> </ul> <p>Additionally, Patient #14's record did not include evidence of Home Health Aide supervision by an RN. During an interview on 1/07/16 beginning at 5:18 PM, the MCP reviewed Patient #14's record and confirmed there was no documentation of Home Health Aide supervision by an RN.</p> <p>Patient #14 received unsupervised Home Health Aide services.</p>	<ul style="list-style-type: none"> <li>• Pt #14 sup visit done 1/13/16 LPN and HHA</li> </ul>	<p>MCP, MCPQA, CTC RN/CTC</p> <p>RN</p> <p>RN</p>	<ul style="list-style-type: none"> <li>• See above noted education</li> <li>• HHA supervisory visits will be performed Q14days to ensure oversight of the HHA</li> <li>• The primary nurse will be responsible for the HHA Supervisor visit</li> <li>• Supervisory visit information will be complete in the documentation</li> <li>• MCP is auditing 100% of HHAjide charts weekly to ensure compliance</li> <li>• CTC will utilize reports in LINK weekly on supervisory visits to monitor and inform team and MCP</li> <li>• CTC report every Thursday at standup to ensure standard is met</li> <li>• MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>• Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/13/16 1/13/16 and ongoing</p> <p>1/13/16 and ongoing</p> <p>1/13/16 and ongoing</p> <p>1/18/16 and ongoing</p> <p>1/18/16 and ongoing</p> <p>1/21/16 and weekly thereafter 1/18/16 and ongoing</p> <p>1/13/16 and prn</p>

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<b>G229 and N119 continued</b>				
<p>2. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>2. Patient #4 was a 55 year old male admitted to the agency on 2/28/15, for services related to multiple pressure ulcers. Additional diagnoses included insulin dependent DM, quadriplegia and CKD. He received SN, PT, OT, MSW and Home Health Aide services. His record, including the POC, for the certification period 2/28/15 to 4/28/15, was reviewed.</p> <p>Patient #4's POC included an order for Home Health Aide visits 2 times a week. The first Home Health Aide visit was documented on 3/09/15. The first Home Health Aide supervisory visit, completed by an RN, was documented on 4/06/15, 26 days after Home Health Aide services were initiated.</p> <p>During an interview on 1/07/16 at 5:15 PM, the Branch Director reviewed Patient #4's record and confirmed Home Health Aide supervisory visits were not completed every 14 days.</p> <p>The agency failed to ensure Patient #4 received on-site Home Health Aide supervisory visits no less frequently than every 2 weeks.</p>	<ul style="list-style-type: none"> <li>Pt #4 d/c'd on April 2015</li> </ul>	MCP, MCPQA, CTC	<b>G229 and N119 continued</b>	1/13/16 See above dates
<p>3. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, for care following a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including</p>	<ul style="list-style-type: none"> <li>Pt #7 HHA sup visit done 1/14/16</li> </ul>	MCP, CTC	<b>G229 and N119 see related information above r/t this tag</b>	1/13/16 See above dates

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<p>the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>Patient #7's POC included an order for Home Health Aide visits 2 times a week. The first Home Health Aide visit was documented on 12/09/15. However, no Home Health Aide RN supervisory visits were documented as of 1/07/15, 28 days after Home Health Aide services were initiated.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed Patient #7's record and confirmed no Home Health Aide supervisory visits were documented.</p> <p>The agency failed to ensure Patient #7 received on-site Home Health Aide supervisory visits no less frequently than every 2 weeks.</p>				
<p>4. Patient #10 was an 88 year old male admitted to the agency on 7/01/15, for services related to a pressure ulcer on his heel. Additional diagnoses included CHF and CKD. He received SN and Home Health Aide services. His record, including the POCs, for the certification periods 10/29/15 to 12/27/15, and 12/28/15 to 2/25/15, was reviewed.</p> <p>Patient #10's POC for the certification period 10/29/15 to 12/27/15, included an order for Home Health Aide visits 2 times a week. Home Health Aide visits were documented 2 times a week from 11/02/15 to 12/21/15. However, no Home Health Aide supervisory visits were documented during the 60 day certification period.</p> <p>During an interview on 1/07/16 at 1:50 PM, the Branch Director reviewed Patient #10's record and confirmed no Home Health Aide supervisory visits were completed during the certification period 10/29/15 to 12/27/15.</p> <p>The agency failed to ensure Patient #10 received on-site Home Health Aide supervisory visits no less frequently than every 2 weeks.</p>	<ul style="list-style-type: none"> <li>Pt #10 LPN and HHA sup visit done 1/11/16</li> </ul>	<p>MCP, CTC</p> <p>RN</p> <p>RN</p>	<ul style="list-style-type: none"> <li>See education above r/t this tag</li> <li>HHA and LPN supervisory visits will be performed Q14days to ensure oversight of the HHA</li> <li>The primary nurse will be responsible for the HHA Supervisor visit</li> <li>Supervisory visit information will be complete in the documentation</li> <li>MCP is auditing all HHAide charts weekly to ensure compliance</li> <li>CTC will utilize reports in LINK weekly on supervisory visits to monitor and inform team and MCP CTC report every Thursday at standup to ensure standard is met</li> <li>Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/13/16</p>

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<p><b>G322 484.20(b) Accuracy of Encoded Oasis Data</b></p> <p>The encoded OASIS data must accurately reflect the patient's status at the time of assessment.</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 encoded OASIS data reflected the patient's status at the time of assessment for 4 of 16 patients whose records were reviewed (#1, #7, #10 and #13). This resulted in the reporting of inaccurate data. Findings include:</p>	<ul style="list-style-type: none"> <li>Pt #1 d/c'd July 2015</li> </ul>	<p>MCPQA, MCP, Branch Director</p> <p>Clinician</p> <p>MCP/BD</p> <p>MCP/BD</p>	<ul style="list-style-type: none"> <li>1/13/16 Team educated at mandatory post survey meetings which included wound care meeting 1/18/16</li> <li>Wound Zone tool utilization on all wound patients</li> <li>MCPQA and clinical coder upon their review will accurately review the know data from the referral packet and compare it to the assessing clinicians documentation</li> <li>MCP and MCPQA will provide performance coaching to team members as needed to ensure competency with Oasis and initial assessment</li> <li>MCP will ensure all Oasis Gentiva University classes have been completed</li> <li>Supervisory visits will occur as needed to ensure performance and at annual review</li> <li>Outcome data monitored by Branch Director each month to ensure standards are met</li> <li>Non adherent staff will be coached via corrective counseling.</li> </ul>	<p>1/13/16</p> <p>1/13/16 Ongoing 1/13/16 and ongoing</p> <p>1/13/16 and prn</p> <p>2/13/16 and ongoing for new staff</p> <p>2/5/16 and prn</p> <p>2/12/16 and monthly</p> <p>1/13/16 and prn</p>

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<p><b>G322 continued</b></p> <p>1. Patient #1 was a 68 year old female admitted to the agency on 3/13/15. She was recertified for an additional episode of care for continued PT to treat abnormality of gait. Additional diagnoses included insulin dependent DM. Her record, including the POC, for the certification period 5/15/15 to 7/10/15, was reviewed.</p> <p>Patient #1's record included a discharge OASIS comprehensive assessment dated 7/10/15, and signed by the Physical Therapist. OASIS item M2300 stated Patient #1 used a hospital ED and was admitted to the hospital due to an injury caused by a fall, during the certification period 5/15/15 to 7/10/15. However, Patient #1's record did not include documentation of an ED visit or hospital admission.</p> <p>During an interview on 1/07/16 at 4:00 PM, the Branch Director reviewed Patient #1's record and confirmed she did not have an ED visit or hospitalization during the certification period.</p> <p>The agency failed to ensure Patient #1's discharge OASIS contained accurate information.</p>	<ul style="list-style-type: none"> <li>Pt #1 d/c'd July 2015</li> </ul>			
<p>2. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, following discharge from a rehabilitation facility, after a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>Patient #7's record included a discharge summary from the rehabilitation facility, dated 12/03/15. The summary stated she had a total hip arthroplasty on 8/28/15, more than 3 months prior to her HH admission. Additionally, the summary stated the incision to her left hip had healed without complications.</p>				

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<p><b>G322 continued</b>                      Patient #7's record included a SOC OASIS comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. OASIS item M1340 stated Patient #7 had at least one surgical wound. OASIS item M1342 stated the status of the wound was early/partial granulation. Instant OASIS Answers 2015, a CMS-based reference for OASIS guidance, stated "For the purposes of determining the healing status, a surgical wound can be considered fully healed and not reportable as a current surgical wound approximately 30 days after complete epithelialization."                       During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed the record and stated Patient #7's healed incision line should not have been reported as a surgical wound on her SOC OASIS.                       Patient #7's OASIS was not accurate to reflect her status at the time of her SOC.</p>				
<p>3. Patient #10 was an 88 year old male admitted to the agency on 7/01/15, for services related to a pressure ulcer on his heel. Additional diagnoses included CHF and CKD. He received SN and Home Health Aide services. His record, including the POCs, for the certification periods 10/29/15 to 12/27/15, and 12/28/15 to 2/25/15, was reviewed.                       Patient #10's record included a Recertification OASIS assessment dated 12/23/15, and signed by the RN Case Manager. The assessment described 1 wound, on his left heel. The assessment stated 100% of his left heel wound was covered with a scab.                       OASIS item M1308 stated Patient #10 had 1 Stage 3 pressure ulcer. Instant OASIS Answers 2015, a CMS-based reference for OASIS guidance, provided guidance on pressure ulcer staging. It stated ulcers that can not be visualized due to the presence of a scab should be documented on the OASIS as "Unstageable:</p>				

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<p><b>G322 continued</b>                      Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar." During an interview on 1/07/16 at 5:30 PM, the MCP reviewed Patient #10's record and confirmed the pressure ulcer on his left heel was unstageable at the time of his recertification OASIS.                      Patient #10's OASIS was not accurate to reflect his status at the time of his recertification assessment.</p>				
<p>4. Patient #13 was a 62 year old male admitted to the agency on 12/24/15, for services related to cellulitis and ulceration of his left leg. Additional diagnoses included neuropathy and atrial fibrillation. His record, including the POC, for the certification period 12/24/15 to 2/21/15, was reviewed.                       Patient #13's record included a physician order for HH services. The note stated "Anticipated discharge from acute care 12/23/15..." His record included an SOC OASIS assessment dated 12/24/15, and signed by the RN. OASIS item M1000 asks from which inpatient facility the patient was discharged in the last 14 days. It was answered "Patient was not discharged from an inpatient facility."                       During an interview on 1/07/16 at 2:20 PM, the Branch Director reviewed Patient #13's record and confirmed OASIS item M1000 was answered incorrectly on his SOC OASIS.</p>				

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<p><b>G337 484.55(c) (N173) Drug Regimen Review</b></p> <p>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.</p> <p>This STANDARD is not met as evidenced by:                      Based on review of medical records and agency policies, observations during home visits, and staff and patient interviews, it was determined the agency failed to ensure the comprehensive assessment included all medications the patient was taking, as well as a medication review to evaluate for drug interactions, identify significant side effects, and identify duplicative therapy and non-compliance with drug therapy for 6 of 8 patients, (#5, #6, #7, #8, #9, and #14) for whom home visits were completed. This resulted in the potential for patients to experience adverse outcomes related to medications. Findings include:</p> <p>The agency's policy 03-05, titled "Assessment," revised 12/14/15, included a section titled "Review of Patients' Medications." It stated "At the time of the initial assessment and each subsequent assessment, prescription, over-the-counter drugs, and herbals the patient is taking will be evaluated. Review will include viewing the bottles and labels of the drugs the patient has; asking about other over-the counter medications the patient is taking..." Additionally, it stated "The agency will promptly notify the physician of any signs or symptoms of adverse side effects the patient is experiencing, any contraindicated drugs or drug combinations, and any other significant negative responses to the medications. Medications will be entered in the clinical record and will be updated as the agency becomes aware of changes in the prescribed medications." This policy was not followed. Examples include:</p>	<ul style="list-style-type: none"> <li>Pt #5 visit done to correctly view the medication bottles to ensure accurate medication record 1/6/16, skin assessed at this time as well</li> <li>Pt # 5 Clinician counseled for plan of correction after meeting that accompanied surveyor on SOC visit 1/13/15</li> </ul>	<p>MCP, MCPQA</p>	<ul style="list-style-type: none"> <li>1/13/16 Team educated at post survey mandatory meeting:</li> <li>MD will be notified at time of patient visit for any notable change in patient adherence to the POT, change in v/s outside normal parameters or set parameters, falls, injuries, lack of stability of condition.</li> <li>Medication assessment and documentation at SOC will include visualization of the actual medication bottles, review of the medication list provided in the referral, as well as interview with patient or caregiver</li> <li>Every attempt for complete and accurate assessment of medications will be done at the time of the initial assessment</li> <li>MCP and MCPQA to monitor via record review s and supervisory visits with clinical team to ensure meeting current standards of practice</li> <li>MCPQA reviewing the medication d/c list from All referral to ensure accuracy and question the assessing clinician regarding discrepancies at SOC and ROC.</li> <li>Daily monitoring of oasis data by MCPQA as part of the duties of the MCPQA. Quarterly CBR will</li> </ul>	<p>1/13/16</p>

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<p>1. Patient #7 was a 72 year old female admitted to the agency on 12/04/15, following discharge from a rehabilitation facility, after a total hip arthroplasty. Additional diagnoses included insulin dependent DM, heart failure, atrial fibrillation and HTN. Her record, including the POC, for the certification period 12/04/15 to 2/01/16, was reviewed.</p> <p>- Patient #7's medication profile included Novolog insulin, 3 units daily with breakfast, 6 units daily with lunch, and 8 units daily with dinner. She stated that was how her insulin was administered at the rehabilitation facility. However, upon her return home she resumed her sliding scale insulin (insulin dosage determined by current blood glucose level as measure by a glucose testing device) as ordered by her physician. She stated she tested her blood glucose 4 times a day. Patient #7's medication profile did not include sliding scale insulin.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed the record and confirmed Patient #7's medication profile was not accurate.</p> <p>Patient #7's medication profile was not accurate.</p> <p>b. Patient #7's record included an SOC comprehensive assessment dated 12/04/15, and signed by the RN Case Manager. The assessment stated 3 major drug interactions were identified during a review of her medications. Additionally, the assessment stated</p>	<p>Pt #7 pt's report of taking sliding scale as she did previous to hospital stay was not verified to be accurate as MD had not responded for clarification prior to pt d/c. Pt continued to take her insulin as she saw fit. Pt was d/c'd 1/28 to outpatient.</p>		<p>continue as 10% of census chart audits</p>	

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<p><b>G337 and N173 continued</b></p> <p>Patient #7's physician was contacted to resolve the significant medications issues. However, an SN visit note dated 12/10/15, signed by a different RN, stated "Dr. [name] is unavailable this week and has not responded to the medication issue order."</p> <p>Patient #7's record included a "Medication Issue Communication/Order" dated 12/06/15, and signed by the RN Case Manager. The form was not signed by Patient #7's physician as of 1/07/16.</p> <p>During an interview on 1/07/16 at 4:30 PM, the Branch Director reviewed the record and confirmed Patient #7's major drug interactions were not resolved with her physician as of 1/07/16.</p>				
<p><b>G337 and N173 continued</b></p> <p>The agency failed to ensure Patient #7's identified drug interactions were resolved with her</p>				

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<p>2. Patient #5 was a 67 year old female admitted to the agency on 1/04/16, following surgery to repair a fractured ankle. She received PT services. Her record, including the POC, for the certification period 1/04/16 to 3/03/16, was reviewed.</p> <p>A visit was made to Patient #5's home on 1/04/16 at 12:15 PM, to observe the SOC comprehensive assessment completed by the Physical Therapist. During the visit, the Physical Therapist copied Patient #5's medications from her hospital discharge information. He did not visualize her medications.</p> <p>During an interview on 1/07/16 at 2:10 PM, the Branch Director stated the agency's policy requires clinicians to view patients' medications during the SOC assessment. She confirmed the policy was not followed for Patient #5's SOC assessment.</p> <p>Patient #5's medications were not reviewed during her SOC comprehensive assessment.</p>	<ul style="list-style-type: none"> <li>Pt #5 visit done to correctly view the medication bottles to ensure accurate medication record 1/6/16, skin assessed at this time as well</li> <li>Pt # 5 Clinician counseled for plan of correction after meeting that accompanied surveyor on SOC visit 1/13/15</li> </ul>	MCP, MCPQA, Branch Director	See above interventions and education	1/13/16

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<p>3. Patient #8 was a 66 year old female with a SOC of 8/27/15. She received SN services related to wound care. Additional diagnoses included gait disturbances, back pain, hypertension, CHF, depression and peripheral vascular disease. Her record and POC for the certification period 12/25/15 to 2/22/16, were reviewed.</p> <p>A home visit to observe LPN services for Patient #8 was conducted on 1/06/16 at 9:30 AM. The LPN, Patient #8 and the surveyor reviewed her medications in the home with the medication list and her POC. The following was noted:</p>	<ul style="list-style-type: none"> <li>Pt #8 med list corrected 1/6/16 by LPN, reviewed by MCPQA 1/15/16</li> </ul>	<p>MCP, MCPQA</p>	<ul style="list-style-type: none"> <li>See above education and interventions</li> </ul>	<p>1/13/16</p>
<p>G337 and N173 continued</p>				

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<p>-Patient #8's medication list included the pain medications Norco and Hydrocodone. She told the LPN that she took another family member's oxycodone, as well as, her own pain medications. Patient #8 stated she took the oxycodone twice daily, and had been taking them since December.</p> <p>- Patient #8's POC specified Melatonin 3 mg 1 tablet daily, however, Patient #8 stated she did not take the medication.</p> <p>During an interview on 1/07/16 beginning at 7:45 AM, the MCP reviewed Patient #8's record and stated it was her third certification period, and medication non-compliance issues had occurred multiple times. She stated a referral to APS occurred, and it was recommended that Patient #8's pharmacy prepare her medications in bubble packs, but she refused.</p> <p>Patient #8's POC list of medications was not current when medications were reviewed in the home.</p>				
<p>4. Patient #6 was an 83 year old female with a SOC of 11/11/15. She received SN and PT services related to a leg wound. Additional diagnoses included Parkinson's disease and scoliosis. Her record and POC for the certification period 11/11/15 to 1/09/16, were reviewed.</p> <p>A home visit to observe nursing care provided to Patient #6, was conducted on 1/07/16, beginning at 9:45 AM. After the wound care was provided, her medications were reviewed with Patient #6, the RN, and the surveyor. The POC list of medications was not consistent with what was found in the home. Examples include:</p> <p>- The POC specified Gabapentin 100 mg 1 tablet every night. Patient #6 stated she took 2 each night, and had "always" taken 2.</p>	<ul style="list-style-type: none"> <li>Pt #6 med list corrected 1/7/16 by RN Case Mgr in medical record</li> </ul>	<p>MCP, MCPQA</p>	<ul style="list-style-type: none"> <li>See above education and interventions.</li> </ul>	<p>1/13/16</p>

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<p><b>G337 and N173 continued</b>                      - Silvadene cream was not on the POC. However, Patient #6 stated she applied the cream under her right breast.                      - Iron tablets were not on the POC, however Patient #6 stated she took iron tablets daily.                      - Antidiarrheal tablets were not on the POC. However, Patient #6 stated she took them when she took antibiotics.                      - Patient #6's record included an SN visit note dated 11/27/15, which noted Patient #6 had 1 dose of Cipro left. Cipro (an antibiotic) was not on the POC. Her record did not include further entries about Cipro.                      During an interview on 1/07/16 beginning at 4:20 PM, the MCP reviewed Patient #6's record and confirmed she did not see any evidence Patient #6 was on Cipro other than the entry by the LPN on 11/27/15. She confirmed the home visit medications that were reviewed with the RN differed from the POC.                      Patient #6's POC list of medications was not current when medications were reviewed in the home.</p>				
<p>5. Patient #9 was an 86 year old male with an SOC of 12/24/15. He received SN, PT, OT and Home Health Aide services related to a fall which resulted in multiple fractures. Additional diagnoses included dementia and Parkinson's disease. His medical record and POC for the certification period 12/24/15 to 2/21/16, were reviewed.                      A home visit to observe services provided to Patient #9 by the Home Health Aide was conducted on 1/06/15 at 1:00 PM. Patient #9's POC medication list and medications in the home were reviewed with his son and surveyor. Discrepancies were noted as follows:</p>	<ul style="list-style-type: none"> <li>Pt #9 RN visit 1/6/16 for med review and supervisory visit completed</li> </ul>	<p>MCP , CTC, MCPQA</p>	<ul style="list-style-type: none"> <li>See above education and interventions</li> </ul>	<p>1/06/16 1/13/16</p>

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<p><b>G337 and N173 continued</b></p> <ul style="list-style-type: none"> <li>- Patient #9's POC specified Carbidopa/Levodopa 95 mg capsules, (2) twice daily. Patient #9's medication bottle in the home noted it was 47.5 ma. and his son stated he took 1 tablet twice daily. (The dose of the medication on Patient #9's medication list and POC was 4 times the amount he was actually taking.) According to Drugs.com, this medication is used to treat Parkinson's disease.</li> <li>Patient #9's record included a "Case Communication Note," dated 1/06/16, and was addressed to the MCP and Patient #9's care team. The RN wrote that she reported to Patient #9's physician's agent that "...patient's son has stopped giving him his Parkinsons [sic] approximately one week ago." The note to the care team was incorrect, as the only medication that was on his POC and in his home used for Parkinson's disease was Carbidopa/Levodopa, and he was taking the medication, however, in a lower dosage.</li> <li>- Patient #9's POC specified Flecainide Acetate 150 mg, 1/2 tablet twice daily. Patient #9's son stated he took 1/2 tablet once daily, for a daily dose of 75 mg.</li> <li>- Patient #9's POC specified Lisinopril 5 mg 1 tablet daily. Patient #9's son stated he did not take the medication after his hospitalization, as his father's blood pressure was low and he did not need it.</li> <li>- Patient #9's POC specified Rivastigmine Tartrate 1.5 mg, 1 daily. Patient #9's son stated he never filled the prescription. He stated it was for treatment of dementia, and he did not think it was needed.</li> <li>- The SOC assessment dated 12/24/15, documented Patient #9 took Tylenol every 6 hours as needed for hip pain, however, the medication was not included on the medication list or POC.</li> </ul>				

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<p><b>G337 and N173 continued</b></p> <p>During an interview on 1/08/16 beginning at 8:45 AM, the MCP reviewed Patient #9's record and confirmed the medications reviewed in the home did not match the POC.</p> <p>Patient #9's home medication regime was different from that on his POC.</p>				
<p>6. Patient #14 was a 74 year old female with a SOC of 12/16/15. She received SN, PT, and OT services related to a recent fall and multiple fractures. Additional diagnoses included diabetes, vertigo, hypertension and anemia. Her record, including the POC, for the certification period 12/16/15 to 2/13/16, was reviewed.</p> <p>A home visit to observe services provided to Patient #14 by the PTA was conducted on 1/06/16 at 10:00 AM. Patient #14's medication list and medications in the home were reviewed with her and the PTA. Discrepancies were noted as follows:</p> <ul style="list-style-type: none"> <li>- Patient #14's POC specified Metformin 750 mg twice daily, however, the container in the home, as well as, the hospital discharge orders specified 850 mg twice daily. Patient #14 stated she took 850 mg, one in the AM and one in the PM.</li> <li>- Patient #14's POC specified Hydroxyzine 10 mg, 4 times daily as needed for anxiety. The medication container in the home contained 50 mg tablets, to be taken 4 times daily as needed.</li> <li>- Patient #14's POC specified Coumadin 7.5 mg daily. Patient #14 stated she took 7.5 mg every day except Sunday, when she took only 5 mg.</li> </ul> <p>During an interview on 1/07/16 beginning at 5:18 AM, the MCP reviewed Patient #14's record. She stated the agency clinicians were instructed to review medications and medication changes with each visit. She was unable to determine the reason the medications in Patient #14's home did not match her medication profile.</p> <p>Patient #14's home medication regime was different from that on her POC.</p>	<ul style="list-style-type: none"> <li>• Pt #14 RN visit 1/14/16 for medication review</li> </ul>	<p>MCP, MCPQA</p>	<ul style="list-style-type: none"> <li>• See above education and interventions</li> </ul>	<p>1/13/16</p>