



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
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

February 4, 2016

Sharon Anitok, Administrator
Multicare Home Health Services, Inc
P.O Box 355
Meridian, ID 83680

RE: Multicare Home Health Services, Inc, Provider #137093

Dear Ms. Anitok:

This is to advise you of the findings of the Medicare/Licensure survey at Multicare Home Health Services, Inc, which was concluded on January 21, 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.

Sharon Anitok, Administrator
February 4, 2016
Page 2 of 2

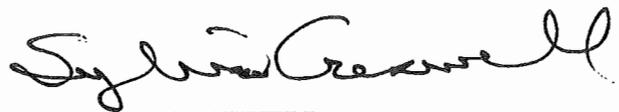
After you have completed your Plan of Correction, return the original to this office by **February 17, 2016**, and keep a copy for your records.

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,



LAURA THOMPSON
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LT/pmt
Enclosures



MULTICARE

Home Health

"Caring
From
The Heart."

February 23, 2016

Attn: Laura
Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Re: MultiCare Home Health Services, Inc., Provider #137093
Revised Corrective Action – Includes plan to monitor corrections

Dear Laura,

Enclosed, please find a revised Plan of Correction to include monitoring of corrections. This is per phone review with Lori Page, RN on 2/22/16 identifying MultiCare needed to add this component to our response per our January 21, 2016 survey.

Thank you for the knowledge and support provided to MultiCare Home Health.

Let me know if you have any questions or concerns.

Sincerely,

Lori Page, RN
Director of Clinical Services

Sharon Anitok
Administrator

Cc: Ben Shatto, Director of Operations
Robin Wallis, President

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

PRINTED: 02/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER MULTICARE HOME HEALTH SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 324 SOUTH MERIDIAN RD, SUITE 10 MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare Recertification survey of your agency from 1/19/16 to 1/21/16. The surveyors conducting the survey were:</p> <p>Laura Thompson, RN, BSN, HFS, Team Leader Nancy Bax, RN, BSN, HFS Dennis Kelly, RN-BC, CHPN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>CKD - Chronic Kidney Disease CHF - Congestive Heart Failure cm - centimeter CNS - Clinical Nurse Specialist DM - Diabetes Mellitus DON - Director of Nursing ED - Emergency Department FBS - Fasting Blood Sugar H&P - History and Physical HHA - Home Health Aide HTN - Hypertension INR - International Normalized Ratio LPN - Licensed Practical Nurse mg - milligrams mg/dt - milligrams per deciliter mm/Hg - millimeters of Mercury MSW - Medical Social Worker OASIS - Outcome and Assessment Information Set OT - Occupational Therapy PT - Physical Therapy PTA - Physical Therapy Assistant POC - Plan of Care RBVO - Read back verbal order RN - Registered Nurse ROC - Resumption of Care</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Amitol TITLE: Administrator (X6) DATE: 16-Feb 2016

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

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G 000	Continued From page 1 SN - Skilled Nurse SOC - Start of Care	G 000			
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on policy review, staff interview and review of complaint documentation, it was determined the agency failed to thoroughly document the investigation and resolution of complaints for 2 of 2 agency patients' complaint records reviewed (Patient #10 and #13). Failure to document resolution of complaints and the investigation process led to a lack of clarity as to whether complaints were addressed and resolved. Findings include: The agency policy, "Grievance Procedure" undated, stated "Multicare [agency] must investigate complaints made by a client or the client's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the client's property by anyone furnishing services on behalf of Multicare. Multicare must document both the existence of a complaint and the resolution of the complaint." The agency's complaint log from 1/01/15 to	G 107	G-107 MultiCare will ensure that complaints are documented; both existence of complaint and follow up to complaint. Administrator will be responsible for educating home health staff on appropriate policy and procedure for handling complaints and grievances. The complaint will be clearly documented to include Patient's name, date of occurrence, who complaint was reported by, who the complaint was reported to, parties involved, date the complaint was received, a clear description of the complaint, and then finally the follow up / resolution of the complaint. This information will be kept in a log book specifically for complaints and grievances in		

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G 107	<p>Continued From page 2</p> <p>12/31/15, was reviewed and included 2 complaints. The complaint documentation did not include investigation or resolution by the agency. Examples include:</p> <p>a. An email dated 5/12/15, sent from the agency receptionist to the Administrator documented a phone call from Patient #10. The email stated he was upset and wanted another nurse to come out to his home. Patient #10 informed the receptionist he was supposed to be wearing compression stockings, per his physician, for his legs and had not had them on for 2 days. He stated he had spoken to his nurse and requested she come to his home to help put the compression stockings on. Patient #10 informed the receptionist the nurse had told him she could not go to his home. The receptionist informed the Administrator Patient #10 was requesting she call him.</p> <p>There was no documentation of a phone conversation with Patient #10 by the Administrator. Additionally, there was no documentation an investigation occurred or the complaint was resolved.</p> <p>b. A fax cover sheet dated 2/14/15, was sent from the RN Case Manager to a physician. The fax included documentation Patient #13's neighbor had called the agency on that day stating she was Patient #13's daughter. The caller was complaining about the RN Case Manager and the LPN. However, the caller's specific complaints were not documented. The fax indicated the RN Case Manager spoke to Patient #13 and she denied having any complaints about the nursing service and did not want a different agency or nurse treating her.</p>	G 107	<p>the Administrators office. The Administrator and the Director of Nursing will educate Home Health disciplines individually, and during staffing meetings. The Director of Nursing will monitor that this is taking place correctly, by passing the appropriate form that needs to be completed to the person responsible for filling it out, checking the grievance log book weekly (or more often if necessary) ongoing. This will be completed by 2/25/16.</p>		

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G 107	Continued From page 3 There was no documentation of an investigation or resolution of the complaint by Patient #13's neighbor. The Administrator and Assistant Administrator were interviewed at the same time on 1/20/16 beginning at 4:00 PM. They stated the complaint process was for the staff member who received the complaint to notify either the Administrator or the Assistant Administrator. They confirmed there was no documentation to show complaints were investigated and/or resolved. The Administrator confirmed they were not following agency policy.	G 107			
G 158	The agency failed to document, investigate, and resolve complaints. 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 12 patients (#1, #2, #4, #5, #8, and #9) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include: 1. Patient #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound.	G 158	G-158 MultiCare will ensure that care provided to a Patient is in accordance with the Plan of Care, and any orders received for the Patient after the initial Plan of Care. Director of Nursing will instruct RN Case Managers that a verbal order must be received from a Doctor of Medicine, Osteopathy, or Podiatric Medicine upon the finding of a new wound or any other treatment that will alter the		

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G 158	<p>Continued From page 4</p> <p>Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to 1/23/15, was reviewed.</p> <p>a. Patient #9's record included an SN visit note dated 12/11/15, and signed by his RN Case Manager. The note stated "...he has a new blister just distal and medial to the original ulcer." The note stated wound care was provided to the new blister.</p> <p>Patient #9's record included an SN visit note dated 12/14/15, and signed by his RN Case Manager. The note stated "...has a new area that is breaking down, it presents with a fluid filled area, not a typical blister. The skin is white and appears to be very bruised underneath. It has a small slit in the distal edge of the blister." The note stated wound care was provided to the new wound.</p> <p>Patient #9's record included an SN visit note dated 12/18/15, and signed by his RN Case Manager. The note stated wound care was provided to the new wound.</p> <p>Patient #9's record did not include an order for wound care to his new blister.</p> <p>During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed the record and confirmed she did not notify Patient #9's physician of his new wound. Additionally, she confirmed there was no physician's order for wound care to his newly developed wound.</p> <p>Wound care was provided to Patient #9 without an order.</p>	G 158	<p>Plan of Care for a Patient.</p> <p>This must be followed up with a written order that is signed by a Doctor of Medicine, Osteopathy, or Podiatric Medicine, and not Nurse Practitioner or Physician's Assistant. RN Case Manager will instruct LPN prior to providing care to a Patient regarding Plan of Care, and any additional orders following initial Plan of Care, if they occur. LPN will be provided a copy of Plan of Care and any new orders that occur for a Patient (IE: PT/INR testing). RN Case Manager will instruct the LPN to call RN Case Manager if there are questions or concerns during a visit. LPN is instructed by RN Case Manager to follow Physician's orders that are in place for each Patient. RN Case Manager will instruct LPN that Physician must be called with a report when Patient is outside of parameters that are listed on</p>		

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G 158	<p>Continued From page 5</p> <p>b. Patient #9's POC included orders for SN visits 2 times a week for the first week, then 3 times a week for 8 weeks. Patient #9 did not receive SN visits as ordered. Examples include:</p> <p>-During week 2, 11/29/15 to 12/05/15, Patient #9 received SN visits on 12/02/15 and 12/04/05. Three SN visits were ordered, 2 SN visits were provided.</p> <p>-During week 4, 12/13/15 to 12/19/15, Patient #9 received SN visits on 12/14/15 and 12/18/15. Three SN visits were ordered, 2 SN visits were provided.</p> <p>-During week 5, 12/20/15 to 12/26/15, Patient #9 received an SN visit on 12/23/15. Three SN visits were ordered, 1 SN visit was provided.</p> <p>During an interview on 1/21/16 at 1:20 PM, the DON reviewed Patient #9's record and confirmed he did not receive SN visits as ordered on his POC.</p> <p>Patient #9 did not receive SN visits as ordered on his POC.</p> <p>c. Patient #9's POC included orders for PT visits 2 times a week for the first week, then 3 times a week for 3 weeks. During week 4, 12/13/15 to 12/19/15, Patient #9 received PT visits on 12/14/15 and 12/16/15. Three PT visits were ordered, 2 PT visits were provided.</p> <p>During an interview on 1/21/15 at 8:45 AM, the Director of Therapy reviewed Patient #9's record and confirmed he did not receive PT visits as ordered during week 4 of his certification period.</p>	G 158	<p>Plan of Care (IE: Blood pressure, blood glucose). Director of Nursing will instruct RN Case Managers of their responsibility to ensure Physician has been notified, if Patient is outside parameters, before signing off on LPN visit note. Director of Nursing will instruct RN Case Managers that services ordered by Physician at SOC/ROC/re-cert. (IE: Therapy services), for Patient must be notified and appropriately set up for a Patient prior to the acceptance of Patient referral. Frequency and duration must be followed according to signed Plan of Care unless order has been received from Physician with change. Director of Nursing will instruct Intake Coordinator & RN Case Managers that all initial referral orders for Patient must be signed by a Doctor of Medicine, Osteopathy, or Podiatric Medicine, and not a Nurse</p>	

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G 158	<p>Continued From page 6</p> <p>Patient #9 did not receive PT visits as ordered on his POC.</p> <p>d. Patient #9's record included an SN visit note, dated 12/30/15, and signed by the LPN. The note stated an INR blood test was performed during the SN visit. However, Patient #9's record did not include a physician's order for an INR blood test to be performed on 12/30/15.</p> <p>During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed Patient #9's record and confirmed there was no physician's order for an INR blood test to be performed on 12/30/15.</p> <p>Patient #9's blood test was completed without a physician's order.</p> <p>2. Patient #5 was an 88 year old female admitted to the agency on 12/08/15, for services related to a viral infection. Additional diagnoses included nausea with vomiting, essential hypertension and epigastric pain. She received SN, PT, MSW and HHA services. Her record, including the POC, for the certification period 12/08/15 to 2/05/16, was reviewed.</p> <p>Patient #5's medical record contained an OASIS Transfer that indicated she was transferred to the hospital for nausea and vomiting on 12/15/15. Additionally, her medical record included an OASIS ROC dated 12/31/15, that indicated Patient #5 resumed services from the agency with an additional diagnosis of other mental disorder due to known physiological condition.</p> <p>a. Patient #5's record included a faxed referral order for Home Health services. The order was</p>	G 158	<p>Practitioner or a Physician's Assistant. Instruction of each discipline will ensure Physician's orders are being followed and Patient will get the best care possible. Director of Nursing will be responsible for orientation of RN Case Manager's, LPN's, and home health care team, individually and during staffing meetings regarding following Plan of Care and Physician's orders. This will be monitored by the Director of nursing using a chart checklist on a weekly basis and more often if necessary, ongoing. This will be completed by 2/25/16.</p>	

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G 158	<p>Continued From page 7 dated 12/07/15, and was received from a Physician's Assistant.</p> <p>Patient #5's record included a faxed record of a telephone encounter between the agency and the referral provider dated 12/08/15. The agency called for medication and order clarification. The faxed response, dated 12/08/15, that clarified the medications and referral orders, was signed by a Physician's Assistant.</p> <p>Patient #5's record included a faxed Doctors Orders form dated 12/08/15. The RN that completed the form stated "I called the MD office and received a verbal order from [Name] to admit this patient to continue making visits while waiting for the plan of care." The faxed orders were signed by the physician on 1/18/16. There was no indication the RN spoke with the physician.</p> <p>Patient #5's record included a faxed Doctors Orders form dated 1/06/16. The RN that completed the form which stated "Verbal order received for a resumption of care for [Patient] from MD office nurse [Name] effective date was 12/31/15." The faxed order was signed by the physician on 1/18/16. There was no indication the RN spoke with the physician.</p> <p>Patient #5's record included services provided prior to receiving physician's orders as follows:</p> <ul style="list-style-type: none"> - 12/10/15 PT Visit - 12/11/15 PT Visit - 12/11/15 SN Visit - 12/13/15 HHA Visit - 12/14/15 PT Visit - 12/15/15 SN Visit - 11/31/15 SN Visit - 1/04/16 PT Visit 	G 158		

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G 158	<p>Continued From page 8</p> <ul style="list-style-type: none"> - 1/07/16 PT Visit - 1/09/16 SN Visit - 1/12/16 MSW Visit - 1/12/16 SN Visit - 1/12/16 PT Visit - 1/14/16 PT Visit - 1/16/16 SN Visit <p>During an interview on 1/21/15 at 1:30 PM, the DON reviewed Patient #5's record and confirmed the referral was taken from a Physician's Assistant. Additionally, she confirmed the orders dated 12/08/15 and 1/06/16 did not state the RN had spoken with the physician. The DON confirmed SN, PT, MSW and HHA services were provided to Patient #5 before a physician order was obtained. The DON stated she was unaware orders could not be obtained from a Nurse Practitioner, a Physician's Assistant or a Clinical Nurse Specialist.</p> <p>The agency failed to ensure Patient #5's physician's order was obtained from a doctor of medicine, osteopathy or podiatric medicine.</p> <p>b. Patient #5's record included a faxed physician order dated and signed by the physician on 12/28/15. The order stated "home health to follow. PT/OT/RN/Bathaide (sic), social services".</p> <p>Patient #5's record included a ROC OASIS Assessment, dated 12/31/15. The ROC OASIS Assessment did not include assessment for OT needs.</p> <p>Patient #5's record included a SUPPLEMENTAL PLAN OF CARE, dated 12/31/15 which did not include OT services.</p>	G 158		

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G 158	<p>Continued From page 9</p> <p>Patient #5's record included a Doctors Orders form, dated 1/06/16 which stated "Services to be provided by the following: SN, PT, OT, MSW." There was no documentation in the record Patient #5 received OT services.</p> <p>During an interview on 1/21/15 at 1:30 PM, the DON reviewed Patient #5's record and confirmed she did not receive OT services as ordered.</p> <p>During an interview on 1/21/16 at 8:30 AM, the Director of Therapy reviewed Patient #5's record and confirmed she did not receive OT services as ordered by the physician.</p> <p>The agency did not provide Patient #5 with OT as ordered.</p> <p>3. Patient #2 was a 64 year old female admitted to the agency on 11/27/15, for services related to an infected surgical incision. Additional diagnoses included insulin dependent DM and HTN. She received SN services. Her record, including the POC, for the certification period 11/27/15 to 1/25/15, was reviewed.</p> <p>a. Patient #2's record included a faxed physician's order for Home Health services. The order was dated 11/24/15. The order included a note stating a verbal order was received to delay the SOC until 11/27/15. However, the verbal order to delay the SOC was taken from a Physician's Assistant.</p> <p>b. Patient #2's record included a physician's order dated 12/04/15, for a new medication and a urinalysis. The order was signed by a Nurse Practitioner.</p>	G 158			

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G 158	<p>Continued From page 10</p> <p>During an interview on 1/21/15 at 1:30 PM, the DON reviewed Patient #2's physician's orders and confirmed the verbal order to delay her SOC was obtained from a Physician's Assistant. Additionally, she confirmed the order for a new medication and urinalysis was signed by a Nurse Practitioner.</p> <p>The agency failed to ensure Patient #2's physician's order was obtained from a doctor of medicine, osteopathy or podiatric medicine.</p> <p>4. Patient #8 was a 73 year old female admitted to the agency on 12/09/15, for services related to Type II DM with hyperglycemia. Additional diagnoses included long term use of insulin, hypertensive heart disease and unsteadiness on feet. She received SN, PT and OT services. Her record, including the POC, for the certification period 12/09/15 to 2/06/16, was reviewed.</p> <p>Patient #8's record included a Communication Note dated 12/09/15. The RN documented "[Patient name] is in stable condition today however blood sugars are still running over three hundred. Call to PCP (sic) he is unable to manage because this is all new for her, at least the insulin. Call to the Diabetic clinic for guidance and [Name], she is the CNS at the clinic called me back with instructions".</p> <p>Patient #8's record included a Doctors Orders form dated 12/09/15, that stated "[Name of CNS] with the Diabetic clinic gave me verbal orders for [Patient #8] today they are as follows.</p> <p>- Increase Novalog Insulin pen to 6 units with meals</p>	G 158		

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G 158	<p>Continued From page 11</p> <ul style="list-style-type: none"> - Increase Levimer insulin to 10 units at bedtime - Use a correction scale as follows: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units and call MD for every 50 mg/dl" <p>Patient #8's record included a Doctors Orders form dated 12/10/15. The RN documented "Verbal order from [Name of CNS]</p> <ul style="list-style-type: none"> - Increase the Levimer insulin to 13 units at bedtime - Increase the Novolog flex pen to 9 units with meals - Continue the correction scale as follows; 1 unit of insulin per every 50 mg/dl of glucose" <p>Patient #8's record included a Doctors Orders form dated 12/12/15. The RN documented "Verbal order received from [Name] CNS on Saturday 12/12/15 evening after 9PM with changes as follows.</p> <ul style="list-style-type: none"> - Continue Levimer 13 units at HS - Decrease the Novolog flex pen to 7 units before meals, if her FBS at 10pm is less than 100 give her 15 gr (sic) carb snack." <p>During an interview on 1/21/15 at 1:30 PM, the DON reviewed Patient #8's record and confirmed orders dated 12/09/15, 12/10/15 and 12/12/15 were obtained from a CNS. The DON stated she was unaware orders could not be obtained from a Nurse Practitioner, a Physician's Assistant or a Clinical Nurse Specialist.</p>	G 158		

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G 158	<p>Continued From page 12</p> <p>The agency failed to ensure Patient #8's orders were obtained from a doctor of medicine, osteopathy or podiatric medicine.</p> <p>5. Patient #4 was a 73 year old female admitted to the agency on 12/14/15, for care related to a small bowel obstruction. Additional diagnoses included unilateral primary osteoarthritis in the right knee, pain in the right knee, dysthymic disorder and atherosclerotic heart disease (a buildup of plaque in the arteries). Her record, including the POC, for the certification period 12/14/15 to 2/11/15, was reviewed.</p> <p>Patient #4's POC, dated 12/14/15, and signed by the physician on 12/28/15, stated "notify MD of complications including parameters for blood pressure <90>140 systolic, and <60>90 diastolic".</p> <p>Patient #4's record included an SN visit note dated 1/05/16, signed by the LPN on 1/05/16 and co-signed by the RN on 1/08/16. The LPN documented Patient #4's blood pressure as 178/94. The note did not include physician notification of Patient #4's blood pressure that was outside of the parameters ordered. Additionally, there was no documentation that the RN that co-signed the LPN's note, notified the physician.</p> <p>During an interview on 1/21/15 at 1:30 PM, the DON reviewed Patient #4's record and confirmed the blood obtained by the LPN on 1/05/16, was outside the parameters ordered in her POC. Additionally, she confirmed the LPN did not call Patient #4's physician at the time and the RN who co-signed the note did not call her physician when she reviewed the note.</p>	G 158		

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G 158	Continued From page 13 The agency's professional staff failed to notify Patient #4's physician of blood pressure measurement outside of the parameters ordered on her POC. 6. Patient #1 was an 88 year old female admitted to the agency on 8/11/15 and 1/13/16, for services related to an arm fracture after a fall and a pressure ulcer. Additional diagnoses included a pacemaker, atrial fibrillation, heart failure, and generalized weakness. Her record, including the POCs, for the certification periods 8/11/15 to 10/09/15, 10/10/15 to 12/08/15, and 1/13/16 to 3/12/16, were reviewed. Patient #1's record included a verbal order dated 10/22/15, for a blood test and medication changes. The verbal order was taken from a Physician's Assistant. Patient #1's record included a physician's order dated 1/15/16, for a blood test. The order was signed by a Physician's Assistant. During an interview on 1/21/16 at 1:25 PM, the DON confirmed the orders were received and signed by the Physician's Assistant. The agency failed to ensure Patient #1's order was obtained from a doctor of medicine, osteopathy or podiatric medicine.	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,	G 159	G-159 MultiCare will ensure Plan of Care covers all pertinent diagnoses, types of services		

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G 159	<p>Continued From page 14</p> <p>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 4 of 12 patients, (#1, #5, #9, and #12) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include:</p> <p>1. Patient #12 was a 72 year old male admitted to the agency on 7/02/15, for PT services. His diagnoses included back pain and HTN. His record, including the POC, for the certification period 7/02/15 to 8/30/15, was reviewed.</p> <p>Patient #12's record included an SOC comprehensive assessment completed on 7/02/15, and signed by the RN Case Manager. The assessment stated Patient #12 required the following:</p> <ul style="list-style-type: none"> -Specific parameters for notifying his physician of changes in vital signs or other clinical findings -Depression interventions -Interventions to monitor and mitigate pain -Interventions to prevent pressure ulcers 	G 159	<p>required, equipment, supplies, functional limitations, treatments, activities permitted, nutritional requirements, medications/allergies, and any safety measures to protect against injury, instructions for timely discharge, and any other appropriate interventions. Director of Nursing will educate / instruct RN Case Managers developing the Plan of Care to include all pertinent initial assessment findings onto the Plan of Care (IE: Depression interventions, monitoring/mitigation of pain, pressure ulcer prevention) to ensure that the Plan of Care is comprehensive and meets Patient's needs. Director of Nursing will educate / instruct RN Case Managers to include all pertinent assessment findings onto the Plan of Care to meet Patient needs and Physician order (IE: Diabetic foot care/education of proper foot care, parameters for vital</p>		

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G 159	<p>Continued From page 15</p> <p>Patient #12's record included a POC for the certification period 7/02/15 to 8/30/15, developed and signed by the RN Case Manager on 7/02/15. The POC did not include specific parameters for notifying his physician of clinical findings, depression interventions, interventions to monitor and mitigate pain, or interventions to prevent pressure ulcers.</p> <p>During an interview on 1/21/16 at 1:40 PM, the DON reviewed Patient #12's record and confirmed his POC did not include the above items.</p> <p>Patient #12's POC was not comprehensive to meet all of his needs.</p> <p>2. Patient #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound. Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to 1/23/15, was reviewed.</p> <p>Patient #9's record included an SOC comprehensive assessment completed on 11/25/15, and signed by the RN Case Manager. The assessment stated Patient #9 required diabetic foot care including monitoring for presence of skin lesions, and patient education on proper foot care. Additionally, the assessment stated Patient #9 required specific parameters for notifying his physician of changes in vital signs or other clinical findings.</p> <p>Patient #9's record included a POC for the certification period 11/25/15 to 1/23/15, developed and signed by the RN Case Manager on</p>	G 159	<p>signs/other clinical findings). Director of Nursing will educate / instruct RN Case Managers individually through home health staff meetings to do a thorough review of the initial referral information regarding Patient (IE: H&P's, operative reports, medications / allergies) so all pertinent interventions are included in the initial assessment and then listed on the Plan of Care. This will ensure that the Patient will get the best care possible, Physician's orders are being followed, and prevention of potential injury to Patient. This will be monitored by the Director of Nursing and RN Case Managers at SOC/ROC/re-cert., and any time there is a change to the Plan of Care during the certification period (IE: Change in Patient's condition, medication/allergy changes), ongoing. This will be met by 2/25/16.</p>		

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G 159	<p>Continued From page 16</p> <p>11/25/15. The POC did not include diabetic foot care monitoring or education. Additionally, it did not include specific parameters for notifying his physician of clinical findings.</p> <p>During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed Patient #9's record and confirmed his POC did not include diabetic foot care, or specific parameters to report to his physician.</p> <p>Patient #9's POC was not comprehensive to meet all of his needs.</p> <p>3. Patient #1 was an 88 year old female admitted to the agency on 8/11/15 and 1/13/16, for services related to an arm fracture after a fall and a pressure ulcer. Additional diagnoses included a pacemaker, atrial fibrillation, heart failure, and generalized weakness. Her record, including the POCs, for the certification periods 8/11/15 to 10/09/15, 10/10/15 to 12/08/15, and 1/13/16 to 3/12/16, were reviewed.</p> <p>Patient #1's record included an SOC comprehensive assessment completed on 1/13/16, and signed by her RN Case Manager. The assessment documented she did not have a surgical wound. However, a referral from a hospital to the agency dated 1/11/16, indicated Patient #1 was to receive SN services for pacemaker site evaluation and education related to the pacemaker and incision care.</p> <p>An observation of HHA care in Patient #1's home occurred on 1/19/16 beginning at 3:00 PM. Patient #1 was observed to have a dressing on her left chest wall. When asked about the dressing Patient #1 confirmed it was a surgical</p>	G 159			

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G 159	<p>Continued From page 17 incision from surgery related to her pacemaker.</p> <p>Patient #1's record included a POC for the certification period 1/13/16 to 3/12/16, developed and signed by the RN Case Manager. The POC did not include surgical incision site monitoring or education on care of the surgical incision. Additionally, it did not include educating Patient #1 about her pacemaker.</p> <p>During an interview on 1/21/16 at 10:00 AM, the RN Case Manager confirmed Patient #1 had a surgical incision to her left chest wall from pacemaker surgery to replace a wire. She stated the physician did not want the dressing removed from the incision site until Patient #1 went to her scheduled physician visit. The RN Case Manager confirmed the POC did not include interventions related to Patient #1's pacemaker or surgical incision.</p> <p>Patient #1's POC was not comprehensive to meet all of her needs.</p> <p>4. Patient #5 was an 88 year old female admitted to the agency on 12/08/15, for services related to a viral infection. Additional diagnoses included nausea with vomiting, essential hypertension and epigastric pain. She received SN, PT, MSW and Home Health Aide services. Her record, including the POC, for the certification period 12/08/15 to 2/05/16, was reviewed.</p> <p>Patient #5's medical record contained an OASIS Transfer that indicated she was transferred to the hospital for nausea and vomiting on 12/15/15. Additionally, her medical record included an ROC OASIS dated 12/31/15, that indicated Patient #5 resumed services from the agency with an</p>	G 159		

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G 159	Continued From page 18 additional diagnosis of other mental disorder due to known physiological condition. Patient #5's record included two H&Ps, dated 12/15/15 and 12/17/15, which included allergies. The two H&Ps documented allergies that included "Latex, Natural Rubber (Severe, RASH 12/26/14)". In addition, Patient #5's record included an ROC OASIS, dated 12/31/15, that included latex as one of Patient #5's allergies. Patient #5's record included a POC, dated 12/08/15, which included a section titled ALLERGIES, however it did not include Patient #5's allergy to latex. During an interview on 1/21/15 at 1:30 PM, the DON reviewed Patient #5's record and confirmed the documentation of latex, natural rubber as a severe allergy in two H&Ps and in the ROC OASIS. Additionally, the DON asked the Assistant Administrator to pull a current Patient Profile. Patient #5's Patient Profile, dated 1/21/16, did not include latex, natural rubber as an allergy. She confirmed the clinical staff did not have information of Patient #5's severe allergy to latex, natural rubber available to them during visits.	G 159			
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.	G 160	G-160 MultiCare will ensure Physician is notified and a verbal order is received prior to making visits for any		

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G 160	Continued From page 19 This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 1 of 12 patients (Patient #12) whose SOC records were reviewed. This resulted in a POC that was developed and initiated without appropriate physician approval. Findings include: Patient #12 was a 72 year old male admitted to the agency on 7/02/15, for PT services. His diagnoses included back pain and HTN. His record, including the POC, for the certification period 7/02/15 to 8/30/15, was reviewed. Patient #12's record included a PT evaluation completed on 7/02/15, and signed by the Director of Physical Therapy. His record included a Physician's verbal order for the PT POC and additional PT visits, dated 7/13/15. However, PT visits were completed on 7/06/15, 7/08/15, and 7/09/15, prior to his physician's approval of the PT POC and additional visits. During an interview on 1/21/16 at 8:49 AM, the Director of Therapy reviewed Patient #12's record and confirmed 3 PT visits were completed prior to his physician's approval of the PT POC. The agency failed to ensure Patient #12's physician approved his PT POC prior to providing additional PT visits.	G 160	service that is ordered for the Patient's care, while waiting for the signed Plan of Care from the Physician. The Physical Therapist or RN Case Manager will call the Physician to receive verbal order. Visits will not be made until the Physician has given verbal consent to provide services. The Director of Nursing will be responsible for educating RN Case Managers, and Physical Therapists individually and at staffing meetings every other week, as well as monitoring records weekly (more often if needed) using a chart checklist to ensure this is taking place, ongoing. This will be completed by 2/25/16.		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the	G 164	G-164 MultiCare will ensure Physician is promptly alerted		

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G 164	<p>Continued From page 20</p> <p>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 12 patients (#4, #9, and #12) 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 #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound. Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to 1/23/15, was reviewed.</p> <p>Patient #9's record included an SN visit note dated 12/11/15, and signed by his RN Case Manager. The note stated "...he has a new blister just distal and medial to the original ulcer." The note stated wound care was provided to the new blister. However, the note did not state Patient #9's physician was notified of the new blister.</p> <p>Patient #9's record included an SN visit note dated 12/14/15, and signed by his RN Case Manager. The note stated "...has a new area that is breaking down, it presents with a fluid filled area, not a typical blister. The skin is white and appears to be very bruised underneath. It has a small slit in the distal edge of the blister." The</p>	G 164	<p>to changes that suggest a need to alter Plan of Care. Director of Nursing will instruct / educate RN Case Managers, Therapists, LPN's, and all other disciplines involved in Patient's care to promptly alert Physician of changes that occur during certification period that may require amending Patient's Plan of Care (IE: New wound, elevated blood pressure, falls). Patient's RN Case Manager will ensure Patient's needs are being met, documented, and communicated appropriately with a call to Physician, (verbal / written orders, if indicated, and updates sent to Physician). Updates will be sent promptly to Physician reflecting detailed changes in Patient's status. LPN will be instructed, per Director of Nursing to call RN Case Manager during a Patient visit if any change in the Patient's status occurs. RN Case</p>		

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G 164	<p>Continued From page 21</p> <p>note stated wound care was provided to the new wound. Additionally, it stated Patient #9 had an appointment at a wound clinic in a few days. However, the note did not state Patient #9's physician was notified of the new wound.</p> <p>Patient #9's record included an SN visit note dated 12/18/15, and signed by his RN Case Manager. The note stated [Patient name] did not make it to the wound clinic as he had hoped. The note stated wound care was provided to the new wound. However, the note did not state Patient #9's physician was notified of the new wound.</p> <p>During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed the record and confirmed she did not notify Patient #9's physician of his new wound.</p> <p>Patient #9's RN Case Manager failed to notify his physician of a newly developed wound on his foot.</p> <p>2. Patient #12 was a 72 year old male admitted to the agency on 7/02/15, for PT services. His diagnoses included back pain and HTN. His record, including the POC, for the certification period 7/02/15 to 8/30/15, was reviewed.</p> <p>Patient #12's record included a PT visit note dated 7/18/15, and signed by the PTA. The note stated "Pt [patient] states he had a fall getting off of the toilet as he reached for a grab bar missing it yesterday. He fell bwds [backwards] to the right into a wall. No injuries other than toes on left foot and back feel hurt [sic]." Patient #12's record did not include documentation stating his physician was notified of his fall and pain.</p>	G 164	<p>Manager will advise LPN on how to proceed. Director of Nursing will instruct home health staff to utilize shared communication note to document changes in Patient's status as they occur. RN Case Managers will be instructed to review communication notes on regular basis to ensure continuity of care. Director of Nursing will instruct RN Case Managers to thoroughly review LPN visit notes before co-signing and to follow up on any change that may have occurred during that visit. Director of Nursing will instruct RN Case Managers individually and during staff meetings to review their Patient charts on a weekly basis (or more often if needed) using a chart checklist, to ensure adequate documentation and orders are in place. The Director of Nursing will monitor this on a weekly basis by performing</p>		

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G 164	<p>Continued From page 22</p> <p>During an interview on 1/21/16 at 10:00 AM, the Director of Therapy reviewed Patient #12's record and confirmed his physician was not notified of his fall and pain.</p> <p>The agency failed to ensure Patient #12's physician was notified of his fall.</p> <p>3. Patient #4 was a 73 year old female admitted to the agency on 12/14/15, for care related to a small bowel obstruction. Additional diagnoses included unilateral primary osteoarthritis in the right knee, pain in the right knee, dysthymic disorder and atherosclerotic heart disease (a buildup of plaque in the arteries). Her record, including the POC, for the certification period 12/14/15 to 2/11/15, was reviewed.</p> <p>Patient #4's POC, dated 12/14/15, and signed by the physician on 12/28/15, stated "notify MD of complications including parameters for blood pressure <90>140 systolic, and <60>90 diastolic".</p> <p>Patient #4's record included an SN visit note dated 1/05/16, signed by the LPN on 1/05/16 and co-signed by the RN on 1/08/16. The LPN documented Patient #4's blood pressure as 178/94. The note did not include physician notification of Patient #4's blood pressure that was outside of the parameters ordered. Additionally, there was no documentation that the RN that co-signed the LPN's note, notified the physician.</p> <p>During an interview on 1/21/15 at 1:30 PM, the DON reviewed Patient #4's record and confirmed the blood obtained by the LPN on 1/05/16, was outside the parameters ordered in her POC. Additionally, she confirmed the LPN did not call</p>	G 164	<p>random chart audits, and meeting with field staff, ongoing. This will be completed by 2/25/16.</p>		

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G 164	Continued From page 23 Patient #4's physician at the time and the RN who co-signed the note did not call her physician when she reviewed the note.	G 164			
G 165	The agency's professional staff failed to notify Patient #4's physician of blood pressure measurement outside of the parameters ordered on her POC. 484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. 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 1 of 12 patients (Patient #9) 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: Patient #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound. Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to 1/23/15, was reviewed. Patient #9's POC included orders to apply PolyMem AG (a wound care dressing) to his left heel wound 3 times a week. His record included an SN visit note dated 12/07/15, and signed by	G 165	G-165 MultiCare will ensure that medications or treatments administered to Patient are done only as ordered per Physician. Director of Nursing will instruct RN Case Managers and LPN's that they must follow the orders as prescribed per Physician at all times (IE: Wound care). RN Case Manager will instruct LPN prior to LPN treating a Patient regarding treatment specifically ordered for Patient. LPN must follow orders, as written. RN Case Manager will provide LPN with copy of Patient's Plan of Care and any new orders for Patient, as they occur to ensure LPN is following order		

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G 165	Continued From page 24 the LPN. The note stated the LPN applied PolyMem AG to his wound, then applied an ace wrap to his heel. Patient #9's POC did not include an order for an ace wrap. During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed Patient #9's record and confirmed there was no Physician order for an ace wrap to his heel. An ace wrap was applied to Patient #9's foot without a physician's order.	G 165	as prescribed per Physician. Director of Nursing will educate RN Case Managers and LPN individually and during home health staffing meetings. This will ensure Physician's orders are being followed and each discipline is practicing within their scope of practice ensuring Patient is receiving the best care possible. The Director of Nursing will be monitoring that this is taking place as instructed, by doing random chart audits, meeting with the field staff on a weekly basis (or more often if needed), ongoing. This will be completed by 2/25/16.		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the agency failed to ensure verbal orders were put in writing by a registered nurse or qualified therapists for 2 of 12 patients (#1 and #9) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include: A policy "Physician's Plan of Care/Change Orders" undated, stated "Only designated, qualified clinicians, authorized by state and federal regulations may accept and write verbal orders." This policy was not followed. Examples	G 166	G-166 MultiCare will ensure verbal orders are received in writing and signed/dated with date of receipt by RN Case Managers or qualified Therapists responsible for furnishing or supervising ordered services.		

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G 166	<p>Continued From page 25 include:</p> <p>1. Patient #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound. Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to 1/23/15, was reviewed.</p> <p>Patient #9's record included a physician's verbal order, received on 12/02/15, for a change in his Coumadin dosage and an INR blood test to be completed in 1 week. The order was signed by an LPN.</p> <p>During an interview on 1/21/16 at 1:20 PM, the DON reviewed Patient #9's record and confirmed the physician's verbal order was taken by the LPN.</p> <p>The agency failed to ensure physician's verbal orders are taken by the RN or qualified therapist.</p> <p>2. Patient #1 was an 88 year old female admitted to the agency on 8/11/15 and 1/13/16, for services related to an arm fracture after a fall and a pressure ulcer. Additional diagnoses included a pacemaker, atrial fibrillation, heart failure, and generalized weakness. Her record, including the POCs, for the certification periods 8/11/15 to 10/09/15, 10/10/15 to 12/08/15, and 1/13/16 to 3/12/16, were reviewed.</p> <p>Patient #1's record included a verbal order, received on 10/12/15, for a change in her Coumadin dosage and an INR blood test to be completed in 1 week. The order was signed by an LPN.</p>	G 166	<p>Director of Nursing will instruct / educate home health staff that only an RN or qualified Therapist can accept a verbal order from a Physician. RN Case Manager or qualified Therapist will instruct LPN / PTA that they are not able to accept a verbal order. Director of Nursing will educate home health staff individually, and during home health staff meetings to ensure each service is performed within scope of practice. This will be monitoring on a weekly basis per the Director of Nursing, by doing random chart audits, and meeting with staff, ongoing. This will be completed by 2/25/16.</p>		

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G 166	Continued From page 26	G 166			
G 176	<p>During an interview on 1/21/16 at 1:25 PM, the DON reviewed Patient #1's record and confirmed the verbal order was taken by an LPN.</p> <p>The agency failed to ensure verbal orders are taken by an RN or qualified therapist.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</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, observation, and medical record review, it was determined the facility failed to ensure RNs appropriately prepared clinical notes, and coordinated care with the physician for 3 of 12 patients (#1, #4, and #9) 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 #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound. Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to 1/23/15, was reviewed.</p> <p>a. Patient #9's record did not include complete</p>	G 176	G-176	<p>MultiCare will ensure that RN Case Manager is preparing clinical and progress notes, coordinating services and informing Physician and other personnel of Patient needs and / or changes in Patient's condition. The Director of Nursing will educate RN Case Managers to do a complete and comprehensive assessment at start of care to include detailed information that will impact care provided beyond the start of care visit (IE: wound status, location, incision). RN Case Manager will provide LPN with copy of Plan of Care and report regarding status of Patient before LPN provides care to their Patient. The RN Case</p>	

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G 176	<p>Continued From page 27 and consistent documentation related to his left foot wound, as follows:</p> <p>Patient #9's record included an SOC comprehensive assessment completed on 11/25/15, and signed by his RN Case Manager. The assessment stated he did not have a pressure ulcer. It stated he had an open wound on his left heel. However, the section of the assessment titled "Wound/Lesion" documented the status of his left heel wound as closed. The type of wound was documented as "other (specify)." However, the documentation did not specify the type of wound. The wound size was documented as 1.5 cm wide by 1.5 cm long.</p> <p>Patient #9's record included an SN visit note completed on 11/27/15, and signed by the LPN. The note stated he had a sore on his right heel, rather than his left heel as documented on the SOC assessment. It was described as a pressure ulcer, measuring 3 cm wide by 3 cm long.</p> <p>Patient #9's record included an SN visit note completed on 12/02/15, and signed by the LPN. The note stated wound care was provided to his left heel pressure ulcer, measuring 2 cm wide by 2 cm long.</p> <p>During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed Patient #9's record. She stated the wound was on his left heel and was caused by trauma. She confirmed he did not have a pressure ulcer. Additionally, she confirmed the wound measurements were inconsistent, and stated the LPN may have included the reddened area around the wound in her measurements.</p>	G 176	<p>Manager will call the Physician promptly to report changes (IE: new wound, elevated blood pressure), and receive a verbal order for anything that will require a change to Plan of Care. A written order will then be sent to Physician and communicated to other disciplines providing care to Patient. The Director of Nursing will educate RN Case Managers and LPN individually and during home health staff meetings to ensure Patient's needs are being met, Physician orders are being followed, and Patient is safe and well cared for. The Director of Nursing will monitor this on a weekly basis (or more if needed) by doing random chart audits using a chart checklist, and meeting with field staff, ongoing. This will be completed by 2/25/16.</p>		

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G 176	<p>Continued From page 28</p> <p>Patient #9's SN visit notes did not provide complete and consistent documentation regarding the status of his wound.</p> <p>b. Patient #9's physician was not notified of a change in his status, as follows:</p> <p>Patient #9's record included an SN visit note dated 12/11/15, and signed by his RN Case Manager. The note stated "...he has a new blister just distal and medial to the original ulcer." The note stated wound care was provided to the new blister. However, the note did not state Patient #9's physician was notified of the new blister.</p> <p>Patient #9's record included an SN visit note dated 12/14/15, and signed by his RN Case Manager. The note stated "...has a new area that is breaking down, it presents with a fluid filled area, not a typical blister. The skin is white and appears to be very bruised underneath. It has a small slit in the distal edge of the blister." The note stated wound care was provided to the new wound. Additionally, it stated Patient #9 had an appointment at a wound clinic in a few days. However, the note did not state Patient #9's physician was notified of his new wound.</p> <p>Patient #9's record included an SN visit note dated 12/18/15, and signed by his RN Case Manager. The note stated [Patient name] did not make it to the wound clinic as he had hoped. The note stated wound care was provided to the new wound. However, the note did not state Patient #9's physician was notified of his new wound.</p> <p>During an interview on 1/20/16 at 4:30 PM, the</p>	G 176			

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G 176	<p>Continued From page 29</p> <p>RN Case Manager reviewed the record and confirmed she did not notify Patient #9's physician of his new wound.</p> <p>Patient #9's RN Case Manager failed to notify his physician of a newly developed wound on his foot.</p> <p>2. Patient #1 was an 88 year old female admitted to the agency on 8/11/15, for services related to a pressure ulcer. Additional diagnoses included a pacemaker, atrial fibrillation, heart failure, and generalized weakness. Her record, including the POCs, for the certification periods 8/11/15 to 10/09/15, 10/10/15 to 12/08/15, and 1/13/16 to 3/12/16, were reviewed.</p> <p>Patient #1's record included an SOC comprehensive assessment completed on 1/13/16, and signed by her RN Case Manager. The assessment documented she did not have a surgical wound. However, a referral from a hospital to the agency dated 1/11/16, indicated Patient #1 was to receive SN services for pacemaker site evaluation and education related to the pacemaker and incision care.</p> <p>An SN visit note dated 1/15/16, signed by the LPN, did not include documentation of assessment or care of a surgical incision.</p> <p>An observation of HHA care in Patient #10's home occurred on 1/19/16 beginning at 3:00 PM. Patient #1 was observed to have a dressing on her left chest wall. When asked about the dressing Patient #1 confirmed it was a surgical incision from surgery related to her pacemaker.</p>	G 176			

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G 176	<p>Continued From page 30</p> <p>During an interview on 1/21/16 at 10:00 AM, the RN Case Manager confirmed Patient #1 had a surgical incision to her left chest wall from pacemaker surgery to replace a wire. She stated the physician did not want the dressing removed from the incision site until Patient #1 went to her scheduled physician visit. The RN Case Manager confirmed the SOC assessment did not include documentation of the surgical incision.</p> <p>Patient #1's SN visit notes did not provide complete and consistent documentation regarding the status of her surgical incision.</p> <p>3. Patient #4 was a 73 year old female admitted to the agency on 12/14/15, for care related to a small bowel obstruction. Additional diagnoses included unilateral primary osteoarthritis in the right knee, pain in the right knee, dysthymic disorder and atherosclerotic heart disease (a buildup of plaque in the arteries). Her record, including the POC, for the certification period 12/14/15 to 2/11/15, was reviewed.</p> <p>Patient #4's POC, dated 12/14/15, and signed by the physician on 12/28/15, stated "notify MD of complications including parameters for blood pressure <90>140 systolic, and <60>90 diastolic".</p> <p>Patient #4's record included an SN visit note dated 1/05/16, signed by the LPN on 1/05/16 and co-signed by the RN on 1/08/16. The LPN documented Patient #4's blood pressure as 178/94. The note did not include physician notification of Patient #4's blood pressure that was outside of the parameters ordered. Additionally, there was no documentation that the RN that co-signed the LPN's note, notified the physician.</p>	G 176			

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G 176	Continued From page 31	G 176		
G 331	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT</p> <p>A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included a thorough examination of identified items of concern for 2 of 12 patients, (#1 and #9) whose SOC records were reviewed. This failure placed patients at risk for negative outcomes. Findings include:</p> <p>1. Patient #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound. Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to</p>	G 331	<p>G-331</p> <p>MultiCare will ensure RN Case Managers conducting the initial assessment of a Patient contains accurate assessment data clearly stating the Patient's condition as SOC/ROC, and re-cert. (IE: Wound type, description, incision). If there is missing documentation from discharging hospital or referring Physician, RN Case Manager will request needed documentation to support assessment findings to appropriately complete the initial assessment. The</p>	

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G 331	<p>Continued From page 32 1/23/15, was reviewed.</p> <p>Patient #9's record included an SOC comprehensive assessment completed on 11/25/15, and signed by his RN Case Manager. The assessment stated he did not have a pressure ulcer. The type of wound was documented as "other (specify)." However, the documentation did not specify the type of wound. It was unclear if the wound was a pressure ulcer, diabetic ulcer, stasis ulcer, or the result of surgery or trauma.</p> <p>The SOC assessment stated Patient #9 had an open wound on his left heel. However, the section of the assessment titled "Wound/Lesion" documented the status of his left heel wound as closed.</p> <p>During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed Patient #9's record. She stated the wound on his left heel was caused by trauma. She confirmed the SOC assessment did not clearly document the type and status of his wound.</p> <p>Patient #9's SOC assessment did not provide complete and consistent documentation regarding the status of his wound.</p> <p>2. Patient #1 was an 88 year old female admitted to the agency on 8/11/15 and 1/13/16, for services related to an arm fracture after a fall and a pressure ulcer. Additional diagnoses included a pacemaker, atrial fibrillation, heart failure, and generalized weakness. Her record, including the POCs, for the certification periods 8/11/15 to 10/09/15, 10/10/15 to 12/08/15, and 1/13/16 to 3/12/16, were reviewed.</p>	G 331	<p>Director of Nursing will be responsible for educating the RN Case Managers on how to complete a comprehensive initial assessment. RN Case Managers will be responsible for educating LPN and other disciplines involved in treating Patient. This will ensure that everyone involved in the Patient's treatment plan is providing the best care possible, following the Physician ordered Plan of Care, and any orders subsequent to the Plan of Care. Director of Nursing will educate RN Case Managers individually and during home health staff meetings. The Director of Nursing will monitor that this is taking place by checking charts using a chart checklist on a weekly basis (or more often if needed), ongoing. This will be completed by 2/25/16.</p>		

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G 331	Continued From page 33 Patient #1 was sent to a hospital on 1/04/16, for a syncopal episode (fainting) in her home witnessed by the RN Case Manager. She was admitted to the hospital and had surgery to replace a wire on her pacemaker. Patient #1 was discharged from home health services during her hospital admission. On 1/12/16, Patient #1 was discharged from the hospital to her home and a referral was sent to the agency for home health services. Patient #1's record included an SOC comprehensive assessment completed on 1/13/16, and signed by her RN Case Manager. The assessment documented she did not have a surgical wound. However, the referral from the hospital to the agency indicated Patient #1 was to receive SN services for pacemaker site evaluation and education related to the pacemaker and care of her surgical incision. During an interview on 1/21/16 at 10:00 AM, the RN Case Manager confirmed Patient #1 had a surgical incision to her left chest wall from pacemaker surgery to replace a wire. She stated the physician did not want the dressing removed from the incision site until Patient #1 went to her scheduled physician visit. The RN Case Manager confirmed the SOC assessment did not include documentation of the surgical incision. Patient #1's SOC assessment did not provide complete documentation regarding her surgical incision.	G 331			
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a	G 337	G-337 MultiCare will ensure		

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G 337	<p>Continued From page 34</p> <p>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 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 2 of 12 patients, (#9 and #12) whose records were reviewed. This resulted in the potential for patients to experience adverse outcomes related to medications. Findings include:</p> <p>1. Patient #9 was an 84 year old male admitted to the agency on 11/25/15, for care related to Legionnaire's Disease, and an open foot wound. Additional diagnoses included chronic respiratory failure, DM and CKD. His record, including the POC, for the certification period 11/25/15 to 1/23/15, was reviewed.</p> <p>Patient #9's record included an SN visit note dated 12/02/15, and signed by the LPN. The note stated his blood pressure medication should be held if his systolic blood pressure (top number) was less than 120 mm/Hg. Patient #9's medication profile included 2 medications used to treat high blood pressure, Lisinopril and Metoprolol. The SN visit note did not indicate which medication should be held. Additionally, his medication profile did not include orders to</p>	G 337	<p>comprehensive assessment includes a review of all medications Patient is currently taking / using in order to identify any potential adverse reactions / effects, including ineffective drug therapy, significant side effects/drug interactions, duplicate drug therapy, and non-compliance with drug therapy. Director of Nursing will educate RN Case Managers that specific parameters must be included on the Patient's Plan of Care at initial assessment, resumption of care, re-cert., or any other time there is a change during certification period (IE: Blood pressure parameters to hold a medication if blood pressure is below Physician ordered parameters, new pain medication ordered during a Patient visit to emergency department). This information will be clearly documented during the initial</p>		

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G 337	<p>Continued From page 35</p> <p>hold either medication for a systolic blood pressure less than 120 mm/Hg. Patient #9's record did not include documentation stating his physician was contacted to clarify the instruction to hold his blood pressure medication.</p> <p>During an interview on 1/20/16 at 4:30 PM, the RN Case Manager reviewed Patient #9's record and confirmed there was no physician order to hold blood pressure medication. She stated his physician should have been contacted to clarify the instruction.</p> <p>Patient #9's medications were not reconciled with his physician to clarify instructions to hold medication when his blood pressure was low.</p> <p>2. Patient #12 was a 72 year old male admitted to the agency on 7/02/15, for PT services. His diagnoses included back pain and HTN. His record, including the POC, for the certification period 7/02/15 to 8/30/15, was reviewed.</p> <p>Patient #12's record included documentation from an ED visit on 6/26/15. The documentation stated he went to the ED with complaints of back pain, and was given a prescription for Percocet to be taken every 4 hours as needed for pain. Patient #12's record included a PT visit note dated 7/08/15, and signed by the PTA. The note stated Patient #12 reported the Percocet was not helping his pain. However, Percocet was not included on Patient #12's POC or medication profile.</p> <p>During an interview on 1/21/16 at 8:49 AM, the Director of Therapy reviewed Patient #12's record and confirmed Percocet was not included on his POC or medication profile.</p>	G 337	<p>assessment, ROC/re-cert., and any other time during certification period when a medication change occurs. RN Case Managers will instruct all disciplines involved in care of their Patient to review medication profile, and any new medications that are ordered to include potential side effects and adverse reactions. This will ensure Patient is taking all medications, as prescribed, and decrease the potential for injury to Patient. This will also ensure that all assigned disciplines are following Physician's orders. RN Case Manager will be responsible for calling Physician if any adverse reactions or side effects are present, or if there is potential for this to occur. Director of Nursing will educate RN Case Managers, Therapists, and all other disciplines individually, and during staffing meetings. The Director of Nursing will be</p>		

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G 337	Continued From page 36	G 337	monitoring that this is taking place by checking charts on a weekly basis using a chart checklist (or more often if needed), ongoing. This will be completed by 2/25/16.		
G 340	<p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the comprehensive assessment was updated and revised within 2 days of the patient's return home from a hospital admission for 1 of 3 patients (Patient #10) whose care was resumed after a hospitalization and whose records were reviewed. This resulted in an assessment that was not sufficiently comprehensive to meet the patient's needs, and had the potential to result in adverse patient outcomes. Findings include:</p> <p>Patient #10 was a 61 year old male admitted to the agency on 3/27/15, for services related to a traumatic brain injury. Additional diagnoses included Intracranial injury, spinal cord injury, depression, osteoarthritis, and generalized weakness. His record, including the POC for the certification period 6/17/15 to 7/24/15, was reviewed.</p> <p>Patient #10's record included a referral for resumption of PT and OT services dated 6/12/15.</p>	G 340	<p>G-340</p> <p>MultiCare will ensure that a comprehensive assessment, if updated / revised (including the administration of the OASIS), within 48 hours of Patient returning home from a hospital admission of 24 hours of more for any reason other than diagnostic testing. Director of Nursing will educate RN Case Managers and Physical Therapists that Physician must be called when there is a delay in start of services beyond 48 hours of receiving referral. Delay in service is only acceptable if requested by Patient or Patient's Family member. Delay beyond 48 hours is not acceptable for scheduling convenience or other.</p>		

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G 340	<p>Continued From page 37</p> <p>A communication note from the agency receptionist dated 6/12/15, documented Patient #10 requested the ROC visit be moved to 6/16/15, and the Physical Therapist was notified. There was no documentation his physician was notified of the delay.</p> <p>A subsequent communication note from the Director of Physical Therapy dated 6/15/15, documented the Physical Therapist was not available that week and he contacted Patient #10. The Director of Therapy documented Patient #10 agreed for the ROC visit to occur on 6/17/15. The ROC assessment visit was 5 days after the agency received the referral order. There was no documentation in the record Patient #5's physician was notified of the delay.</p> <p>During an interview on 1/21/16 at 8:30 AM, the Director of Therapy reviewed the record and confirmed the ROC visit was delayed per Patient #10's request initially and then due to the Physical Therapist being unavailable. He confirmed Patient #10's physician was not informed of the delay.</p> <p>Patient #10's physician was not informed in the delay for the ROC visit.</p>	G 340	<p>Referral will be declined if discipline ordered is not able to evaluate the Patient within the 48 hour rule. This will ensure that the Patient is seen promptly to prevent potential for injury or adverse outcomes. The Director of Nursing will educate RN Case Managers and Therapists individually and at home health staffing meetings. The Director of Nursing will monitor this weekly using a chart checklist, and doing random chart audits, ongoing. This will be completed by 2/25/16.</p>	

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N 026	<p>03.07020. ADMIN. GOV. BODY</p> <p>N026 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following:</p> <p>d.viii. The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and must document both the existence of the complaint and the resolution of the complaint.</p> <p>This Rule is not met as evidenced by: Refer to G107</p>	N 026	See G-107	
N 093	<p>03.07024. SK. NSG. SERV.</p> <p>N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:</p> <p>a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs;</p> <p>This Rule is not met as evidenced by: Refer to G331</p>	N 093	See G-331	
N 097	<p>03.07024. SK. NSG. SERV.</p>	N 097	See G-176	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bureau of Facility Standards

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N 097	Continued From page 1 N097 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G176	N 097		
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G176	N 098	See G-176	
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	N 152	See G-158	

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N 152	Continued From page 2 includes: This Rule is not met as evidenced by: Refer to G158	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 G159	N 155	See G-159	
N 170	03.07030.04.PLAN OF CARE N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to G160	N 170	See G-160	
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.	N 172	See G-164	

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N 172	Continued From page 3 This Rule is not met as evidenced by: Refer to G164	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 medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G165, G166, and G337	N 173	See G-165, G-166 & G-337	