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

March 4, 2016

Brent Schneider, Administrator
Legacy Home Health
680 S Progress Avenue, Suite 2A
Meridian, ID 83642

RE: Legacy Home Health, Provider #137106

Dear Mr.. Schneider:

This is to advise you of the findings of the Medicare/Licensure survey at Legacy Home Health, which was concluded on February 19, 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.

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

LEGACY
HOME HEALTH CARE
"Where Caring Comes Home"

680 S. Progress Ave., Ste. # 2A | Meridian, ID 83642 | Phone: 208-888-3669 | Fax: 208-888-3675

3-17-16

Laura Thompson, R.N., B.S.N
Health Facility Surveyor
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0009

Dear Laura:

Enclosed please find our plan of correction for the survey conducted at our agency on 2-19-16. It was a pleasure working with you and your team. We appreciated the professional manner the survey was conducted and the opportunity to work with you.

Sincerely;

Brent Schneider, Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your home health agency on 2/16/16 through 2/19/16. The surveyors conducting the recertification were: Laura Thompson RN, BSN, HFS - Team Lead Susan Costa RN, HFS Gary Guiles RN, HFS Acronyms used in this report include: ADL - Activities of Daily Living ALF - Assisted Living Facility CHF - Congestive Heart Failure CKD - Chronic Kidney Disease COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DM - Diabetes Mellitus DM Type II- Insulin resistance or not enough insulin in the body EMR - Electronic Medical Record GERD - Gastroesophageal Reflux Disease HTN - Hypertension OASIS - Outcome and Assessment Information Set, a standardized home health assessment tool OT - Occupational Therapy PD - Peritoneal Dialysis POC - Plan of Care prn - as needed PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy	G 000		
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND	G 107	See attached plan of correction.	

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

[signature] Administrator 3-17-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 107	Continued From page 1 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 staff interview and review of patient complaints, it was determined the home health agency failed to ensure complaints were investigated and the resolution of complaints was documented. This directly affected 2 of 4 patients (#4 and #17) who complained about care issues and had the potential to affect all patients with complaints. The lack of a consistent system to process complaints resulted in a lack of feedback to patients and to the agency. Findings include: A "Legacy Home Health Complaint Form," dated 10/26/15, stated a complaint was received regarding the care of Patient #4. The complaint stated Patient #4 requested discharge from the agency. The complaint alleged the RN Case Manager was demanding and demeaning. The complaint form did not document an investigation of the allegations, how the complaint was resolved, or notification of the complainant that an investigation had been conducted. Another "Legacy Home Health Complaint Form," dated 12/14/15, stated a complaint was received regarding the care of Patient #17. The complaint alleged breaches in infection prevention	G 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 107	Continued From page 2 techniques and stated the nurse was "unprofessional." The complaint form documented a review of the medical record but there was no determination about the conduct of the nurse or the care the patient received. The complaint form did not document how the complaint was resolved or notification of the complainant that an investigation had been conducted. The Administrator reviewed the complaints on 2/17/16 beginning at 11:20 AM. He agreed the complaints did not include documentation of investigation of the allegations or notification of the complainants of the resolution of the complaints. The agency failed to investigate complaints and document their resolution.	G 107		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 3 of 16 patients (#4, #7, and #11) whose records were reviewed. This resulted in unauthorized treatments, as well as omissions of care and had the potential to result in negative patient outcomes. Findings include: 1. Patient #4 was a 55 year old male admitted to	G 158	See attached plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 158	Continued From page 3 the agency on 2/09/16, for SN services related to osteomyelitis (infection of the bone) to the right lower leg bone. Additional diagnoses included hemiplegia (paralysis of one side of the body), Type II DM, HTN, staphylococcus infection, and a vascular access device. His record, including the POC, for the certification period 2/09/16 to 4/08/16, was reviewed. Patient #4's record included an SOC comprehensive assessment dated 2/09/16, signed by the RN. The assessment documented Patient #4 had Type II DM which was controlled with difficulty, affected his daily functioning and needed ongoing monitoring. The POC included orders for reinforcement and education on diabetic care. Additional orders related to Patient #4's DM included diabetic foot care, education on a diabetic diet, and assessment of blood glucose testing. SN visit notes, dated 2/11/16 and 2/15/16, documented Patient #4's DM was not assessed because it was not appropriate at the time of the visit. There was no documentation of a blood sugar measurement. Additionally, the record did not include documentation of education about a diabetic diet or foot care. During a telephone interview on 2/18/16 at 3:50 PM, the RN Case Manager reviewed the record and confirmed there was no documentation about diabetic education or a diabetic assessment in her visit notes. She stated Patient #4 did not have a glucometer to measure his blood sugar in the home. The RN Case Manager confirmed she did not follow the orders on the POC. Patient #4's POC was not followed as ordered	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 158	Continued From page 4 related to his DM. 2. Patient #11 was a 75 year old male who was admitted to the agency on 1/06/16, for SN and therapy services related to generalized weakness. Additional diagnoses included altered mental status, DM Type II, and HTN. Patient #11's record and POC, for the certification period 1/06/16 to 3/05/16, was reviewed. Patient #11's POC included diabetic interventions, however the interventions were not performed as ordered. His POC stated "Skilled nurse for instructions/reinforcement of diabetic care to include...administration of insulin, blood glucose testing." Patient #11's medication list did not include insulin and the nursing visits performed on 1/14/16, 1/18/16, 1/21/16, 1/28/16, 2/05/16 and 2/11/16, did not include blood glucose testing. During an interview on 2/18/16 beginning at 2:40 PM, the Clinical Supervisor reviewed Patient #11's record and confirmed diabetic interventions were included on his POC. Additionally, the Clinical Supervisor confirmed Patient #11 was not on diabetic medications of any kind. She stated the diabetic interventions to monitor the blood glucose testing and insulin administration on his POC were not necessary. Patient #11's POC was not accurate and was not followed. 3. Patient #7 was a 94 year old female who was admitted to home health services on 12/26/15, and was currently a patient as of 2/17/16. Her diagnosis was a pressure ulcer.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 158	Continued From page 5 Patient #7's medical record for the certification period 12/26/15-2/24/16 was reviewed. Patient #7's record included a verbal order, signed by the physician on 12/29/15, for nursing services 1 time a week for 1 week and 2 times a week for 3 weeks. Nursing progress notes documented a visit on 12/26/16, week 1, and the next visit was dated 1/06/16, in week 3. No visits were documented during week 2. No documentation was present to explain why there were no visits during week 2 of the certification period. The RN Case Manager for Patient #7 was interviewed on 2/18/16, beginning at 3:50 PM. She reviewed the record and stated she did not know why nursing visits were not made during week 2. The agency did not follow Patient #7's 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 review of patient records and staff interview, it was determined the agency failed to ensure POCs included all pertinent information, including diagnosis and nursing interventions,	G 159	See attached plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 6 equipment and all pertinent treatments for 2 of 16 patients (#2 and #11) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include: 1. Patient #2 was a 68 year old male who was admitted to the agency on 12/23/15, for SN and therapy services related to end stage renal disease. Additional diagnoses included spinal stenosis, anemia, postural hypotension and CHF. Patient #2's medical record and POC, for the certification period 12/23/15 to 2/20/16, was reviewed. His record documented he received Peritoneal Dialysis on a daily basis in his home. However, the POC did not include information related to his home dialysis regimen. Patient #2's SOC and comprehensive assessment dated 12/23/15, noted his wife administered the dialysis. Patient #11's POC did not include CHF interventions such as monitoring his weight on a daily basis. Additionally, his SOC included documentation he received Ensure, a nutritional supplement, however the supplement was not included on his POC. The American College of Cardiology website, accessed on 1/225/16, included patient education entitled "Heart Failure: Checking Your Weight Daily." It stated "When you have heart failure, you need to watch for changes in your weight. A sudden weight gain can mean more fluid is building up in your body and your heart failure is getting worse." Additionally it stated "Call your doctor if you notice a sudden weight gain. In general, call if you gain 3 pounds or more in 2 to 3 days."	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 7 These interventions were not included on Patient #2's POC to ensure monitoring of his CHF. During an interview on 2/18/16, beginning at 9:40 AM, the RN Case Manager reviewed Patient #2's record and confirmed his Peritoneal Dialysis regimen and nutritional supplement were not included on his POC. The RN Case Manager confirmed CHF and interventions to monitor his weight and fluid status were not included on his POC. She stated CHF was not a current problem, and therefore she did not include interventions and education related to CHF. Patient #2's POC did not include his Peritoneal Dialysis regimen, supplements or CHF interventions. 2. Patient #11 was a 75 year old male who was admitted to the agency on 1/06/16, for SN and therapy services related to generalized weakness. Additional diagnoses included altered mental status, DM Type II, history of alcohol abuse, HTN and recent hospitalization. Patient #11's H&P from his hospitalization described a history of falls and fractures to his ribs, femur and pelvis. Patient #11's record and POC, for the certification period 1/06/16 to 3/05/16, was reviewed. Patient #11's nursing visits included documentation he took nutritional supplementation in the form of vitamins, minerals and Ensure daily. However, his POC did not include the Ensure. Patient #11's SOC assessment noted he lived alone, and received caregiver assistance intermittantly. His weight was documented on admission as 135 pounds.	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 8 The addition of a dietary nutritional supplement provided additional intake of vitamins, minerals, protein and calories. These interventions were not included on Patient #11's POC to ensure monitoring of his CHF. During an interview on 2/18/16 beginning at 2:40 PM, the Clinical Supervisor reviewed Patient #11's record and confirmed the Ensure was not included on his POC. Patient #11's POC was not complete to include his dietary supplements.	G 159		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients' POCs were initiated and revised to ensure their medical and nursing needs were met for 1 of 8 patients (Patient #5) who received SN services only and whose records were reviewed. This resulted in inaccurate POCs and a lack of assessment and patient/caregiver education relevant to patient needs. Findings include: Patient #5 was a 77 year old male admitted to the agency on 1/02/16, for SN services related to medication management. Additional diagnoses included anxiety, depression, unspecified dementia, HTN, Type II DM, arthritis, and chronic pain. His record, including the POC, for the	G 173	See attached plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 173	Continued From page 9	G 173		

certification period 1/02/16 to 3/01/16, was reviewed.

Patient #5's record included an SOC comprehensive assessment dated 1/02/16, signed by the RN. The assessment documented Patient #5 had Type II DM which was controlled with difficulty, affected his daily functioning and needed ongoing monitoring. The POC included orders for reinforcement and education on diabetic care. Additional orders related to Patient #5's DM included diabetic foot care, education on a diabetic diet, and assessment of blood glucose testing.

SN visit notes, dated 1/21/16, 1/29/16 and 2/03/16, documented Patient #5's DM was within normal limits. There was no documentation of a blood glucose level. Additionally, the record did not include documentation of education about a diabetic diet or foot care.

During a telephone interview on 2/18/16 at 3:40 PM, the RN that completed the SOC assessment stated Patient #5 was not a diabetic. She stated the referral received by the agency documented he was not a diabetic. The RN stated Patient #5 had a history of an abnormal glucose during a previous hospitalization, but he was not taking any medications for diabetes.

During a telephone interview on 2/19/16 at 8:10 AM, the RN Case Manager stated Patient #5 was not a diabetic. She confirmed he had an abnormal glucose during a previous hospitalization. The RN Case Manager confirmed the POC was not updated.

Patient #5's POC was not revised to reflect his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 173	Continued From page 10 current needs.	G 173		
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. 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 1of 16 patients whose records were reviewed (Patient #16). This resulted in the reporting of inaccurate data. Findings include: Patient #16 was an 86 year old female who was admitted to the agency on 1/26/16, for therapy services related to weakness. Additional diagnoses included Dementia, DM Type II, HTN, and weakness. Patient #16's record and POC for the certification period 1/26/16 to 3/25/16, were reviewed. Patient #16's record included documentation that conflicted with the SOC assessment as follows: 1. Patient #16's record included documentation she was hospitalized from 1/19/16 to 1/24/16, for treatment of sepsis. A SOC assessment was performed on 1/26/16, by the Physical Therapist. The SOC assessment had OASIS questions incorporated into the EMR for admission assessments. The Physical Therapist entered the response "No," for the item (M1000) which queried "Was the patient discharged from an inpatient facility within the last 14 days?" The narrative response entered by the Physical	G 322	See attached plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 322	Continued From page 11 Therapist noted "N/A, Patient was not discharged from an inpatient facility." Additionally, for item (M1017), the Physical Therapist responded "N/A, not applicable [no medical or treatment regimen changes within the past 14 days.]" The responses were incorrect, as Patient #16 was discharged from a hospital 2 days before her admission to the agency. During a phone interview on 2/19/16 at 8:40 AM, the Physical Therapist confirmed he responded no to the questions on the SOC assessment. He stated the EMR was difficult to navigate, and if he responded "Yes," the EMR would have taken him on a path which included questions he could not answer. He stated it was easier to answer "no". 2. The SOC assessment, which included an OASIS question (M2000), which was related to medication review, the Physical Therapist responded "No Problems found during review." However, her record included a medication interaction report which described two severe interactions between drugs. The medication interaction report was dated 2/01/16, which was 6 days after Patient #16's SOC was performed. During a phone interview on 2/19/16 beginning at 8:40 AM, the Physical Therapist confirmed he noted there were no interactions noted on the medication review. He stated his process of medication review included comparing the hospital medication list with Patient #16's ALF medication list. He stated an RN at the HHA would perform an interaction check and notify the physician if problems were found. Patient #16's record included documentation that was inaccurate.	G 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the agency failed to ensure the drug review was comprehensive for 1 of 2 patients (Patient #16) whose SOC comprehensive assessments were completed by a Physical Therapist, and whose records were reviewed. This had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: An agency policy titled "680, Clinical Documentation," undated, included a section titled Medication Profile. The policy stated "At the time of admission, the admission professional shall check all medications a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication. The clinician shall promptly report any identified problems to the physician." The Physical Therapist did not perform a complete and comprehensive medication review for Patient #16, as follows: Patient #16 was an 86 year old female who was admitted to the agency on 1/26/16, for therapy services related to weakness. Additional diagnoses included Dementia, DM Type II, HTN, and weakness. Patient #16's record and POC,	G 337	See attached plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 337	Continued From page 13 for the certification period 1/26/16 to 3/25/16, was reviewed. The SOC assessment dated 1/26/16, included an OASIS question (M2000), which was related to medication review, the Physical Therapist responded "No Problems found during review." However, her record included a medication interaction report which described two severe interactions between drugs. The medication interaction report was dated 2/01/16, which was 6 days after Patient #16's SOC assessment was performed. Patient #16's medication interaction report, dated 2/01/16, included interactions with the following medications: - Aricept and Ondansetron, severe interaction, "Action is required to reduce the risk of severe adverse interaction." "The use of Ondansetron in patients maintained on agents that prolong the QTC interval may result in potentially life-threatening cardiac arrhythmias, including Torsades De Pointes," (a sometimes fatal form of ventricular tachycardia.) - Clonidine HCL oral and Bystolic oral, severe interaction, "Action is required to reduce the risk of severe adverse interaction." "Severe hypertension may occur upon abrupt discontinuation of Clonidine in patients receiving both Clonidine and beta-blockers." During a phone interview on 2/19/16 beginning at 8:40 AM, the Physical Therapist confirmed he noted there were no interactions noted on the medication review. He stated his process of medication review included comparing the hospital medication list with Patient #16's ALF	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 337	Continued From page 14 medication list. He stated an RN at the HHA would perform an interaction check and notify the physician if problems were found. The therapist was unable to confirm if or when the notice of drug interactions was sent to Patient #16's physician. A comprehensive medication review was not performed by Patient #16's admitting Physical Therapist.	G 337		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001310	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho state licensure survey of your home health agency on 2/16/16 through 2/19/16. The surveyors conducting the review were: Laura Thompson RN, BSN, HFS - Team Lead Susan Costa RN, HFS Gary Guiles RN, HFS	N 000	RECEIVED MAR 17 2016 FACILITY STANDARDS	
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G-173 as it relates to the agency's failure to ensure RN staff re-evaluated the patient's nursing needs.	N 093	See attached plan of correction.	
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:	N 152	See attached plan of correction.	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001310	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 152	Continued From page 1 This Rule is not met as evidenced by: Refer to G 158 as it relate to a failure of the agency to ensure patient care followed the POC.	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 as it relates to the failure of the agency to ensure patients' POCs included all pertinent services and equipment.	N 155	See attached plan of correction.	
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: i. Medication and treatment orders; This Rule is not met as evidenced by: Refer to G159 as it refers to the failure of the agency to ensure the POC included all pertinent	N 161	See attached plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001310	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 2 treatments.	N 161		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G 337 as it relates to the failure of the agency to ensure a comprehensive review of patient medications was performed.	N 173	See attached plan of correction.	

PLAN OF CORRECTION
SURVEY 2/15/16

Brent Schneider, Administrator/ Tammy Colbert, RN Clinical Supervisor/Isabelle Corson, RN Clinical Supervisor

LEGACY HOME HEALTH 680 S. Progress Ave. Meridian, ID 83642

Deficiency Tag #	Provider's Plan of Correction	Individual(s) Responsible for Compliance	Monitoring Frequency	Completion Date
G107	484.10 (b)(5) EXERCISE OF RIGHTS AND RESPECT OF PROPERTY Action/Plan: The action that will be taken to correct this deficiency will be to follow the agency's grievance/ complaint policy which states grievances will be investigated and the results of the investigation/ resolution will be documented. A section to document the investigation results was added to the grievance/complaint form. These actions will improve the process by providing space to document the investigative results. A space to document the resolution is currently present on the form. The administrator will review all complaints to make sure the complaint was thoroughly documented/ processed/and resolved per policy. Description of Improvement: Developing consistency in standards of practice for all Home Health complaints. Monitoring: The administrator will also monitor the Plan of Correction for this deficiency to make sure the agency is in compliance.	Administrator or designee	With each complaint received	Complaint/resolution form updated effective: March 9th, 2016

Deficiency Tag #	Provider's Plan of Correction	Individual(s) responsible for compliance	Monitoring frequency	Completion Date
G158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER: Plan of Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine <u>Action:</u> Legacy Home Health will have a mandatory staff meeting for all clinicians involved in patient care 4/12/16. The following topics will be discussed: If a patient has a diagnosis of Diabetes, then the RN must verify with the patient if they are checking blood sugars and if they have a glucometer. The RN must clarify with the physician if blood sugars are to be checked and the frequency. If the physician does not want the patient to check blood sugars, then the RN must obtain an order stating such. The frequency of blood sugar checks and normal blood sugar ranges will be part of patient plan of care. If blood sugars are to be checked, then the RN must inquire of the blood sugar ranges at each visit and documented in the clinical record. If the sugars are outside of parameters, then the physician must be notified. If the patient does not own a glucometer, then the nurse must check the blood sugar at each visit and notify the MD so that a prescription can be received for the patient to obtain one. Glucometers have been provided to each RN to complete this task. If the patient lives in an ALF, the RN must obtain the glucose readings obtained by the ALF and document these in the clinical record. If the sugars are outside of parameters, the MD must be notified. The RN must provide education at each visit concerning the management of Diabetes including diet and	Director of Clinical Services or designee Administrator Clinical Supervisor	Comprehensive chart audits at start of care and end of care.	Mandatory staff meeting April 12th, 2016

	diabetic foot care including educational material that will be left in the patient home and also uploaded in the patient chart for proof of material provided concerning this education from home health. Diabetes education will be provided at each visit until patient/caregiver is able to verbalize an understanding of the education being provided and this goal has been accomplished. Patient/caregiver acknowledgment of this education must be documented in the patient's clinical record. Description of Improvement: Developing consistency in standard of RN practice for the Diabetic patient. Plan: Mandatory staff meeting on 4/12/16 and then annual education will be provided regarding documentation and management of Diabetes. Every clinician must review the Plan of Care at each visit to ensure the plan of care is specific for the patient and management of their Diabetes. Monitoring: Clinical Supervisors will review every plan of care established for each patient and confirm that they are specific for the patient before the Plan of Care is completed and sent to the MD for signature. A comprehensive chart audit will be completed by the Clinical Director or designee on each patient's medical record. Diabetes Education and blood sugar monitoring will occur with each patient who has a diagnosis of Diabetes. Mandatory staff meeting will be completed by 4/12/16 and annual education will be provided to all clinicians in the field.			

	Action/Plan: The following process for scheduling patient frequency and processing missed visits will be reviewed with all visiting clinicians and office staff that assist with scheduling patient visits on 4/12/16. The initial evaluating clinician and all add-on disciplines involved with the patient care will establish a frequency for the patient. The evaluating clinician (RN, PT, OT, ST, MSW) will plot this frequency on a calendar as part of the EMR program and a signed order or verbal order will be received by the MD for approval of this frequency. This frequency and calendar will be reviewed by the Scheduler and Clinical Supervisor for accuracy. The visits will then be assigned to the clinician by the scheduler. It is the responsibility of the clinician to accept the visit and see the patient or miss the visit and it will be sent back to the scheduler. If the visit is missed, it is the responsibility of the clinician to contact the patient or caregiver and document in the missed visit report why the visit was missed. The missed visit report and clinical documentation of the missed visit is part of the patient medical record. A missed visit report will be sent to MD daily with explanation for each missed visit. Description of Improvement: Frequency in Patient specific plan of care will be followed according to MD approval. Comprehensive missed visit report will be reviewed by the Clinical Director and Administrator daily with review of missed visits and documentation of the reasons for missed visits.	Director of Clinical Services or designee Clinical Supervisor	Missed visits and missed visit reports are monitored daily	Mandatory staff meeting April 12th, 2016

Deficiency Tag #	Provider's Plan of Correction	Individual(s) responsible for compliance	Monitoring frequency	Completion Date
G159	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 measurements to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Action/Plan: The following will be discussed at the mandatory staff meeting scheduled for 4/12/16. If a patient is receiving treatments at home such as peritoneal dialysis, the regimen, education and assessment of the treatment will be part of the patient specific Plan of Care. Visiting clinicians will document at each visit their assessment of patient/caregiver independence of regimen, education provided for the treatment until the stated goal in the plan of care has been met. All equipment, medications, supplements used in this treatment will also be included in the patient specific Plan of Care and part of the medication record. Description of Improvement: Developing consistency in standards of practice that is specific to patient receiving treatment at home. Monitoring: Every Plan of Care will be reviewed by the Clinical Supervisors for accuracy and inclusion of the specifics of the treatment, equipment, medications required for the patient. A	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Comprehensive chart audits at start of care and end of care.	Mandatory staff meeting April 12th, 2016

	comprehensive chart audit will be completed on each patient's medical record by the Clinical Supervisor and Clinical Director or designee before final claim is sent to insurance company for billing. Action/Plan: The following will be discussed at the mandatory staff meeting scheduled for 4/12/16. If a patient is receiving a nutritional supplement, this supplement will be added to the patient's medication profile and education of this supplement will be part of the patient specific Plan of Care. Visiting clinicians will document their education provided to patient and caregiver concerning the supplement at each visit until the stated goal in the plan of care has been met in the clinical record. Description of Improvement: Developing consistency in standards of practice that is specific to patient receiving nutritional supplements at home. Monitoring: The Clinical Supervisor will review each plan of care for accuracy and ensure that the nutritional supplement has been added to the medication profile and education of the nutritional supplement added to the plan of care. A comprehensive chart audit will be completed on each patient's medical record by the Clinical Supervisor and Clinical Director or designee before final claim is sent to insurance company for billing. Action/Plan: The following will be discussed at the mandatory staff meeting scheduled for 4/12/16. If the patient has a diagnosis of CHF - primary diagnosis or a co-morbidity, then the RN must include CHF management and education on the patients plan of care including education on daily			

	weights and to establish the parameters of weight fluctuations that are to be reported to the MD. It is the responsibility of each visiting clinician to obtain and document weights at each visit or document why a weight was not obtained and report any weight outside of set parameters to the MD. If the patient does not have a scale, then the agency RN must bring a scale and obtain weights at their visits, document weight in the EMR, then notify the MD of patient inability to obtain weights, and coordinate with family, caregiver, physician, MSW, etc. to find community resources to obtain scale. If the patient resides in an ALF, then the RN must inquire of the weights obtained by ALF and assess the patient condition and document ALF weights in the clinical record at each visit. Description of Improvement: Developing consistency in standards of practice that specific for the CHF patient receiving treatment at home. Monitoring: Clinical Supervisors will review every plan of care established for each patient and confirm that if a patient has a diagnosis of CHF that CHF education and monitoring of weight with set weight parameter are part of patient Plan of Care and they are specific for the patient before the Plan of Care is completed and sent to the MD for signature. A comprehensive chart audit will be completed on each patient's medical record by the Clinical Supervisor and Clinical Director or designee before final claim is sent to insurance company for billing.			

Deficiency Tag #	Provider's Plan of Correction	Individual(s) responsible for compliance	Monitoring frequency	Completion Date
G173	484.30(a) Duties of the Registered Nurse The registered nurse initiates the plan of care and necessary revisions. Action/Plan: Mandatory staff in-service has been scheduled for 4/12/16 to review with nursing staff that patient specific plan of cares will be established at start of care for each patient. It is the responsibility of the nursing staff to review these plan of cares at each visit. If a revision to the plan of care needs to be initiated, it is the responsibility of the nurse who discovers the need for a revision to send an update to the MD using an "update plan of care order". The plan of care will be updated by this nurse and this update will be reviewed by the Clinical Supervisor and ultimately sent to the MD for approval and signature. Description of Improvement: Developing consistency in standards of practice that is specific to patient receiving treatment at home. Monitoring: Clinical Supervisor to review all updated plan of care orders when submitted for accuracy and inclusive for new update to plan of care prior to being submitted to MD. A comprehensive chart audit will be completed on each patient's medical record by the Clinical Supervisor and Clinical Director or designee before final claim is sent to insurance company for billing.	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Comprehensive chart audits at start of care and end of care.	Mandatory staff meeting April 12th, 2016

Deficiency Tag #	Provider's Plan of Correction	Individual(s) responsible for compliance	Monitoring frequency	Completion Date
G322	484.20(b) ACCURACY OF ENCODED OASIS DATA 1. THE ENCODED OASIS DATA MUST ACCURATELY REFLECT THE PATIENT'S STATUS AT THE TIME OF ASSESSMENT <u>Action/Plan:</u> Mandatory staff meeting will be held on 4/12/16 – the following education will be provided to the clinical staff. Oasis Items – M1000 – From which of the following Inpatient Facilities was the patient discharged within the past 14 days. (Mark all that apply). M1005 – In patient Discharge Date. M1011 – Inpatient Diagnosis. M1017 – Diagnosis Requiring Medical or Treatment Regimen Change within past 14 days. The above items will be reviewed and education from Instant Oasis Answers 2016/ICD-10 edition will be presented to clinicians with handouts regarding how to answer questions appropriately. Re-education will be provided to clinicians concerning navigation in our EMR system concerning the above mentioned questions. Handouts will also be provided to each clinician to give them guidance on navigating through out the EMR. Clinicians will also be required to complete the Oasis training modules with the dates already specified with a completion rate of 80%. These training modules will give reinforcement to the education provided in the staff meeting concerning how to answer the above questions appropriately. 1. OASIS-C1: Beyond the Basics due by	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Education will be completed yearly	Mandatory staff meeting April 12th, 2016

	8/31/16 2. OASIS-C1: Room BY Room due by 9/30/16 3. OASIS-C1/ICD-10: Assessment and Coding of Wounds due by 10/31/16 4. OASIS-C1: Clinical Domain due by 11/30/16 5. OASIS-C1: Technical Knowledge due by 11/30/16 6. OASIS-C1 Competency: Functional and Service Domain Knowledge due by 12/31/16 <u>Description of Improvement:</u> Developing consistency in standards of practice for appropriately answered Oasis questions to provide accurate comprehensive assessments as per CMS guidelines. <u>Monitoring:</u> Every OASIS and patient specific Plan of Care will be reviewed by the Clinical Supervisors for accuracy and inclusion of the specifics of the treatment for the patient. A comprehensive chart audit will be completed on each patient's medical record by the Clinical Supervisor, Clinical Director or designee before final claim is sent to insurance company for billing. 2. Medication Reviews/ Notification/ Documentation of potential interactions. (M2000) M2000 - Drug Regimen Review - If clinically significant medication issues were found that pose an actual threat to the patient health and safety of the patient and M2002 Medication Follow-up - was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues.			

	Action/Plan: Education material will be given to each staff member to assist them in answering this question correctly following CMS guidelines at the mandatory staff meeting held on 4/12/16. Clinicians are also required to complete the Oasis courses assigned to them and complete these courses by the designated date which will reinforce the education provided. Description of Improvement: This education will assist the clinicians to answer the questions correctly according to CMS guidelines and the Oasis data reported will be accurate according to CMS guidelines. Clinically significant medication issues will be reported, resolved and education provided within a timely manner. Monitoring: Clinical Supervisors will review each Oasis, clinical documentation, MAR provided by referral source, and collaboration with clinician responsible for the comprehensive assessment to review medications and identify clinically significant medication issues so they can be reported to the physician or physician-designee within one calendar day for resolution as per CMS guidelines as per guidance from Oasis Answers manual. A comprehensive chart audit will be completed on each patient's medical record by the Clinical Supervisor, Clinical Director or designee before final claim is sent to insurance company for billing.			
Deficiency Tag #	Provider's Plan of Correction	Individual(s) responsible for	Monitoring frequency	Completion Date

		compliance		
G337	484.55(c) Drug Regimen Review Agency policy titled #680, "Clinical Documentation" Action/Plan: A meeting will be held on April 12th, 2016 to review the following education with staff. Skilled Clinicians will thoroughly review all medications with patient in the home at the time of assessment, documenting any discrepancies between what the doctor has prescribed and what the patient is actually taking. Upon entering medications into EMR charting program, if any interactions alert the Skilled clinician will then at that time notify the MD of the medication interaction and any pertinent information as well as documenting any education provided to the patient in the clinical record/ interaction report. Description of Improvement: This education will assist the clinicians to answer the answers correctly according to CMS guidelines and the Oasis data reported will be accurate according to CMS guidelines. Clinically significant medication issues will be reported, resolved and education provided within a timely manner. Monitoring: Medication interaction reports will be sent by Clinical Supervisors on the day that the Oasis is evaluated. Clinical Director will review all medication interaction reports.	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Comprehensive chart audits at start of care and end of care.	Mandatory staff meeting April 12th, 2016
ID PREFIX TAG#	Provider's Plan of Correction	Individual(s)responsible for compliance	Monitoring frequency	Completion date

N093	Please refer to plan of correction under G-173	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Comprehensive chart audits at start of care and end of care.	Mandatory staff meeting April 12th, 2016
N152	Please refer to plan of correction under G-158	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Comprehensive chart audits at start of care and end of care. Missed visits and missed visit reports are monitored daily	Mandatory staff meeting April 12th, 2016
ID PREFIX TAG#	Provider's Plan of Correction	Individual(s) responsible for compliance	Monitoring frequency	Completion date

N155/N161	Please refer to plan of correction under G-159	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Comprehensive chart audits at start of care and end of care.	Mandatory staff meeting April 12th, 2016
N173	Please refer to plan of correction under G-337	Director of Clinical Services or designee Administrator Clinical Supervisor PT Rehabilitation Director	Comprehensive chart audits at start of care and end of care.	Mandatory staff meeting April 12th, 2016