



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

CERTIFIED MAIL: 7012 3050 0001 2125 5860

March 16, 2016

Tamala Slatter, Administrator
Visions Home Health
1770 Park View Drive
Twin Falls, ID 83301

RE: Visions Home Health, Provider #137107

Dear Ms. Slatter:

Based on the survey completed at Visions Home Health, on March 1, 2016, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA)

Conditions of Participation:

- **Organization, Services & Administration (42 CFR 484.14)**
- **Acceptance Of Patients, Poc, Med Super (42 CFR 484.18)**
- **Skilled Nursing Services (42 CFR 484.30)**

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

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

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

An acceptable Plan of Correction contains the following elements:

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

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **March 29, 2016**. It is recommended the Credible Allegation of Correction for each Condition of Participation and related standard level deficiencies show compliance no later than **April 15, 2016**. We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

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

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

- Termination [42 CFR 488.865]
- Civil Monetary Penalty [42 CFR 488.820(a)]

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

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

Tamala Slatter, Administrator
March 16, 2016
Page 3 of 3

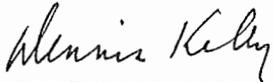
In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal dispute resolution (IDR) process.

To be given such an opportunity, you are required to send your written request and all required information as directed in the attached document. This request must be received by **March 29, 2016**. If your request for IDR is received after **March 29, 2016**, the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting (Refer to page 6 of the attached IDR Guidelines).

We urge you to begin correction immediately.

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

Sincerely,



DENNIS KELLY
Co-Supervisor
Non-Long Term Care

DK/pmt

Enclosures

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office - Region 10
701 Fifth Avenue, Suite 1600
Seattle, WA 98104



**THIS SERVES AS OFFICIAL NOTICE SENT VIA FACSIMILE PURSUANT TO 42 CFR
§488 NO HARD COPY TO FOLLOW**

IMPORTANT NOTICE – PLEASE READ CAREFULLY

March 18, 2016

Tamala Slatter, Administrator
Visions Home Health
1770 Park View Drive
Twin Falls, ID 83301

**Re: CMS Certification Number: 13-7014
Notice of CMS Enforcement Action
Mandatory Termination if not back in substantial compliance by September 1, 2016
Intent to Impose Civil Money Penalty**

Dear Ms. Slatter:

After careful review of the facts, the Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS) has determined that Visions Home Health no longer meets the requirements for participation as a provider of services in the Medicare Home Health program as established under Title XVIII of the Social Security Act (the Act).

Background

On **March 1, 2016**, a recertification survey was completed at Visions Home Health by the Idaho Department of Health and Welfare, Bureau of Facility Standards (State survey agency) to determine compliance with the Federal requirements for HHAs participating in the Medicare and/or Medicaid programs. The survey found that the agency was not in substantial compliance with three Conditions of Participation. CMS agrees with the State survey agency that the following Conditions of Participation were not met as stated in the summary of deficiencies (CMS 2567) that was sent to you:

42 CFR § 484.14 Organization, Services & Administration

42 CFR § 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision

42 CFR § 484.30 Skilled Nursing Services

Alternative Sanctions

Because Visions Home Health is not in compliance with the Conditions of Participation in the Medicare Home Health Program, CMS is imposing the following alternative sanctions:

- **Mandatory Termination 42 CFR 488.865**
- **Civil Money Penalty 42 CFR 488.820(b)**

Mandatory Termination

To participate in the Medicare program as a home health agency (HHA), a provider must meet all the requirements in section 1861(o) of the Act. In particular, HHAs must be in compliance with each of the Conditions of Participation established by the Secretary of Health & Human Services, be free of hazards to the health and safety of patients, and meet such other requirements as established by law or regulation. **If Visions Home Health remains out of compliance, mandatory termination of our provider agreement will take effect by September 1, 2016.**

Public Notice of Termination

In accordance with 42 CFR 489.53(d), CMS will publish legal notice of your pending termination in a newspaper within your locale at least **15 days** before the termination date.

Civil Money Penalty

CMS intends to impose a **“per instance” civil money penalty in the amount of \$3,500.00 for violation of the above Conditions of Participation.** Under section 1891(f)(2)(A)(i) of the Social Security Act and 42 C.F.R. §488.845, CMS may impose a civil money penalty against an HHA that is determined to be out of compliance with one or more Conditions of Participation regardless of whether or not the HHA’s deficiencies pose immediate jeopardy to patient health and safety. Civil money penalties can range from \$1,000.00 to \$10,000.00 per instance or per day, in accordance with 42 CFR § 488.845(a)(1). The following factors were considered in determining the amount of the civil money penalty being imposed:

1. The extent to which the deficiencies are directly related to a failure to provide quality patient care.
2. An indication of a system-wide failure to provide quality care.
3. The HHA’s compliance history.

Please do not send payment at this time. We will send you a letter to inform of the actual imposition of the civil money penalty.

Appeal Rights

If you do not agree with this determination, you may request a hearing before an administrative law judge (ALJ) of the Departmental Appeals Board in accordance with 42 C.F.R. §§ 498.40 through

498.78. A request for a hearing must be filed **electronically** no later than **sixty (60) calendar days** from the date of this notice. 42 C.F.R. § 498.40. You should file your request for an appeal (accompanied by a copy of this letter) through the Departmental Appeals Board Electronic Filing System website (DAB Efile) at

<https://dab.efile.hhs.gov>.

Please note: All documents must be submitted in Portable Document Format (“pdf”). You are **required** to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing.

A written request for appeals must also be filed no later than sixty (60) calendar days from the date you receive this notice, and must be submitted to the following address:

Chief, Civil Remedies Division Departmental Appeals Board MS 6132 Cohen Building, Room 637-D 330 Independence Avenue, SW Washington, D.C. 20201	Please also send a copy to:	Chief Counsel DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 MS RX -10 Seattle, WA 98104
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A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. 42 C.F.R. § 498.40(b)(1). It should also specify the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.40(b)(2). You may be represented by counsel at a hearing at your own expense.

If you have further questions, please contact Fe Yamada of my staff at (206) 615-2381 or by email at marie.yamada@cms.hhs.gov.

Sincerely,



Patrick Thrift, Manager
Seattle Regional Office
Division of Survey, Certification & Enforcement

cc: Bureau of Facility Standards
ID Medicaid
DHHS Regional Counsel



RECEIVED

APR 13 2016

FACILITY STANDARDS

April 12, 2016

Mr. Dennis Kelly
Co-Supervisor, Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720-0009

Dear Mr. Kelly:

Your survey team completed a Medicare Licensure and Certification survey at Visions Home Health provider number 137107 in Twin Falls on February 23rd thru February 26th, 2016. In response to your findings, we have developed a plan of correction. Enclosed is our plan. If you have any questions regarding the plan, you may contact me by phone (208) 732-5365.

The Visions Home Health Team will learn from the survey and make the necessary improvements in our agency's process to ensure quality patient care. I would like to thank your staff for the professional manner in which the survey was conducted and for your guidance in assisting us in completing our plan of correction.

Sincerely,

A handwritten signature in black ink that reads "Tamala Slatter, RN BSN". The signature is written in a cursive style with a large, looped initial "T".

Tamala Slatter, RN BSN
Administrator

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

PRINTED: 04/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER VISIONS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1770 PARK VIEW DRIVE TWIN FALLS, ID 83301
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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 home health agency on 2/23/16 through 3/01/16. The surveyors conducting the recertification were:</p> <p>Susan Costa RN, HFS, Team Lead Nancy Bax RN, HFS Laura Thompson RN, HFS</p> <p>Acronyms used in this report include:</p> <p>ADA - American Diabetes Association ADL - Activities of Daily Living BG - Blood Glucose BID - twice daily CAD - Coronary Artery Disease CHF - Congestive Heart Failure CMS - Centers for Medicare and Medicaid Services COPD - Chronic Obstructive Pulmonary Disease COTA - Certified Occupational Therapy Assistant CVA - Cerebral Vascular Accident DME - Durable Medical Equipment DM - Diabetes Mellitus EMR - Electronic Medical Record GERD - Gastroesophageal Reflux Disease GI - gastrointestinal HEP - Home Exercise Program HH - Home Health HHA - Home Health Agency H&P - History and Physical HTN - Hypertension IADL - Instrumental Activities of Daily Living IBS - Irritable Bowel Syndrome IM - Intramuscular IV - Intravenous LPN - Licensed Practical Nurse</p>	G 000	<p style="text-align: center;">RECEIVED MAR 29 2016 FACILITY STANDARDS</p> <p style="text-align: center;">RECEIVED APR 13 2016 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		04/12/2016

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

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G 000	Continued From page 1 MAHC - Missouri Alliance for Home Care mEq - millequivalents mg - milligram mg/dl - milligrams per deciliter ml - milliliter MRSA - Methicillin Resistant Staphylococcus Aureus MSW - Medical Social Worker NOMNC - Notice of Medicare Non-Coverage OASIS - Outcome and Assessment Information Set OT - Occupational Therapy PAC - Professional Advisory Committee - Name of the agency's group of professional personnel PCC - Patient Care Coordinator PCP - Primary Care Physician POC - Plan of Care prn - as needed pt - patient PT - Physical Therapy PTA - Physical Therapy Assistant PT/INR - Prottime/International Normalized Ratio - a blood test used to measure how long it takes blood to clot RN - Registered Nurse ROC - Resumption of Care ROM - Range of Motion SOB - Shortness of Breath SOC - Start of Care SN - Skilled Nursing SW - Social Worker TIF - Transfer to an Inpatient Facility UTI - Urinary Tract Infection	G 000			
G 106	484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to voice grievances regarding treatment or care that is (or fails to be)	G 106		4/15/16	

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G 106	<p>Continued From page 2</p> <p>furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p> <p>This STANDARD is not met as evidenced by: Based on patient and staff interview, record review, and observations during home visits, it was determined the agency failed to ensure concerns about clinician visits by patients were received without fear of reprisal for 1 of 1 patient (Patient #3) who was seen by an Occupational Therapist and verbalized concern about her care during a home visit. This resulted in unnecessary distress to the patient and family. Findings include:</p> <p>Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>A home visit was conducted on 2/24/16 beginning at 7:15 AM, to observe the Occupational Therapist during a routine visit. Upon entering the home, Patient #3's daughter pressed a note into the surveyor's hand. The note read "Please don't mention this note. PLEASE! I'd like to walk you to your car when you leave and chat outside"</p> <p>The therapist was in the home for approximately 45 minutes, and was observed to work with Patient #3 in upper body exercises, ambulation, stretching, balance, and specific ROM to her right shoulder. At the beginning of his visit, he told Patient #3 that he wanted to observe her getting</p>	G 106		

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G 106	<p>Continued From page 3</p> <p>into the bathtub. She refused, and told him that she did that with the Home Health Aide, and had no difficulty. The Occupational Therapist then told her that he would be sure to come when the Home Health Aide was there to make sure she was safe with that process. He ended his visit with soft tissue massage of her neck, upper back, and shoulders. The therapist explained during his visit that he had been working with Patient #3 since her SOC, after she suffered a fall and broke her right arm.</p> <p>After the Occupational Therapist finished his visit and left the home, Patient #3 and her daughter were interviewed regarding care that was provided by the HHA during the year she was receiving services. Patient #3's daughter stated she was glad to have an opportunity to talk without the Occupational Therapist present, and that is why she provided the note to the surveyor at the beginning of the visit.</p> <p>Patient #3 stated her OT routine that morning with the Occupational Therapist was not like any session she had with him before.</p> <p>Patient #3 stated she was surprised the routine was so different. She stated the Occupational Therapist called her and her daughter on 2/23/16, on 3 separate occasions, to inform them of the home visit and the observation by the "State Surveyor." Patient #3 stated the Occupational Therapist's first call was to inform her of the visit with the surveyor. The Occupational Therapist then called Patient #3's daughter with the same information. Patient #3 stated she received a third phone call about 6:30 PM that evening. The Occupational Therapist spoke with her and said the routine would be different when he and the</p>	G 106		

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G 106	<p>Continued From page 4</p> <p>surveyor were there. He further advised her to "not ask questions," and just "go along with the session." Patient #3's daughter stated they felt uncomfortable with the multiple calls and the request to not ask questions.</p> <p>Patient #3 stated that when the Occupational Therapist entered that morning and first stated he wanted to observe her getting into the bathtub, she refused, as he had never observed her do that before. She said she felt comfortable with the Home Health Aide helping her into the bath, but as the Occupational Therapist had not previously evaluated her ability to use the bathtub, she felt she should refuse.</p> <p>Patient #3's daughter described a routine visit with the Occupational Therapist. She stated he never brought in his work bag or computer, as he had that morning. Her daughter stated the therapist never took her vital signs or pulse oximeter readings as he did that morning. Patient #3's daughter stated a usual visit lasted 10 or 15 minutes, her mother never got out of her chair, and the only thing the therapist would do was massage her neck, shoulders, and upper back. Patient #3's daughter stated the Occupational Therapist would come in three times a week, early in the morning, "rub her back," then leave. She stated the therapist did not provide written materials for exercises, and she thought he was just there to massage her back and neck.</p> <p>Patient #3 stated she did not know what the routine for an OT visit would include. She stated after the visit that morning, she thought she had a better idea of what he should have been doing during the other visits. Patient #3 stated she did not want to complain, and she felt bad talking</p>	G 106		

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G 106	<p>Continued From page 5 about the other visits.</p> <p>Patient #3's daughter contacted the surveyor on 2/25/16, following the home visit and observation. She stated the Occupational Therapist called their home repeatedly that morning. She stated she had caller ID and saw that the Occupational Therapist was calling. She stated she did not answer the phone, and wanted to talk with the surveyor before speaking with the therapist. Patient #3's daughter reported the Occupational Therapist left messages on the phone, stating he needed to know what they told the surveyor, and he may lose his job. Patient #3's daughter stated after multiple calls that went unanswered, the Occupational Therapist came to their home unannounced. She stated he was not scheduled for a visit until the following morning. He came into the house and pressed her and Patient #3 for information regarding the visit. Patient #3's daughter stated she told him that the surveyor examined the medications, looked at the bedroom and bathroom, and asked questions about the nursing care, Home Health Aide care, and the care he provided. Patient #3's daughter stated the Occupational Therapist told her the HHA was pulling all his patients' records, and he may lose his job or be fined.</p> <p>Patient #3's daughter stated they felt "threatened" by the phone calls from the Occupational Therapist. She stated when he came to her home, she and her mother were "frightened he might harm [them]". She stated she felt by sharing the information with the surveyor the previous day, the Occupational Therapist would find out. The daughter stated she was afraid it would affect how her mother would be treated in the future. She stated she felt it would be best if</p>	G 106		

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G 106	Continued From page 6 the HHA provided a different Occupational Therapist. During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist initially denied calling Patient #3's phone that morning. He also initially denied going to her home after the phone calls went unanswered. The Occupational Therapist then confirmed he did call, the calls went unanswered and so he went to her home to speak with her. He said that he wanted to know what the patient and her daughter spoke with the surveyor about, as he knew he would be called in for an interview. The Occupational Therapist confirmed he went to Patient #3's home, entered the home without an appointment, and questioned her and her daughter about the surveyor's visit.	G 106		
G 108	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The HHA failed to ensure Patient #3 was not subjected to discrimination or reprisal after a grievance was voiced. The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made.	G 108		4/15/16

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G 108	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on patient interview, staff interview, observation during home visits and review of patient records, it was determined the agency failed to ensure patients were informed of their POC for 1 of 6 patients (Patient #3) who were interviewed in the home and whose records were reviewed. This resulted in a clinician providing services without the patient's participation in her POC. Findings include:</p> <p>Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>A home visit was conducted on 2/24/16 beginning at 7:15 AM, to observe the Occupational Therapist.</p> <p>The therapist was in the home for approximately 45 minutes, and was observed to work with Patient #3 in upper body exercises, ambulation, stretching, balance, and specific ROM to her right shoulder. At the beginning of his visit, he told Patient #3 that he wanted to observe her getting into the bathtub. She refused, and told him that she did that with the Home Health Aide, and had no difficulty. The Occupational Therapist then told her that he would be sure to come when the Home Health Aide was there to make sure she was safe with that process. He ended his visit with soft tissue massage of her neck, upper back, and shoulders. The therapist explained during his visit that he had been working with Patient #3 since her SOC, after she suffered a fall and broke her right arm.</p>	G 108		
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G 108	<p>Continued From page 8</p> <p>After the Occupational Therapist finished his visit and left the home, Patient #3 and her daughter were interviewed regarding care that was provided by the HHA during the year she was receiving services.</p> <p>Patient #3 stated she was surprised the routine that morning was so different from other OT sessions. She stated that when the Occupational Therapist entered that morning and stated he wanted to observe her getting into the bathtub, she refused, as the Occupational Therapist had not previously evaluated her ability to use the bathtub.</p> <p>Patient #3's daughter described a routine visit with the Occupational Therapist. She stated he never brought in his work bag or computer, as he had that morning. Her daughter stated the therapist never took her vital signs or pulse oximeter readings as he did that morning. Patient #3's daughter stated a usual visit lasted 10 or 15 minutes, her mother never got out of her chair, and the only thing the therapist did was massage her neck, shoulders, and upper back. Patient #3's daughter stated the Occupational Therapist came three times a week, early in the morning, "rubbed her back," then left. She stated the therapist did not provide written materials for exercises, and she thought he was just there to massage her back and neck.</p> <p>Patient #3 stated she did not know what the routine for an OT visit would include. She stated after the visit that morning, she thought she had a better idea of what he should have been doing during the other visits.</p>	G 108		

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G 108	Continued From page 9 During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist reviewed Patient #3's record. He stated his visits with Patient #3 were "around 35-45 minutes" in duration. He stated Patient #3 received written material for home exercises, but as he was providing OT to her for so long, he did not remember when he provided it to her. The Occupational Therapist confirmed he did not provide a POC to Patient #3, and he did not discuss with her evaluations of her progress, goals, or discharge plans. Occupational Therapist did not inform Patient #3 of her POC prior to initiating services.	G 108			
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: Based on staff interview, review of patient records, and review of administrative documents, it was determined the Governing Body failed to provide necessary organizational and administrative controls and oversight of agency practices, policies, and procedures. This failure resulted in a lack of support and guidance to agency personnel. Findings include: 1. Refer to G128 as it relates to the Governing Body's failure to ensure the overall effective operation of the HHA 2. Refer to G129 as it relates to the Governing	G 122		4/15/16	

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G 122	Continued From page 10 Body's failure to ensure a qualified Administrator was appointed. 3. Refer to G133 as it relates to the Administrator's failure to ensure the administrator maintained ongoing liaison among the governing body and the group of professional personnel. 4. Refer to G137 as it relates to the Administrator's failure to ensure a qualified person was authorized in writing to act in her absence.	G 122		
G 128	484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. This STANDARD is not met as evidenced by: Based on staff interview, policy review, and review of administrative documents, it was determined the agency's governing body failed to assume responsibility for the operation of the agency. This resulted in a lack of leadership and direction to agency personnel. Findings include: The agency's Policy #1003 "Governing Body," dated 11/13/03, stated "Visions Home Health is organized under a governing body, namely the Executive Board, which shall assume full legal responsibility for the conduct of the agency. The Executive Board shall consist of the Administrator and Director of Visions Home Health. The	G 128		4/15/16

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G 128	<p>Continued From page 11</p> <p>governing body shall assume responsibility for appointing the group of professional personnel ...Appointing an administrator qualified to carry out the agency's overall responsibilities in relation to written goals and objectives and applicable state and federal laws." Additionally, the policy stated the governing body was responsible for "Providing a continuing and annual program of overall agency evaluation."</p> <p>The Administrator was unavailable for interview.</p> <p>The Director was interviewed on 2/25/16 beginning at 4:45 PM. When asked, she indicated minutes showing the Executive Board's oversight of the operations of the agency were not available. The Director stated she met with the Administrator on a regular basis, however, these meetings were not documented. There was no documentation the Executive Board had provided oversight of the agency in the past year. The only documentation provided pertaining to the Executive Board's oversight of the agency, was a document titled Professional Advisory Meeting, which included an agenda. There was no documentation of who was in attendance or meeting minutes.</p>	G 128		
G 129	<p>484.14(b) GOVERNING BODY</p> <p>The governing body appoints a qualified administrator.</p> <p>This STANDARD is not met as evidenced by: Based on review of administrative documents,</p>	G 129		4/15/16

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G 129	<p>Continued From page 12</p> <p>job descriptions and policies, and staff interview, it was determined the governing body did not participate in appointing a qualified administrator. This had the potential for agency functions to be directed by a person not qualified to act as an administrator, and may have resulted in the inappropriate care of patients. Findings include:</p> <p>The agency's Policy #1003 "Governing Body," dated 11/13/03, stated "Visions Home Health is organized under a governing body, namely the Executive Board, which shall assume full legal responsibility for the conduct of the agency. The Executive Board shall consist of the Administrator and Director of Visions Home Health. The governing body shall assume responsibility for appointing an administrator qualified to carry out the agency's overall responsibilities in relation to written goals and objectives and applicable state and federal laws."</p> <p>A request was made for a job description for the Administrator and for evidence the current Administrator was appointed by the governing body. The Director was unable to present documentation of a job description for the Administrator. She also could not present documentation the Administrator was appointed by the governing body.</p> <p>The Administrator was not available for interview.</p> <p>During an interview on 2/25/16 beginning at 4:45 PM, the Director confirmed the Executive Board members included herself, the Administrator, and a co-owner, which made up the governing body. She confirmed the policy did not include the co-owner as part of the Executive Board. The Director confirmed there was no documentation</p>	G 129		

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G 129	Continued From page 13 the Administrator was appointed by the governing body. She also confirmed there was not a job description for the Administrator.	G 129			
G 133	The governing body did not participate in appointing the Administrator. 484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on review of administrative documents and staff interview, it was determined the agency failed to ensure the administrator maintained ongoing liaison among the governing body and the group of professional personnel. This resulted in a lack of consultation to persons responsible for running the agency. Findings include: The Director was interviewed on 2/25/16 beginning at 4:45 PM. She stated she did not have evidence the group of professional personnel was appointed by the governing body. She confirmed there were no meeting minutes, only agendas, documented for the 2 PAC meetings, dated 4/23/15 and 10/28/15. The Director also confirmed there was no documentation of who attended the meetings. No documentation was available to verify the Administrator maintained ongoing liaison between	G 133		4/15/16	

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G 133	Continued From page 14 the governing body and the group of professional personnel.	G 133		
G 137	484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure a qualified person was authorized in writing to act in the absence of the Administrator. This had the potential to interfere with availability of a qualified person in the absence of the Administrator. Findings include: The Administrator was not available for interview at the time of the survey. During an interview on 2/25/16 at 4:15 PM, the Director was asked who was authorized to act in the absence of the Administrator. She stated she would act in the Administrator's absence, however, she was unable to provide a written documentation which authorized her to act in the Administrator's absence.	G 137		4/15/16
G 152	484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other	G 152		4/15/16

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G 152	<p>Continued From page 15 professional disciplines.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure a group of professional personnel had been appointed which included at least one physician, one registered nurse, and appropriate representation from other professional disciplines. This limited the ability of the agency to utilize the expertise of staff and others to oversee its operations. Findings include:</p> <p>A request was made, on 2/25/16, to review documentation of the biannual PAC meetings for 2015. The Director presented 5 documents related to the PAC. One of the documents was a list of PAC members. The list included a physician, 2 RNs, and 1 PT. There were also 6 other members from the community listed. There was no documentation the members listed were appointed to the committee. The agency offered OT, ST and MSW services. However, these disciplines were not represented in the PAC.</p> <p>A form titled Professional Advisory Agenda, dated 4/23/15, did not include documentation of which members attended the meeting. There was a document titled Policy and Procedure Review Form, dated 4/23/15, which included 5 signatures. The signatures did not include a physician, RN or other professional disciplines.</p> <p>Another form titled Professional Advisory Meeting, dated 10/28/15, did not include documentation of which members attended the</p>	G 152			

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G 152	Continued From page 16 meeting. There was a document titled Policy and Procedure Review Form, dated 10/28/15, which included 5 signatures. The signatures did not include a physician, RN or other professional disciplines. During an interview on 2/25/16 beginning at 4:45 PM, the Director confirmed there was no documentation stating the required personnel were appointed to the PAC. Additionally, she confirmed there was no documentation of representation of professional disciplines at the 2 PAC meetings held in 2015.	G 152			
G 153	Evidence that a group of professional personnel had been appointed and had served the agency in the past year was not present. 484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. This STANDARD is not met as evidenced by: Based on review of agency PAC documents, policy review, and staff interview, it was determined the agency failed to ensure the PAC established and annually reviewed the agency's policies. This resulted in a lack of oversight and direction to the agency. Findings include:	G 153		4/15/16	

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G 153	<p>Continued From page 17</p> <p>A policy, Policy #1006 "Advisory Board," dated 11/14/03, stated "To assist and advise the Executive Board relative to the overall agency functions, to promote economy, efficiency of the operation and quality of care." One of the objectives listed in the policy was "The Home Health Advisory Board will meet bi-annually to evaluate Visions Home Health's performance in relation to its written statement of purposes and objective, policies, and procedures. The tools to be used in the review are the agency's written policies, clinical records, and pertinent statistical data."</p> <p>A request was made, on 2/25/16, to review documentation of the biannual PAC meetings for 2015. The Director presented 3 documents related to the PAC. One of the documents was a list of PAC members. The list included a physician, 2 RNs, and 1 PT. There were also 6 other members from the community.</p> <p>A form titled Professional Advisory Agenda, dated 4/23/15, documented the agenda for the meeting. The agenda included policy review as one of the matters to be discussed.</p> <p>Another form titled Professional Advisory Meeting, dated 10/28/15, documented the agenda for the meeting. The agenda included policy review as one of the matters to be discussed.</p> <p>The Director was asked to provide documentation of an annual policy review by the PAC. She presented the policy and procedure binder for the agency. At the front of the binder was a document, dated 2012, signed by the Executive Board members, which stated all agency policies</p>	G 153			

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G 153	Continued From page 18 were reviewed and approved. In the same binder there were 2 documents titled Policy and Procedure Review Form, dated 4/23/15 and 10/28/15. Both forms included signatures of PAC members, under the section titled Professional Advisory Board. The review form dated 4/23/15, stated the policies reviewed were Use of Protime Microcoagulation System, Tuberculosis Control Plan, and Infection Control Plan. The review form dated 10/28/15, stated the policies reviewed were OASIS Corrections and Care and Use of Ipad Tablets. There was no documentation other policies were reviewed. During an interview on 2/25/16 beginning at 4:45 PM, the Director confirmed the documents did not include minutes of the meetings. She stated at each meeting they reviewed all agency policies. The Director confirmed an annual review of agency policies and procedures was not documented since 2012.	G 153			
G 155	484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel's meetings are documented by dated minutes. This STANDARD is not met as evidenced by: Based on review of the PAC biannual evaluation minutes and staff interview, it was determined the PAC failed to document meetings with dated meeting minutes. This resulted in a lack of documented progress toward agency goals and	G 155		4/15/16	

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G 155	Continued From page 19 actions taken. Findings include: A review of the PAC's biannual meeting agendas, dated 4/23/15 and 10/28/15, revealed a list of the items below: Staff Changes Census and Referrals Policy Review Ipad Implementation Employee Handbook Home Health Compare ICD-10 (International Classification of Diseases) 5 Star Rating (A CMS established rating system) The PAC did not maintain meeting minutes to document what was discussed, and action taken, related to the listed items. During an interview with the Director on 2/25/16 beginning at 4:00 PM, she verified the PAC did not have meeting minutes, only the list of topics. The Governing Body did not ensure PAC meeting minutes were maintained.	G 155			
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on medical record review, policy review, observations during home visits, and staff and patient/caregiver interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, the POCs included all pertinent information, physicians were	G 156		4/15/16	

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G 156	Continued From page 20 consulted to approve POCs, the physician was notified of changes in patients' conditions, treatments were administered as ordered by the physician, and physician verbal orders were taken and documented appropriately. This resulted in unmet patient needs, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with patients' POCs. 2. Refer to G159 as it relates to the failure of the agency to ensure patients' POCs included all pertinent information. 3. Refer to G160 as it relates to the failure of the agency to ensure a physician was contacted to approve changes or additions in patients' POCs. 4. Refer to G164 as it relates to the failure of the agency to notify the physician of changes in patients' conditions. 5. Refer to G165 as it relates to the failure of the agency to ensure treatments were administered only as ordered by the physician. 6. Refer to G166 as it relates to the failure of the agency to ensure verbal orders were put into writing, and obtained by those who were authorized to accept verbal orders. The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to provided quality care in accordance with established POCs.	G 156		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC,	G 158		4/15/16

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G 158	<p>Continued From page 21 MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 6 of 12 patients (#3, #5, #6, #8, #11, and #12) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include:</p> <p>1. Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to cellulitis of the left lower leg. Additional diagnoses included pressure ulcer, atrial fibrillation, and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16, and 2/10/16 to 4/09/16, was reviewed.</p> <p>a. An SN recertification assessment dated 2/08/16, and signed by the RN Case Manager, documented Patient #8 had diabetes in which the symptoms were controlled with difficulty, the disease affected his daily functioning, and needed ongoing monitoring.</p> <p>Patient #8's POC, dated 2/10/16, included a diagnosis of Type II DM. His POC included orders for the SN to assess for diabetic complications.</p> <p>Patient #8's record included SN visit notes completed on 2/11/16, 2/16/16, and 2/19/16. The 3 SN visit notes did not include BG levels.</p>	G 158		
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G 158	<p>Continued From page 22</p> <p>Additionally, the notes did not include documentation of patient education related to diabetic complications.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed Patient #8's record and confirmed she did not check his BG levels because he did not have a glucometer. She confirmed there was no documentation of education related to DM or diabetic complications.</p> <p>Patient #8 did not receive diabetic assessments as ordered on his POC.</p> <p>b. Patient #8's record included an SOC comprehensive assessment completed on 12/12/15, and signed by the RN. The assessment stated Patient #8 had 2 diabetic ulcers located on his left ankle and arch of the left foot. The RN documented he had cellulitis (a bacterial infection, often associated with redness, swelling and warmth) of his left leg from his knee to his toes.</p> <p>The SOC comprehensive assessment stated wound care was required by the clinician and was performed at the visit. Additionally, the assessment listed adhesive surgical dressing and Kerlix wrap as wound care supplies.</p> <p>SN visit notes, dated 12/15/15, 12/21/15, 12/24/15, 12/28/15, 1/04/16, 1/07/16, 1/12/16, 1/14/16, 1/21/16, 1/25/16, 1/28/16, 2/01/16, and 2/04/16, documented wound care and dressing changes were performed.</p> <p>Patient #8's POC, dated 12/12/15, did not include orders for wound care. Additionally, wound care</p>	G 158		

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G 158	<p>Continued From page 23 supplies were not listed under DME and supplies.</p> <p>Patient #8's record included a recertification comprehensive assessment completed on 2/08/16, and signed by the RN Case Manager. The assessment stated Patient #8 had a diabetic ulcer on the arch of his left foot. The RN Case Manager documented wound care and a dressing change was performed during the visit.</p> <p>SN visit notes, 2/11/16, 2/16/16, and 2/19/16, documented wound care and dressing changes were performed.</p> <p>Patient #8's POC, dated 2/10/16, did not include orders for wound care.</p> <p>During an interview on 2/26/16 at 8:40 AM, the RN who completed the SOC assessment reviewed the record and confirmed Patient #8 had 2 diabetic ulcers and cellulitis of his left lower extremity. She confirmed wound care was performed during the visit and wound supplies were documented in the assessment note. The RN confirmed the POC did not include orders for wound care or list wound care supplies.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed the record and confirmed she performed wound care at each of her visits. She confirmed the POCs dated 12/12/15 and 2/10/16 did not include orders for wound care.</p> <p>Patient #8's POC did not include orders for wound care or dressing changes.</p> <p>c. Patient #8's POC, dated 12/12/15, included orders for SN visits 2 times a week for 1 week, 3</p>	G 158		

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G 158	<p>Continued From page 24</p> <p>times a week for 2 weeks, 2 times a week for 3 weeks, and 1 time a week for 1 week, effective the week of 12/15/15. SN visits were not completed as ordered. Examples include:</p> <ul style="list-style-type: none"> - During week 1, 12/13/15 to 12/19/15, 3 SN visits were ordered. An SN visit was completed on 12/15/15, and a missed SN visit was documented on 12/17/15. Patient #8's record did not include a 3rd SN visit for the week. - During week 2, 12/20/15 to 12/26/15, 3 SN visits were ordered. SN visits were completed on 12/21/15 and 12/24/15. Patient #8's record did not include a 3rd SN visit for the week, or documentation of a missed visit. - During week 6, 1/17/16 to 1/23/16, 2 SN visits were ordered. An SN visit was completed on 1/21/16. Patient #8's record did not include a 2nd SN visit for the week, or documentation of a missed visit. <p>d. Patient #8's POC included an order for an MSW evaluation. There was no documentation in his record of an MSW visit.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed the record and confirmed no MSW evaluation was completed. She stated she had spoken with the MSW regarding an evaluation for Patient #8, but it was not completed as of 2/25/16. The RN Case Manager confirmed SN visits were not completed as ordered on his POC.</p> <p>Patient #8's POC was not followed as ordered for SN visit frequency and an MSW evaluation.</p>	G 158		

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G 158	<p>Continued From page 25</p> <p>2. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's record included a physician's order, dated 12/21/15. The order stated "Sacral Decubitus - wet to dry dressing change (normal saline) once daily."</p> <p>Patient #11's record included a referral order, dated 12/31/15, for SN to assess for wound management. The referral order did not include specific wound care orders. Patient #11's HH care was initiated on 1/02/16.</p> <p>Patient #11's record included an SOC Comprehensive assessment completed on 1/02/16, signed by the RN Case Manager. Patient #11's record did not include documentation of contact with her physician following her SOC assessment to obtain orders for wound care, including frequency of wound dressing changes.</p> <p>Patient #11's record documented SN visits on 1/03/16, 1/05/16, and 1/08/15, during the first week of her certification period. There was no documentation in Patient #11's record stating how wound care would be completed on the days the SN did not visit. No SN visits were documented on 1/04/16, 1/06/16, or 1/07/16. Daily visits were initiated on 1/08/16.</p> <p>During an interview on 2/26/16 at 12:20 PM, the RN PCC stated the prescription for daily wound</p>	G 158			

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G 158	<p>Continued From page 26</p> <p>care was given to Patient #11 during a physician office visit. Patient #11 presented the order to the agency on 12/31/15. The agency called the physician on 12/31/15, and received an order for SN to assess for wound management, but did not obtain an order for specific wound care, including frequency of dressing changes. The PCC confirmed specific wound care orders were not obtained from Patient #11's physician following her SOC assessment. She was unable to explain how the frequency of SN visits was determined, and confirmed the wound care was not provided daily as ordered on the physician's order presented to the agency on 12/31/15.</p> <p>Patient #11 did not receive daily wound care as ordered by her physician.</p> <p>3. Patient #12 was an 88 year old female admitted to the agency on 2/10/16, with a diagnosis of weakness. Additional diagnoses included arthritis, depression, and irritable bowel syndrome. She received SN, PT, OT, MSW, and Home Health Aide services. Her record, including the POC, for the certification period 2/10/16 to 4/09/16, was reviewed.</p> <p>a. Patient #12's record included a referral order dated 2/09/16, stating "Physical Therapy to assess and evaluate." Her record included a PT SOC visit dated 2/10/16. Additionally, Patient #12's record included an MSW visit dated 2/10/16, and SN and OT visits dated 2/11/16. Patient #12's record did not include a physician's order for MSW, SN, or OT evaluations.</p> <p>During an interview on 2/26/16 at 8:50 AM, the Physical Therapist stated he assessed Patient #12 on 2/10/16, and felt she needed additional</p>	G 158		

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G 158	<p>Continued From page 27</p> <p>services. He stated he called the HH office to report his findings. He confirmed he did not call the physician to obtain orders for MSW, SN, and OT services.</p> <p>During an interview on 2/26/16 at 10:15 AM, the PCC reviewed Patient #12's record and confirmed there was no physician's order for MSW, SN, and OT evaluations.</p> <p>Patient #12 's MSW, SN, and OT evaluations were completed without a physician's order.</p> <p>b. Patient #12's POC included an order for OT visits 2 times a week for 8 weeks, effective 2/14/16. However, Patient #12's record included 3 OT visit notes during the week of 2/14/16 to 2/20/15, on 2/15/16, 2/16/16, and 2/18/16.</p> <p>During an interview on 2/25/16 at 1:10 PM, the Occupational Therapist reviewed Patient #12's record and confirmed 2 OT visits were ordered and 3 OT visits were completed.</p> <p>Patient #12's OT visit was completed without a physician's order.</p> <p>4. Patient #5 was a 66 year old female admitted to the agency on 2/02/16, for SN, PT, OT and Home Health Aide services related to care after orthopedic surgery. Additional diagnoses included spinal stenosis, Type II DM, HTN, and chronic pain. Her record, including the POC, for the certification period 2/02/16 to 4/01/16, was reviewed.</p> <p>Patient #5's POC included orders for PT visits 2 times a week for 3 weeks beginning on 2/08/16. A PT visit was completed on 2/04/16, prior to the</p>	G 158		

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G 158	<p>Continued From page 28</p> <p>effective date. During weeks 1 and 2 of the certification period 1 PT visit was documented and completed instead of 2 as ordered. The 2 visits were dated 2/10/16 and 2/19/16.</p> <p>During an interview on 2/25/16 at 1:30 PM, the Director reviewed the record and confirmed a PT visit was completed prior to the effective date and the frequency of visits was not followed as ordered.</p> <p>Patient #5's POC was not followed as ordered for PT visit frequency.</p> <p>5. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POCs, for the certification periods 11/26/15 to 1/24/16, and 1/25/16 to 3/24/16, was reviewed.</p> <p>a. Patient #3's record included orders which were received from physicians who were not included on her POC as consulting or partner physicians in her care. Examples include:</p> <p>i. Patient #3's record included a referral to the agency on 1/23/15 for a SOC on 1/30/15. The referral sheet completed by the HHA included notation that Patient #3's PCP was Physician A. The referral papers included a "Face-to-Face Encounter," completed by Physician B, during the time Patient #3 was receiving therapy services at a rehabilitation facility. The document included the notation "All future paperwork to PCP-[Physician A]."</p> <p>Patient #3's record included POCs for the</p>	G 158		

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G 158	<p>Continued From page 29</p> <p>certification periods 11/26/15 to 1/24/16, and 1/25/16 to 3/24/16. The POCs were signed by her PCP, Physician A, on 12/01/15, and 2/08/16. The POCs did not identify additional physicians who were authorized to give orders for Patient #3's care.</p> <p>Patient #3's record included a "Physician Phone Order," dated 1/14/16, which was noted as received from Physician C. The order stated "Recertify patient for home health services. My signature on this recertification order attests that I certify the estimate of required Home Health Services remaining for the entire course of the patients care to be 60 days. The signature on the line designated "Physician's Signature," dated 1/15/16, was illegible, however, it did not match Physician A's signature on Patient #3's POCs.</p> <p>Patient #3's record included a "Verbal Order," dated 1/27/16 at 3:01 PM. The order was documented as received from Physician C, by an LPN. The order included medication clarification orders. The signature on the line designated "Physician's Signature," dated 2/02/16, was illegible, however, it did not match Physician A's signature on Patient #3's POCs.</p> <p>During an interview on 2/26/16 beginning at 10:30 AM, the PCC reviewed Patient #3's record and confirmed the orders were sent to and received from physicians other than Patient #3's PCP (Physician A), who signed her POCs. She stated she did not know why the other physicians were contacted for orders. She compared the orders and signatures with Physician A's signature on the POC, and they did not match. The PCC confirmed Patient #3's POC did not identify other physicians authorized to give orders for her care.</p>	G 158			

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G 158	<p>Continued From page 30</p> <p>ii. Patient #3's record included a "Verbal Order," dated 1/25/16 at 8:54 AM. The order was documented as received from Physician B, by Patient #3's Occupational Therapist. The order read "Occupational Therapy 3 wk 8 wk; Total visits 24. Start Date: 1/25/16. End Date 3/19/16." The signature on the line designated "Physician's Signature," dated 1/28/16, was illegible, however, it did not match Physician A's signature on Patient #3's POCs.</p> <p>During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist reviewed Patient #3's record and the verbal order that he received from Physician B. He stated he did not remember if he got a verbal order, or if he sent a request for an order for frequency of OT visits for Patient #3's new certification period. The Occupational Therapist stated he was not sure how he got the name of Physician B, who was listed on the Verbal Order. The Occupational Therapist stated he may have clicked on the wrong physician name on the computer, and was not sure which physician he spoke with, or if he called a physician for the orders. The Occupational Therapist was unable to determine if Patient #3's PCP (Physician A) was aware that OT services were continued into a new certification period.</p> <p>The agency failed to ensure Patient #3's care followed a POC directed by her physician.</p> <p>b. Patient #3's POC included OT visits 3 times weekly for 8 weeks. Her record indicated two visits were provided the week of 2/14/16 to 2/20/16, on 2/17/16 and 2/19/16.</p>	G 158			

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G 158	Continued From page 31 During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist reviewed Patient #3's record and confirmed 2 visits were performed that week. He stated he did not document the reason of the missed visit, was unable to explain why the visit did not occur and confirmed Patient #3's physician was not informed of the missed visit. Patient #3 did not receive OT visits as were ordered on her POC. 6. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16 for SN, OT, and PT services related to CHF, UTI, and history of falls. Patient #6's record, including her POC for the certification period 1/08/16 to 3/07/16, was reviewed. Patient #6's POC included SN visits once weekly for 6 weeks. Her record did not include an SN visit for week 4 of her certification period (1/24/16 to 1/30/16). During an interview on 2/26/16 beginning at 10:20 AM, the RN Case Manager reviewed Patient #6's record and confirmed an SN visit was not performed during week 4. The RN Case Manager stated she did not document the missed visit, and Patient #6's physician was not notified. Patient #6 did not receive SN visits as ordered on her POC.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and	G 159		4/15/16

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G 159	<p>Continued From page 32</p> <p>equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on observation, medical record review, policy review, patient and caregiver interview, and staff interview it was determined the agency failed to ensure the POC covered all appropriate items for 10 of 12 patients, (#1, #2, #3, #5, #6, #7, #8, #10, #11, and #12) whose records were reviewed. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include:</p> <p>The agency's policy #3005, "Plan of Care," revised 1/22/13, stated "A written plan of care shall be developed and implemented for each patient with participation from all disciplines providing services for that patient." The policy included elements required as part of the POC. The elements included all pertinent diagnoses, types of services and equipment, nutritional requirements, medication and treatment orders, teaching needs of the patient and family, all patient medications, and goals of patient care.</p> <p>During an interview on 2/26/16 beginning at 9:00 AM, the PCC stated the agency did not have a policy for staff to refer to which included acceptable vital signs and when a physician should be notified for vital signs outside of normal parameters.</p>	G 159			

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G 159	<p>Continued From page 33</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>a. Patient #2's POC for the certification period 10/17/15 to 12/15/15, did not include all pertinent information, as follows:</p> <p>i. Patient #2's POC included a diagnosis of DM. However, his POC did not include interventions related to DM, such as assessment of his blood glucose levels, or patient education regarding DM.</p> <p>ii. Patient #2's POC included a diagnosis of CHF. However, his POC did not include interventions related to CHF, such as assessment of his cardiac status, or patient education regarding CHF.</p> <p>iii. Patient #2's POC included a diagnosis of non-pressure chronic skin ulcer. His SOC comprehensive assessment, dated 10/17/15, signed by the RN, referred to his ulcer as a Stage 2 pressure ulcer. However, his POC did not include interventions related to care of his ulcer.</p> <p>iv. Patient #2's POC included a diagnosis of atrial fibrillation, requiring Coumadin (anticoagulant) to prevent blood clots. However, his POC did not include patient education related</p>	G 159			

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G 159	<p>Continued From page 34</p> <p>to anticoagulant therapy, or PT/INR blood tests used to monitor individuals taking Coumadin, to determine whether they are taking the correct dosage.</p> <p>v. Patient #2's SOC comprehensive assessment completed on 10/17/15, signed by the RN, stated he used a BG monitor to test his BG levels. However, his POC did not include a BG monitor.</p> <p>vi. Patient #2's SOC comprehensive assessment stated he was on an 1800 calorie ADA prescribed diet. However, his POC stated he was on a regular (no restrictions) diet.</p> <p>vii. Patient #2's SOC comprehensive assessment stated his physician ordered POC would include specific parameters for notifying his physician of changes in vital signs or other clinical findings. However, his POC did not include parameters to direct his clinicians to notify his physician of findings outside of the normal range.</p> <p>viii. Patient #2's SOC comprehensive assessment stated his physician ordered POC would include diabetic foot care including monitoring for skin lesions, and patient education on proper foot care. However, his POC did not include interventions related to diabetic foot care.</p> <p>ix. Patient #2's SOC comprehensive assessment included the MAHC-10 Fall Risk Assessment, a validated tool to assess risk of falling in community dwelling elders, on which a score of 4 or more is considered at risk for falling. Patient #2's score was 6. However, his POC did not include interventions related to his risk of falling.</p> <p>x. Patient #2's SOC comprehensive assessment</p>	G 159			

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G 159	<p>Continued From page 35</p> <p>stated he was at risk of developing pressure ulcers. However, his POC did not include interventions or patient education to prevent pressure ulcers.</p> <p>xi. Patient #2's POC included an order for PT visits twice a week for 6 weeks. However, his POC did not include PT interventions to be provided during the PT visits. Additionally, his POC did not include goals related to his PT services.</p> <p>xii. Patient #2's SOC comprehensive assessment included a pain assessment. It noted his pain level ranged from 2 to 9, on a scale of 0 to 10, with 10 indicating the worst pain. Additionally, it stated his pain was controlled with a narcotic analgesic, and he had taken 2 doses of the analgesic in the last 24 hours. However, his POC did not include a narcotic analgesic, or interventions to monitor and mitigate his pain.</p> <p>b. Patient #2 was recertified for an additional certification period following a hospitalization. Patient #2's POC for the certification period 12/16/15 to 2/13/16, did not include all pertinent information, as follows:</p> <p>i. Patient #2's ROC comprehensive assessment dated 12/13/15, signed by his RN Case Manager, stated he was hospitalized for heart failure. It stated his heart failure required a changed treatment regimen.</p> <p>Patient #2's PT visit note, dated 12/15/15, signed by the Physical Therapist, stated he was discharged from the hospital following an admission due to CHF exacerbation with fluid overload and shortness of breath.</p>	G 159			

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G 159	Continued From page 36 Patient #2's POC for the certification period 12/16/15 to 2/13/16, included a primary diagnosis of heart failure. However, his POC did not include interventions related to heart failure. There were no orders to assess his cardiac status, or educate him regarding heart failure. ii. Patient #2's POC included a diagnosis of DM. However, his POC did not include interventions related to DM, such as assessment of his blood glucose levels, or patient education regarding DM. iii. Patient #2's POC included a diagnosis of non-pressure chronic skin ulcer. However, his POC did not include interventions related to care of his ulcer. iv. Patient #2's POC included a diagnosis of atrial fibrillation, requiring Coumadin (anticoagulant) to prevent blood clots. However, his POC did not include patient education related to anticoagulant therapy, or PT/INR blood tests used to monitor individuals taking Coumadin, to determine whether they are taking the correct dosage. During an interview on 2/25/16 at 4:30 PM, the RN Case Manager reviewed Patient #2's record and POCs. She confirmed the POCs did not include pertinent interventions related to CHF, DM, atrial fibrillation, skin ulcer, fall risk or pressure ulcer prevention. Additionally, she confirmed the POCs did not include his BG monitor, narcotic analgesic, prescribed diet, or patient specific parameters for reporting to his physician. During an interview on 2/26/16 at 8:15 AM, the	G 159		

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G 159	<p>Continued From page 37</p> <p>Physical Therapist reviewed Patient #2's record and confirmed his POC did not include interventions or goals related to his PT services.</p> <p>Patient #2's POC was not comprehensive to include all services, interventions, medications, treatments and supplies required for his care.</p> <p>2. Patient #10 was a 7 year old male admitted to the agency on 1/24/16, for care related to gastroparesis (a disorder that slows or stops the movement of food from the stomach to the small intestine). Additional diagnoses included feeding disorder and management of a venous vascular device. He received SN services. His record, including the POC, for the certification period 1/24/16 to 3/23/16, was reviewed.</p> <p>Patient #10's POC for the certification period 1/24/16 to 3/23/16, did not include all pertinent information, as follows:</p> <p>a. Patient #10's SOC assessment completed on 1/24/16, signed by his RN Case Manager, stated he had a gastrostomy tube (a tube inserted through the abdomen to deliver nutritional feedings directly to his stomach). However, his POC did not include the nutritional feedings given through the tube. A home visit was made on 2/24/16 at 10:00 AM, to observe an SN visit. During the visit Patient #10's mother was observed preparing and administering a feeding through his tube.</p> <p>b. During the home visit, an "Oxygen in Use" sign was noted on the front door. Patient #10's mother stated he used oxygen as needed. However, oxygen was not included on Patient #10's POC.</p>	G 159			

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G 159	<p>Continued From page 38</p> <p>c. During the home visit, Patient #10's mother stated he had a monitor that was used overnight to assess his heart rate and oxygen saturation level. However, the monitor was not included on Patient #10's POC.</p> <p>During an interview on 2/26/16 at 9:30 AM, the RN Case Manager reviewed Patient #10's record and confirmed his POC did not include his tube feedings, oxygen, or monitor.</p> <p>Patient #10's POC was not comprehensive to include his nutritional needs and equipment.</p> <p>3. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's POC for the certification period 10/17/15 to 12/15/15, did not include all pertinent information, as follows:</p> <p>a. Patient #11's POC included a diagnosis of pressure ulcer. Her SOC comprehensive assessment completed on 1/02/16, signed by her RN Case Manager, stated she had a Stage 4 pressure ulcer. Her POC included an order to treat her wound. However, it did not include specific wound care to be provided, including wound care products to be used.</p> <p>b. Patient #11's SOC comprehensive assessment stated her physician ordered POC would include specific parameters for notifying</p>	G 159		
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G 159	<p>Continued From page 39</p> <p>her physician of changes in vital signs or other clinical findings. However, her POC did not include parameters to direct her clinicians to notify her physician of findings outside of the normal range.</p> <p>c. Patient #11's SOC comprehensive assessment included the MAHC-10 Fall Risk Assessment, on which a score of 4 or more is considered at risk for falling. Patient #11's score was 6. However, her POC did not include interventions related to her risk of falling.</p> <p>d. Patient #11's SOC comprehensive assessment stated she was at risk of developing additional pressure ulcers. However, her POC did not include interventions or patient education to prevent pressure ulcers.</p> <p>e. A visit was made to Patient #11's home on 2/24/16 at 4:00 PM to observe an LPN visit. During the visit, Patient #11 stated her usual weight was 100-104 pounds. She stated her current weight was 92 pounds. She was concerned about her weight loss.</p> <p>Patient #11's SOC comprehensive assessment stated she had a Stage 4 pressure ulcer. The National Institutes for Health website, accessed 3/02/16, contained an article titled "Understanding the role of nutrition and wound healing." The article stated "Optimal wound healing requires adequate nutrition...Malnourished patients can develop pressure ulcers, infections, and delayed wound healing that result in chronic nonhealing wounds."</p> <p>Patient #11's POC did not include assessment of her weight or nutritional intake, or patient</p>	G 159		

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G 159	<p>Continued From page 40 education related to nutrition and wound healing.</p> <p>During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed Patient #11's record and stated nutrition assessment and education was pertinent to her care. She confirmed Patient #11's POC did not include interventions related to nutrition.</p> <p>Patient #11's POC was not comprehensive to include all interventions required for her care.</p> <p>4. Patient #12 was an 88 year old female admitted to the agency on 2/10/16, with a diagnosis of weakness. Additional diagnoses included arthritis, depression, and irritable bowel syndrome. She received SN, PT, OT, MSW, and Home Health Aide services. Her record, including the POC, for the certification period 2/10/16 to 4/09/16, was reviewed.</p> <p>Patient #12's POC for the certification period 2/10/16 to 4/09/16, did not include all pertinent information, as follows:</p> <p>a. Patient #12's SOC comprehensive assessment stated her physician ordered POC would include specific parameters for notifying her physician of changes in vital signs or other clinical findings. However, her POC did not include parameters to direct her clinicians to notify her physician of findings outside of the normal range.</p> <p>b. Patient #12's SOC comprehensive assessment included the MAHC-10 Fall Risk Assessment, on which a score of 4 or more is considered at risk for falling. Patient #12's score was 8. However, her POC did not include</p>	G 159			

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G 159	<p>Continued From page 41 interventions to prevent falls.</p> <p>c. Patient #12's SOC comprehensive assessment included a pain assessment. It noted her pain level ranged from 3 to 9, on a scale of 0 to 10, with 10 indicating the worst pain. However, her POC did not include interventions to monitor and mitigate her pain.</p> <p>d. Patient #12's SOC comprehensive assessment stated she was at risk of developing pressure ulcers. However, her POC did not include interventions or patient education to prevent pressure ulcers.</p> <p>During an interview on 2/26/16 at 8:50 AM, the Physical Therapist who completed Patient #12's SOC assessment reviewed her POC and confirmed it did not include pertinent interventions related to parameters, fall risk, pain, and pressure ulcer prevention.</p> <p>Patient #12's POC was not comprehensive to include all interventions required for her care.</p> <p>5. Patient #5 was a 66 year old female admitted to the agency on 2/02/16, for SN, PT, OT and home health aide services related to care after orthopedic surgery. Additional diagnoses included spinal stenosis, Type II DM, HTN, and chronic pain. Her record, including the POC, for the certification period 2/02/16 to 4/01/16, was reviewed.</p> <p>a. Patient #5's record included a SOC comprehensive assessment completed on 2/02/16, and signed by the RN. The POC for the certification period 2/02/16 to 4/01/16, did not include all pertinent information as follows:</p>	G 159		

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G 159	Continued From page 42 i. Patient #5's SOC comprehensive assessment stated her physician ordered POC would include specific parameters for notifying her physician of changes in vital signs or other clinical findings. However, her POC did not include parameters to direct her clinicians to notify her physician of findings outside of the normal range. ii. The SOC comprehensive assessment stated Patient #5's physician ordered POC would include diabetic foot care including monitoring for skin lesions, and patient education on proper foot care. However, her POC did not include interventions related to diabetic foot care. iii. The SOC comprehensive assessment stated Patient #5's physician ordered POC would include interventions for depression, which included medications, referral for treatment, or a monitoring plan for current treatment. Patient #5's medication list included Duloxetine and Trazodone, anti-depressant medications. However, her POC did not include interventions related to depression. iv. The SOC comprehensive assessment stated Patient #5 had Type II DM. However, her POC did not include interventions for monitoring her blood glucose or education regarding DM. v. The SOC comprehensive assessment stated Patient #5 used a CPAP device (Continuous Positive Airway Pressure) for sleep apnea. However, the CPAP was not included on her POC. vi. The SOC comprehensive assessment stated Patient #5 had HTN which was controlled with	G 159			

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G 159	<p>Continued From page 43</p> <p>difficulty, affected daily functioning, and needed ongoing monitoring. However, her POC did not include interventions for cardiovascular monitoring and education.</p> <p>During an interview on 2/25/16 at 2:00 PM, the RN who completed the SOC comprehensive assessment reviewed the record. She confirmed the POC did not include all pertinent information or findings from her SOC assessment.</p> <p>Patient #5's POC was not comprehensive to include all interventions, treatments, and supplies required for her care.</p> <p>b. A home visit was conducted at Patient #5's home on 2/23/16, beginning at 4:00 PM. During the visit discrepancies were observed between her POC and what was in the home. Examples include:</p> <p>i. A request was made to review Patient #5's medications in the home. Patient #5's medication list on her POC did not include all the medications she was taking in her home. Medications which were not on the POC included Lactulose 10 gm/15 ml and Norco 10/325. Additionally, Percocet 10/325 was included on the POC which Patient #5 was not taking.</p> <p>When asked about her medications Patient #5 stated she had an appointment with her physician on 2/11/16. Her pain medications were changed at that time per her request. She also stated the Lactulose was prescribed by her physician prior to her surgery, and due to severe constipation she had taken it a couple of days ago to help alleviate the problem.</p>	G 159			

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G 159	<p>Continued From page 44</p> <p>During an interview on 2/26/15 at 8:50 AM, the RN Case Manager reviewed the record and confirmed the discrepancies on the medication list. She stated she was unaware Patient #5 had a medication change and that she was taking Lactulose which was previously prescribed by her physician.</p> <p>Patient #5's POC and medication list were not accurate to reflect her current medications.</p> <p>ii. During the visit a glucometer, diabetic test strips, and a cane were observed in Patient #5's home. However, these items were not included on her POC.</p> <p>During an interview on 2/25/16 at 2:00 PM, the RN who completed the SOC assessment confirmed DME was missing from Patient #5's POC.</p> <p>Patient #5's POC did not include all equipment and supplies required for her care.</p> <p>6. Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to cellulitis of the left lower leg. Additional diagnoses included pressure ulcer, atrial fibrillation, and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>a. Patient #8's record included a SOC comprehensive assessment completed on 12/12/15, and signed by the RN. The POC for the certification period 12/12/15 to 2/09/16, did not include all pertinent information as follows:</p> <p>i. Patient #8's SOC comprehensive assessment</p>	G 159			

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G 159	<p>Continued From page 45</p> <p>stated his physician ordered POC would include specific parameters for notifying his physician of changes in vital signs or other clinical findings. However, his POC did not include parameters to direct his clinicians to notify his physician of findings outside of the normal range.</p> <p>ii. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions for depression, which included medications, referral for treatment, or a monitoring plan for current treatment. Patient #8's medication list included Sertraline, an anti-depressant medication. However, his POC did not include interventions related to depression.</p> <p>iii. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions to prevent pressure ulcers. The assessment stated Patient #8 was at risk for developing pressure ulcers. However, his POC did not include interventions related to pressure ulcers.</p> <p>iv. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions to monitor and mitigate pain. It noted his pain level ranged from 3 to 10, on a scale of 0 to 10, with 10 indicating the worst pain. However, his POC did not include interventions related to pain.</p> <p>v. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions for pressure ulcer treatment using moist wound healing. However, his POC did not include a diagnosis of a pressure ulcer or interventions for pressure ulcer treatment using</p>	G 159			

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G 159	<p>Continued From page 46 moist wound healing.</p> <p>vi. The SOC comprehensive assessment stated Patient #8 had HTN and peripheral vascular disease. His medication list included aspirin, Metoprolol (an anihypertensive medication), and Diltiazem (a heart medication used to treat HTN or an irregular heart beat). However, his POC did not include these diagnoses or include interventions related to the disease.</p> <p>During an interview on 2/26/16 at 8:40 AM, the RN who completed the SOC comprehensive assessment reviewed the record and confirmed the POC did not include all pertinent information or findings from her SOC assessment.</p> <p>Patient #8's POC was not comprehensive to include all interventions, treatments, and supplies required for his care.</p> <p>b. Patient #8's record included a recertification comprehensive assessment completed on 2/08/16, and signed by the RN Case Manager. The POC for the certification period 2/10/16 to 4/09/16, did not include all pertinent information as follows:</p> <p>i. Patient #8's primary diagnosis was pressure ulcer. The assessment stated he had a diabetic ulcer to the arch of his left foot. However, his POC did not include interventions or treatments related to treatment of a pressure ulcer or wound.</p> <p>ii. The recertification comprehensive assessment stated Patient #8 had HTN and peripheral vascular disease. However, his POC did not include these diagnoses or include interventions related to the disease.</p>	G 159		

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G 159	<p>Continued From page 47</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed the record and confirmed Patient #8's POC did not include all pertinent information or findings from her recertification assessment.</p> <p>c. Patient #8's POC included Kerlix wrap (gauze bandage wrap), normal saline, 4 x 4 dressings, and Allevyn (a moist wound dressing) as supplies in the home. However, his recertification comprehensive assessment stated he had a brace, reacher, shoe/sock aid, tracheostomy (a surgical opening in the neck to place a tube for breathing) supplies, ace wraps (elastic bandage wraps), and compression stockings which were not included on his POC.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager confirmed DME and supplies were missing from Patient #8's POC.</p> <p>Patient #8's POC did not include all equipment and supplies required for his care.</p> <p>7. Patient #1 was a 92 year old female who was admitted to the HHA on 10/10/15, for SN and therapy services related to a UTI. Additional diagnoses included dementia and repeated falls. Patient #1's record, including her POC for the certification period 10/10/15 to 12/08/15, was reviewed.</p> <p>Patient #1's SOC comprehensive assessment stated her physician ordered POC would include specific parameters for notifying her physician of changes in vital signs or other clinical findings. However, her POC did not include parameters to direct her clinicians to notify her physician of</p>	G 159			

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G 159	<p>Continued From page 48 findings outside of the normal range.</p> <p>During an interview on 2/26/16 beginning at 9:00 AM, the PCC reviewed Patient #1's record and confirmed the RN Case Manager did not include patient specific parameters on the POC for notifying her physician. The PCC also confirmed the agency did not have a policy for staff to refer to which included acceptable vital signs and when a physician should be notified.</p> <p>Patient #1's POC did not include vital sign parameters to alert the clinicians when to notify her physician.</p> <p>8. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to Heart failure, Type II DM Type, and weakness. Patient #3's record, including her POC, for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>Patient #3's POC did not include all pertinent information, as follows:</p> <p>a. Patient #3's POC listed her primary diagnosis as "Heart Failure, Unspecified." However, her POC did not include interventions related to heart failure such as assessment of her cardiac status or patient education regarding CHF.</p> <p>b. Patient #3's POC section 14, "DME and Supplies," included a walker. During a home visit on 2/24/16 beginning at 7:15 AM, the following DME were noted:</p> <ul style="list-style-type: none"> - An electric bed, - Electric recliner chair that also lifts to an upright 	G 159			

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G 159	<p>Continued From page 49</p> <p>position, - Bed rail, - Grab bars in bathroom and shower, - Elevated toilet seat with arm supports, - Shower chair, - 4 point cane, - Grabber device to pick up items from the floor, - Glucometer.</p> <p>During an interview on 2/25/16 beginning at 4:30 PM, the RN Case Manager reviewed Patient #3's record and confirmed her POC did not include interventions for heart failure, and the DME that she had in her home.</p> <p>Patient #3's POC was not comprehensive to include all interventions and supplies required for her care.</p> <p>9. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16 for Nursing and PT services related to CHF, UTI, and history of falls. Patient #6's record, including her POC for the certification period 1/08/16 to 3/07/16, was reviewed.</p> <p>Patient #6's POC did not include all pertinent information, as follows:</p> <p>a. Patient #6's POC listed her primary diagnosis as "Acute onset chronic systolic heart failure," (CHF). However, her POC did not include interventions related to CHF, such as assessment of her cardiac status, or patient education regarding CHF.</p> <p>b. Patient #6's SOC comprehensive assessment stated her physician ordered POC would include specific parameters for notifying her physician of</p>	G 159		

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G 159	<p>Continued From page 50</p> <p>changes in vital signs or other clinical findings. However, her POC did not include parameters to direct her clinicians to notify her physician of findings outside of the normal range.</p> <p>c. Patient #6's SOC comprehensive assessment stated her physician ordered POC would include diabetic foot care including monitoring for skin lesions, and patient education on proper foot care. However, her POC did not include interventions related to diabetic foot care.</p> <p>d. Patient #2's SOC comprehensive assessment included the MAHC-10 Fall Risk Assessment, a validated tool to assess risk of falling in community dwelling elders, on which a score of 4 or more is considered at risk for falling. Patient #6's score was 7. However, her POC did not include interventions related to her risk of falling.</p> <p>e. Patient #2's SOC comprehensive assessment stated she was at risk of developing pressure ulcers. However, her POC did not include interventions or patient education to prevent pressure ulcers.</p> <p>f. Patient #6's POC section 14, "DME and Supplies," included a walker. During a home visit on 2/25/16 beginning at 3:00 PM, the following DME were noted:</p> <ul style="list-style-type: none"> - grab bars in the bathroom, - a CPAP machine for sleep apnea, - shower chair. <p>During an interview on 2/26/16 beginning at 10:20 AM, the RN Case Manager reviewed Patient #6's record and confirmed the POCs did not include pertinent interventions related to CHF, DM, fall</p>	G 159			

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G 159	<p>Continued From page 51</p> <p>risk or pressure ulcer prevention. Additionally, she confirmed the POCs did not include his DME, or patient specific parameters for reporting to his physician.</p> <p>Patient #6's POC was not comprehensive to include all interventions, equipment and supplies required for her care.</p> <p>10. Patient #7 was an 88 year old female who was admitted to the HHA on 5/04/15, for SN services related to a CVA. Additional diagnoses included major depressive disorder, weakness, and chronic kidney disease. Patient #7's record, including her POC for the certification period 12/30/15 to 2/27/16, was reviewed.</p> <p>Patient #7's H&P documented she had sleep apnea, and she was on oxygen at night. Her POC included orders for her to receive oxygen at 2 liters per minute via nasal cannula while asleep. However, the recertification assessment performed on 12/29/15, included documentation she was on oxygen continuously, at 2 liters per minute. Additionally, nursing visit notes for the certification period (12/30/15, 1/05/16, 1/06/16, 1/12/16, 1/19/16, 1/26/16, 2/11/16 and 2/17/16) were reviewed, and documented continuous oxygen, rather than only while sleeping.</p> <p>During an interview on 2/25/16 beginning at 4:20 PM, the RN Case Manager reviewed Patient #7's record and confirmed that Patient #7 was on oxygen continuously, rather than only while sleeping. She stated Patient #7's husband monitored her oxygen saturations multiple times during the day, and would place her on oxygen according to her saturations. She stated she did not contact Patient #7's physician for additional</p>	G 159			

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G 159	Continued From page 52 oxygen therapy orders.	G 159			
G 160	<p>Patient #7's POC did not include orders for oxygen during her awake hours.</p> <p>484.18(a) PLAN OF CARE</p> <p>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.</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 a physician was consulted to approve the plan of care for 10 of 12 patients (#1, #2, #3, #5, #6, #8, #9, #10, #11, and #12) whose records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>a. Patient #2's record included a PT evaluation completed on 10/27/15, signed by the Physical Therapist. Patient #2's record did not include documentation of contact with his physician</p>	G 160		4/15/16	

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G 160	<p>Continued From page 53 following the PT evaluation, to obtain approval for his PT POC.</p> <p>Patient #2's record included a POC for the certification period 10/17/15 to 12/15/15, signed by his physician on 10/28/15. The POC included an order for PT visits twice a week for 6 weeks. However, the POC did not include PT interventions to be provided during the certification period. Patient #2's record included PT visits completed on 10/29/15, 11/03/15, 11/10/15, 11/12/15, 11/17/15, 11/19/15, 11/24/15, 11/27/15, 12/01/15, 12/03/15, and 12/15/15. However, his record did not include documentation of physician approval of his PT POC, including interventions to be provided, during the certification period.</p> <p>During an interview on 2/26/16 at 8:15 AM, the Physical Therapist reviewed Patient #2's PT evaluation, and confirmed there was no documentation of physician approval of his PT POC. Additionally, the Physical Therapist reviewed Patient #2's POC for the certification period 10/17/15 to 12/15/15, and confirmed it did not include PT interventions to be provided. He was unable to explain why PT interventions were not included on Patient #2's POC.</p> <p>Patient #2 received PT interventions without the approval of his physician.</p> <p>b. Patient #2's record included an SOC comprehensive assessment completed on 10/17/15, signed by the RN. Patient #2's record did not include documentation of contact with his physician following the assessment, to obtain approval for his SN POC.</p>	G 160			

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G 160	<p>Continued From page 54</p> <p>Patient #2's record included a POC for the certification period 10/17/15 to 12/15/15, signed by his physician on 10/28/15. However, his record included SN visit notes completed on 10/22/15 and 10/27/15, prior to physician approval of his POC.</p> <p>During an interview on 2/26/16 at 9:15 AM, the RN who completed Patient #2's SOC comprehensive assessment reviewed his record and confirmed she did not obtain physician approval for the SN POC following his SOC assessment.</p> <p>The agency failed to ensure Patient #2's physician approved his SN POC prior to providing additional SN visits.</p> <p>2. Patient #10 was a 7 year old male admitted to the agency on 1/24/16, for care related to gastroparesis (a disorder that slows or stops the movement of food from the stomach to the small intestine). Additional diagnoses included feeding disorder and management of a venous vascular device. He received SN services. His record, including the POC, for the certification period 1/24/16 to 3/23/16, was reviewed.</p> <p>Patient #10's record included an SOC comprehensive assessment completed on 1/24/16, signed by the RN Case Manager. Patient #10's record did not include documentation of contact with his physician following the assessment, to obtain approval of the POC.</p> <p>Patient #10's POC was signed by his physician on 2/22/16. However, SN visits were completed on 2/04/16, 2/11/16, and 2/17/16, prior to</p>	G 160			

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G 160	<p>Continued From page 55 physician approval of his POC.</p> <p>During an interview on 2/26/16 at 9:30 AM, the RN Case Manager reviewed Patient #10's record and confirmed she did not contact his physician to obtain approval for his POC.</p> <p>The agency failed to ensure Patient #10's physician approved his SN POC prior to providing additional SN visits.</p> <p>3. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's record included an SOC comprehensive assessment completed on 1/02/16, signed by the RN Case Manager. The assessment did not include documentation of physician contact to obtain approval for the SN POC. Patient #11's POC was signed by her physician on 1/07/16. However, SN visits were completed on 1/03/16 and 1/05/16, prior to receipt of physician approval of the POC.</p> <p>During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed the record and confirmed she did not contact Patient #11's physician to receive approval for the POC. She confirmed 2 SN visits were completed prior to receiving physician approval of the POC.</p> <p>The agency failed to ensure Patient #11's physician approved her SN POC prior to providing additional SN visits.</p>	G 160			

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G 160	Continued From page 56 4. Patient #12 was an 88 year old female admitted to the agency on 2/10/16, with a diagnosis of weakness. Additional diagnoses included arthritis, depression, and irritable bowel syndrome. She received SN, PT, OT, MSW, and Home Health Aide services. Her record, including the POC, for the certification period 2/10/16 to 4/09/16, was reviewed. a. Patient #12's record included an SOC comprehensive assessment completed on 2/10/16, signed by the Physical Therapist. The assessment did not include documentation of physician contact to obtain approval for the PT POC. Patient #12's POC was signed by her physician on 2/24/16. However, PT visits were completed on 2/15/16, 2/17/16 and 2/22/16, prior to receipt of physician approval of the POC. During an interview on 2/26/16 at 8:50 AM, the Physical Therapist reviewed Patient #12's record and confirmed there was no documentation of physician approval of the POC prior to 2/24/16. The agency failed to ensure Patient #12's physician approved her PT POC prior to providing additional PT visits. b. Patient #12's record included an SN assessment completed on 2/11/16, signed by the RN. The assessment did not include documentation of physician contact to obtain approval for the SN POC. Patient #12's POC was signed by her physician on 2/24/16. However, an SN visit was completed on 2/16/16, prior to receipt of physician approval of the POC. During an interview on 2/25/16 at 2:20 PM, the	G 160			

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G 160	<p>Continued From page 57</p> <p>RN reviewed the record and confirmed she did not contact Patient #12's physician to obtain approval of her SN POC.</p> <p>The agency failed to ensure Patient #12's physician approved her SN POC prior to providing additional SN visits.</p> <p>c. Patient #12's record included an OT assessment completed on 2/11/16, signed by the Occupational Therapist. The assessment did not include documentation of physician contact to obtain approval for the OT POC. Patient #12's POC was signed by her physician on 2/24/16. However, OT visits were completed on 2/15/16, 2/16/16, 2/18/16, and 2/23/16, prior to receipt of physician approval of her POC.</p> <p>During an interview on 2/25/16 at 1:10 PM, the Occupational Therapist reviewed the record and confirmed he did not contact Patient #12's physician to obtain approval of the OT POC.</p> <p>The agency failed to ensure Patient #12's physician approved her OT POC prior to providing additional OT visits.</p> <p>5. Patient #5 was a 66 year old female admitted to the agency on 2/02/16, for SN, PT, OT and home health aide services related to care after orthopedic surgery. Additional diagnoses included spinal stenosis, Type II DM, HTN, and chronic pain. Her record, including the POC, for the certification period 2/02/16 to 4/01/16, was reviewed.</p> <p>a. Patient #5's record included a PT evaluation completed on 2/03/16, signed by the Physical Therapist. Patient #5's record did not include</p>	G 160			

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G 160	<p>Continued From page 58</p> <p>documentation of contact with the physician following the PT evaluation, to obtain approval for his PT POC.</p> <p>Patient #5's record included a POC for the certification period 2/02/16 to 4/01/16, signed by her physician on 2/18/16. Patient #5's record included PT visits completed on 2/04/16 and 2/10/16, prior to physician approval of the POC.</p> <p>During an interview on 2/25/16 at 1:30 PM, the Director reviewed the record and confirmed there was no documentation of physician approval for the PT POC.</p> <p>The agency failed to ensure Patient #5's physician approved her PT POC prior to providing additional PT visits.</p> <p>b. Patient #5's record included an SOC comprehensive assessment completed on 2/02/16, and signed by the RN. Patient #5's record did not include documentation of contact with her physician following the assessment, to obtain approval for her SN POC.</p> <p>Patient #5's record included a POC for the certification period 2/02/16 to 4/01/16, signed by her physician on 2/18/16. However, her record included an SN visit note completed on 2/11/16, prior to physician approval of her POC.</p> <p>During an interview on 2/25/16 at 2:00 PM, the RN who completed the SOC assessment reviewed the record and confirmed she did not obtain approval for the SN POC following her assessment.</p> <p>The agency failed to ensure Patient #5's</p>	G 160			

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G 160	<p>Continued From page 59</p> <p>physician approved her SN POC prior to providing an additional SN visit.</p> <p>6. Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to cellulitis of the left lower leg. Additional diagnoses included pressure ulcer, atrial fibrillation, and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>a. Patient #8's record included an SOC comprehensive assessment completed on 12/12/15, and signed by the RN. Patient #8's record did not include documentation of contact with his physician following the assessment, to obtain approval for his SN POC.</p> <p>Patient #8's record included a POC for the certification period 12/12/15 to 2/09/16, signed by his physician on 1/05/16. However, his record included SN visit notes completed on 12/15/15, 12/21/15, 12/24/15, 12/28/15, and 1/04/16, prior to physician approval of his POC.</p> <p>During an interview on 2/26/16 at 8:40 AM, the RN who completed Patient #8's SOC assessment reviewed the record and confirmed she did not obtain approval for his SN POC following her assessment.</p> <p>The agency failed to ensure Patient #8's physician approved his SN POC prior to providing additional SN visits.</p> <p>b. Patient #8's record included a recertification comprehensive assessment completed on 2/08/16, and signed by the RN Case Manager. Patient #8's record did not include documentation</p>	G 160			

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G 160	<p>Continued From page 60</p> <p>of contact with his physician following the assessment, to obtain approval for his SN POC.</p> <p>Patient #8's record included a POC for the certification period 2/10/16 to 4/09/16, signed by his physician on 2/17/16. However, his record included SN visit notes completed on 2/11/16 and 2/16/16, prior to physician approval of his POC.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed Patient #8's record and confirmed she did not obtain physician approval for his SN POC following her assessment.</p> <p>The agency failed to ensure Patient #8's physician approved his SN POC prior to providing additional SN visits.</p> <p>7. Patient #1 was a 92 year old female who was admitted to the HHA on 10/10/15, for SN, OT, and PT services related to a UTI. Additional diagnoses included dementia and repeated falls. Patient #1's record, including her POC, for the certification period 10/10/15 to 12/08/15, was reviewed.</p> <p>Patient #1's record included a referral for home health services, dated 10/09/15. The referral included orders for SN, PT, OT and MSW to assess and evaluate. Her POC was signed on 10/29/15.</p> <p>a. An SOC comprehensive assessment was performed by the RN Case Manager on 10/10/15. Her record did not include documentation the RN contacted Patient #1's physician to develop a POC and secure orders for further visits.</p>	G 160		

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G 160	<p>Continued From page 61</p> <p>An SN Visit Note dated 10/12/15, included documentation the RN Case Manager provided an SN visit. However, her record did not include orders to authorize further visits.</p> <p>During an interview on 2/26/16 beginning at 9:00 AM, the PCC reviewed Patient #1's record and confirmed the RN Case Manager did not contact her physician for orders. She stated that often the clinician would perform the comprehensive assessment, develop the POC, then send the POC to the physician to be signed. The PCC confirmed a nursing visit was performed before the RN received orders for the visit.</p> <p>b. The Occupational Therapist performed an evaluation on 10/12/15. However, Patient #1's record did not include documentation her physician was contacted for further orders.</p> <p>Patient #1's record included an OT visit note dated 10/13/15, signed by the Occupational Therapist.</p> <p>During an interview on 2/25/16 beginning at 1:30 PM, the Occupational Therapist reviewed Patient #1's record and confirmed an OT visit was performed on 10/13/15, before therapy orders were received from her physician.</p> <p>Patient #1's physician was not contacted after initial nursing and therapy assessments to review her POC and secure orders for future visits.</p> <p>8. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC, for the certification period</p>	G 160			

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G 160	<p>Continued From page 62 1/25/16 to 3/24/16, was reviewed.</p> <p>a. Patient #3's record included an OT evaluation completed on 1/25/16, signed by the Occupational Therapist. Patient #3's record included a "Verbal Order," dated 1/25/16, received by the OT from a physician other than Patient #3's PCP. The order read: Occupational Therapy 3 wk 8 wk (three times a week for 8 weeks), Total visits 24. Start Date: 1/25/16, End Date: 3/19/16. However, the order was not from Patient #3's attending physician.</p> <p>Patient #3's record did not include documentation the Occupational Therapist received orders from Patient #3's attending physician following the OT evaluation, to obtain approval for her OT POC.</p> <p>Patient #3's record included a POC for the certification period 1/25/16 to 3/24/16, signed by her attending physician on 2/08/16, date stamped as received by the agency on 2/23/16. The POC included an order for OT visits three times weekly for 8 weeks.</p> <p>OT visits were provided to Patient #3 on the following dates before the POC was signed by her attending physician: 1/25/16, 1/27/16, 1/29/16, 2/01/16, 2/03/16, 2/05/16, 2/08/16, 2/10/16, 2/12/16, 2/17/16, 2/18/16 and 2/22/16.</p> <p>During an interview on 2/25/16 beginning at 1:20 PM, Patient #3's Occupational Therapist reviewed her record, and confirmed the physician he received a verbal order from was not Patient #3's attending physician. He was unable to determine if Patient #3's attending physician, who was listed on her POC, was notified of the OT POC before it was signed and returned on 2/23/16.</p>	G 160			

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G 160	Continued From page 63 b. A recertification assessment was performed on 1/20/16 by an RN. The documentation of physician notification did not indicate the assessment was performed for recertification with disciplines, frequency of visits, etc. The RN included in her notes that Patient #3's physician was contacted, however, her note stated the physician was contacted to report lab results. There were no orders written by the RN to continue with a new certification period. A POC for the certification period 1/25/16 to 3/24/16, was signed by Patient #3's physician and sent to the HHA on 2/01/16. An SN visit was performed on 1/26/16 , before the signed POC was received by the agency. c. The recertification assessment was performed on 1/20/16, however physician orders were not received for Home Health Aide visits. The signed POC was received by the agency on 2/01/16, and included Home Health Aide visit orders for twice weekly for 9 weeks. The Home Health Aide performed visits to Patient #3 on 1/26/16 and 1/28/16, before the physician signed POC was received by the agency. During an interview on 2/25/16 beginning at 4:30 PM, Patient #3's RN Case Manager reviewed her record and confirmed SN visits and Home Health Aide visits were performed prior to receiving signed physician orders. The HHA did not ensure Patient #3's physician was contacted after evaluations were completed to authorize her POC.	G 160			

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G 160	<p>Continued From page 64</p> <p>9. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16, for SN, OT, and PT services related to CHF, UTI, and history of falls. Patient #6's record, including her POC, for the certification period 1/08/16 to 3/07/16, was reviewed.</p> <p>An SOC comprehensive assessment was performed on 1/08/16. In the section of the assessment which read "Contact[s] Made as a Result of This Visit," the RN wrote "No one contacted as a result of this visit."</p> <p>Patient #6's record did not include orders for home health services. A physician signed POC dated as received 1/20/16, included orders for PT, SN, and OT services.</p> <p>An SN visit was performed on 1/14/16, prior to receipt of orders for HHA services.</p> <p>A PT evaluation was ordered with Patient #6's referral to home health. The PT evaluation visit was performed on 1/08/16.</p> <p>PT visits were performed on 1/12/16, 1/14/16, and 1/19/16, before a physician signed POC was received by the HHA.</p> <p>During an interview on 2/26/16 beginning at 10:20 AM, the RN Case Manager reviewed Patient #6's record and confirmed the above visits were performed before they were ordered by her physician.</p> <p>The HHA did not ensure Patient #6's physician was contacted to approve her POC.</p> <p>10. Patient #9 was an 88 year old male who was</p>	G 160			

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G 160	Continued From page 65 admitted to the HHA on 9/28/15, for SN, PT and Home Health Aide services related to a CVA. Additional diagnoses included DM Type II. Patient #9's record, including his POC for the certification period 1/26/16 to 3/25/16, was reviewed. A recertification assessment was performed on 1/25/16. The assessment did not include documentation Patient #9's physician was contacted regarding the POC for the next certification period, or to receive orders. The POC was signed by Patient #9's physician on 2/02/16, and documented as received on 2/04/16. a. An SN visit was completed on 1/29/16, prior to physician approval. b. Home Health Aide visits were completed on 1/26/16, and 1/29/16 prior to physician approval. During an interview on 2/26/16 beginning at 10:20 AM, the RN Case Manager reviewed Patient #9's record. She confirmed she did not contact Patient #9's physician after performing the recertification assessment. She stated she completed her assessment and the POC was created and sent to the physician to be signed. She stated she did not contact a physician after a recertification unless there were problems noted during that assessment. The HHA did not ensure Patient #9's physician was contacted to approve his POC following evaluation visits.	G 160			
G 161	484.18(a) PLAN OF CARE Orders for therapy services include the specific	G 161		4/15/16	

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G 161	<p>Continued From page 66</p> <p>procedures and modalities to be used and the amount, frequency, and duration.</p> <p>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 patients' POCs included the specific procedures and modalities to be used by therapists for 1 of 7 patients (Patient #2) who received therapy services and whose records were reviewed. This resulted in therapy services provided without specific physician authorization. Findings include:</p> <p>The agency's policy #3027, "Plan of Care," revised 2/17/16, stated "Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency and duration."</p> <p>Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #2's record included a POC for the certification period 10/17/15 to 12/15/15, signed by his physician on 10/28/15. The POC included an order for PT visits twice a week for 6 weeks. However, the POC did not include specific procedures and modalities to be used during his</p>	G 161			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2016	
NAME OF PROVIDER OR SUPPLIER VISIONS HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 PARK VIEW DRIVE TWIN FALLS, ID 83301		
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G 161	Continued From page 67 PT visits. During an interview on 2/26/16 at 8:15 AM, the Physical Therapist reviewed Patient #2's POC for the certification period 10/17/15 to 12/15/15, and confirmed it did not include PT interventions, procedures and modalities to be provided. He was unable to explain why PT interventions were not included on Patient #2's POC.	G 161		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of clinical records, policy review, and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 2 of 12 patients (#2 and #11) whose records were reviewed. This resulted in missed opportunities for the physician to alter patients' POCs to meet their needs. Findings include: The agency's policy #3002, "Coordination of Care," updated on 4/01/14, stated "Home Health staff will maintain on-going communication with the physician. This includes both verbal and written reports that address the following at a minimum: a. Any changes in the patient's	G 164		4/15/16

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G 164	<p>Continued From page 68 condition..."</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>The American College of Cardiology website, accessed on 3/01/16, 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."</p> <p>a. Patient #2's record included an SN visit note dated 12/06/15, signed by the LPN. An interdisciplinary communication note also dated 12/06/15, signed by the LPN, stated Patient #2 called to report shortness of breath. The LPN noted his right leg was swollen and he complained of bloating in his abdomen. Additionally, the LPN noted fine crackles in his left lung. These findings are consistent with symptoms of fluid build up in the body, possibly related to CHF. The LPN documented she encouraged Patient #2 to make an appointment with his physician, and to start weighing himself</p>	G 164			

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G 164	<p>Continued From page 69</p> <p>every day. The LPN's visit note stated she communicated with the RN Case Manager. However, there was no documentation the RN Case Manager contacted Patient #2's physician to report the change in his condition.</p> <p>The next visit documented in Patient #2's record was an ROC comprehensive assessment dated 12/13/15, signed by the RN Case Manager. The assessment did not state the reason his care was being resumed. However, a PT visit note dated 12/15/15, signed by the Physical Therapist, stated "Patient came home from hospital over the weekend, was admitted due to reported CHF exacerbation with fluid overload and SOB [shortness of breath]. Documentation of the date he was admitted to the hospital was not found in his record.</p> <p>During an interview on 2/25/16 at 4:30 PM, the RN Case Manager reviewed Patient #2's record and stated she did not remember receiving a call from the LPN regarding Patient #2's change in condition. She confirmed she did not communicate with Patient #2's physician. She stated she did not know when Patient #2 went to the hospital.</p> <p>b. Patient #2's record did not include documentation stating he was instructed to weigh himself daily to monitor for fluid build up related to his congestive heart failure. However, SN visits recorded his weight as follows:</p> <p>-1/12/16 189 pounds -1/21/16 195 pounds -1/26/16 197 pounds -2/03/16 198 pounds</p>	G 164			

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G 164	<p>Continued From page 70</p> <p>Patient #2 experienced a 6 pound weight gain in 9 days. His record did not include documentation of physician contact to report his weight gain. His weight continued to increase slightly over the next 2 weeks, increasing by 9 pounds in 3 weeks. There was no documentation stating his physician was notified of his weight gain. Patient #2 was discharged from SN services on 2/03/16.</p> <p>During an interview on 2/25/16 at 4:00 PM, the LPN who completed Patient #2's SN discharge visit stated she did not notify Patient #2's RN Case Manager of his weight gain. She confirmed Patient #2's physician was not notified of his weight gain.</p> <p>Patient #2's physician was not notified of changes in his condition.</p> <p>2. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's SN visit notes dated 1/03/16, 1/11/16, and 1/17/16, included measurements of her sacral wound. Each note included the length, width and depth of the surface wound, 1 measurement of undermining (a wider area of wound that lies beneath the wound opening) and 1 measurement of tunneling (a channel that extends from a wound into subcutaneous tissue or muscle). However, an SN visit note dated 1/29/16, signed by the RN Case Manager, included measurements of the surface wound, 2 measurements of undermining, and 2</p>	G 164			

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G 164	Continued From page 71 measurements of tunneling. Patient #11's record did not include documentation stating her physician was notified of the new undermining and tunnel identified in her wound. During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed the record and confirmed she did not notify Patient #11's physician of the change in her wound. The agency failed to ensure Patient #11's physician was notified of the new undermining and tunnel identified in her wound.	G 164			
G 165	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, policy review, and staff interview it was determined the agency failed to ensure drugs and treatments were administered only as ordered by the physician for 2 of 12 patients (Patient #8 and #11) 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: The agency's policy #3027, "Plan of Care," revised 2/17/16, stated "Drugs and treatments are administered by agency staff only as ordered by the physician." 1. Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related	G 165		4/15/16	

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G 165	<p>Continued From page 72</p> <p>to cellulitis of the left lower leg. Additional diagnoses included pressure ulcer, atrial fibrillation, and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>a. Patient #8's record included an SOC comprehensive assessment completed on 12/12/15, and signed by the RN. The assessment stated Patient #8 had 2 diabetic ulcers located on his left ankle and arch of the left foot. The RN documented he had cellulitis (a bacterial infection, often associated with redness, swelling and warmth) of his left leg from his knee to his toes. Patient #8 was admitted to the HHA for cellulitis of his left leg on 12/12/15</p> <p>Patient #8's SOC comprehensive assessment stated wound care was required by the clinician and was performed at the visit. Additionally, the assessment listed adhesive surgical dressing and Kerlix wrap as wound care supplies.</p> <p>SN visit notes, dated 12/15/15, 12/21/15, 12/24/15, 12/28/15, 1/04/16, 1/07/16, 1/12/16, 1/14/16, 1/21/16, 1/25/16, 1/28/16, 2/01/16, and 2/04/16, documented wound care and dressing changes were performed.</p> <p>Patient #8's record did not include orders for wound care.</p> <p>b. Patient #8's record included a recertification comprehensive assessment completed on 2/08/16, and signed by the RN Case Manager. The assessment stated Patient #8 had a diabetic ulcer on the arch of his left foot. The RN Case Manager documented wound care and a dressing change was performed during the visit.</p>	G 165		

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G 165	<p>Continued From page 73</p> <p>SN visit notes dated 2/11/16, 2/16/16, and 2/19/16, documented wound care and dressing changes were performed.</p> <p>Patient #8's POC, dated 2/10/16, did not include orders for wound care.</p> <p>During an interview on 2/26/16 at 8:40 AM, the RN who completed the SOC assessment reviewed the record and confirmed Patient #8 had 2 diabetic ulcers and cellulitis of his left lower extremity. The RN confirmed the POC did not include orders for wound care.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed the record and confirmed she performed wound care at each of her visits. She confirmed the POCs dated 12/12/15 and 2/10/16, did not include orders for wound care.</p> <p>Patient #8's wound care and dressing changes were administered without a physician order.</p> <p>2. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's record included a physician's order, dated 12/21/15. The order stated "Sacral Decubitus - wet to dry dressing change (normal saline) once daily."</p> <p>Patient #11's record included a referral order,</p>	G 165			

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G 165	<p>Continued From page 74</p> <p>dated 12/31/15, for SN to assess for wound management. The referral order did not include specific wound care orders. Patient #11's HH care was initiated on 1/02/16.</p> <p>Patient #11's record included an SOC Comprehensive assessment completed on 1/02/16, signed by the RN Case Manager. Patient #11's record did not include documentation of contact with her physician following her SOC assessment to obtain orders for wound care, including frequency of wound dressing changes.</p> <p>Patient #11's record documented SN visits on 1/03/16, 1/05/16, and 1/08/15, during the first week of her certification period. There was no documentation in Patient #11's record stating how wound care would be completed on the days the SN did not visit. No SN visits were documented on 1/04/16, 1/06/16, or 1/07/16. Daily visits were initiated on 1/08/16.</p> <p>During an interview on 2/26/16 at 12:20 PM, the RN PCC stated the prescription for daily wound care was given to Patient #11 during a physician office visit. Patient #11 presented the order to the agency on 12/31/15. The agency called the physician on 12/31/15, and received an order for SN to assess for wound management, but did not obtain an order for specific wound care, including frequency of dressing changes. The PCC confirmed specific wound care orders were not obtained from Patient #11's physician following her SOC assessment. She was unable to explain how the frequency of SN visits was determined, and confirmed the wound care was not provided daily as ordered on the physician's order presented to the agency on 12/31/15.</p>	G 165			

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G 165	Continued From page 75	G 165			
G 166	<p>Patient #11 did not receive daily wound care as ordered by her physician.</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>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.</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 verbal orders were put in writing by an RN or qualified therapist for 4 of 12 patients (#7, #10, #11, and #12) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include:</p> <p>1. Patient #7 was an 88 year old female who was admitted to the HHA on 5/04/15, for SN services related to a CVA. Additional diagnoses included major depressive disorder, weakness, and chronic kidney disease. Patient #7's record, including her POC, for the certification period 12/30/15 to 2/27/16, was reviewed.</p> <p>Patient #7's record included verbal orders recieved from a physician by an LPN as follows:</p> <p>- 1/06/16, verbal orders for medication changes, signed by her physician on 1/08/16.</p>	G 166		4/15/16	

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G 166	<p>Continued From page 76</p> <ul style="list-style-type: none"> - 1/06/16, verbal orders for SN visit frequency orders, signed by her physician on 1/08/16. - 1/12/16, verbal orders for Coumadin dose change, signed by her physician on 1/25/16. - 1/26/16, verbal orders for Coumadin dose change, signed by her physician on 2/05/16. <p>During an interview on 2/25/16 at 4:20 PM, the RN Case Manager reviewed Patient #11's record and confirmed the LPN received verbal orders from the physician.</p> <p>The agency failed to ensure verbal orders were taken by an RN or qualified therapist.</p> <p>2. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's record included a verbal order, received on 2/06/16, for a new antibiotic. The order was signed by an LPN.</p> <p>During an interview on 2/25/16 at 3:40 PM, the LPN reviewed Patient #11's record and confirmed she took the verbal order from the Physician, then called the pharmacy to order the antibiotic.</p> <p>The agency failed to ensure verbal orders were taken by an RN or qualified therapist.</p> <p>3. Patient #10 was a 7 year old male admitted to the agency on 1/24/16, for care related to</p>	G 166			

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G 166	<p>Continued From page 77</p> <p>gastroparesis (a disorder that slows or stops the movement of food from the stomach to the small intestine). Additional diagnoses included feeding disorder and management of a venous vascular device. He received SN services. His record, including the POC, for the certification period 1/24/16 to 3/23/16, was reviewed.</p> <p>Patient #10's record included a verbal order, received on 1/24/16, for SN services to assess and admit to HH. The order was signed by an LPN.</p> <p>During an interview on 2/26/16 at 10:30 AM, the PCC reviewed the order and confirmed it was taken by an LPN.</p> <p>The agency failed to ensure verbal orders were taken by an RN or qualified therapist.</p> <p>4. Patient #12 was an 88 year old female admitted to the agency on 2/10/16, with a diagnosis of weakness. Additional diagnoses included arthritis, depression, and irritable bowel syndrome. She received SN, PT, OT, MSW, and Home Health Aide services. Her record, including the POC, for the certification period 2/10/16 to 4/09/16, was reviewed.</p> <p>Patient #12's record included a verbal order, received on 1/24/16, for PT to assess and admit to HH. The order was signed by an LPN.</p> <p>During an interview on 2/26/16 at 10:15 AM, the PCC reviewed the order and confirmed it was taken by an LPN.</p> <p>The agency failed to ensure verbal orders were taken by an RN or qualified therapist.</p>	G 166		

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G 168	<p>484.30 SKILLED NURSING SERVICES</p> <p>This CONDITION is not met as evidenced by: Based on record review, policy review, observation, patient/caregiver interview and staff interview, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the POC and consistent with patients' needs, patients' needs were regularly re-evaluated, and failed to ensure patients received comprehensive assessments. This negatively impacted quality, coordination, and safety of patient care. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G169 as it relates to the failure of the agency to ensure SN services were provided by or under the supervision of an RN. 2. Refer to G170 as it relates to the failure of the agency to ensure skilled nursing services were furnished in accordance with the plan of care. 3. Refer to G172 as it relates to the failure of the agency to ensure the patients' nursing needs were regularly re-evaluated. 4. Refer to G173 as it relates to the failure of the agency to ensure nursing staff developed and updated POCs to meet patients' medical and nursing needs. 5. Refer to G176 as it relates to the agency's failure to ensure that staff informed the physician and other members of the health care team of changes in patients' conditions. 6. Refer to G177 as it relates to the failure of the agency to ensure the registered nurse counseled 	G 168		4/15/16

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G 168	Continued From page 79 patients and families in meeting nursing and related needs. 7. Refer to G331 as it relates to the failure of the agency to ensure an RN completed a comprehensive assessment to determine the needs of the patient. 8. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment completed by the RN included a medication review to obtain a current list of patient medications, evaluation of drug interactions, identification of possible significant side effects or noncompliance, and reconciliation of the medications with the physician. 9. Refer to G338 as it relates to the failure of the agency to ensure the comprehensive assessment was updated and revised by the RN as frequently as the patient's conditions warranted. The cumulative effects of these negative practices seriously impeded the ability of the agency to provide services of sufficient scope and quality.	G 168			
G 169	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services by or under the supervision of a registered nurse. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure sufficient RN supervision of LPN skilled nursing services for 1 of 6 patients (Patient #2) who received SN services from LPNs. This had the	G 169		4/15/16	

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G 169	<p>Continued From page 80</p> <p>potential to negatively impact quality and coordination of patient care. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #2's record included an SN visit note dated 1/26/16, signed by an RN. The note documented a BG level of 176 mg/dl from 2 days prior. The note stated Patient #2 said he did not always check his BG levels or take his insulin as ordered. It stated he last checked his BG level 2 days ago. Additionally, it stated he did not take his sliding scale insulin as ordered. The American Diabetes Association defines sliding scale as a set of instructions for adjusting insulin on the basis of blood glucose test results, meals, or activity levels. Patient #2's record did not include orders for sliding scale insulin. The note documented patient education related to BG monitoring, and complications of DM. However, it did not specify instructions for his sliding scale insulin. SN visit notes prior to 1/26/16, did not include documentation of patient education related to BG monitoring or sliding scale insulin.</p> <p>The next SN visit was completed by the LPN on 2/03/16. The SN visit note stated Patient #2's recent BG levels ranged from 77-368. The American Diabetes Association website,</p>	G 169			

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G 169	<p>Continued From page 81</p> <p>accessed 3/01/16, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl. The note did not state whether Patient #2 was taking his daily or sliding scale insulin as ordered. Additionally, it did not document patient education related to DM, insulin or complications of DM.</p> <p>Patient #2's record included an interdisciplinary communication note dated 2/03/16, and signed by the LPN. It stated Patient #2 was ready to be discharged from SN services. The note stated the LPN discussed the importance of checking BG levels. Additionally, it stated he took his meds and insulin "as he sees fit." SN visit notes prior to 2/03/16, did not include documentation of lack of compliance with medication management, or education related to medication management. Patient #2's record did not include documentation stating the LPN spoke with an RN regarding concerns related to medication management, or his discharge from SN. No additional SN visits were documented.</p> <p>During an interview on 2/26/16 at 8:15 AM, the Physical Therapist reviewed Patient #2's record. He stated the RN Case Manager was on an extended leave, and the LPN took over Patient #2's care.</p> <p>During an interview on 2/25/16 at 4:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed there was no documentation an RN was consulted regarding his discharge from SN services. She confirmed that based on the information in the 1/26/16 LPN visit note, Patient #2 required additional education and was not ready for discharge from SN services.</p> <p>Patient #2 SN services, and discharge from SN</p>	G 169			

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G 169	Continued From page 82	G 169		
G 170	services, were not supervised by an RN. 484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure SN services were furnished in accordance with the POC for 3 of 12 patients (#6, #8, and #11) who received SN services and whose records were reviewed. This resulted in patients not receiving skilled services as ordered, and unauthorized treatments being performed, and had the potential for negative patient outcomes. Findings include: 1. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed. Patient #11's record included a physician's order, dated 12/21/15. The order stated "Sacral Decubitus - wet to dry dressing change (normal saline) once daily." Patient #11's record included a referral order, dated 12/31/15, for SN to assess for wound management. The referral order did not include specific wound care orders. Patient #11's HH care was initiated on 1/02/16.	G 170		4/15/16

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G 170	<p>Continued From page 83</p> <p>Patient #11's record included an SOC comprehensive assessment completed on 1/02/16, signed by the RN Case Manager. Patient #11's record did not include documentation of contact with her physician following her SOC assessment to obtain orders for wound care, including frequency of wound dressing changes.</p> <p>Patient #11's record documented SN visits on 1/03/16, 1/05/16, and 1/08/15, during the first week of her certification period. There was no documentation in Patient #11's record stating how wound care would be completed on the days the SN did not visit. No SN visits were documented on 1/04/16, 1/06/16, or 1/07/16. Daily visits were initiated on 1/08/16.</p> <p>During an interview on 2/26/16 at 12:20 PM, the PCC stated the prescription for daily wound care was given to Patient #11 during a physician office visit. Patient #11 presented the order to the agency on 12/31/15. The agency called the physician on 12/31/15, and received an order for SN to assess for wound management, but did not obtain an order for specific wound care, including frequency of dressing changes. The PCC confirmed specific wound care orders were not obtained from Patient #11's physician following her SOC assessment. She was unable to explain how the frequency of SN visits was determined, and confirmed the wound care was not provided daily as ordered on the physician's order presented to the agency on 12/31/15.</p> <p>Patient #11 did not receive daily wound care as ordered by her physician.</p> <p>2. Patient #8 was a 56 year old male admitted to</p>	G 170			

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G 170	<p>Continued From page 84</p> <p>the agency on 12/12/15, for SN services related to cellulitis of the left lower leg. Additional diagnoses included pressure ulcer, atrial fibrillation, and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>a. An SN recertification assessment dated 2/08/16, and signed by the RN Case Manager, documented Patient #8 had diabetes in which the symptoms were controlled with difficulty, the disease affected his daily functioning, and needed ongoing monitoring.</p> <p>Patient #8's POC, dated 2/10/16, included a diagnosis of Type II DM. His POC included orders for the SN to assess for diabetic complications.</p> <p>Patient #8's record included SN visit notes completed on 2/11/16, 2/16/16, and 2/19/16. The 3 SN visit notes did not include BG levels. Additionally, the notes did not include documentation of patient education related to diabetic complications.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed Patient #8's record and confirmed she did not check his BG levels because he did not have a glucometer. She confirmed there was no documentation of education related to DM or diabetic complications.</p> <p>The SN did not perform diabetic assessments as ordered on his POC.</p> <p>b. Patient #8's record included an SOC comprehensive assessment completed on</p>	G 170			

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G 170	<p>Continued From page 85</p> <p>12/12/15, and signed by the RN. The assessment stated Patient #8 had 2 diabetic ulcers located on his left ankle and arch of the left foot. The RN documented he had cellulitis (a bacterial infection, often associated with redness, swelling and warmth) of his left leg from his knee to his toes.</p> <p>The SOC comprehensive assessment stated wound care was required by the clinician and was performed at the visit. Additionally, the assessment listed adhesive surgical dressing and Kerlix wrap as wound care supplies.</p> <p>SN visit notes, dated 12/15/15, 12/21/15, 12/24/15, 12/28/15, 1/04/16, 1/07/16, 1/12/16, 1/14/16, 1/21/16, 1/25/16, 1/28/16, 2/01/16, and 2/04/16, documented wound care and dressing changes were performed.</p> <p>Patient #8's POC, dated 12/12/15, did not include orders for wound care. Additionally, wound care supplies were not listed under DME and supplies.</p> <p>Patient #8's record included a recertification comprehensive assessment completed on 2/08/16, and signed by the RN Case Manager. The assessment stated Patient #8 had a diabetic ulcer on the arch of his left foot. The RN Case Manager documented wound care and a dressing change was performed during the visit.</p> <p>SN visit notes, 2/11/16, 2/16/16, and 2/19/16, documented wound care and dressing changes were performed.</p> <p>Patient #8's POC, dated 2/10/16, did not include orders for wound care.</p>	G 170			

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G 170	<p>Continued From page 86</p> <p>During an interview on 2/26/16 at 8:40 AM, the RN who completed the SOC assessment reviewed the record and confirmed Patient #8 had 2 diabetic ulcers and cellulitis of his left lower extremity. She confirmed wound care was performed during the visit and wound supplies were documented in the assessment note. The RN confirmed the POC did not include orders for wound care or list wound care supplies.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed the record and confirmed she performed wound care at each of her visits. She confirmed the POCs dated 12/12/15 and 2/10/16 did not include orders for wound care.</p> <p>The SN performed wound care without orders.</p> <p>c. Patient #8's POC, dated 12/12/15, included orders for SN visits 2 times a week for 1 week, 3 times a week for 2 weeks, 2 times a week for 3 weeks, and 1 time a week for 1 week, effective the week of 12/15/15. SN visits were not completed as ordered. Examples include:</p> <ul style="list-style-type: none"> - During week 1, 12/13/15 to 12/19/15, 3 SN visits were ordered. An SN visit was completed on 12/15/15, and a missed SN visit was documented on 12/17/15. Patient #8's record did not include a 3rd SN visit for the week. - During week 2, 12/20/15 to 12/26/15, 3 SN visits were ordered. SN visits were completed on 12/21/15 and 12/24/15. Patient #8's record did not include a 3rd SN visit for the week, or documentation of a missed visit. - During week 6, 1/17/16 to 1/23/16, 2 SN visits 	G 170			

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G 170	Continued From page 87 were ordered. An SN visit was completed on 1/21/16. Patient #8's record did not include a 2nd SN visit for the week, or documentation of a missed visit. During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed the record and confirmed SN visits were not completed as ordered on his POC. Patient #8's POC was not followed as ordered for SN visit frequency. 3. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16 for SN, OT, and PT services related to CHF, UTI, and history of falls. Patient #6's record, including her POC for the certification period 1/08/16 to 3/07/16, was reviewed. Patient #6's POC included SN visits once weekly for 6 weeks. Her record did not include an SN visit for week 4 of her certification period (1/24/16 to 1/30/16). During an interview on 2/26/16 beginning at 10:20 AM, the RN Case Manager reviewed Patient #6's record and confirmed an SN visit was not performed during week 4. The RN Case Manager stated she did not document the missed visit, and Patient #6's physician was not notified. Patient #6 did not receive SN visits as ordered on her POC.	G 170			
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the	G 172		4/15/16	

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G 172	<p>Continued From page 88 patients nursing needs.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure the SN re-evaluated the nursing needs for 2 of 12 patients (#2 and #11) whose records were reviewed. This had the potential to result in unmet patient needs and to negatively impact the quality of patient care. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #2's record included a ROC comprehensive assessment dated 12/13/15, signed by the RN Case Manager. The assessment did not state the reason his care was being resumed. However, a PT visit note dated 12/15/15, signed by the Physical Therapist stated "Patient came home from hospital over the weekend, was admitted due to reported CHF exacerbation with fluid overload and SOB [shortness of breath].</p> <p>Patient #2 was recertified for an additional certification period beginning 12/16/15. His record included a POC for the certification period 12/16/15 to 2/13/16. His new POC included CHF</p>	G 172			

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G 172	<p>Continued From page 89</p> <p>as his primary diagnosis. However, the POC did not include patient assessment or education related to CHF.</p> <p>During an interview on 2/25/16 at 4:40 PM, the RN Case Manager confirmed Patient #2 was hospitalized for exacerbation of CHF. Additionally, she confirmed his POC for the certification period 12/16/15 to 2/13/16, did not include interventions related to CHF.</p> <p>The agency failed to ensure Patient #2's nursing needs were evaluated and met.</p> <p>2. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's record included an SN visit note completed on 2/05/16, signed by the RN Case Manager. The note stated Patient #11 was experiencing diarrhea related to her IBS (irritable bowel syndrome). The note stated Patient #11 complained of fatigue due to the diarrhea. The RN stated she cleaned stool off her buttocks prior to performing wound care on her sacral wound. This indicated a risk of contamination of her wound with stool.</p> <p>An SN visit note dated 2/06/16, signed by the LPN, included an assessment of her GI status. It stated her stools were watery and she was experiencing incontinence of stool.</p> <p>SN visit notes dated 2/07/16, and 2/09/16, signed</p>	G 172		

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G 172	Continued From page 90 by the LPN, did not include an assessment of her GI status. There was no information to determine if her diarrhea continued or had resolved. An SN visit was not completed on 2/08/16. SN visit notes dated 2/10/16, 2/11/16, and 2/12/16, signed by the RN Case Manager, did not include an assessment of her GI status. There was no information to determine if her diarrhea continued or had resolved. During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed Patient #11's record and confirmed her GI status was not assessed following her episode of diarrhea caused by IBS. Additionally, she confirmed diarrhea placed Patient #11 at increased risk of wound infection due to the location of her wound.	G 172		
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, observation, 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 7 of 12 patients (#2, #3, #5, #6, #8, #10, and #11), whose records were reviewed. This resulted in incomplete POCs and a lack of assessment and patient/caregiver education relevant to patient needs, and negatively	G 173		4/15/16

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G 173	<p>Continued From page 91</p> <p>impacted the quality of patient care. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>a. Patient #2's POC, developed by the RN, for the certification period 10/17/15 to 12/15/15, did not include all interventions necessary to meet his needs. Examples include:</p> <p>i. Patient #2's POC included a diagnosis of DM. However, his POC did not include interventions related to DM, such as assessment of his BG levels, or patient education regarding DM.</p> <p>ii. Patient #2's POC included a diagnosis of CHF. However, his POC did not include interventions related to CHF, such as assessment of his cardiac status, or patient education regarding CHF.</p> <p>iii. Patient #2's POC included a diagnosis of non-pressure chronic skin ulcer. His SOC comprehensive assessment completed on 10/17/15, signed by the RN, referred to the ulcer as a Stage 2 pressure ulcer. However, his POC did not include interventions related to care of his ulcer.</p>	G 173			

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G 173	<p>Continued From page 92</p> <p>iv. Patient #2's POC included a diagnosis of atrial fibrillation, requiring Coumadin (anticoagulant) to prevent blood clots. However, his POC did not include patient education related to anticoagulant therapy, or PT/INR blood tests used to monitor individuals taking Coumadin, to determine whether they are taking the correct dosage.</p> <p>v. Patient #2's SOC comprehensive assessment completed on 10/17/15, signed by the RN, stated he used a BG monitor to test his BG levels. However, his POC did not include a BG monitor.</p> <p>vi. Patient #2's SOC comprehensive assessment stated he was on an 1800 calorie ADA prescribed diet. However, his POC stated he was on a regular (no restrictions) diet.</p> <p>vii. Patient #2's SOC comprehensive assessment stated his physician ordered POC would include specific parameters for notifying his physician of changes in vital signs or other clinical findings. However, his POC did not include parameters to direct his clinicians to notify his physician of findings outside of the normal range.</p> <p>viii. Patient #2's SOC comprehensive assessment stated his physician ordered POC would include diabetic foot care including monitoring for skin lesions, and patient education on proper foot care. However, his POC did not include interventions related to diabetic foot care.</p> <p>ix. Patient #2's SOC comprehensive assessment included the MAHC-10 Fall Risk Assessment, a validated tool to assess risk of falling in community dwelling elders, on which a score of 4 or more is considered at risk for falling. Patient</p>	G 173			

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G 173	<p>Continued From page 93</p> <p>#2's score was 6. However, his POC did not include interventions related to his risk of falling.</p> <p>x. Patient #2's SOC comprehensive assessment stated he was at risk of developing pressure ulcers. However, his POC did not include interventions or patient education to prevent pressure ulcers.</p> <p>xi. Patient #2's SOC comprehensive assessment included a pain assessment. It noted his pain level ranged from 2 to 9, on a scale of 0 to 10, with 10 indicating the worst pain. Additionally, it stated his pain was controlled with a narcotic analgesic, and he had taken 2 doses of the analgesic in the last 24 hours. However, his POC did not include a narcotic analgesic, or interventions to monitor and mitigate his pain.</p> <p>b. Patient #2 was recertified for an additional certification period following a hospitalization. Patient #2's POC, developed by the RN, for the certification period 12/16/15 to 2/13/16, did not include all interventions necessary to meet his needs. Examples include:</p> <p>i. Patient #2's ROC comprehensive assessment dated 12/13/15, signed by his RN Case Manager, stated he was hospitalized for heart failure. It stated his heart failure required a changed treatment regimen.</p> <p>Patient #2's PT visit note, dated 12/15/15, signed by the Physical Therapist, stated he was discharged from the hospital following an admission due to CHF exacerbation with fluid overload and shortness of breath.</p> <p>Patient #2's POC for the certification period</p>	G 173		

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G 173	<p>Continued From page 94</p> <p>12/16/15 to 2/13/16 included a primary diagnosis of heart failure. However, his POC did not include interventions related to heart failure. There were no orders to assess his cardiac status, or educate him regarding heart failure.</p> <p>ii. Patient #2's POC included a diagnosis of DM. However, his POC did not include interventions related to DM, such as assessment of his BG levels, or patient education regarding DM.</p> <p>iii. Patient #2's POC included a diagnosis of CHF. However, his POC did not include interventions related to CHF, such as assessment of his cardiac status, or patient education regarding CHF.</p> <p>iv. Patient #2's POC included a diagnosis of non-pressure chronic skin ulcer. However, his POC did not include interventions related to care of his ulcer.</p> <p>v. Patient #2's POC included a diagnosis of atrial fibrillation, requiring Coumadin (anticoagulant) to prevent blood clots. However, his POC did not include patient education related to anticoagulant therapy, or PT/INR blood tests used to monitor individuals taking Coumadin, to determine whether they are taking the correct dosage.</p> <p>During an interview on 2/25/16 at 4:30 PM, the RN Case Manager reviewed Patient #2's record and POCs. She confirmed the POCs did not include pertinent interventions related to CHF, DM, atrial fibrillation, skin ulcer, fall risk or pressure ulcer prevention. Additionally, she confirmed the POCs did not include his BG monitor, narcotic analgesic, prescribed diet, or patient specific parameters for reporting to his</p>	G 173		

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G 173	<p>Continued From page 95 physician.</p> <p>Patient #2's POC, initiated and revised by the RN, was not comprehensive to include all services, interventions, medications, treatments and supplies required for his care.</p> <p>2. Patient #10 was a 7 year old male admitted to the agency on 1/24/16, for care related to gastroparesis (a disorder that slows or stops the movement of food from the stomach to the small intestine). Additional diagnoses included feeding disorder and management of a venous vascular device. He received SN services. His record, including the POC, for the certification period 1/24/16 to 3/23/16, was reviewed.</p> <p>Patient #10's POC, developed by the RN, for the certification period 1/24/16 to 3/23/16, did not include all interventions necessary to meet his needs. Examples include:</p> <p>a. Patient #10's SOC assessment completed on 1/24/16, signed by the RN Case Manager, stated he had a gastrostomy tube (a tube inserted through the abdomen to deliver nutrition feedings directly to his stomach). A home visit was made on 2/24/16 at 10:00 AM, to observe an SN visit. During the visit Patient #10's mother was observed preparing and administering a feeding through his tube. However, his POC did not include the nutritional feedings given through the tube.</p> <p>b. During the home visit, an "Oxygen in Use" sign was noted on the front door. Patient #10's mother stated he used oxygen as needed. However, oxygen was not included on Patient #10's POC. Additionally, his POC did not include</p>	G 173			

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G 173	<p>Continued From page 96 interventions to assess his respiratory status.</p> <p>c. During the home visit, Patient #10's mother stated he had a monitor that was used overnight to assess his heart rate and oxygen saturation level. However, the monitor was not included on Patient #10's POC.</p> <p>During an interview on 2/26/16 at 9:30 AM, the RN Case Manager reviewed Patient #10's record and confirmed his POC did not include his tube feedings, oxygen, or monitor, or assessment of his respiratory status.</p> <p>Patient #10's POC, initiated by the RN, was not comprehensive to include all interventions and equipment required for his care.</p> <p>3. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's POC, developed by the RN, for the certification period 1/02/16 to 3/01/16, did not include all interventions necessary to meet his needs. Examples include:</p> <p>a. Patient #11's POC included a diagnosis of pressure ulcer. Her SOC comprehensive assessment completed on 1/02/16, signed by the RN Case Manager, stated she had a Stage 4 pressure ulcer. Her POC included an order to treat her wound. However, it did not include specific wound care to be provided, including wound care products to be used.</p>	G 173			

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G 173	<p>Continued From page 97</p> <p>b. Patient #11's SOC comprehensive assessment stated her physician ordered POC would include specific parameters for notifying her physician of changes in vital signs or other clinical findings. However, her POC did not include parameters to direct her clinicians to notify her physician of findings outside of the normal range.</p> <p>c. Patient #11's SOC comprehensive assessment included the MAHC-10 Fall Risk Assessment, on which a score of 4 or more is considered at risk for falling. Patient #11's score was 6. However, her POC did not include interventions related to her risk of falling.</p> <p>d. Patient #11's SOC comprehensive assessment stated she was at risk of developing additional pressure ulcers. However, her POC did not include interventions or patient education to prevent pressure ulcers.</p> <p>e. Patient #11's SOC comprehensive assessment stated she had a Stage 4 pressure ulcer. A visit was made to Patient #11's home on 2/24/16 at 4:00 PM to observe an LPN visit. During the visit, Patient #11 stated her usual weight was 100-104 pounds. She stated her current weight was 92 pounds. She was concerned about her weight loss.</p> <p>The National Institutes for Health website, accessed 3/02/16, contained an article titled "Understanding the role of nutrition and wound healing." The article stated "Optimal wound healing requires adequate nutrition...Malnourished patients can develop pressure ulcers, infections, and delayed wound</p>	G 173		

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G 173	<p>Continued From page 98 healing that result in chronic nonhealing wounds."</p> <p>Patient #11's POC did not include assessment of her weight or nutritional intake, or patient education related to nutrition and wound healing.</p> <p>During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed Patient #11's record and stated nutrition assessment and education was pertinent to her care. She confirmed Patient #11's POC did not include interventions related to nutrition.</p> <p>Patient #11's POC was not comprehensive to include all interventions required for her care.</p> <p>4. Patient #5 was a 66 year old female admitted to the agency on 2/02/16, for SN, PT, OT and home health aide services related to care after orthopedic surgery. Additional diagnoses included spinal stenosis, Type II DM, HTN, and chronic pain. Her record, including the POC, for the certification period 2/02/16 to 4/01/16, was reviewed.</p> <p>a. Patient #5's record included a SOC comprehensive assessment completed on 2/02/16, and signed by the RN. The POC, developed by the RN, for the certification period 2/02/16 to 4/01/16, did not include all interventions necessary to meet her needs. Examples include:</p> <p>i. Patient #5's SOC comprehensive assessment stated her physician ordered POC would include specific parameters for notifying her physician of changes in vital signs or other clinical findings. However, her POC did not include parameters to direct her clinicians to notify her physician of</p>	G 173			

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G 173	<p>Continued From page 99 findings outside of the normal range.</p> <p>ii. The SOC comprehensive assessment stated Patient #5's physician ordered POC would include diabetic foot care including monitoring for skin lesions, and patient education on proper foot care. However, her POC did not include interventions related to diabetic foot care.</p> <p>iii. The SOC comprehensive assessment stated Patient #5's physician ordered POC would include interventions for depression, which included medications, referral for treatment, or a monitoring plan for current treatment. Patient #5's medication list included Duloxetine and Trazodone, anti-depressant medications. However, her POC did not include interventions related to depression.</p> <p>iv. The SOC comprehensive assessment stated Patient #5 had Type II DM. However, her POC did not include interventions for monitoring her BG levels or education regarding DM.</p> <p>v. The SOC comprehensive assessment stated Patient #5 used a CPAP device (Continuous Positive Airway Pressure) for sleep apnea. However, the CPAP was not included on her POC.</p> <p>vi. The SOC comprehensive assessment stated Patient #5 had HTN which was controlled with difficulty, affected daily functioning, and needed ongoing monitoring. However, her POC did not include interventions for cardiovascular monitoring and education.</p> <p>During an interview on 2/25/16 at 2:00 PM, the RN who completed the SOC comprehensive</p>	G 173			

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G 173	<p>Continued From page 100</p> <p>assessment reviewed the record. She confirmed the POC did not include all SN interventions necessary for her care.</p> <p>Patient #5's POC was not comprehensive to include all interventions, treatments, and supplies required for her care.</p> <p>b. A home visit was conducted at Patient #5's home on 2/23/16, beginning at 4:00 PM. During the visit discrepancies were observed between her POC and what was in the home. Examples include:</p> <p>i. A request was made to review Patient #5's medications in the home. Patient #5's medication list on her POC did not include all the medications she was taking in her home. Medications which were not on the POC included Lactulose 10 gm/15 ml and Norco 10/325. Additionally, Percocet 10/325 was included on the POC which Patient #5 was not taking.</p> <p>When asked about her medications Patient #5 stated she had an appointment with her physician on 2/11/16, and her pain medications were changed at that time per her request. She also stated the Lactulose was prescribed by her physician prior to her surgery, and due to severe constipation she had taken it a couple of days ago to help alleviate the problem.</p> <p>During an interview on 2/26/16 at 8:50 AM, the RN Case Manager reviewed the record and confirmed the discrepancies on the medication list. She stated she was unaware Patient #5 had a medication change and that she was taking Lactulose which was previously prescribed by her physician.</p>	G 173		
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G 173	<p>Continued From page 101</p> <p>Patient #5's POC and medication list were not accurate to reflect her current medications.</p> <p>ii. During the visit a glucometer, diabetic test strips, and a cane were observed in Patient #5's home. However, these items were not included on her POC.</p> <p>During an interview on 2/25/16 at 2:00 PM, the RN who completed the SOC assessment confirmed DME was missing from Patient #5's POC.</p> <p>Patient #5's POC did not include all equipment and supplies required for her care.</p> <p>5. Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to a pressure ulcer. Additional diagnoses included atrial fibrillation and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>a. Patient #8's record included an SOC comprehensive assessment completed on 12/12/15, and signed by the RN. The POC for the certification period 12/12/15 to 2/09/16, did not include all interventions necessary to meet his needs. Examples include:</p> <p>i. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include patient specific parameters for notifying the physician of changes in vital signs or other clinical findings. However, his POC did not include parameters to direct clinicians to notify his physician of findings outside of the normal range.</p>	G 173			

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G 173	Continued From page 102 ii. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions for depression, which included medications, referral for treatment, or a monitoring plan for current treatment. Patient #8's medication list included Sertraline, an anti-depressant medication. However, his POC did not include interventions related to depression. iii. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions to prevent pressure ulcers. The assessment stated Patient #8 was at risk for developing pressure ulcers. However, his POC did not include interventions related to pressure ulcers. iv. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions to monitor and mitigate pain. It noted his pain level ranged from 3 to 10, on a scale of 0 to 10, with 10 indicating the worst pain. However, his POC did not include interventions related to pain. v. The SOC comprehensive assessment stated Patient #8's physician ordered POC would include interventions for pressure ulcer treatment of moist wound healing. The assessment stated he was at risk for pressure ulcers. However, his POC did not include a diagnosis of a pressure ulcer or interventions for pressure ulcer treatment. vi. The SOC comprehensive assessment stated Patient #8 had HTN and peripheral vascular disease. His medication list included aspirin, Metoprolol (an anithypertensive medication), and	G 173			

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G 173	<p>Continued From page 103</p> <p>Diltiazem (a heart medication used to treat HTN or an irregular heart beat). However, his POC did not include these as diagnoses or include interventions related to the disease.</p> <p>During an interview on 2/26/16 at 8:40 AM, the RN who completed the SOC comprehensive assessment reviewed the record and confirmed the POC did not include all interventions required for his care.</p> <p>Patient #8's POC was not comprehensive to include all interventions, treatments, and supplies required for her care.</p> <p>b. Patient #8's record included a recertification comprehensive assessment completed on 2/08/16, and signed by the RN Case Manager. The POC for the certification period 2/10/16 to 4/09/16, did not include all interventions necessary to meet his needs. Examples include:</p> <p>i. Patient #8's primary diagnosis was pressure ulcer. The assessment stated he had a diabetic ulcer to the arch of his left foot. However, his POC did not include interventions or treatments related to treatment of a pressure ulcer or wound.</p> <p>ii. The recertification comprehensive assessment stated Patient #8 had HTN and peripheral vascular disease. However, his POC did not include these diagnoses or include interventions related to the diseases.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed the record and confirmed the POC did not include all interventions required for her care.</p>	G 173		

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G 173	<p>Continued From page 104</p> <p>c. Patient #8's POC included Kerlix wrap (gauze bandage wrap), normal saline, 4 x 4 dressings, and Allevyn (a moist wound dressing) as supplies in the home. However, his recertification comprehensive assessment stated he had a brace, reacher, shoe/sock aid, tracheostomy (a surgical opening in the neck to place a tube for breathing) supplies, ace wraps (elastic bandage wraps), and compression stockings which were not included on his POC.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager confirmed DME and supplies were missing from Patient #8's POC.</p> <p>Patient #8's POC did not include all equipment and supplies required for his care.</p> <p>6. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC, for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>Patient #3's POC, developed by the RN, for the certification period 1/25/16 to 3/24/16, did not include all interventions necessary to meet his needs. Examples include:</p> <p>a. Patient #3's POC listed her primary diagnosis as "Heart Failure, Unspecified." However, her POC did not include interventions related to heart failure, such as assessment of her cardiac status, or patient education regarding CHF.</p> <p>b. Patient #3's POC section 14, "DME and Supplies," included a walker. During a home visit on 2/24/16 beginning at 7:15 AM, the following</p>	G 173		

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G 173	<p>Continued From page 105</p> <p>DME was noted:</p> <ul style="list-style-type: none"> - An electric bed, - Electric recliner chair that also lifts to an upright position, - Bed rail, - Grab bars in bathroom and shower, - Elevated toilet seat with arm supports, - Shower chair, - 4 point cane, - Grabber device to pick up items from the floor, - Glucometer. <p>During an interview on 2/25/16 beginning at 4:30 PM, the RN Case Manager reviewed Patient #3's record and confirmed the POC did not include interventions for heart failure, or the DME that she had in her home.</p> <p>Patient #3's POC was not comprehensive to include all interventions and supplies required for her care.</p> <p>7. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16 for Nursing, PT and OT services related to CHF, UTI, and history of falls. Patient #6's record, including her POC, for the certification period 1/08/16 to 3/07/16, was reviewed.</p> <p>Patient #6's POC, developed by the RN, for the certification period 1/08/16 to 3/07/16, did not include all interventions necessary to meet her needs. Examples include:</p> <p>a. Patient #6's POC listed her primary diagnosis as "Acute CHF." However, her POC did not include interventions related to CHF, such as assessment of her cardiac status, or patient</p>	G 173			

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G 173	Continued From page 106 education regarding CHF. b. Patient #6's POC section 14, "DME and Supplies," included a walker. During a home visit on 2/25/16 beginning at 3:00 PM, the following DME was noted: - Grab bars in bathroom and shower. - Shower chair. During an interview on 2/26/16 beginning at 10:20 AM, Patient #6's RN Case Manager reviewed her record and confirmed the POC did not include interventions for CHF and the DME she had in her home. Patient #6's POC was not comprehensive to include all interventions and supplies required for her care.	G 173			
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure RNs appropriately prepared clinical notes, and coordinated care with the physician and other clinicians for 2 of 12 patients (Patient #2 and #11) 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	G 176		4/15/16	

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G 176	<p>Continued From page 107 negatively impacted quality and coordination of patient care. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>The American College of Cardiology website, accessed on 3/01/16, 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."</p> <p>a. Patient #2's record included an SN visit note dated 12/06/16, signed by the LPN. An interdisciplinary communication note also dated 12/06/15, signed by the LPN, stated Patient #2 called to report shortness of breath. The LPN noted his right leg was swollen and he complained of bloating in his abdomen. Additionally, the LPN noted fine crackles in his left lung. These findings were consistent with symptoms of fluid build up in the body, possibly related to CHF. The LPN documented she encouraged Patient #2 to make an appointment</p>	G 176		
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G 176	<p>Continued From page 108</p> <p>with his physician, and to start weighing himself every day. The LPN's visit note stated she communicated with the RN Case Manager. However, there was no documentation of contact with Patient #2's physician to report the change in his condition.</p> <p>The next visit documented in Patient #2's record was a ROC comprehensive assessment dated 12/13/15, signed by the RN Case Manager. The assessment did not state the reason his care was being resumed. However, a PT visit note dated 12/15/15, signed by the Physical Therapist stated "Patient came home from hospital over the weekend, was admitted due to reported CHF exacerbation with fluid overload and SOB [shortness of breath]. Documentation of the date he was admitted to the hospital could not be found in his record.</p> <p>During an interview on 2/25/16 at 4:30 PM, the RN Case Manager reviewed Patient #2's record and stated she did not remember receiving a call from the LPN regarding Patient #2's change in condition. She confirmed she did not communicate with Patient #2's physician. She stated she did not know when Patient #2 went to the hospital.</p> <p>Patient #2's symptoms of fluid overload were not reported to his physician.</p> <p>b. Patient #2's record did not include documentation stating he was instructed to weigh himself daily to monitor for fluid build up related to his congestive heart failure. However, SN visits recorded his weight as follows:</p> <p>-1/12/16 189 pounds</p>	G 176			

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G 176	<p>Continued From page 109</p> <p>-1/21/16 195 pounds -1/26/16 197 pounds -2/03/16 198 pounds</p> <p>Patient #2 experienced a 6 pound weight gain in 9 days (1/12/16 to 1/21/16). His record did not include documentation of physician contact to report his weight gain. His weight continued to increase slightly over the next 2 weeks, increasing by 9 pounds in 3 weeks. His physician was not notified of his weight gain. Patient #2 was discharged from SN services on 2/03/16.</p> <p>During an interview on 2/25/16 at 4:00 PM, the LPN who completed Patient #2's SN discharge visit confirmed she did not notify Patient #2's physician of his weight gain.</p> <p>Patient #2's physician was not notified of changes in his condition.</p> <p>c. Patient #2's POC for the certification period 10/17/15 to 12/15/15, included a diagnosis of a non-pressure chronic ulcer of his right lower leg. Patient #2's record included an SOC comprehensive assessment completed on 10/17/15, signed by the RN. The assessment stated Patient #2 had a stage II pressure ulcer. However, Patient #2's POC did not include care of a pressure ulcer.</p> <p>During an interview on 2/26/16 at 9:15 AM, the RN who completed Patient #2's SOC comprehensive assessment reviewed his record and stated he did not have a pressure ulcer. She confirmed the documentation of a pressure ulcer on his SOC assessment was inaccurate.</p> <p>Patient #2's SOC assessment included</p>	G 176			

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G 176	<p>Continued From page 110 inaccurate information.</p> <p>2. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>a. Patient #11's SN visit notes dated 1/03/16, 1/11/16, and 1/17/16, included measurements of her sacral wound. Each note included the length, width and depth of the surface wound, 1 measurement of undermining (a wider area of wound that lies beneath the wound opening) and 1 measurement of tunneling (a channel that extends from a wound into subcutaneous tissue or muscle). However, an SN visit note dated 1/29/16, signed by the RN Case Manager, included measurements of the surface wound, 2 measurements of undermining, and 2 measurements of tunneling. Patient #11's record did not include documentation stating her physician was notified of the change in her wound.</p> <p>During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed the record and confirmed she did not notify Patient #11's physician of the change in her wound.</p> <p>The agency failed to ensure Patient #11's physician was notified of a change in her wound.</p> <p>b. Patient #11's SN visit notes were not accurate and complete. Examples include:</p> <p>i. An SN visit note completed on 2/22/16, and</p>	G 176			

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G 176	Continued From page 111 signed by the LPN, stated Patient #11 had an existing MRSA infection (a bacteria that is resistant to many antibiotics). Documentation of an MRSA infection was not found elsewhere in Patient #11's record. During an interview on 2/25/16 at 3:40 PM, the LPN reviewed Patient #11's record and confirmed she did not have an MRSA infection. She stated the entry was made in error. ii. Patient #11's record included an order for wound care to be provided daily. However, SN visit notes dated 1/18/16, 1/23/16, and 1/31/16, signed by an RN, did not include documentation of wound care provided during the visit. During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed Patient #11's record. She stated wound care was provided on the visits noted above, however, the RN failed to document the wound care. Patient #11's SN visit notes did not accurately document the care provided.	G 176			
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure the RN provided necessary instruction to patients or caregivers for for 4 of 12 patients (#2, #5, #6, and #8) who received SN services and whose records	G 177		4/15/16	

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G 177	<p>Continued From page 112</p> <p>were reviewed. This created the potential for patients to experience adverse outcomes. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>a. Patient #2's POC for the certification period 10/17/15 to 12/15/15, included DM as his secondary diagnosis. His POC and medication profile included Lantus insulin to be taken daily. Additionally, they included Glucotrol and Metformin, oral medications used to control blood sugar in diabetics.</p> <p>The National Institutes for Health website, accessed 3/01/16, included an article titled "Postoperative management of the diabetic patient." The article stated "Diabetic patients are at increased risk for adverse outcomes of surgery...Hyperglycemia [elevated blood glucose level] is associated with likely risks for poorer wound healing, increased susceptibility to infection..."</p> <p>Patient #2's record included an SOC comprehensive assessment dated 10/17/15, signed by the RN. The assessment stated he had a BG monitor and checked his BG twice daily. Additionally, it stated his recent BG results</p>	G 177		

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G 177	<p>Continued From page 113</p> <p>were higher than expected. The SOC comprehensive assessment did not indicate patient education related to DM, BG testing or diabetic medications was provided.</p> <p>The next SN visit, dated 10/22/16, and completed by the RN, did not include documentation of Patient #2's BG level, or patient education related to DM, BG testing or diabetic medications.</p> <p>Patient #2's record included a document titled Transfer to an Inpatient Facility, dated 10/23/15, and signed by the Physical Therapist. The document stated Patient #2 was admitted to the hospital on 10/23/15 due to cardiac dysrhythmia and wound infection or deterioration.</p> <p>Patient #2's record included an ROC Assessment dated 10/27/15, and signed by the RN Case Manager. The assessment stated Patient #2 was hospitalized for wound infection and sepsis. The Centers for Disease Control and Prevention defines sepsis as the body's overwhelming and life-threatening response to an infection which can lead to tissue damage, organ failure, and death. The ROC assessment stated he had a BG monitor and checked his BG twice daily. Additionally, it stated his recent BG results were higher than expected. The ROC assessment did not include documentation of patient education related to DM, BG testing or diabetic medications.</p> <p>Patient #2's record included SN visit notes dated 10/29/15, 11/06/15, 11/13/15, 11/19/15, 11/28/15, 12/06/15, and 12/13/15. The notes did not include documentation of patient education related to DM, BG testing or diabetic medications.</p> <p>Patient #2 was recertified for an additional</p>	G 177			

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G 177	<p>Continued From page 114</p> <p>certification period beginning 12/16/15. His record included a POC for the certification period 12/16/15 to 2/13/16. His new POC included DM as his secondary diagnosis, and included Lantus insulin to be taken daily. Additionally, it included Glucotrol and Metformin, oral medications used to control blood sugar in diabetics.</p> <p>Patient #2's record included SN visit notes dated 12/17/15, 12/23/15, 12/31/15, 1/06/16, 1/12/16, and 1/21/16. The notes did not include documentation of patient education related to DM, BG testing or diabetic medications.</p> <p>Patient #2's record included an SN visit note dated 1/26/16, signed by the RN. The note documented a BG level of 176 mg/dl from 2 days prior. The note stated Patient #2 said he did not always check his BG levels or take his insulin as ordered. It stated he last checked his BG level 2 days ago. Additionally, it stated he did not take his sliding scale insulin as ordered. The American Diabetes Association defines sliding scale as a set of instructions for adjusting insulin on the basis of blood glucose test results, meals, or activity levels. Patient #2's record did not include orders for sliding scale insulin. The note documented patient education related to BG monitoring, and complications of DM. However, it did not specify instructions for his sliding scale insulin.</p> <p>The next SN visit was completed by the LPN on 2/03/16. The SN visit note stated Patient #2's recent BG levels ranged from 77-368. The American Diabetes Association website, accessed 3/01/16, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl. The note did not state whether Patient #2 was</p>	G 177		
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G 177	<p>Continued From page 115</p> <p>taking his daily or sliding scale insulin as ordered. Additionally, it did not document patient education related to DM, insulin or complications of DM.</p> <p>Patient #2's record included an interdisciplinary communication note dated 2/03/16, and signed by the LPN. It stated Patient #2 was ready to be discharged from SN services. The note stated the LPN discussed the importance of checking BG levels. Additionally, it stated he took his meds and insulin "as he sees fit." No additional SN visits were documented.</p> <p>During an interview on 2/25/16 at 4:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed Patient #2 did not receive education related to DM, including BG monitoring and insulin administration, prior to the SN visit on 1/26/16, more than 14 weeks after his admission on 10/17/15. Additionally, she stated she was not aware Patient #2 had orders for sliding scale insulin, and confirmed he was not educated on proper administration of sliding scale insulin.</p> <p>During an interview on 2/26/16 at 9:15 AM, the RN who completed Patient #2's SOC comprehensive assessment reviewed his record and confirmed the POC initiated at the time of his admission did not include patient education related to DM.</p> <p>The agency failed to ensure Patient #2 received education related to his DM.</p> <p>b. Patient #2's POC for the certification period 10/17/15 to 12/15/15, included a diagnosis of heart failure. His record included a physician's visit note dated 10/15/15, 2 days prior to his home health admission. The physician's note</p>	G 177			

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G 177	<p>Continued From page 116 documented a history of CHF.</p> <p>The American College of Cardiology website, accessed on 3/01/16, 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."</p> <p>Patient #2's record included an SOC comprehensive assessment dated 10/17/15, signed by the RN. The assessment stated he was short of breath with minimal exertion. Shortness of breath is a symptom of CHF. The assessment did not document Patient #2's weight or patient education related to the importance of obtaining a daily weight, to monitor for exacerbation of his CHF. Additionally, it did not document patient education regarding reporting weight gain, increased shortness of breath or other symptoms of CHF.</p> <p>Patient #2's record included SN visit notes dated 10/29/15, 11/06/15, 11/13/15, 11/19/15, and 11/28/15. The notes did not include his weight, or documentation of patient education related to CHF.</p> <p>Patient #2's record included an SN visit note dated 12/06/16, signed by the LPN. An interdisciplinary communication note also dated 12/06/15, signed by the LPN stated Patient #2 called to report shortness of breath. The LPN noted his right leg was swollen and he</p>	G 177			

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G 177	<p>Continued From page 117</p> <p>complained of bloating in his abdomen, both symptoms of fluid build up in the body, possibly related to CHF. Additionally, the LPN noted fine crackles in his left lung. The LPN documented she encouraged Patient #2 to make an appointment with his physician, and to start weighing himself every day. However, there was no documentation of patient education regarding changes in his condition to be reported immediately.</p> <p>The next visit documented in Patient #2's record was a ROC comprehensive assessment dated 12/13/15, signed by the RN Case Manager. The assessment did not state the reason his care was being resumed. However, a PT visit note dated 12/15/15, signed by the Physical Therapist stated "Patient came home from hospital over the weekend, was admitted due to reported CHF exacerbation with fluid overload and SOB [shortness of breath].</p> <p>During an interview on 2/25/16 at 4:00 PM, the LPN confirmed there was no documentation in her 12/06/15 visit note regarding patient education related to CHF and symptoms to report.</p> <p>During an interview on 2/25/16 at 4:40 PM, the RN Case Manager confirmed Patient #2's weight was not obtained during SN visits, and he was not educated regarding the importance of monitoring his weight, or of symptoms of CHF exacerbation, prior to his hospitalization for CHF exacerbation.</p> <p>The agency failed to ensure Patient #2 received education related to his CHF.</p> <p>2. Patient #5 was a 66 year old female admitted</p>	G 177			

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G 177	<p>Continued From page 118</p> <p>to the agency on 2/02/16, for SN, PT, OT and home health aide services related to care after orthopedic surgery. Additional diagnoses included spinal stenosis, Type II DM, HTN, and chronic pain. Her record, including the POC, for the certification period 2/02/16 to 4/01/16, was reviewed.</p> <p>Patient #5's POC for the certification period 2/02/16 to 4/01/16, included DM as her secondary diagnosis. Her POC and medication profile included Metformin to be taken daily.</p> <p>Patient #5's record included an SOC comprehensive assessment dated 2/02/16, signed by the RN. The assessment stated she had Type II DM. However, there was no documentation of education related to DM, BG monitoring, or diabetic medications. Additionally, there was no documentation of whether Patient #5 had a glucometer and how frequently she monitored her BG levels.</p> <p>The next 2 SN visits, dated 2/11/16 and 2/19/16, completed by the RN Case Manager, did not include documentation of Patient #5's BG level, or patient education related to DM, BG testing or diabetic medications.</p> <p>A home visit was conducted at Patient #5's home on 2/23/16, beginning at 4:00 PM. Patient #5 stated she had a glucometer for testing her BG levels. She stated she tested her BG levels every 3 to 4 days.</p> <p>During an interview on 2/25/16 at 2:00 PM, the RN who completed the SOC assessment confirmed Patient #5 had DM. She confirmed she did not check Patient #5's BG level or</p>	G 177			

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G 177	<p>Continued From page 119 perform education related to DM.</p> <p>During an interview on 2/26/16 at 8:50 AM, the RN Case Manager confirmed Patient #5 was a DM and she did not perform education related to DM at her visits.</p> <p>The agency failed to ensure Patient #5 received education related to her DM.</p> <p>3. Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to a pressure ulcer. Additional diagnoses included atrial fibrillation and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>Patient #8's POC for the certification period 12/12/15 to 2/09/16, included DM as his secondary diagnosis.</p> <p>Patient #8's record included an SOC comprehensive assessment dated 12/12/15, signed by the RN. The assessment stated he had Type II DM. There was no documentation of a BG measurement or assessment of how frequently Patient #8 monitored his BG levels. Additionally, there was no documentation of education related to DM or BG monitoring.</p> <p>Patient #8's record included SN visit notes dated 12/15/15, 12/21/15, 12/24/15, 12/28/15, 1/04/16, 1/07/16, 1/12/16, 1/14/16, 1/21/16, 1/25/16, 1/28/16, 2/01/16, and 2/04/16. The notes did not include documentation of patient education related to DM or BG testing.</p> <p>Patient #8 was recertified for an additional</p>	G 177		

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G 177	<p>Continued From page 120</p> <p>certification period beginning 2/10/16. His record included a POC for the certification period 2/10/16 to 4/09/16. His new POC included DM as his secondary diagnosis.</p> <p>Patient #8's record included SN visit notes dated 2/11/16, 2/16/16, and 2/19/16. The notes did not include documentation of patient education related to DM or BG testing.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed Patient #8's record and confirmed Patient #8 did not receive education related to DM, including BG monitoring. Additionally, she stated Patient #8 did not have a glucometer and she was trying to get him one.</p> <p>During an interview on 2/26/16 at 8:40 AM, the RN who completed Patient #8's SOC comprehensive assessment reviewed his record and confirmed the POC initiated at the time of his admission did not include patient education related to DM.</p> <p>The agency failed to ensure Patient #8 received education related to his DM.</p> <p>4. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16, for SN and therapy services related to CHF, UTI, and history of falls. Patient #6's record, including her POC, for the certification period 1/08/16 to 3/07/16, was reviewed.</p> <p>Patient #6's POC listed her primary diagnosis as "Acute CHF." However, her POC did not include interventions related to CHF, such as assessment of her cardiac status, or patient education regarding CHF.</p>	G 177			

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G 177	Continued From page 121 Patient #6's record included SN visits completed on 1/08/16, 1/14/16, 1/22/16, and 2/05/16. The 4 SN visit notes did not include documentation of patient education related to CHF, such as monitoring for signs and symptoms of CHF exacerbation, or when to notify her physician of changes in her condition. During a home visit on 2/25/16 beginning at 3:00 PM, to observe PT services, Patient #6 was interviewed. Patient #6 was asked how she was managing her CHF, and she responded "I don't have CHF." She stated she had difficulty with breathing, and she stated she had high blood pressure. Patient #6 denied receiving education related to CHF during her HH SN visits, such as monitoring her weight, monitoring edema in her extremities or managing her diet. During an interview on 2/26/16 beginning at 8:20 AM, Patient #6's RN Case Manager reviewed her record and confirmed she did not provide CHF education to Patient #6.	G 177			
G 186	484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure the	G 186		4/15/16	

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G 186	<p>Continued From page 122</p> <p>therapists assisted the physician in developing or revising the plan of care to meet the patient's needs for 2 of 7 patients (#2 and #3) who received therapy services and whose records were reviewed. This resulted in patients receiving therapy services without physician input or physician awareness of the services being provided. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #2's record included a PT evaluation completed on 10/27/15, signed by the Physical Therapist. Patient #2's record did not include documentation of contact with his physician following the PT evaluation, to obtain approval for his PT POC.</p> <p>Patient #2's record included a POC for the certification period 10/17/15 to 12/15/15, signed by his physician on 10/28/15. The POC included an order for PT visits twice a week for 6 weeks. However, the POC did not include PT interventions to be provided during the certification period. Patient #2's record included PT visits completed on 10/29/15, 11/03/15, 11/10/15, 11/12/15, 11/17/15, 11/19/15, 11/24/15, 11/27/15, 12/01/15, 12/03/15, and 12/15/15. However, his record did not include</p>	G 186			

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G 186	<p>Continued From page 123</p> <p>documentation of physician approval of his PT POC, including interventions to be provided, during the certification period.</p> <p>During an interview on 2/26/16 at 8:15 AM, the Physical Therapist reviewed Patient #2's PT evaluation, and confirmed there was no documentation of physician approval of his PT POC. Additionally, the Physical Therapist reviewed Patient #2's POC for the certification period 10/17/15 to 12/15/15, and confirmed it did not include PT interventions to be provided. He was unable to explain why PT interventions were not included on Patient #2's POC.</p> <p>Patient #2's record did not include a PT POC, or physician approval of PT services.</p> <p>2. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POCs, for the certification periods 11/26/15 to 1/24/16, and 1/25/16 to 3/24/16, was reviewed.</p> <p>Patient #3's POC for the certification period 11/26/15 to 1/24/15, included an order for OT visits 3 times a week. The OT interventions on the POC included evaluation, ADL assistance, muscle re-education, adaptive equipment training, perceptual motor training, fine motor training, family training and HEP. The OT goals on the POC included independence with dressing and tub transfers, increased bilateral upper extremity AROM, and increased standing tolerance.</p> <p>Patient #3's record included an OT visit note,</p>	G 186			

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G 186	<p>Continued From page 124</p> <p>titled "Reassessment Visit" completed on 1/25/16, the first day of her new certification period. The visit note was signed by the Occupational Therapist. The section titled "Areas assessed this visit" stated "Musculoskeletal." Under "Findings" it stated "Rigidity." The reassessment visit note did not document an assessment of Patient #3's ability to dress herself or perform a tub transfer. It did not include an assessment of her upper extremity AROM or her standing tolerance. Under "Progress towards Goals" the note stated "Goals partially achieved; patient continues to make progress according to plan of care." However, it was unclear which goals were achieved, or partially achieved, and how her progress toward her goals was determined.</p> <p>Patient #3's POC for the certification period 1/25/16 to 3/24/16, included an order for OT visits 3 times a week. The OT interventions on the POC were unchanged from the previous POC. The OT goals on the POC stated "Patient to be modified independent using assistive device, compensatory strategies and techniques to complete AM ADL routines." It was unclear how Patient #3's goals were determined, as her ability to use her assistive device and complete her AM ADL routine was not assessed during the reassessment visit.</p> <p>A home visit was conducted on 2/24/16 beginning at 7:15 AM, to observe OT services provided to Patient #3. Patient #3 and her daughter spoke with the surveyor after the Occupational Therapist was finished and left the home.</p> <p>Patient #3 stated she was receiving HH services for approximately a year, and had the same Occupational Therapist during that time. She</p>	G 186			

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G 186	Continued From page 125 described services provided by the Occupational Therapist as "massaging" her neck, upper back, and shoulders. Patient #3's daughter stated her mother had lost some of her mobility, balance, and ability to perform ADL's over the past 6 months. During an interview on 2/25/16 at 1:25 PM, the Occupational Therapist reviewed Patient #3's record. He stated he was unsure how often reassessment visits were to be completed. He confirmed he did not assess Patient #3's progress toward all of her goals. He stated he did not perform assessments of her ability to dress or bathe herself for privacy reasons. He stated "As a man, sometimes it's a modesty issue." The Occupational Therapist was unable to state how he determined her level of function and progress toward her goals, to develop and revise her POC.	G 186			
G 187	484.32 THERAPY SERVICES The agency failed to ensure the Occupational Therapist developed and revised the POC to meet the patient's needs. The qualified therapist prepares clinical and progress notes. This STANDARD is not met as evidenced by: Based on record review, staff and patient interview, and observation during home visits, it was determined the agency failed to ensure the Occupational Therapist documented accurate clinical findings and progress toward goals, for 1 of 5 patients (Patient #3), who received OT services, and whose record was reviewed. This negatively impacted coordination, quality, and	G 187		4/15/16	

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G 187	<p>Continued From page 126</p> <p>safety of patient care. Findings include:</p> <p>Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC, for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>Visit notes completed by the Occupational Therapist did not accurately document services provided. Examples include:</p> <p>1. OT visit notes dated 1/25/16, 1/29/16, and 2/01/16, signed by the Occupational Therapist, stated Patient #3 was given a written HEP, and she and her caregiver were instructed regarding the HEP.</p> <p>A home visit was conducted on 2/24/16 beginning at 7:15 AM, to observe OT services provided to Patient #3. Patient #3 and her daughter spoke with the surveyor after the Occupational Therapist was finished and left the home. Patient #3 and her daughter stated they did not receive written home exercise material from the Occupational Therapist.</p> <p>During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist stated he did not give Patient #3 a written HEP. He confirmed the documentation was inaccurate.</p> <p>2. An OT Visit note dated 2/10/16, signed by the Occupational Therapist, stated Patient #3 was provided training regarding bathing/grooming activities, and required minimum assistance with a sinkside bath and combing hair.</p>	G 187			

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G 187	Continued From page 127 During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist reviewed the 2/10/16 OT visit note, and stated he did not provide bathing/grooming training, or assess Patient #3's ability to complete a sinkside bath and combing her hair. He stated the Home Health Aide performed those tasks, and reported to him. The Occupational Therapist stated he did not participate with bathing and grooming activities for Patient #3. He stated "As a man, it is sometimes a modesty issue." 3. On 2/24/16, beginning at 7:15 AM, a home visit was conducted to observe the Occupational Therapist complete an OT reassessment. Following the visit, the completed OT reassessment visit note was reviewed. The Occupational Therapist documented he assessed Patient #3's transfer ability. He noted Patient #3 required minimum assistance for tub/shower transfer. However, the Occupational Therapist did not perform a tub/shower transfer assessment with Patient #3 during the 2/24/16 visit. During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist confirmed he did not assess Patient #3's ability to perform a tub/shower transfer during his OT visit on 2/24/16.	G 187			
G 188	The agency failed to ensure OT clinical notes were accurate to indicate services provided. 484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel.	G 188		4/15/16	

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G 188	<p>Continued From page 128</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interview, patient/family interview, and observation, it was determined the agency failed to ensure Occupational Therapists advised patients/families on progress toward goals and outcomes. This negatively impacted 1 of 5 patients who received OT services (Patient #3) and whose records were reviewed. Findings include:</p> <p>Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>The OT interventions on the POC included evaluation, ADL assistance, muscle re-education, adaptive equipment training, perceptive motor training, fine motor training, family training and HEP. The OT goals on the POC included independence with dressing and tub transfers, increased bilateral upper extremity AROM, and increased standing tolerance.</p> <p>Each OT visit note completed 1/27/16 to 2/22/16, included a section titled "Case Communications, contacts made as a result of this visit". Each note indicated communication with the primary caregiver.</p> <p>A home visit was conducted on 2/24/16 beginning at 7:15 AM, to observe the Occupational Therapist provide services.</p> <p>The Occupational Therapist was in the home for</p>	G 188			

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G 188	<p>Continued From page 129</p> <p>approximately 45 minutes, and was observed to work with Patient #3 in upper body exercises, ambulation, stretching, balance, and specific ROM to her right shoulder. At the beginning of his visit, he told Patient #3 that he wanted to observe her getting into the bathtub. She refused, and told him that she did that with the Home Health Aide, and had no difficulty. The Occupational Therapist then told her that he would be sure to come when the Home Health Aide was there to make sure she was safe with that process. He ended his visit with soft tissue massage of her neck, upper back, and shoulders. The Occupational Therapist explained during his visit that he had been working with Patient #3 since her SOC, after she suffered a fall and broke her right arm.</p> <p>After the Occupational Therapist finished his visit and left the home, Patient #3 and her daughter were interviewed regarding care provided by the HHA during the year she was receiving services.</p> <p>Patient #3 stated she was surprised the routine that morning was so different from other OT sessions. She stated that when the Occupational Therapist entered that morning and first stated he wanted to observe her getting into the bathtub, she refused, as the Occupational Therapist had not previously evaluated her ability to use the bathtub.</p> <p>Patient #3's daughter described a routine visit with the Occupational Therapist. She stated he never brought in his work bag or computer, as he had that morning. Her daughter stated the therapist never took Patient #3's vital signs or pulse oximeter readings as he did that morning. Patient #3's daughter stated a usual visit lasted</p>	G 188			

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G 188	Continued From page 130 10 or 15 minutes, her mother never got out of her chair, and the only thing the therapist did was massage her neck, shoulders, and upper back. Patient #3's daughter stated the Occupational Therapist came three times a week, early in the morning, "rubbed [Patient #3's] back," then left. She stated the therapist did not provide written materials for exercises, and she thought he was just there to massage her back and neck. Patient #3 stated she did not know what an "HEP" or home exercise program, meant. Patient #3 stated she was not aware of the OT Care Plan and planned interventions for her during the current certification period. During an interview on 2/25/16 beginning at 1:20 PM, the Occupational Therapist reviewed Patient #3's record. He stated his visits with Patient #3 were "around 35-45 minutes" in duration. He stated Patient #3 received written material for home exercises, but as he was providing OT to her for so long, he did not remember when he provided it to her. The Occupational Therapist confirmed he did not provide a POC to Patient #3, and he did not discuss evaluations of her progress, goals, or discharge plans, with her. Patient #3's Occupational Therapist did not inform her of the treatment modalities he would be using. Additionally, the Occupational Therapist failed to provide Patient #3 with progress updates, as well as, treatment goals.	G 188			
G 195	484.34 MEDICAL SOCIAL SERVICES If the agency furnishes medical social services,	G 195		4/15/16	

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G 195	<p>Continued From page 131</p> <p>those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and review of medical records, it was determined the agency failed to ensure social services were provided by a qualified social worker in accordance with the plan of care for 1 of 3 patients (Patient #8) who received social services visits and whose records were reviewed. This failure had the potential to negatively impact the ability of the agency to meet patient needs. Findings include:</p> <p>Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to a pressure ulcer. Additional diagnoses included atrial fibrillation and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>Patient #8's record included an SOC comprehensive assessment completed on 12/12/15, and signed by the RN. The assessment stated Patient #8 lacked spiritual and friend/neighbor support. Additionally, the assessment stated he needed community resources for medical transportation, personal care services, and social services.</p> <p>Patient #8's POC, dated 12/12/15, included</p>	G 195		

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G 195	Continued From page 132 orders for an MSW evaluation. There was no documentation in his record of an MSW visit. During an interview on 2/25/16 at 3:10 PM, the RN Case Manager and Director reviewed the record and confirmed there was no MSW evaluation. The RN Case Manager stated she had spoken with the MSW regarding an evaluation for Patient #8, but it was not completed as of 2/25/16. The Director stated since the MSW was working for both the HHA and the hospice he had a lot of patients to evaluate, which made scheduling difficult.	G 195			
G 200	Patient #8's POC was not followed as ordered for an MSW evaluation. 484.34 MEDICAL SOCIAL SERVICES The social worker participates in discharge planning and in in-service programs. This STANDARD is not met as evidenced by: Based on interview and review of personnel files, it was determined the agency failed to ensure participation in in-service programs for 1 of 1 MSW whose personnel file was reviewed. This had the potential to result in patients receiving care from under-qualified SWs. Findings include: Personnel files were reviewed with the Human Resources Manager on 2/26/16 at 9:30 AM. The MSW's personnel file lacked documentation of participation in in-service programs. The Human Resources Manager stated in-service education files were in the Director's office. During an interview on 2/26/16 at 10:50 AM, the	G 200		4/15/16	

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G 200	Continued From page 133 Director stated the MSW worked for both the hospice and the home health agency. She stated he participated in in-services for the hospice but not for the HHA.	G 200			
G 214	The agency failed to ensure the MSW participated in in-service programs. 484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must complete a performance review of each home health aide no less frequently than every 12 months. This STANDARD is not met as evidenced by: Based on personnel record review and staff interview, it was determined the facility failed to ensure yearly evaluations were conducted for 1 of 1 home health aide, who had been employed for more than one year. This had the potential to negatively impact quality and safety of patient care. Findings include: Personnel files were reviewed with the Human Resources Manager on 2/26/16 at 9:30 AM. The aide had been employed for more than one year, with a hire date of 7/16/07. The aide's personnel file did not include an annual performance review, since 6/19/14. The Director confirmed the annual evaluation had not been completed for 2015.	G 214		4/15/16	
G 321	Home health aide performance reviews were not conducted at least every 12 months. 484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient	G 321		4/15/16	

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G 321	<p>Continued From page 134 within 30 days of completing an OASIS data set.</p> <p>This STANDARD is not met as evidenced by: Based on record review, OASIS submission report results, and staff interview, it was determined the agency failed to ensure OASIS data was transmitted for 1 of 1 patient (Patient #2) who was a Medicare recipient and whose OASIS validation report was reviewed. This resulted in the failure of the agency to report OASIS data as required for statistical and quality improvement purposes. Finding include:</p> <p>Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #2's record included an ROC OASIS completed on 12/13/15, signed by his RN Case Manager. The OASIS stated Patient #2 was discharged from the hospital on 12/12/15. However, his record did not include a TIF OASIS completed upon his transfer to the hospital.</p> <p>An OASIS validation report for Patient #2's ROC OASIS completed on 12/13/15, was requested. The Agency's OASIS Coordinator provided a validation report dated 12/17/15. The report stated Patient #2's ROC OASIS, completed on</p>	G 321			

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G 321	Continued From page 135 12/13/15, was transmitted on 12/17/15. However, the validation report included the following warning "Inconsistent Record Sequence: Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one." During an interview on 2/25/16 at 9:15 AM, the OASIS Coordinator stated the warning occurred because a ROC OASIS was transmitted without prior transmission of a TIF OASIS, indicating Patient #2's care was resumed following an inpatient admission, without documentation of the inpatient admission. She confirmed she did not take measures to reconcile the error when the warning was received. During an interview on 2/25/16 at 4:40 PM, the Director reviewed Patient #2's record and confirmed a TIF OASIS was not completed or transmitted when he was transferred to the hospital.	G 321			
G 322	The agency failed to transmit TIF OASIS data when Patient #2 was transferred to the hospital. 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 4 of 12 patients (#2, #3, #6, and #12) whose records	G 322		4/15/16	

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G 322	<p>Continued From page 136</p> <p>were reviewed . This resulted in the reporting of inaccurate data. Findings include:</p> <p>1. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC, for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>a. Patient #3's record included a recertification assessment completed on 1/20/16. The M1023 section, which listed the additional diagnoses and severity codes, included major depressive disorder and obesity. A severity code of 3 was assigned to both diagnoses. The OASIS guidelines define a severity code of 3 as "symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring."</p> <p>- Patient #3's recertification assessment included a cognitive/emotional/behavioral status section. The assessment stated her orientation and alertness were within normal levels. It stated her behavior was appropriate and cooperative, and documented a coping behavior of acceptance. There was no documentation to indicate she had poorly controlled symptoms of depression. Patient #3's medication profile included the antidepressant medication Duloxetine, with a start date of 3/30/15, indicating she had been taking the medication for almost 10 months. There was no documentation to indicate she required frequent adjustments to treat her depression.</p> <p>- Patient #3's recertification assessment did not include her weight. SN and OT visit notes did not document concerns or complications related to</p>	G 322			

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G 322	<p>Continued From page 137</p> <p>her weight. Patient #3's POC stated she was on a regular diet. There was no documentation to indicate she had poorly controlled symptoms or required treatment to treat obesity.</p> <p>During an interview on 2/25/16 beginning at 4:30 PM, the RN Case Manager reviewed Patient #3's record. She stated she was not comfortable with the severity coding of diagnoses, and confirmed the diagnoses listed with a severity level of 3, did not have documentation showing they were poorly controlled or required frequent changes in treatment.</p> <p>Patient #3's recertification OASIS data did not accurately reflect her status at time of her assessment.</p> <p>3. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>a. Patient #2's POC for the certification period 10/17/15 to 12/15/15, included a diagnosis of a non-pressure chronic ulcer of his right lower leg. Patient #2's record included an SOC OASIS completed on 10/17/15, signed by the RN. M1306 asked "Does this patient have at least one unhealed pressure ulcer at stage II or higher or designated as 'unstageable'?" The response was yes. M1308 noted one stage II pressure ulcer</p>	G 322		

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G 322	<p>Continued From page 138</p> <p>currently present. However, Patient #2's SOC assessment did not include a description or measurements of a pressure ulcer.</p> <p>During an interview on 2/26/16 at 9:15 AM, the RN who completed Patient #2's SOC comprehensive assessment reviewed his record and stated he did not have a pressure ulcer. She confirmed M1306 and M1308 were answered incorrectly on his SOC OASIS.</p> <p>b. Question M2000 on Patient #2's SOC OASIS asked "Does a complete drug regimen review indicate potential clinically significant medication issues...? The answer stated "No problems found during review." Question M2002, "Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation" was not answered because M2000 stated no issues were identified. However, Patient #2's record noted clinically significant medication issues, without physician contact for resolution, as follows:</p> <p>i. Patient #2's record include referral information from the hospital where his surgery was performed. The information stated he was allergic to a class of medications called statins, used to lower cholesterol . However, his POC included Lipitor, a statin medication. His record did not include documentation of physician contact to reconcile the medication issue.</p> <p>ii. Patient #2's medication profile included Lantus 30 mg by mouth daily. Lantus is an insulin, measured in units, and administered by subcutaneous injection. It is not measured in mg, and can not be given by mouth. His record did</p>	G 322		

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G 322	<p>Continued From page 139</p> <p>not include documentation of physician contact to determine the correct Lantus dose and route.</p> <p>iii. Patient #2's SOC comprehensive assessment stated his pain was controlled with a narcotic analgesic, and he had taken 2 doses of the analgesic in the last 24 hours. However, his POC did not include a narcotic analgesic. His record did not include documentation of physician contact to determine the type and dose of narcotic analgesic.</p> <p>During an interview on 2/26/16 at 9:15 AM, the RN who completed Patient #2's SOC comprehensive assessment reviewed his record and stated she did not note his allergy to statins. She confirmed the dose and route of Lantus on his POC was incorrect, and his physician was not contacted to determine the correct dosage. She confirmed Patient #2's narcotic analgesic was not included on his POC. The RN confirmed Patient #2 did have significant medication issues and M2000 was answered incorrectly.</p> <p>Patient #2's SOC OASIS data did not accurately reflect his status at the SOC.</p> <p>4. Patient #12 was an 88 year old female admitted to the agency on 2/10/16, with a diagnosis of weakness. Additional diagnoses included arthritis, depression, and irritable bowel syndrome. She received SN, PT, OT, MSW, and Home Health Aide services. Her record, including the POC, for the certification period 2/10/16 to 4/09/16, was reviewed.</p> <p>Patient #12's record included an SOC OASIS assessment completed on 2/10/16, signed by the Physical Therapist. Question M2000 on Patient</p>	G 322		

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G 322	Continued From page 140 #12's SOC OASIS asked "Does a complete drug regimen review indicate potential clinically significant medication issues...? The answer stated "No problems found during review." However, Patient #12's record included documentation of a major drug interaction between 2 medications she was taking, Sertraline and Tramadol. During an interview on 2/26/16 at 8:50 AM, the Physical Therapist reviewed Patient #12's SOC OASIS, and confirmed Question M2000 was answered incorrectly. He stated he did not enter medications into the EMR when he did an SOC OASIS. He stated he made a list of the medications and submitted it to the office, and someone in the office entered the medications into the EMR and checked them for interactions. He confirmed he did not know if there were interactions between Patient #12's medications when he answered M2000 on her SOC OASIS.	G 322			
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. 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	G 331			4/15/16

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G 331	<p>Continued From page 141</p> <p>concern for 6 of 9 patients, (#2, #4, #6, #8, #10, and #11) whose SOC records were reviewed. This failure placed patients at risk for negative outcomes. Findings include:</p> <p>1. Patient #10 was a 7 year old male admitted to the agency on 1/24/16, for care related to gastroparesis (a disorder that slows or stops the movement of food from the stomach to the small intestine). Additional diagnoses included feeding disorder and management of a venous vascular device. He received SN services. His record, including the POC, for the certification period 1/24/16 to 3/23/16, was reviewed.</p> <p>Patient #10's record included an SOC comprehensive assessment completed on 1/24/16, signed by the RN Case Manager. The assessment was not comprehensive to identify all his needs. Examples include:</p> <p>Patient #10's record included referral information from his physician's office, including notes from an office visit on 1/13/16, and notes from a nutrition assessment completed by a Registered Dietician on 1/20/16,</p> <p>a. The physician's note stated Patient #10 had a gastrostomy tube, a tube inserted through the abdomen to deliver nutrition directly to his stomach. Additionally, it stated he had a recent history of recurrent infections at his gastrostomy tube insertion site. Patient #10's SOC assessment stated he had a gastrostomy tube. However, it did not include an assessment of the tube and the insertion site, to determine possible signs of infection.</p> <p>b. The physician's note stated that due to Patient</p>	G 331			

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G 331	<p>Continued From page 142</p> <p>#10's history of severe constipation, he had an appendicostomy (surgical opening of the tip of the appendix to allow for irrigation of the bowel) performed in 2015. The note stated he had a Chait tube (a tube at the umbilicus used for irrigation of the bowel) and had daily colon irrigations through the Chait tube. Patient #10's SOC assessment included an assessment of his abdomen. However, it did not include an assessment of his Chait tube. Additionally, it did not include an assessment of his bowel status, including daily colon irrigations.</p> <p>c. The nutrition assessment stated Patient #10 was unable to tolerate his tube feedings, and he had lost weight. However, Patient #10's SOC assessment did not include documentation of his current weight, to determine additional weight loss on subsequent visits. Additionally, it did not include information regarding his tube feedings, or an assessment of his tolerance of tube feedings.</p> <p>d. Patient #10's assessment included his temperature and respiratory rate. However, it did not include his heart rate or his blood pressure. Patient #10's POC included Norvasc, a medication used to treat high blood pressure. However, his blood pressure was not assessed during his SOC visit.</p> <p>During an interview on 2/26/16 at 9:30 AM, the RN Case Manager reviewed Patient #10's record and confirmed she did not assess his heart rate, blood pressure or weight during her SOC assessment. She stated she did not complete an assessment of his abdomen, and was not aware he had a Chait tube and daily bowel irrigations. Additionally, she stated she did not include</p>	G 331			

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G 331	<p>Continued From page 143</p> <p>information about his tube feedings or an assessment of his ability to tolerate his tube feedings.</p> <p>Patient #10's SOC assessment was not comprehensive.</p> <p>2. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #2's record included an SOC comprehensive assessment completed on 10/17/15, signed by the RN. The assessment was not comprehensive to identify all his needs. Examples include:</p> <p>a. Patient #2's diagnoses included a non-pressure chronic ulcer of his right lower leg. The SOC assessment stated he had a stage II pressure ulcer. Patient #2's record included a physician visit note, dated 10/15/15, 2 days prior to his HH admission. The note stated the ulcers on his 4th and 5th toes were slowly healing. However, Patient #2's SOC assessment did not include information regarding the ulcers, such as location, size, appearance, or presence of drainage.</p> <p>b. Patient #2's diagnoses included CHF, a weakness of the heart that leads to a buildup of</p>	G 331		
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G 331	<p>Continued From page 144</p> <p>fluid in the lungs and other body tissues. One of the first symptoms of CHF exacerbation is weight gain. However, Patient #2's SOC assessment did not include documentation of his current weight, to determine weight gain on subsequent visits.</p> <p>During an interview on 2/26/16 at 9:15 AM, the RN who completed Patient #2's SOC comprehensive assessment stated he did not have a pressure ulcer as documented. She confirmed she did not assess the ulcers on his 4th and 5th toes. Additionally, she confirmed she did not weigh Patient #2 during the assessment or ask him for a recent weight.</p> <p>Patient #2's SOC assessment was not comprehensive to include his current weight or an assessment of his wounds.</p> <p>3. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>Patient #11's record included an SOC comprehensive assessment completed on 1/02/16, signed by the RN Case Manager. The assessment documented one stage IV pressure ulcer (full thickness tissue loss with visible bone, tendon or muscle.) However, Patient #11's SOC assessment did not include information regarding the pressure ulcer, such as size, appearance, or presence of drainage.</p> <p>During an interview on 2/25/16 at 2:30 PM, the</p>	G 331		
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G 331	<p>Continued From page 145</p> <p>RN Case Manager reviewed Patient #11's record and confirmed it did not include a description or measurements of her pressure ulcer.</p> <p>Patient #11's SOC assessment was not comprehensive to include an assessment of her pressure ulcer.</p> <p>4. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16 for Nursing and therapy services related to CHF, UTI, and history of falls. Patient #6's record, including her POC, for the certification period 1/08/16 to 3/07/16, was reviewed.</p> <p>Patient #6's record included an SOC comprehensive assessment completed on 1/08/16, signed by the RN. The assessment was not comprehensive to identify all her needs. Examples include:</p> <p>Patient #6's diagnoses included CHF, a weakness of the heart that leads to a buildup of fluid in the lungs and other body tissues. One of the first symptoms of CHF exacerbation is weight gain. However, Patient #3's SOC assessment did not include documentation of her current weight, to determine weight gain on subsequent visits.</p> <p>During an interview on 2/26/16 beginning at 10:20 AM, Patient #6's RN Case Manager reviewed her record and confirmed she did not obtain a baseline weight during the SOC comprehensive assessment.</p> <p>Patient #6's SOC assessment was not comprehensive to include her current weight.</p>	G 331		

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G 331	<p>Continued From page 146</p> <p>5. Patient #4 was a 71 year old female admitted to the agency on 2/24/16, for SN services related to pneumonia. Additional diagnoses included COPD, hypothyroid, restless leg syndrome, and HTN. Her record, including the POC, for the certification period 2/24/16 to 4/23/16, was reviewed.</p> <p>Patient #4's record included referral information from the hospital where she was a patient from 2/21/16 to 2/23/16. The information included a face-to-face encounter, signed by a physician, with discharge diagnoses of pneumonia and COPD. The face-to-face encounter stated Patient #4 remained hypoxic (a condition in which the body is deprived of an adequate oxygen supply), and she needed monitoring of her oxygen needs and oxygen level.</p> <p>A home visit was conducted on 2/24/16 beginning at 1:00 PM, to observe a SOC comprehensive assessment by the RN. The assessment was not comprehensive to determine all of Patient #4's needs. Examples include:</p> <p>a. During the visit, the RN used her stethoscope to listen to Patient #4's breath sounds. The RN placed the stethoscope on Patient #4's nightgown to listen. The RN asked her if she was feeling short of breath and Patient #4 stated not more than she usually experienced.</p> <p>The SOC assessment completed by the RN stated Patient #4 had shortness of breath with moderate exertion, however, Patient #4 sat on her couch during the visit and did not ambulate or exert herself to demonstrate this finding.</p> <p>b. During the visit the RN asked Patient #4 if she</p>	G 331		

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G 331	<p>Continued From page 147</p> <p>had any skin breakdown. She replied she had not had any problems with her skin, but she was feeling a burning sensation to both of her elbows from sheets at the hospital. The RN did not examine her elbows or any other areas that were covered by clothing.</p> <p>The SOC assessment completed by the RN stated Patient #4 did not have skin breakdown or redness, however, the RN did not examine all areas of her body.</p> <p>c. During the visit the RN asked Patient #4 if she wanted a home health aide to come to her home and assist her with bathing. She stated she did not need this service or assistance. The RN asked if Patient #4 was able to administer her own medications. She stated she used a weekly pill organizer she filled for the week on Sundays. Patient #4 denied any problems administering her own medications, or performing ADLs independently.</p> <p>The SOC assessment completed by the RN stated Patient #4 currently had assistance in the home with dressing, bathing, transferring, and eating/feeding. Additionally, the assessment stated she had a caregiver provide assistance with her medications.</p> <p>d. During the visit Patient #4 received a delivery of oxygen and oxygen supplies from her DME provider. She was also wearing a nasal cannula and using oxygen during the RN visit. The RN asked Patient #4 if the oxygen was new for her. She stated she was using oxygen at night prior to her hospitalization.</p> <p>The SOC assessment completed by the RN</p>	G 331		

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G 331	<p>Continued From page 148</p> <p>stated Patient #4 had no DME supplies in the home.</p> <p>During an interview on 2/25/16 at 2:40, the RN who completed the SOC comprehensive assessment confirmed she did not have Patient #4 ambulate to assess whether she experienced shortness of breath or difficulty breathing on exertion. She confirmed she did not assess Patient #4's elbows for skin breakdown, or have her undress to assess for areas of breakdown or possible pressure ulcers because she was ambulatory and alert. The RN confirmed she documented Patient #4 required assistance with her ADLs. She stated she documented this because Patient #4's son was living with her the last 6 months. The RN stated she incorrectly documented there were no DME supplies in the home.</p> <p>Patient #4's SOC assessment was not comprehensive to determine her needs.</p> <p>6. Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to a pressure ulcer. Additional diagnoses included atrial fibrillation and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>Patient #8's record included an SOC comprehensive assessment completed on 12/12/15, and signed by the RN. The assessment was not comprehensive to identify all his needs. Examples include:</p> <p>a. Patient #8's diagnoses included Type II DM. The SOC assessment stated Patient #8's DM</p>	G 331		

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G 331	Continued From page 149 was well controlled with his current therapy. However, the SOC assessment stated he had 2 diabetic ulcers which required treatment, 1 on the arch of his left foot and 1 on the left ankle. Additionally, there was no BG level documented in the assessment. b. Patient #8's record included an H&P from his most recent hospitalization, dated 11/22/15, which stated he had a history of a heart attack and high cholesterol. The cardiovascular assessment completed during his SOC visit documented peripheral vascular disease, which was not noted as a diagnosis on his H&P. However, the assessment did not include documentation of his history of a heart attack and high cholesterol. During an interview on 2/26/16 at 8:40 AM, the RN who completed the SOC comprehensive assessment reviewed the record and confirmed the assessment did not include all pertinent information or findings. She stated she was not aware Patient #8 had a history of a previous heart attack. The RN stated she included peripheral vascular disease as part of her assessment because it was "obvious" due to his diabetic ulcers. She confirmed there was not a diagnosis of peripheral vascular disease included in his record.	G 331			
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	G 337		4/15/16	

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G 337	<p>Continued From page 150</p> <p>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, observation, and staff and patient/family interviews, it was determined the agency failed to ensure the comprehensive assessment included a drug regimen review of all medications the patient was taking, and physician notification of any problems that were identified for 6 of 12 patients, (#2, #3, #5, #6, #10, and #11) whose records were reviewed. This resulted in the potential for patients to experience adverse outcomes related to medications. Findings include:</p> <p>1. Patient #2 was a 76 year old male admitted to the agency on 10/17/15, for care following vascular bypass surgery on his right leg. Additional diagnoses included insulin dependent DM, peripheral vascular disease, chronic ulcer not caused by pressure, CHF, and atrial fibrillation. He received SN and PT services. He was discharged from the agency on 2/11/16. His record, including the POCs, for the certification periods 10/17/15 to 12/15/15, and 12/16/15 to 2/13/16, was reviewed.</p> <p>Patient #2's record included an SOC comprehensive assessment completed on 10/17/15, signed by the RN. A patient's POC is created based on the findings of the comprehensive assessment completed at the SOC. The assessment did not include a comprehensive review of all medications to determine significant issues. Examples include:</p>	G 337		

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G 337	<p>Continued From page 151</p> <p>a. Patient #2's POC stated he was allergic to a class of medications called statins, used to lower cholesterol . However, his POC included Lipitor, a statin medication. His record did not include documentation of physician contact to reconcile the medication issue.</p> <p>b. Patient #2's POC included Lantus 30 mg by mouth daily. Lantus is an insulin, measured in units, and administered by subcutaneous injection. It is not measured in mg, and can not be given by mouth. His record did not include documentation of physician contact to determine the correct Lantus dose and route.</p> <p>c. Patient #2's SOC comprehensive assessment stated his pain was controlled with a narcotic analgesic, and he had taken 2 doses of the analgesic in the last 24 hours. However, his POC did not include a narcotic analgesic. His record did not include documentation of physician contact to determine the type and dose of narcotic analgesic.</p> <p>d. Patient #2's record included an SN visit note dated 1/26/16, signed by the RN. The note stated Patient #2 said he did not take his sliding scale insulin as ordered. The American Diabetes Association defines sliding scale as a set of instructions for adjusting insulin on the basis of blood glucose test results, meals, or activity levels. Patient #2's record did not include orders for sliding scale insulin. His record did not include documentation of physician contact to determine the sliding scale orders.</p> <p>During an interview on 2/26/16 at 9:15 AM, the RN who completed Patient #2's SOC</p>	G 337		

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G 337	<p>Continued From page 152</p> <p>comprehensive assessment reviewed his record and stated she did not note his allergy to statins. She confirmed the dose and route of Lantus on his POC were incorrect. She confirmed Patient #2's narcotic analgesic was not included on his POC.</p> <p>During an interview on 2/25/15 at 4:30 PM, the RN Case Manager stated she was not aware sliding scale insulin was ordered for Patient #2. She confirmed the sliding scale insulin was not documented on his POC or medication profile.</p> <p>Patient #2's medications were not fully reviewed and reconciled with his physician to determine the correct dosages and routes, or to clarify his documented allergy to statins.</p> <p>2. Patient #10 was a 7 year old male admitted to the agency on 1/24/16, for care related to gastroparesis (a disorder that slows or stops the movement of food from the stomach to the small intestine). Additional diagnoses included feeding disorder and management of a venous vascular device. He received SN services. His record, including the POC, for the certification period 1/24/16 to 3/23/16, was reviewed.</p> <p>A visit was made to Patient #10's home on 2/24/16 at 10:00 AM. Patient #10's mother was asked about his medications. She stated he was on Keppra for prevention of seizures. However, Keppra was not included on Patient #10's POC or his medication profile.</p> <p>During an interview on 2/26/16 at 9:30 AM, the RN Case Manager reviewed Patient #10's record and confirmed his POC and medication profile did not include Keppra.</p>	G 337			

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G 337	<p>Continued From page 153</p> <p>Patient #10's POC and medication profile did not include all medications he was taking.</p> <p>3. Patient #11 was a 76 year old female admitted to the agency on 1/02/16, for care of a pressure ulcer on her sacrum. Additional diagnoses included HTN and asthma. She received SN services. Her record, including the POC, for the certification period 1/02/16 to 3/01/16, was reviewed.</p> <p>A visit was made to Patient #11's home on 2/24/16 at 4:00 PM to observe an LPN visit. During the visit, Patient #11's medications were reviewed. Patient #11 stated she was taking Paxil daily, and had been for approximately 10 years. However, Paxil was not included on Patient #11's POC or medication profile.</p> <p>During an interview on 2/25/16 at 2:30 PM, the RN Case Manager reviewed the record and stated she was not aware Patient #11 was taking Paxil. She confirmed the medication was not on her POC or medication profile.</p> <p>Patient #11's medication profile did not include all medications she was taking.</p> <p>4. Patient #5 was a 66 year old female admitted to the agency on 2/02/16, for SN, PT, OT and home health aide services related to care after orthopedic surgery. Additional diagnoses included spinal stenosis, Type II DM, HTN, and chronic pain. Her record, including the POC, for the certification period 2/02/16 to 4/01/16, was reviewed.</p> <p>a. A home visit was conducted at Patient #5's</p>	G 337			

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G 337	<p>Continued From page 154</p> <p>home on 2/23/16, beginning at 4:00 PM. During the visit discrepancies were observed between her medication list on the POC and medications in the home. Patient #5's medication list on her POC did not include all the medications she was taking in her home. Medications which were not on the POC included Lactulose 10 gm/15 ml and Norco 10/325. Additionally, Percocet 10/325 was included on the POC, however, Patient #5 stated she was no longer taking it.</p> <p>Patient #5 stated she had an appointment with her physician on 2/11/16, and her pain medications were changed at that time per her request. She also stated the Lactulose was prescribed by her physician prior to her surgery, and due to severe constipation she had taken it a couple of days ago to help alleviate the problem.</p> <p>During an interview on 2/26/15 at 8:50 AM, the RN Case Manager reviewed the record and confirmed the discrepancies on the medication list. She stated she was unaware Patient #5 had a medication change and that she was taking Lactulose which was previously prescribed by her physician.</p> <p>Patient #5's medication list was not comprehensive to reflect all of her current medications.</p> <p>b. An SOC comprehensive assessment was completed on 2/02/16, and signed by the RN. The comprehensive assessment stated problems were found during a review of Patient #5's medications and her physician was notified within 1 calendar day of the problems.</p> <p>Patient #5's record included a Physician Phone</p>	G 337			

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G 337	<p>Continued From page 155</p> <p>Order, dated 2/02/16, signed by the RN which stated there were 2 contraindicated drug combinations. The first was between potassium and Phenergan (an antihistamine) and the second was between Trazodone (an antidepressant) and Duloxetine (an antidepressant and nerve pain medication). The order requested a physician response if he wanted to change the medications. The order was faxed to Patient #5's physician on 2/02/16. As of 2/25/16, the order was not signed by the physician.</p> <p>Patient #5's medications were entered in to "Drugs.com" (an internationally recognized database and public access website established as a standard for nurses and clinical staff in determination of drug interactions) to check the severity of the drug interactions. The interaction between Potassium and Phenergan was identified as a major interaction, as these medications may result in ulcers, bleeding and other gastrointestinal injury. The interaction between Traxodone and Duloxetine was also identified as a major interaction, which can increase the risk of a rare but serious condition called serotonin syndrome.</p> <p>During an interview on 2/25/16 at 2:00 PM, the RN who completed the SOC comprehensive assessment confirmed the contraindications between the medications. She confirmed Patient #5's physician was sent the fax and it was not returned or signed by the physician. The RN stated she did not phone the physician about the medication interactions.</p> <p>The agency failed to ensure Patient #5's physician was contacted to resolve potentially significant medication interactions.</p>	G 337			

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G 337	Continued From page 156 5. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC, for the certification period 1/25/16 to 3/24/16, was reviewed. A home visit was conducted on 2/24/16 beginning at 7:15 AM, to observe the Occupational Therapist as he provided care. Interviews were also conducted with Patient #3 and her daughter. Medications were reviewed and compared with Patient #3's POC and medication record provided by the agency. Discrepancies were noted as follows: a. The POC included Cardura (a medication that relaxes veins and arteries to allow blood to circulate) 4 mg, daily. The medication was not on the agency printed Medication Profile, or in the home. b. The POC included Melatonin (used to treat insomnia or sleep disorders) 1000 mg, at bedtime. The medication was not on the agency printed Medication Profile, or in the home. c. The POC and the agency Medication Profile included Hydrocodone/APAP 10-325, 1 tablet every 6 hours as needed for pain, however the bottle of the medication in her home stated "1 tablet every 8 hours" as needed for pain. d. The POC included potassium chloride 10 mEq, twice daily. The Medication Profile stated 3 times daily, and the medication in Patient #3's home included potassium chloride ER 10 mEq, once daily.	G 337			

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G 337	<p>Continued From page 157</p> <p>The following "over the counter" medications were disclosed by Patient #3, however, they were not included on her POC or the Medication Profile.</p> <ul style="list-style-type: none"> - Stool softener, - Systane drops, an eye lubricant, - Seratame for restless legs, 2 capsules every morning, - Unisom, a sleep aid. <p>During an interview on 2/25/16 beginning at 4:30 PM, the RN Case Manager reviewed Patient #3's record and confirmed the medication discrepancies. She stated she tried to, but did not always review Patient #3's medications when she provided a nursing visit. She was unable to explain why the Medication Profile and the POC differed.</p> <p>The agency did not ensure it maintained a current and accurate medication profile.</p> <p>6. Patient #6 was a 74 year old female who was admitted to the HHA on 1/08/16 for SN and therapy services related to CHF, UTI, and history of falls. Patient #6's record, including her POC, for the certification period 1/08/16 to 3/07/16, was reviewed.</p> <p>A home visit was conducted on 2/25/16 beginning at 3:00 PM to observe the Physical Therapist as he provided care. Patient #6 was interviewed after the PT session was completed. Medications were reviewed and compared with Patient #6's POC and Medication Profile provided by the agency.</p>	G 337		

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G 337	Continued From page 158 Medications were disclosed by Patient #6 which were not on the POC or Medication Profile as follows: Calcium 500+D, 1 tablet twice daily. Fish Oil 500 mg, 4 capsules daily. Flonase nasal spray 50 mcg, twice daily for nasal congestion. Lasix 40 mg, 1 tablet daily, diuretic. Requip 4 mg, 1 tablet daily, for Parkinson's disease. Triamterene hctz 75-50, 1.5 tablets every morning, for high blood pressure. Day Quil/ Ny Quil, (over the counter cold medications). Advil 200 mg tablets, as needed for pain. During an interview on 2/26/16 beginning at 10:20 AM, Patient #6's RN Case Manager reviewed her record and stated she was not aware of the additional medications. She stated she and the therapy staff were to update medications if changes were discovered during visits.	G 337		
G 338	The agency did not ensure it maintained a current and accurate medication profile. 484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to	G 338		4/15/16

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G 338	<p>Continued From page 159</p> <p>ensure patients' recertification assessments were updated and included necessary information for the care of patients for 2 of 5 patients (Patient #3 and #8) who were recertified for service and whose records were reviewed. This resulted in conflicting assessment information and a lack of information available to staff providing care which had the potential to negatively affect patient care and treatment. Findings include:</p> <p>Patient #8 was a 56 year old male admitted to the agency on 12/12/15, for SN services related to a pressure ulcer. Additional diagnoses included atrial fibrillation and Type II DM. His record, including the POCs, for the certification periods 12/12/15 to 2/09/16 and 2/10/16 to 4/09/16, was reviewed.</p> <p>Patient #8's record included a recertification assessment completed on 2/08/16, and signed by the RN Case Manager. The assessment was not comprehensive to identify all his needs. Examples include:</p> <p>a. Patient #8's primary diagnosis was a pressure ulcer. The recertification assessment stated Patient #8 had a diabetic ulcer on his left foot. However, there was no documentation he had a pressure ulcer. The recertification assessment did not include a description or measurement of the diabetic ulcer on his left foot to establish a baseline for assessing progress of the wound.</p> <p>b. Patient #8's diagnoses included Type II DM. The recertification assessment stated Patient #8's DM was controlled with difficulty, it affected his daily functioning, and he needed ongoing monitoring. However, the assessment did not include documentation of a BG level.</p>	G 338		

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G 338	<p>Continued From page 160</p> <p>c. Patient #8's recertification assessment stated he need supplies for a tracheostomy (a surgical incision in the throat to place a tube for breathing). However, there was no documentation Patient #8 had a tracheostomy.</p> <p>During an interview on 2/25/16 at 3:10 PM, the RN Case Manager reviewed Patient #8's record and confirmed she documented he needed ongoing monitoring of his DM. She confirmed she did not document a BG level. The RN Case Manager stated Patient #8 did not have a glucometer and she was trying to get him one. She confirmed he did not have a tracheostomy. The RN Case Manager stated she incorrectly documented he needed supplies for a tracheostomy. She confirmed Patient #8 did not have a pressure ulcer, but a diabetic ulcer. The RN Case Manager confirmed there was no documentation included in the assessment of the appearance or measurement of the diabetic ulcer.</p> <p>Patient #8's recertification assessment failed to include a wound assessment and included conflicting information.</p> <p>2. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC, for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>A recertification assessment was performed on 1/20/16. Patient #3's primary diagnosis was CHF, with a severity code of 2, indicating her symptoms were controlled with difficulty, affected</p>	G 338			

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G 338	<p>Continued From page 161</p> <p>her daily functioning, and required ongoing monitoring. However, her POC did not include interventions related to CHF, such as monitoring her weight on a daily basis. Her recertification assessment did not include a baseline weight.</p> <p>During an interview on 2/25/16, beginning at 4:30 PM, the RN reviewed Patient #3's record. She confirmed Patient #3's recertification assessment was not complete to include a baseline weight.</p> <p>Patient #3's recertification assessment was not complete.</p> <p>c. The recertification assessment included an assessment of Patient #3's gastrointestinal system. The clinical findings included documentation by the RN "Clinical Conditions Cirrhosis r/t [related to] fatty liver." However, Patient #3's medical record did not include documentation of a diagnosis of cirrhosis in her physician referral, or H&P.</p>	G 338			

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State recertification survey of your homehealth agency on 2/23/16 through 3/01/16. The surveyors conducting the recertification were: Susan Costa RN, HFS, Team Lead Nancy Bax RN, HFS Laura Thompson RN, HFS	N 000		
N 001	03.07020.01. ADMIN.GOV.BODY 020. ADMINISTRATION - GOVERNING BODY. N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency. This Rule is not met as evidenced by: Refer to G128	N 001	See G128	
N 025	03.07020. ADMIN. GOV. BODY N025 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.vii. A patient has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to	N 025		

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

Smala Statherson

TITLE

Administrator

(X6) DATE

3/28/16

Bureau of Facility Standards

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N 025	Continued From page 1 discrimination or reprisal for doing so. This Rule is not met as evidenced by: Refer to G106	N 025	See G106	
N 034	03.07020. ADMIN. GOV. BODY N034 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xvi. The HHA must advise a patient, in advance, of the disciplines that will be furnished, care, and frequency of visits proposed to be furnished. This Rule is not met as evidenced by: Refer to G108	N 034	See G108	
N 044	03.07021. ADMINISTRATOR N044 021. ADMINISTRATOR. An administrator shall be appointed by the governing body and shall be responsible and accountable for implementing the policies and programs approved by the governing body. This Rule is not met as evidenced by: Refer to G129	N 044	See G129	
N 046	03.07021.02.ADMINISTRATOR	N 046		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001650	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER VISIONS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1770 PARK VIEW DRIVE TWIN FALLS, ID 83301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 046	Continued From page 2 N046 02. Absences. The administrator shall designate, in writing, a qualified person to perform the functions of the administrator to act in his absence. This Rule is not met as evidenced by: Refer to G137	N 046	See G137	
N 047	03.07021.03.ADMINISTRATOR N047 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: a. Organizing and coordinating administrative functions of the program, delegating duties, establishing a formal means of accountability on the part of staff members, and maintaining continuing liaison among the governing body, the group of professional personnel and the staff. This Rule is not met as evidenced by: Refer to G133	N 047	See G133	
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G169 and G170	N 091	See G169 and G170	

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N 093	Continued From page 3	N 093		
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 style="padding-left: 40px;">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 G172 and G331</p>	N 093	See G172 and G331	
N 094	<p>03.07024. SK. NSG. SERV.</p> <p>N094 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:</p> <p style="padding-left: 40px;">b. Initiates the plan of care and makes necessary revisions;</p> <p>This Rule is not met as evidenced by: Refer to G173</p>	N 094	See G173	
N 097	<p>03.07024. SK. NSG. SERV.</p> <p>N097 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified</p>	N 097		

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N 097	Continued From page 4 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	See G176	
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 G176	
N 099	03.07024.SK. NSG. SERV. N099 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: g. Counsels the patient and family in meeting nursing and related	N 099		

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N 099	Continued From page 5 needs; This Rule is not met as evidenced by: Refer to G177	N 099	See G177	
N 102	03.07024.SK.NSG.SERV. N102 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: j. For patients receiving care from a licensed practical nurse, the registered nurse reviews the plan of care and nursing services received at least every two (2) weeks and documents this in the patient's medical record. This Rule is not met as evidenced by: Based on record review, and staff interview, it was determined the agency failed to ensure sufficient RN supervision of LPN skilled nursing services for 2 of 6 patients (#3 and #7) who received SN services from an LPN. This negatively impacted quality and coordination of patient care. Findings include: During the entrance conference with the agency Director on 2/23/16 beginning at 10:30 AM, she stated LPN supervision was performed every 2 weeks. She stated the EMR had a section in the visit note to document the supervisory activity. The Director stated it was tracked for compliance	N 102	See G169	

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N 102	<p>Continued From page 6</p> <p>by routine chart audits.</p> <p>Patients received LPN services without RN supervision, as follows:</p> <p>a. Patient #3 was an 82 year old female who was admitted to the HHA on 1/30/15, for SN, OT and Home Health Aide services related to CHF, DM Type II, and weakness. Patient #3's record, including her POC, for the certification period 1/25/16 to 3/24/16, was reviewed.</p> <p>The POC included orders for SN visits once weekly for the duration of the certification period. Patient #3 received an RN visit on 1/20/16, when she was recertified for an additional 60 days. The recertification comprehensive assessment performed that day included an LPN supervisory visit.</p> <p>Patient #3's record documented SN visits weekly, with an LPN on 1/26/16, 2/02/16, and 2/09/16. The following week on 2/18/16, Patient #3 was seen by an RN. The RN visit note included supervisory oversight documentation for the LPN. From 1/20/16 to 2/18/16, three LPN visits occurred without documentation of RN supervision.</p> <p>During an interview on 2/25/16 beginning at 4:30 PM, the RN Case Manager reviewed Patient #3's record and confirmed RN supervision of LPN care was not performed. The RN Case Manager stated she was on maternity leave during that time and LPN supervision was not done.</p> <p>Patient #3 received care by an LPN without supervision by an RN every 2 weeks.</p> <p>b. Patient #7 was an 88 year old female who was</p>	N 102	See G169	

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N 102	<p>Continued From page 7</p> <p>admitted to the HHA on 5/04/15, for SN services related to a CVA. Additional diagnoses included major depressive disorder, weakness, and chronic kidney disease. Patient #7's record, including her POC, for the certification period 12/30/15 to 2/27/16, was reviewed.</p> <p>Patient #7's record documented LPN weekly SN visits on 1/05/16, 1/06/16, 1/12/16, 1/19/16, 1/27/16, 2/03/16 and 2/11/16. There was no LPN supervision documented from 12/30/15 until 12/17/15.</p> <p>During an interview on 2/25/16 beginning at 4:20 PM, the RN Case Manager reviewed Patient #7's record and confirmed RN supervision of LPN care was not performed. The RN Case Manager stated she was on maternity leave during that time and LPN supervision was not done.</p> <p>Patient #7 received care by an LPN without supervision by an RN every 2 weeks.</p>	N 102		
N 124	<p>03.07025.01.THERAPY SERV.</p> <p>N124 01. Qualified Therapist. A qualified therapist duties include the following:</p> <p style="padding-left: 40px;">a. Assists in developing the plan of care and revising it when necessary;</p> <p>This Rule is not met as evidenced by: Refer to G186</p>	N 124	See G186	
N 125	<p>03.07025.THERAPY SERV.</p> <p>N125 01. Qualified Therapist. A</p>	N 125		

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N 125	Continued From page 8 qualified therapist duties include the following: b. Advises and consults with the family and other agency personnel; This Rule is not met as evidenced by: Refer to G188	N 125	See G188	
N 126	03.07025.THERAPY SERV. N126 01. Qualified Therapist. A qualified therapist duties include the following: c. Prepares clinical and progress notes, and summaries of care, and This Rule is not met as evidenced by: Refer to G187	N 126	See G187	
N 138	03.07026.01.SOC.SERV. N138 01. Service Providers. If the agency furnishes medical social services, those services are given by a qualified social worker, licensed in Idaho, in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G195	N 138	See G195	
N 144	03.07026.SOC.SERV. N144 02. Social Worker. A social worker performs the following duties:	N 144		

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N 144	Continued From page 9 f. Participates in in-service programs, and This Rule is not met as evidenced by: Refer to G200	N 144	See G200.	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158	N 152	See G158	
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159	N 153	See G159	
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A	N 155		

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N 155	Continued From page 10 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 G159	
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	N 161	See G159	
N 165	03.07030.PLAN OF CARE N165 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 165		

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N 165	Continued From page 11 m. The patient and his family's teaching needs; This Rule is not met as evidenced by: Refer to G159	N 165	See G159	
N 168	03.07030.02. PLAN OF CARE N168 02. Goals of Patient Care. The goals of patient care must be expressed in behavioral terms that provide measurable indices for performance. This Rule is not met as evidenced by: Refer to G159	N 168	See G159	
N 169	03.07030.03.PLAN OF CARE N169 03. Orders for Therapy Services. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. This Rule is not met as evidenced by: Refer to G161	N 169	See G161	
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 G160	

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N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164	N 172	See G164	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G165, G166, and G337	N 173	See G165, G166, G337	
N 193	03.07040.AGENCY EVALUATION N193 040. AGENCY EVALUATION. A group of professional personnel, which includes at least one (1) physician, one (1) registered nurse, and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing the scope of	N 193		

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N 193	<p>Continued From page 13</p> <p>services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one (1) member of the group is neither an owner nor an employee of the agency.</p> <p>This Rule is not met as evidenced by: Refer to G152 and G153</p>	N 193	See G152 and G153	



VISIONS
HOME HEALTH, LLC

RECEIVED
APR 13 2016
FACILITY STANDARDS

4/8/2016	<p>Plan of Correction-Visions Home Health, LLC Provider #13-7107. Response to: Medicare/Licensure Survey-State of Idaho State Survey Date: February 23-26, 2016.</p>		<p><i>Damald Patterson</i></p>	<p>4/12/2016</p>
Deficiency Tag #	How the deficiency will be corrected	Who will be responsible for making the corrections	What will be done to prevent reoccurrence and how we will monitor for continued compliance	When the correction will be completed
G 106 N025	<p>484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP Director educated staff on patient's rights to voice grievances regarding treatment or care without fear of reprisal. Instructed staff on educating patients upon admission regarding their rights, responsibilities, and problem solving procedure that is in Admission Packet. The Director will review all complaints and contact patient regarding the complaint. Director to make sure the complaint is adequately resolved.</p>	Director or Delegate	<p>Mandatory Meeting was held to instruct staff regarding patient's rights on March 25, 2016. Each complaint received will be monitored by calling the patient and/or their caregiver and educating them on their rights.</p>	4/15/2016
G 108 N034	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE Director educated staff on the importance of informing patients of their Home Health services that are ordered by their physician. Multidisciplinary Care Plans will be mailed to the patient's home. New forms are included in the admission packets to assist patients in knowing what services they should expect and what treatment those disciplines will provide</p>	Director Patient Care Coordinator or Delegate	<p>All Multidisciplinary Care Plans will be mailed to the patient's home at SOC, Recertification and Significant Change of Condition. Beginning 4/1/2016, Director or Designee will make 2 home visits per week to review patient's home health folder for current Multidisciplinary Care Plan and medication record. Will continue weekly visits until 100% compliance. 10% of patient census will have a home visit performed quarterly</p>	4/15/2016

4/8/2016	Plan of Correction-Visions Home Health, LLC Provider #13-7107. Response to: Medicare/Licensure Survey-State of Idaho State Survey Date: February 23-26, 2016.			
Deficiency Tag #	How the deficiency will be corrected	Who will be responsible for making the corrections	What will be done to prevent reoccurrence and how we will monitor for continued compliance	When the correction will be completed
			to ensure multi disciplinary care plans are in the home.	
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION The Governing body appointed the Director to serve as the Administrator in their absence. A Policy was written to designate who will function as the administrator when the administrator is absence.	Administrator or Delegate	Policy will be reviewed Annually by Governing Body and Professional Advisory Group.	4/15/2016
G 128 N001	484.14(b) GOVERNING BODY The Governing body will meet bi-annual and as needed to review the operations of the agency. This will included policies, procedures, and financials.	Administrator or Delegate	Executive Meetings will be scheduled bi-annually. As needed meetings will be scheduled as issues arise. Compliance with these meeting will be addressed in the Professional Advisory Meetings bi-annually.	4/15/2016
G 129 N044	484.14(b) GOVERNING BODY The Governing body appointed the Administrator who will carry out the home health programs administrative responsibilities. Policy 1009-A was written.	Governing Body or Delegate	Governing Body and Professional Advisory Group will meet bi-annual. Policy will be reviewed annually.	4/15/2016
G 133 N047	484.14(c) ADMINISTRATOR The Governing body appointed the Administrator who will carry out the home health programs administrative responsibilities. Policy 1009-A was written.	Governing Body or Delegate	Policy will be reviewed annually by the Governing Body and Professional Advisory group.	4/15/2016
G 137 N046	484.14(c) ADMINISTRATOR The Governing body appointed the Director to serve as the Administrator in their absence. Policy 1010-A was	Administrator or Delegate	Policy will be reviewed Annually by Governing Body and Professional	4/15/2016

4/8/2016	Plan of Correction-Visions Home Health, LLC Provider #13-7107. Response to: Medicare/Licensure Survey-State of Idaho State Survey Date: February 23-26, 2016.			
Deficiency Tag #	How the deficiency will be corrected	Who will be responsible for making the corrections	What will be done to prevent reoccurrence and how we will monitor for continued compliance	When the correction will be completed
	written to designate who will function as the administrator when the administrator is absent.		Advisory Group.	
G 152 N193	484.16 GROUP OF PROFESSIONAL PERSONNEL Professional Advisory Group will consist of an MD, RN, and other professional disciplines.	Director or Delegate	Director will email Professional Advisory Group members at least 1 month prior to bi-annual meeting. Follow-up email will be sent 1 week prior to remind members of the meeting.	4/15/2016
G 153 N193	484.16 GROUP OF PROFESSIONAL PERSONNEL Professional Advisory Group will review agency Policies and Procedures annually and as needed when policies are revised.	Director or Delegate	Annual Policy and Procedure review will be scheduled on the Annual Spring Professional Advisory Meeting.	4/15/2016
G 155	484.16(a) ADVISORY AND EVALUATION FUNCTION Professional Advisory Group meetings will have minutes attached to each meeting.	Director or Delegate	Director will create minutes from the Professional Advisory Meeting. These minutes will be reviewed at the executive Board Meeting bi-annual.	4/15/2016
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Refer to G158, G159, G160, G161, G164, G165, G166,			
G 158 N152	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Clinicians were educated on obtaining orders prior to care. Clinicians were educated on contacting the physician or the physician's representative to get approval for the continuation of care. These orders must include frequency, duration and services that will be furnished. Clinicians were educated on scheduling	Director, Patient Care Coordinator, or Delegate	Patient Care Coordinator will review all orders for completeness. Patient Care Coordinator will review every plan of care for new and recertified patients before the plan of care is completed and sent to the MD for signature. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record	4/15/2016

4/8/2016	Plan of Correction-Visions Home Health, LLC Provider #13-7107. Response to: Medicare/Licensure Survey-State of Idaho State Survey Date: February 23-26, 2016.			
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	<p>visits according to the Plan of Care. All visits will be scheduled for the duration of orders so that the clinicians are notified from the task hotlist located in Brightree that a visit is missed. Office Staff will print weekly a report titled "Missed Visit Report" to identify visits that were missed by the clinicians. Those visits will be printed off and faxed to the physician. Clinicians that complete paper documentation will have their missed visits faxed to the physician as it is submitted to the agency. Documentation will be stamped faxed to indicate this was completed.</p>		<p>review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.</p>	
G 159 N153 N155 N161 N165 N168	484.18(a) PLAN OF CARE <p>Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, & 3/25. Educated clinicians on the need to include all pertinent interventions and goals related to the patient's diagnosis. Educated clinicians on accurate and precise documentation of education and patient assessment that will be part of the patient specific Plan of Care. Educated clinicians on completion of the 485 and importance of listing all supplies, DME, medications, and treatments. Educated Clinicians on obtaining parameters for all patients' with the diagnosis of CHF, Diabetes, and HTN. Educate clinicians on notifying the MD at the time of the patient visit for any change in the patient's condition that may warrant a change in the Plan of Care.</p>	Patient Care Coordinator Director, Clinicians, or Designate	Patient Care Coordinator will monitor start of care, resumption of care, recertification and anytime there is a change to the patient's plan of care. Patient Care Coordinator will review every plan of care to ensure that the plan of care is comprehensive and meets the patient's needs prior to being sent to the physician for signature. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016

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G 160 N170	484.18(a) PLAN OF CARE Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated staff and contract therapist on obtaining verbal orders after initial visit. The staff must call the physician and consult with either the physician or the physician's representative to get approval for the continuation of care. These verbal orders must contain a frequency and duration for services. Verbal order must contain intervention and goals pertinent to that patient. Written orders are acceptable if they are signed and approved by the physician prior to any further visits after the initial visit. Physician will be called with changes in patient's condition that may warrant a change in treatment and/or services. Primary Care physician will need to authorize any physicians who are allowed to give orders on patients.	Patient Care Coordinator, Intake Coordinator, or Designate	Patient Care Coordinator will monitor all verbal orders to ensure that they are complete and accurate. Verbal orders need to indicate name of the physician or physician representative who gave the verbal order. Patient Care Coordinator will continue to monitor all verbal orders ongoing. Patient Care Coordinator will monitor plan of care for new and recertified patients for orders indicating other physicians that are approved by patient's primary MD to give orders. All visits prior to orders obtained will be non-billable. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance is achieved. 10% of census chart audit will be done quarterly ongoing.	4/15/2016
G 161 N169	484.18(a) PLAN OF CARE Educated therapy staff that therapy orders need to include frequency, duration, interventions, and goals.	Patient Care Coordinator or Delegate	Patient Care Coordinator or Delegate will review all therapy orders to ensure that they are complete. All orders will be reviewed ongoing.	4/15/2016
G 164 N172	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated clinicians on promptly notifying the physician of changes in the patient's condition that may	Director, Patient Care Coordinator,	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record	4/15/2016

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	<p>require a change in the plan of care. Educated clinicians on ensuring that the patient's ongoing needs are being met, documented, and communicated promptly to the physician. Instructed LPN that if there is a change in the patient's status that is noted on their visit she must notify the RN during the visit. The plan of care will include individual parameters. Parameters established for the patient must be communicated to the physician. Casemanager will instruct the LPN how to proceed. Communication between staff and the physician will be documented in the communication section of the patient's electronic record.</p>	Clinicians.	<p>review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.</p>	
G 165 N173	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated Clinicians on importance of following all medication and treatment orders as specified by the physician. All wound care orders will have specific dressing change instructions. Orders will include frequency of dressing changes and who will be performing them. Educated on promptly notifying the physician when there is a change of condition that may warrant a change in the patient's plan of care.</p>	Director, Patient Care Coordinator, Clinicians	<p>Patient Care Coordinator will monitor all new admissions, recertification orders, and 100% verbal orders for completeness ongoing. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.</p>	4/15/2016
G 166 N173	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated Staff that only an RN or a qualified Therapist can accept a verbal order from a physician. Director educated the LPN's that they are not able to</p>	Director, Patient Care Coordinator, or Designate	<p>Patient Care Coordinator will monitor all verbal orders to ensure that they are complete and accurate. Verbal orders need to indicate name of the person who gave the verbal order.</p>	4/15/2016

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	accept a verbal order.		Monitoring 100% verbal orders will remain an ongoing process.	
G 168	484.30 SKILLED NURSING SERVICES Refer to G169, G170, G172, G173, G176, G177			
G 169 N091 N102	484.30 SKILLED NURSING SERVICES Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated staff that if patients are receiving services from an LPN the RN is required to make a supervisory visit every 2 weeks or more frequently if the patient's condition warrants RN oversight.	Director, Patient Care Coordinator or Designate	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016
G 170 N091	484.30 SKILLED NURSING SERVICES Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated Clinicians on following the orders on the Plan of Care. The Plan of Care needs to have patient specific orders that address the patient's clinical needs. All wound care orders need to have clear dressing change instructions. Chronic conditions need to be addressed in the plan of care with set parameters. Documentation needs to reflect the interventions and goals on the POC.	Director, Patient Care Coordinator, or Designate	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016
G 172 N093	484.30(a) DUTIES OF THE REGISTERED NURSE Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated the staff on expectations for each routine visit with emphasis on head to toe assessment, vital signs, and medication review. Clinicians must clearly document the patient's condition. Charting needs to be clear, specific and measurable. See Routine Visit	Patient Care Coordinator or Designate	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016

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	Assessment Policy #3024.			
G 173 N094	484.30(a) DUTIES OF THE REGISTERED NURSE Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated clinicians that each patient requires a Plan of Care/485 and that all areas of the Plan of Care need to be completed. Patient's Plan of Care needs to address diagnoses that are pertinent to the patient's condition. Interventions include assessment, procedure, and education. Plan of Care will address measurable goals and parameters for patients that their condition warrants parameters. Plan of Care needs to be revised as needed based on the patient's medical condition. Educated Staff on importance of proper and detailed documentation. Charting needs to be clear, specific and measurable. Educated clinicians that they must review current orders prior to each routine visit.	Director, Patient Care Coordinator, or Designate	Patient Care Coordinator will monitor start of care, resumption of care, recertification and anytime there is a change to the patient's plan of care. Patient Care Coordinator will review every plan of care to ensure that the plan of care is comprehensive and meets the patient's needs prior to being sent to the physician for signature. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016
G 176 N097 N098	484.30(a) DUTIES OF THE REGISTERED NURSE Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated clinicians on doing a complete and comprehensive assessment at the start of care to include detailed information that will impact care provided beyond the start of care visit. Educated Clinicians that the patient's physician must be notified if the patient has a change of condition that warrants a change in the Plan of Care. Clinicians need to notify other services of any changes in patient's condition. Educated the clinicians on accurate and precise documentation regarding patient's condition and any	Director, Patient Care Coordinator, or designate.	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016

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	coordination of care.			
G 177 N099	484.30(a) DUTIES OF THE REGISTERED NURSE Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated the staff on the importance of patient education. Patient education should include chronic diseases and resources that are used to improve the patient's outcomes. Patient education should enhance efforts to improve patients' knowledge of their disease and treatment plans. Implemented the use of patient education forms. These forms will be included in the admission packet according to primary diagnosis. Clinicians will need to use them as the patient's condition warrants. All education provided to the patient or their caregiver will be documented each visit.	Director, Patient Care Coordinator, or Designate	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016
G 186 N124	484.32 THERAPY SERVICES Educated therapy staff that orders for continuing care must be obtained by calling the physician and discussing the Plan of Care with the physician, physician's representative, or their written Plan of Care must be signed by the physician prior to any further visits being completed. Educated the therapist that they must develop a plan of care that meets the patient's needs. All clinical visit notes need to be precise and accurate reflecting the care being provided. Educated therapy staff that interventions and goals need to be updated at least every 60 days and as needed when patient's condition warrants a change in the plan of care.	Director, Patient Care Coordinator, or Designate	Patient Care Coordinator will monitor all verbal orders to ensure that they are complete and accurate. Verbal orders need to indicate name of the physician or physician's representative that gave the verbal order. Monitoring 100% verbal orders will remain an ongoing process. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016

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G 187 N126	484.32 THERAPY SERVICES Educated Therapists that they need to develop a plan of care in conjunction with the physician that is patient specific. Therapy documentation needs to reflect the interventions and goals that are established on the plan of care. Educated therapy staff that interventions and goals need to be reviewed every visit and updated at least every 60 days when the patient's condition warrants a change in the plan of care.	Director, Patient Care Coordinator, or Designate	Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.	4/15/2016
G 188 N125	484.32 THERAPY SERVICES Implemented that patient Plan of Care and Medication sheets will be mailed out to the patient's home at start of care, Recertification, and with any changes in Plan of Care and/or medications. Educated Clinicians those patients need to be educated and take part in developing their plan of care. Patients and their caregivers need to be educated on the expectations of home health services.	Director, Patient Care Coordinator, or Designate	Monitoring will occur via completing 2 home visits per week until 100% compliance with Multidisciplinary Care Plan and Medication record are in the patient's home health folder. Patient will verbalize understanding of therapy interventions and goals. Home visits will then be conducted 10% of patient census per quarter ongoing.	4/15/2016
G 195 N138	484.34 MEDICAL SOCIAL SERVICES Administrator and Director met with MSW on 3/28/2016. Discussed home health conditions of participation related to Social Services, survey results, and referral process. MSW verbalized understanding of conditions of participation. Educated MSW that he is expected to visit the patient within 48 hours.	Director, Patient Care Coordinator, or Designate	Each new referral will be followed up by a text or phone call to the Clinician assigned to verify that they have seen the patient within 48 hours of the referral until 100% compliance x 60 days. This will be monitored ongoing with 10% of census chart audit every quarter.	4/15/2016
G 200 N144	484.34 MEDICAL SOCIAL SERVICES Educated MSW that he is expected to attend 80% of Home Health in-services a year.	Director or Designate	Monitoring will be conducted with MSW yearly evaluation ongoing.	4/16/2015

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G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAINING Home Health aide annual performance review will be conducted yearly.	Director or Designate	Monitoring will be conducted in conjunction of the agency annual training.	4/15/2016
G 321	484.20(a) ENCODING OASIS DATA Educated OASIS Coordinator on what measures to take to reconcile the OASIS transmittal errors. All errors need to be brought to the attention of the Patient Care Coordinator.	Patient Care Coordinator or Designate	Monitoring will be conducted by reviewing transmittal report 1-2xs weekly until 100% compliance x 60 days. Monitoring will be ongoing when errors are indicated.	4/15/2016
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, & 3/25. Educated Clinicians on Diagnosis Coding and Severity Codes. Admitting Clinicians need to list Diagnosis according to importance on the form and then assign a severity to that diagnosis. This form will be turned in with admission documentation. Clinicians are signed up to take an OASIS Education class on-line through Fazzi. Clinicians are required to take a test at the end of the modules. Record of the test will be kept in the clinicians file. All future clinicians will be required to take this class upon hire.	Director, Patient Care Coordinator, or Designate	Patient Care Coordinator will monitor start of care, resumption of care, recertification and anytime there is a change to the patient's plan of care. Patient Care Coordinator will review every plan of care to ensure that the plan of care is comprehensive and meets the patient's needs prior to being sent to the physician for signature. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly.	4/15/2016
G 331 N093	484.55(a)(1) INITIAL ASSESSMENT VISIT Mandatory Meetings for clinicians on 3/4, 3/11, 3/18,		Patient Care Coordinator will monitor	4/15/2016

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	<p>&3/25. Educated clinicians on the importance of the Comprehensive Assessment. Clinicians need to review the patient's medical history prior to making the initial visit. If there is missing documentation from the referral source the intake coordinator will request the needed documentation to support assessment findings to appropriately complete the initial assessment. Clinicians need to look at all aspects of the patient's medical condition with focus on all body systems. Clinicians need to do a head to toe assessment. Clinicians were given a scale to make sure that patients are weighed on SOC and as needed. Educated clinicians on Oxygen orders and reassessing these orders q visit due to Oxygen orders can change frequently. Educated clinicians on skin assessments. This will assist the Clinician in determining the patient's immediate care and support needs.</p>	<p>Director, Patient Care Coordinator, or Designate</p>	<p>all new admissions to ensure complete and accurate documentation. An admission checklist will be used to ensure all areas are covered. Patient Care Coordinator will do an admission visit with each RN to educate them on the process. Further oversight of SOC visits will be done based on issues found.</p> <p>Monitoring will occur via completing 2 home visits per week until 100% compliance. Home visits will then be conducted 10% patient census per quarter ongoing.</p> <p>Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly.</p>	
G 337 N173	<p>484.55(c) DRUG REGIMEN REVIEW Mandatory Meetings for clinicians on 3/4, 3/11, 3/18, &3/25. Educated Clinicians on medication reconciliation. Clinicians are required to do a thorough medication review. Medication assessment at Start of Care, Resumption of Care, and Recertification will include visualization of the actual medication bottles, review of the medication list provided in the referral, as well as interview with the patient and/or caregiver. Clinicians must notify the physician of any issues regarding medication reconciliation. Brightree software</p>	<p>Director, Patient Care Coordinator, or Designate</p>	<p>Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% chart audits will be done quarterly ongoing.</p> <p>Monitoring will occur via completing 2 home visits per week until 100% compliance. Home visits will then be</p>	<p>4/15/2016</p>

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	<p>has the capability to indicate a drug to drug interaction. Clinicians were reminded and educated on using this tool. Educated clinicians on clear and precise documentation regarding medication regime and any issues noted. Educated Clinicians that every routine visit will include medication review. Clinicians need to interview patients every visit to see if they have had any new or changed medications. Medications need to have a physician order.</p> <p>Medication Record will be mailed to the patient's home upon completion and with any new or changed medications. Clinicians will instruct patient to put medication record in their Home Health folder so that staff can access during routine visits.</p>		<p>conducted 10% patient census per quarter ongoing. Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly.</p>	
G 338	<p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>Educated clinicians that the comprehensive assessments need to be complete and capture patient's diagnosis and conditions that affect their medical conditions. Educated clinicians on correct and precise documentation. Educated staff on Recertification, Resumption of Care, Transfer to Inpatient Facility, and "other follow-up" OASIS assessment which will need to be completed at certain time points in their care or when the patient has a significant change in condition. Documentation to explain the need for specific OASIS assessments will be documented in the communication section of the patient record.</p>	<p>Director, Patient Care Coordinator, or Designate</p>	<p>Monitoring will occur via 100% medical record review until 90% compliance is achieved then 50% medical record review until 90% compliance achieved. 10% of census chart audits will be done quarterly ongoing.</p>	4/15/2016