



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7012 3050 0001 2125 5709

July 21, 2016

Cheryl Abel, Administrator
Advanced Home Health
PO Box 1784
Idaho Falls, ID 83403

RE: Advanced Home Health, Provider #137116

Dear Ms. Abel:

Based on the survey completed at Advanced Home Health, on July 11, 2016, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA)

Conditions of Participation:

- **Acceptance of Patients, POC, Med Super (42 CFR 484.18)**

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

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Advanced 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;

Cheryl Abel, Administrator

July 21, 2016

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- 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 **August 3, 2016**. It is suggested that the Credible Allegation of Compliance/Plan of Correction for each Condition of Participation and related standard level deficiencies show compliance no later than **August 25, 2016**, 45 days from survey exit. We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

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

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

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

We must recommend to the CMS Regional Office and /or State Medicaid Agency that your provider agreement be terminated [42 CFR 488.865] on **January 7, 2017**, if substantial compliance is not achieved by that time.

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

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

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

Cheryl Abel, Administrator
July 21, 2016
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The IDR Guidelines can be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NonLongTermCare/tabid/427/Default.aspx>

Scroll down to Home Health Agencies (HHA) and select the following:

Informal Dispute Resolution (IDR)

IDR Guidelines

IDR Request Form

This request must be received by **August 3, 2016**. If your request for IDR is received after **August 3, 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.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,



DENNIS KELLY, RN
Co-Supervisor
Non-Long Term Care

DK/pt

Enclosures:

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

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

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2016
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2110 NIAGARA ST IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your agency from 7/06/16 to 7/11/16. The surveyors conducting the complaint investigation survey were:</p> <p>Nancy Bax, RN, BSN, HFS Susan Costa, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DM - Diabetes Mellitus DME - Durable Medical Equipment H&P - History and Physical HHA - Home Health Agency HTN - Hypertension lpm - liters per minute LPN - Licensed Practical Nurse LSW - Licensed Social Worker MD - Medical Doctor MS - Multiple Sclerosis MSW - Medical Social Worker NP - Nurse Practitioner OT - Occupational Therapy PA - Physician Assistant POA - Power of Attorney POC - Plan of Care pt - Patient PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse SLP - Speech-Language Pathology SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy</p>	G 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Advanced Home Health does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.</p>		

RECEIVED
AUG -2 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 8/1/16

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

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G 108	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>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.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records and agency policies, patient and caregiver interviews, and staff interview, it was determined the agency failed to inform patients their physician would not be involved in their plan of care for 3 of 7 patients (#2, #4, and #5) whose records were reviewed. This resulted in the plan of care and orders approved by, and care directed by, a physician other than the patients' referring or attending physician. Findings include:</p> <p>The agency's policy #10001, "ACCEPTANCE/ADMISSION OF PATIENTS," revised 5/15/15, included "The patient must be under a physician's care and the physician must be willing to provide the required written orders for care and/or services."</p> <p>The agency's policy #10002, "INTAKE SERVICE," revised 5/15/15, included criteria for patient admission to the agency. The criteria included "There is a preferred physician taking medical responsibility for the patient's care, i.e., the</p>	G 108	<p><u>G108</u></p> <p>The patient will be informed in advance about the care to be furnished and any changes in the care to be furnished, the disciplines that will furnish care and the frequency of visits proposed to be furnished. The patient will be advised in advance of any change in the plan of care before the change is made. This is to include any change in physician directing the plan of care. Advanced home health staff was in-serviced by Director on 7/12 and 7/19/2016 regarding the patient's right to be informed. Patients will be notified of any potential for change in physician and documentation entered into the chart for and acceptance of new physician directing their plan of care, 100% of patients changing to new PCP charts will be audited by Director or designee for documentation of patient notification and acceptance of change in physician until 100% compliance is achieved. Then 10% of charts will be audited at</p>		

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G 108	<p>Continued From page 2 physician will establish and periodically review the plan of care."</p> <p>The agency's policy #10004, "PLAN OF CARE (PLAN OF TREATMENT)," REVISED 5/15/15, included "The total plan of care shall be reviewed by the attending physician and HHA staff as often as the severity of the patient's condition requires, but at least once every 60 days..."</p> <p>The agency's document "HOME CARE PATIENT RIGHTS AND RESPONSIBILITIES," presented to agency patients during their initial visit, included "Have the right to choose a health care provider, including choosing an attending physicians [sic] and the right to receive appropriate care without discrimination in accordance with physician orders."</p> <p>The agency failed to follow its policies and ensure patients were informed of changes in their POC. Examples include:</p> <ol style="list-style-type: none"> 1. Patient #2 was an 83 year old male admitted to the agency on 2/25/16, for care related to COPD. Additional diagnoses included bronchitis and DM Type II. He received SN, PT, OT, and ST services. His record, including the POCs, for the certification periods 2/25/16 to 4/24/16, and 4/25/16 to 6/23/16, was reviewed. <p>Patient #2's record included a referral for home health services, dated 2/23/16. It stated Patient #2 was referred to the agency for SN, PT, OT, and ST services by Physician A.</p> <p>Patient #2's record included an SN SOC comprehensive assessment dated 2/25/16, signed by his RN Case Manager. The</p>	G 108	<p>least quarterly to reassess for compliance. Policies regarding Patient's Rights will be reviewed and revised if needed by Director under the direction of the Governing Board. These corrections will be completed by 8/19/2016. "Physician A" was notified of potential for violation of Patient's right to be informed and was notified by Director and marketer on 7/14/2016 at 0900 in person that after discussing with Governing Board, if the physician orders Home Health services he must either follow his own patients or</p> <ol style="list-style-type: none"> 1. Notify the patient that he will not follow home health, 2. Physician's office will facilitate transition to new PCP of their choice. 3. The physician's office will be responsible to notify the new physician, give report and send medical records as needed 4. The patient will be established by new PCP and orders for Home Health services will come from new PCP 		

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G 108	<p>Continued From page 3 assessment stated "PATIENT ADMITTED TO ADVANCED HOME HEALTH ON 2/25/16 UNDER ORDERS OF [Physician A]..."</p> <p>Patient #2's record included a POC for the certification period 2/25/16 to 4/24/16. The POC stated his physician was Physician B, and it was signed by Physician B. There was no documentation in Patient #2's record to explain why Physician B was listed as his physician when his home health referral order came from Physician A.</p> <p>Patient #2's record included documents titled "Client Coordination Note Report." They included the following statements:</p> <ul style="list-style-type: none"> - 3/01/16, signed by the Medical Records Specialist, "CASE MANAGER WAS EMAILED AND ASKED TO HELP THE PATIENT GET AN APPOINTMENT WITH [Physician B] FOR HIS FACE TO FACE." - 3/03/16, signed by the RN Case Manager, "ENCOURAGED PT [patient] TO SCHEDULE A FACE TO FACE WITH [Physician B]." - 3/08/16, signed by the RN Case Manager, "ENCOURAGE PATIENT TO MAKE AN APPOINTMENT WITH [Physician B]." - 3/10/16, signed by the RN Case Manager, "SCHEDULE THE FACE-TO-FACE WITH [Physician B] ON 3/16/16." - 3/15/16, signed by the RN Case Manager, "PT ALSO STATED THAT HE CANCELED [sic] HIS DR APPT [appointment] WITH [Physician B] D/T [due to] THE OFFICE NOT TAKING MEDICARE." 	G 108	<p>5. The patient will also be informed by the physician or physician designee that they will not be seen or their healthcare needs will need to be managed by receiving PCP at least until the time they are discharged from Home Health services.</p> <p>The Physician verbalized understanding and agreed to follow his patients referred to Advanced Home Health in the future.</p>	
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G 108	<p>Continued From page 4</p> <p>Patient #2's record did not include documentation stating he was informed his POC was signed by Physician B. It did not state why he was encouraged to make an appointment with Physician B.</p> <p>Patient #2's record included a POC for the certification period 4/25/16 to 6/23/16. The POC was signed by Physician B. His record included an H&P from the local acute care hospital where he was admitted on 6/12/16, for cardiac disease. The H&P stated his primary care physician was Physician A.</p> <p>A visit was made to Patient #2's home on 7/07/16 at 10:00 AM, to observe an SN visit completed by the LPN. During the visit Patient #2 reported a low blood glucose level that morning. His oxygen saturation was abnormally low when checked by the LPN.</p> <p>Following the visit, Patient #2 was asked if he knew Physician B. He stated he did not know who that was and stated he had never seen Physician B. He stated Physician A was his primary care physician, and stated he had an appointment to see Physician A the following day. When asked who he would contact if he had questions or concerns about his health, he stated he would contact Physician A. Patient #2 was not aware Physician B was directing his home health care.</p> <p>During an interview on 7/07/16 at 1:30 PM, the RN Case Manager stated Patient #2's primary care physician was Physician A. She stated Physician A did not follow patients or sign orders for home health, so Physician B, the agency's</p>	G 108			

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G 108	<p>Continued From page 5</p> <p>Medical Director, signed Patient #2's home health POCs and orders. She stated she thought Patient #2 had an appointment with Physician B following his SOC. However, she stated she called Physician A the previous day, due to concerns related to Patient #2's blood pressure.</p> <p>During an interview on 7/07/16 at 1:00 PM, the LPN stated she would report Patient #2's low blood glucose and oxygen saturation level to Physician B, as he was following Patient #2 for home health.</p> <p>The physician responsible for Patient #2's home health POC was changed. Patient #2 was not involved in, or notified of, the change.</p> <p>2. Patient #4 was a 42 year old female admitted to the agency on 2/11/16, with a primary diagnosis of catatonic schizophrenia. Additional diagnoses included generalized muscle weakness, obesity and DM Type II. She received PT services. Her record, including the POCs, for the certification periods 2/11/16 to 4/10/16, 4/11/16 to 6/09/16, and 6/10/16 to 8/08/16, was reviewed.</p> <p>Patient #4's record included a referral for home health services, dated 2/08/16. It stated Patient #4 was referred to the agency for PT services by Physician A.</p> <p>Patient #4's record included a POC for the certification period 2/11/16 to 4/10/16. The POC stated her physician was Physician B, and it was signed by Physician B. There was no documentation in Patient #4's record to explain why Physician B was listed as her physician when her home health referral order came from</p>	G 108		
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G 108	<p>Continued From page 6</p> <p>Physician A. Patient #2's record did not include documentation stating she was informed her POC was signed by Physician B.</p> <p>Patient #2's record included a "Client Coordination Note Report" dated 3/09/16, signed by the PTA. It stated "PT HAS MD APPT WITH [Physician A] TOMORROW..." There was no documentation in her record to indicate she had seen Physician B.</p> <p>Patient #4's record included POCs for subsequent certification periods 4/11/16 to 6/09/16, and 6/10/16 to 8/08/16. The POCs were signed by Physician B.</p> <p>During an interview on 7/07/16 at 1:55 PM, the Physical Therapist who was Patient #4's Case Manager, stated Patient #4 was a patient of Physician A. She stated the care of Physician A's patients was usually directed by Physician B and stated it was confusing. She stated she did not know if Patient #4 had seen Physician B. She stated she did not inform Patient #4 that her home health care would be directed by Physician B.</p> <p>The physician responsible for Patient #4's home health POC was changed. Patient #4 was not involved in, or notified of, the change.</p> <p>3. Patient #5 was a 73 year old female admitted to the agency on 3/11/16, for care related to dementia and weakness. She received SN, PT, OT, and SLP services. Her record, including the POCs, for the certification periods 3/11/16 to 5/09/16 and 5/10/16 to 7/08/16, was reviewed.</p> <p>Patient #5's record included a referral for home</p>	G 108			

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G 108	<p>Continued From page 7</p> <p>health services, dated 3/08/16, and signed by Physician A.</p> <p>Patient #5's record included a POC for the certification period 3/11/16 to 5/09/16. The POC stated her physician was Physician B, and it was signed by Physician B. There was no documentation in Patient #5's record to explain why Physician B was listed as her physician when the referral order came from Physician A. Patient #5's record did not include documentation stating she was informed her POC was signed by Physician B.</p> <p>Patient #5's record included a POC for the subsequent certification period 5/10/16 to 7/08/16. The POC was signed by Physician B.</p> <p>Patient #5's record documented her daughter was her legal POA. Patient #5's daughter was interviewed by phone on 7/07/16 at 1:00 PM. Patient #5's daughter was asked if she or her mother were informed that Physician A would not be directing her POC while on home health services. She said "We never got a choice, but were told that if my mother was to receive therapy services, she had to see Physician B." Patient #5's daughter stated "I do not know who Physician B is, I have never met him, and my mother has not seen him." She said her mother's doctor was Physician A. The daughter of Patient #5 said she refused to have her mother leave the A.F. that it would be too upsetting for her mother to leave her environment and meet with a new doctor.</p> <p>During an interview on 7/07/16 at 10:04 AM, the Director reviewed Patient #5's record. She stated Physician A would initiate a referral, but would not</p>	G 108		
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G 108	Continued From page 8 sign orders once the patient was receiving home health services. She stated the referral was sent to Physician B's office, or to a physician of the patients' choice. The Director stated Patient #5's record did not include documentation of conversations with Patient #5 or her daughter/POA related to oversight of her care by another physician.	G 108		
G 114	<p>Physician A ordered PT and OT services for Patient #5. However Physician B directed her POC. Patient #5 and her POA were not included in the choice of a different physician.</p> <p>484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT</p> <p>Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay.</p> <p>This STANDARD is not met as evidenced by: Based on review of admission paperwork, staff interview, and review of policies, it was determined the agency failed to ensure Medicare patients were informed in writing of the extent to which payment could be expected, and the charges the individual might have to pay, for 3 of 5 patients (#1, #2, and #5) whose records were reviewed. This had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related</p>	G 114	<p>G114</p> <p>Patient Liability for Payment</p> <p>The patients will be informed verbally and in writing the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. All staff was in-serviced by Director on 7/12 and 7/19/16 regarding proper notification of patients Liability for payment (including notification of no</p>	

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G 114	<p>Continued From page 9 to the agency's care and treatment. Findings include:</p> <p>A policy titled "Patient Liability for Payment," revised 5/15/15, stated "Before the care is initiated, the HHA informs the patient, orally and in writing, of the following:</p> <ul style="list-style-type: none"> - The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA. - The charges for services that will not be covered by Medicare. - The charges that the individual may have to pay." <p>The HHA did not ensure their policy was followed. Examples include:</p> <p>The Agency's Admission packet and each patient record contained a form, titled "ADMISSION SERVICE AGREEMENT." The section of the form titled "AUTHORIZATION FOR PAYMENT," stated "I hereby certify that all the information given by me to the organization is correct for requesting and applying for payment under Title XVIII (MEDICARE) or XIX (MEDICAID) of the Social Security Act and/or from any third party payer. I understand and agree to pay deductibles, copayments, spend-downs, and any amount due after payment of benefits on my behalf by any third party payers."</p> <p>Additionally, each record included a form titled "FEE/SERVICES DISCLOSURE STATEMENT." The form stated "We are disclosing, in advance, the estimated fee for these services. This, however, is your responsibility." The form included the disciplines of Skilled Nurse, PT, OT,</p>	G 114	<p>additional charge allocated to patient) both verbally and in writing and proper completion of signed documents at admission. 25 percent of admissions will be audited by Director or designee weekly until 100% compliance is reached then at least 10 percent of charts will be audited quarterly to assess for completion and continued compliance with regulation. Staff will continue to be educated as needed by Director / Assistant Director. Anticipated date of compliance is 8/24/2016</p>	
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G 114	<p>Continued From page 10</p> <p>Speech Therapist, Medical Social Services, and Home Health Aide. Beside each discipline, was the estimated fee the agency would charge per visit. The form also stated "Additionally, we require a 20% deposit of ____ [blank] with the remainder of the balance not covered by your insurance plan, due and payable in ninety days, on ____ [blank]." The form included an area where the admitting clinician would project the anticipated number of visits for each discipline that would be providing services.</p> <p>1. Patient #5 was a 73 year old female admitted to the agency on 3/11/16, for care related to dementia and weakness. She received SN, PT, OT, and ST services. Her record, including the POCs, for the certification periods 3/11/16 to 5/09/16, and 5/10/16 to 7/08/16, was reviewed.</p> <p>Patient #5's FEE/SERVICES DISCLOSURE STATEMENT did not include information of any potential out of pocket expense for home health services.</p> <p>2. Patient #1 was a 46 year old female admitted to the agency on 2/20/15, for care related to MS. Additional diagnoses included generalized anxiety disorder, history of blood clot, and long term use of anticoagulants. She received SN, PT, and OT services. Her record, including the POCs, for the certification periods 1/04/16 to 3/03/16, and 3/04/16 to 5/03/16, was reviewed.</p> <p>Patient #1's FEE/SERVICES DISCLOSURE STATEMENT did not include information of what her payment would be, if a deposit was required, or if Medicare would pay the entire amount. Her form included an "X" next to SN, which indicated SN services would be provided. However, her</p>	G 114			

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G 114	<p>Continued From page 11</p> <p>record documented she received PT and OT services as well. Patient 1's FEE/SERVICES DISCLOSURE STATEMENT did not include information of any potential out of pocket expense for home health services.</p> <p>The Assistant Director was interviewed on 6/07/16 at 9:00 AM. When asked if the agency provided information in writing to Medicare patients about what they were expected to pay, she stated they informed Medicare patients verbally that there would not be a deductible, and Medicare would pay the entire cost. She reviewed the FEE/SERVICES DISCLOSURE STATEMENT for Patients #1 and #5, and confirmed they did not provide information that she said was provided verbally to Medicare patients.</p> <p>The agency did not inform patients in writing of the extent to which payment could be expected from Federally funded programs and the charges the individuals may have to pay.</p> <p>3. Patient #2 was an 83 year old male admitted to the agency on 2/25/16, for care related to COPD. Additional diagnoses included bronchitis and DM Type II. He received SN, PT, OT and ST services. His record, included the POCs, for the certification periods 2/25/16 to 4/24/16, and 4/25/16 to 6/23/16, was reviewed.</p> <p>Patient #2's record included an "ADMISSION SERVICE AGREEMENT" signed by Patient #2 on 2/25/16. The section of the form titled "LIABILITY FOR PAYMENT" included the statement "I understand that service provided to me by ADVANCED HOME HEALTH will be billed as follows." The section was not completed to</p>	G 114			

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G 114	<p>Continued From page 12 Indicate the payor for his services.</p> <p>Patient #2's record included a "FEE/SERVICES DISCLOSURE STATEMENT" with the estimated fee for each SN, PT, OT, ST, MSW and Aide visits. The form stated "This fee disclosure information has been explained to me and I agree to pay any balance not covered by my current healthcare insurance plan." However, the form did not state what payment was expected by his insurance plan or what amount he may have to pay. The form included Patient #2's signature, undated, and the RN Case Manager's signature, dated 2/26/16.</p> <p>During an interview on 7/07/16 at 3:37 PM, the Assistant Director reviewed the 2 forms and stated Patient #2's payor source was not completed on the service agreement. She stated the disclosure statement did not state whether Patient #2 had a potential out of pocket expense for home health services.</p>	G 114		
G 143	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</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</p>	G 143	<p>G143</p> <p>Coordination of Patient Services</p> <p>Staff was in-serviced by Director on 7/12 and 7/19/16 regarding coordination of patient services, the need to document the coordination of services that occurs between disciplines in the patient's medical records. Director or designee will audit 20 charts monthly to ensure documentation of coordination of care until 100 % compliance</p>	

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G 143	<p>Continued From page 13</p> <p>coordination between disciplines occurred for 1 of 5 patients (Patient #5) who received services from more than one discipline. This interfered with quality and continuity of patient care. Findings include:</p> <p>Patient #5 was a 73 year old female admitted to the agency on 3/11/16, for care related to dementia and weakness. She received SN, PT, OT, and ST services. Her record, including the POCs, for the certification periods 3/11/16 to 5/09/16, and 5/10/16 to 7/08/16, was reviewed.</p> <p>Patient #5's record included a ST Recertification/Visit Note Report, dated 5/05/16, and signed by the Speech Therapist. The Recertification/Visit Note included a section titled "Care Coordination," in which the Speech Therapist documented "Not Applicable."</p> <p>Patient #5's record included a POC for the certification period 5/10/16 to 7/06/16. The POC included orders for PT visits once weekly for 9 weeks. Additionally, the POC included documentation "The licensed professional whose signature appears in block 23 attests that the Physicians Orders were received on 5/05/16." Block 23 of the POC included an electronic signature of the Speech Therapist, as well as, the Assistant Director, both dated 5/05/16.</p> <p>Patient #5's record included a verbal order dated 5/04/16, received from Physician B by a Physical Therapist. The order stated "Pt [Patient #5] to recertify and continue with maintenance therapy for limited mobility and balance. PT frequency 1 W 8 [once weekly for 8 weeks]."</p> <p>In a Physical Therapy Recertification/Visit Note</p>	G 143	<p>Is reached. Then at least 10% of charts will be audited every quarter to ensure continued compliance. Anticipated date of compliance is 8/24/2016</p>	
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G 143	<p>Continued From page 14</p> <p>Report, dated 5/06/16, the Physical Therapist wrote "P.T. is completing re-evaluation for maintenance therapy. She will be seen 1 W 9 [once weekly for 9 weeks] for review of potential concerns with mobility, gait endurance training and high level balance training."</p> <p>The PT visit frequency on the POC did not match the orders.</p> <p>During a phone interview on 7/11/16 beginning at 8:45 AM, the Speech Therapist stated she did not contact Patient #5's physician for orders to develop the POC for a new certification period. The Speech Therapist stated on 5/05/16, she performed a recertification assessment. She stated that other than completing the documentation for her visit, she was not aware of how the POC was developed. The Speech Therapist stated she did not understand how the attestation statement referring to "Block 23" was included on the POC, as she did not get physician orders.</p> <p>During an interview on 7/07/16 at 10:04 AM, the Director reviewed Patient #5's record and confirmed the PT frequency on the POC and the PT frequency that was received by verbal order on 5/04/16 were different. The Director stated she was unable to find documentation of any other orders that would explain how the frequency was changed. She stated the only orders that could be found indicated PT frequency of once weekly for 8 weeks. She stated the POC should have reflected that order.</p> <p>The Speech Therapist who performed the Recertification assessment did not ensure care coordination occurred with the other discipline</p>	G 143		

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G 143	Continued From page 15 Involved in Patient #5's care. This resulted in a POC that was not correct in the visit frequency as ordered by the physician.	G 143		
G 156	The agency did not ensure the disciplines communicated and coordinated their efforts in providing patient care. 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on record review, review of agency contracts, policies, and staff and patient/caregiver interview, it was determined the agency failed to ensure patient needs were met, care was provided in accordance with patients' POCs, the POCs included all pertinent information, physicians were consulted to approve POCs, the physicians were notified of changes in patients' conditions, and verbal orders were secured by authorized personnel. This resulted in unmet patient needs, and care provided without physician authorization. Findings include: 1. Refer to G157 as it relates to the agency's failure to ensure patients were accepted for treatment on the basis of a reasonable expectation that the patients' needs could be met. 2. Refer to G158 as it relates to the agency's failure to ensure care was provided in accordance with POCs. 3. Refer to G159 as it relates to the agency's failure to ensure the POC included all pertinent	G 156	G156 Acceptance of patients, POC, Med Super 1. Refer to G157 "Physician A" was notified by Director and Marketer on 7/14/16 at 0900 of potential for violation of Patient's right to be informed and was notified that after discussing with Governing Board, if the physician orders Home Health services he must either follow his own patients or 1. Notify the patient that he will not follow home health, 2. The physician's office will facilitate transfer to new PCP of patient's choice 3. The physician's office will be responsible to notify the new physician, give report	

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G 156	Continued From page 16 diagnoses, types of services and equipment required. 4. Refer to G160 as it relates to the agency's failure to consult physicians to approve POCs following evaluation visits. 5. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter their POCs. 6. Refer to G166 as it relates to the failure of the agency to ensure verbal orders were obtained by those who were authorized to accept verbal orders.	G 156	and send medical records as needed 4. The patient will be established by new PCP and orders for Home Health services will come from new PCP 5. The patient will also be informed by the physician or physician designee that they will not be seen or their healthcare needs will need to be managed by receiving PCP at least until the time they are discharged from Home Health services.	
G 157	The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs. 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on record review, review of agency contracts, policies, and staff and patient/caregiver interview, it was determined the agency failed to ensure patients were accepted for treatment on the basis of a reasonable expectation that the patients' needs could be met, by accepting	G 157	The physician verbalized understanding and agreed to follow his patients for Home Health services provided by Advanced Home Health in the future. Additionally, staff was in-serviced by Director on 7/12 and 7/19/16 regarding regulation for accepting patients with a Physician that will oversee their plan of care. Patients without said physician will not be accepted or admitted to services without physician to follow their POC. 20 charts will be audited	

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G 157	<p>Continued From page 17</p> <p>patients for treatment without ensuring their eligibility for home health services, for 3 of 7 patients (#2, #4, and #5) whose records were reviewed. This resulted in the admission or recertification of patients without a physician to certify their need for home health and direct their POC, and had the potential to result in negative outcomes for agency patients. Findings include:</p> <p>The Medicare Benefit Policy Manual, Chapter 7, Home Health Services, section 30.3, titled "Under the Care of a Physician" states "The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care in accordance with 42 CFR 424.22."</p> <p>The Code of Federal Regulations, Title 42, section 424.22, titled "Requirements for home health services," states "If a physician has a financial relationship as defined in section 411.354 of this chapter, with an HHA, the physician may not certify or recertify need for home health services provided by that HHA, establish or review a plan of treatment for such services..."</p> <p>The agency's policy #10001, "ACCEPTANCE/ADMISSION OF PATIENTS," revised 5/15/15, included "The patient must be under a physician's care and the physician must be willing to provide the required written orders for care and/or services."</p> <p>The agency's policy #10002, "INTAKE SERVICE," revised 5/15/15, included criteria for patient admission to the agency. The criteria included "There is a preferred physician taking medical responsibility for the patient's care, i.e., the physician will establish and periodically review the</p>	G 157	<p>monthly until 100% compliance is reached. Then 10 % of charts will be audited quarterly to ensure continued compliance. Anticipated date of compliance is 8/24/2016</p> <p>2. Refer to G 158 Staff was educated by Director on 7/12 and 7/19/2016 regarding the regulation for care following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Any orders signed by a nurse practitioner or PA will not be accepted as orders until the physician is contacted and new verbal orders received from physician. 20 charts will be audited by Director / Designee every month until 100% compliance, then 10% of charts will be audited quarterly for continued compliance.</p> <p>3. Refer to G159</p>	

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G 157	<p>Continued From page 18 plan of care."</p> <p>The agency's policy #10004, "PLAN OF CARE (PLAN OF TREATMENT)," REVISED 5/15/16, included "The total plan of care shall be reviewed by the attending physician and HHA staff as often as the severity of the patient's condition requires, but at least once every 60 days..."</p> <p>An interview with the Agency's Director and Assistant Director was conducted on 7/07/16 at 2:20 PM. The Director confirmed Physician B was the agency's Medical Director, and was paid for his services.</p> <p>The Director provided a letter dated 12/04/15, and signed by Physician A. The letter stated "This letter is to inform you that as of January 1, 2016 I will no longer manage patients on Home Health and Hospice. These patients will either need to seek care from a different physician during this time or be followed by the Facilities Supervising Physician. Upon discharge from Home Health or Hospice, I will be happy to resume their healthcare needs."</p> <p>The Director stated the agency received referrals from Physician A and accepted the patients, knowing Physician A would not direct their home health care or sign their POCs. She stated when they received a referral from Physician A, they sent the referral information to Physician B's office to determine if the patient should be admitted to home health. She stated the agency assisted the patient to make an appointment with Physician B, however, the patient was not always seen by Physician B prior to their SOC. The Director stated Physician B signed the patients' POCs and was responsible for directing their</p>	G 157	<p>Staff was In-serviced by Director on 7/12 and 7/19/16 regarding developing a patient specific plan of care for patients. Plans of care (approved by physician) to include DME, supplies, and patient-specific interventions. Plan of care to include mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications, treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items. 20 charts will be audited monthly by Director or Designee until 100 % compliance is reached. Then 10 % of charts will be audited every quarter to ensure continued compliance.</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2016
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2110 NIAGARA ST IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
G 157	<p>Continued From page 19 home health care prior to seeing them.</p> <p>The agency accepted patients knowing their attending physician would not authorize and provide oversight of their POCs. Examples include:</p> <p>1. Patient #2 was an 83 year old male admitted to the agency on 2/25/16, for care related to COPD. Additional diagnoses included bronchitis and DM Type II. He received SN, PT, OT, and ST services. His record, including the POCs, for the certification periods 2/25/16 to 4/24/16, and 4/25/16 to 6/23/16, was reviewed.</p> <p>Patient #2's record included a referral for home health services, dated 2/23/16. It stated Patient #2 was referred to the agency for SN, PT, OT and ST services by Physician A.</p> <p>Patient #2's record included an SN SOC comprehensive assessment dated 2/25/16, signed by his RN Case Manager. The assessment stated "PATIENT ADMITTED TO ADVANCED HOME HEALTH ON 2/25/16 UNDER ORDERS OF [Physician A]..."</p> <p>Patient #2's record included a POC for the certification period 2/25/16 to 4/24/16. The POC stated his physician was Physician B, and it was signed by Physician B. There was no documentation in Patient #2's record to explain why Physician B was listed as his physician when his home health referral order came from Physician A.</p> <p>Patient #2's record included documents titled "Client Coordination Note Report." They included the following statements:</p>	G 157	<p>4. Refer to G160 Staff was educated by Director on 7/12 and 7/19/16 on the need to contact the physician to approve the plan of care developed before the plan of care can be implemented. 20 charts will be audited every month by Director or Designee until 100 % compliance is reached, then 10% of charts will be audited quarterly to ensure continued compliance.</p> <p>5. Refer to G164 Staff was in-serviced by Director on 7/12 and 7/19/2016 to promptly alert the physician to any changes that suggest a need to alter the plan of care and document the notification and any changes in the patient's medical record. Director / Designee will audit 20 charts monthly until 100% compliance is reached. Then 10 % of charts will be audited quarterly to</p>		

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G 157	<p>Continued From page 20</p> <ul style="list-style-type: none"> - 3/01/16, signed by the Medical Records Specialist, "CASE MANAGER WAS EMAILED AND ASKED TO HELP THE PATIENT GET AN APPOINTMENT WITH [Physician B] FOR HIS FACE TO FACE." - 3/03/16, signed by the RN Case Manager, "ENCOURAGED PT [patient] TO SCHEDULE A FACE TO FACE WITH [Physician B]." - 3/08/16, signed by the RN Case Manager, "ENCOURAGE PATIENT TO MAKE AN APPOINTMENT WITH [Physician B]." - 3/10/16, signed by the RN Case Manager, "SCHEDULE THE FACE-TO-FACE WITH [Physician B] ON 3/16/16." - 3/15/16, signed by the RN Case Manager, "PT ALSO STATED THAT HE CANCELED [sic] HIS DR APPT WITH [Physician B] D/T [due to] THE OFFICE NOT TAKING MEDICARE." <p>Patient #2's record included a POC for the certification period 4/25/16 to 6/23/16. The POC was signed by Physician B. His record included an H&P from the local acute care hospital where he was admitted on 6/12/16, for cardiac disease. The H&P stated his primary care physician was Physician A.</p> <p>A visit was made to Patient #2's home on 7/07/16 at 10:00 AM, to observe an SN visit completed by the LPN. Following the visit, Patient #2 was asked if he knew Physician B. He stated he did not know who that was and stated he had never seen Physician B. He stated Physician A was his primary care physician, and stated he had an</p>	G 157	<p>ensure continued compliance.</p> <p>6. Refer to G166 Staff was in-serviced on 7/12 and 7/19/16 that Physician orders can only be written / entered in the chart by an RN or Qualified Therapist. 20 charts will be audited monthly by Director or designee until 100 % compliance is reached then 10 % of charts will be audited quarterly to ensure continued compliance. Anticipated date of compliance is 8/24/2016</p> <p>G157 Acceptance of Patients, POC, Med Super</p>	
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G 157	<p>Continued From page 21</p> <p>appointment to see Physician A the following day. When asked who he would contact if he had questions or concerns about his health, he stated he would contact Physician A.</p> <p>During an interview on 7/07/16 at 1:30 PM, the RN Case Manager stated Patient #2's primary care physician was Physician A. She stated Physician A did not follow patients or sign orders for home health, so Physician B, the agency's Medical Director, signed Patient #2's home health POCs and orders.</p> <p>Patient #2 was admitted to the agency without being under the care of a physician qualified to sign the physician certification and plan of care and who was willing to provide the required written orders for care and services.</p> <p>2. Patient #4 was a 42 year old female admitted to the agency on 2/11/16, with a primary diagnosis of catatonic schizophrenia. Additional diagnoses included generalized muscle weakness, obesity and DM Type II. She received PT services. Her record, included the POCs, for the certification periods 2/11/16 to 4/10/16, 4/11/16 to 6/09/16, and 6/10/16 to 8/08/16, was reviewed.</p> <p>Patient #4's record included a referral for home health services, dated 2/08/16. It stated Patient #4 was referred to the agency for PT services by Physician A.</p> <p>Patient #4's record included a POC for the certification period 2/11/16 to 4/10/16. The POC stated her physician was Physician B, and it was signed by Physician B. There was no documentation in Patient #4's record to explain</p>	G 157	<p>"Physician A" was notified by Director and Marketer on 7/14/16 at 0900 of potential for violation of Patient's right to be informed and was notified that after discussing with Governing Board, if the physician orders Home Health services he must either follow his own patients or</p> <ol style="list-style-type: none"> 1. Notify the patient that he will not follow home health, 2. The physician's office will facilitate transfer to new PCP of patient's choice 3. The physician's office will be responsible to notify the new physician, give report and send medical records as needed 4. The patient will be established by new PCP and orders for Home Health services will come from new PCP 5. The patient will also be informed by the physician or physician designee that they will not be seen or their healthcare needs will need to be managed by receiving PCP at least until the time they are 	
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G 157	<p>Continued From page 22</p> <p>why Physician B was listed as her physician when her home health referral order came from Physician A.</p> <p>There was no documentation in her record to indicate she had seen Physician B.</p> <p>During an interview on 7/07/16 at 1:55 PM, the Physical Therapist who was Patient #4's Case Manager, stated Patient #4 was a patient of Physician A. She stated the care of Physician A's patients was usually directed by Physician B and stated it was confusing. She stated she did not know if Patient #4 had seen Physician B.</p> <p>Patient #4 was admitted to the agency without being under the care of a physician qualified to sign the physician certification and plan of care and who was willing to provide the required written orders for care and services.</p> <p>3. Patient #5 was a 73 year old female admitted to the agency on 3/11/16, for care related to dementia and weakness. She received SN, PT, OT, and ST services. Her record, including the POCs, for the certification periods 3/11/16 to 6/09/16, and 5/10/16 to 7/08/16, was reviewed.</p> <p>Patient #5's record included a referral for home health services, dated 3/08/16, signed by Physician A.</p> <p>Patient #5's record documented her daughter was her legal POA. She was interviewed by phone on 7/07/16 at 1:00 PM. Patient #5's daughter said her mother's doctor was Physician A. She stated she was instructed to bring her mother to an appointment with Physician B. She said she refused, and stated it would be too</p>	G 157	<p>discharged from Home Health services.</p> <p>The physician verbalized understanding and agreed to follow his patients for Home Health services provided by Advanced Home Health in the future.</p> <p>Additionally, staff was In-serviced by Director on 7/12 and 7/19/16 regarding regulation for accepting patients with a Physician that will oversee their plan of care. Patients without said physician will not be accepted or admitted to services without physician to follow their POC. 20 charts will be audited monthly until 100% compliance is reached. Then 10 % of charts will be audited quarterly to ensure continued compliance. Anticipated date of compliance is 8/24/2016</p>	
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G 157	Continued From page 23 upsetting for her mother to leave her environment and meet with a new doctor. During an interview on 7/07/16 beginning at 10:04 AM, the Director stated Patient #5 was referred to the agency for home health services by Physician A. She stated the agency accepted Patient #5 knowing Physician A would not be directing her POC, and would not sign orders. The Director stated the agency Medical Director, Physician B, had agreed to follow Physician A's patients. She stated the referral information was sent to Physician B and the patient or family was contacted to schedule an appointment to see him.	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of clinical records and interviews with HHA staff, it was determined that the agency failed to ensure a physician established and reviewed the written plan of care for 4 of 7 patients (#1, #2, #6 and #7) whose records were reviewed. This resulted in the agency providing services without appropriate physician oversight and had the potential to	G 158	G158 Acceptance of Patients, POC, Med Super Staff was educated by Director on 7/12 and 7/19/2016 regarding the regulation for care following a written plan of	

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G 158	<p>Continued From page 24 negatively impact quality and safety of patient care. Findings include:</p> <p>1. Patient #1 was a 46 year old female admitted to the agency on 2/20/16, for care related to MS. She received SN, PT, OT, and SLP services. Her record, including the POCs, for the certification periods 2/20/16 to 4/20/16, and 7/02/16 to 8/30/16, was reviewed.</p> <p>a. Patient #1's record included an order for home health services dated 2/18/16, and signed by an NP. Her record did not include an order for initiation of home health services signed by a physician.</p> <p>b. Patient #1's record included an order for ST, dated 12/23/16, and signed by an NP.</p> <p>c. Patient #1's record included an order for OT, dated 12/23/16, and signed by an NP.</p> <p>During an interview on 7/07/16 at 11:00 AM, the Director reviewed Patient #1's record. She confirmed Patient #1's record included orders signed by an NP. She stated she was unable to find additional orders from Patient #1's physician that would authorize the OT, ST, and SOC visits.</p> <p>Patient #1's record included orders, signed by an NP, for initiation of home health services, OT, and ST. These orders were not signed by a physician.</p> <p>2. Patient #2 was an 83 year old male admitted to the agency on 2/25/16, for care related to COPD. Additional diagnoses included bronchitis and DM Type II. He received SN, PT, OT and ST services. His record, including the POCs, for the</p>	G 158	<p>care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Any orders signed by a nurse practitioner or PA will not be accepted as orders until the physician is contacted and new verbal orders received from physician. 20 charts will be audited by Director / Designee every month until 100% compliance, then 10% of charts will be audited quarterly for continued compliance.</p> <p>Anticipated date of compliance is 8/24/2016</p>	
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G 158	<p>Continued From page 25 certification periods 2/25/16 to 4/24/16, and 4/25/16 to 6/23/16, was reviewed.</p> <p>Patient #2's POC for the certification period 2/25/16 to 4/24/16, included a diagnosis of dependence on supplemental oxygen. The POC did not include orders related to his oxygen use, such the lpm flow rate, or whether it was to be used continuously or intermiltently.</p> <p>Patient #2's record included an SN visit note, dated 3/03/16, signed by the RN Case Manager. The note stated his oxygen saturation level was stable with an oxygen flow rate of 3 lpm, and stated his flow rate was decreased to 2.5 lpm. Patient #2's record did not include an order to decrease his oxygen flow rate in response to his oxygen saturation level.</p> <p>During an interview on 7/07/16 at 1:30 PM, the RN Case Manager reviewed Patient #2's record and stated his POC did not include an order for his oxygen or an order to change his oxygen flow rate.</p> <p>Patient #2's POC did not include oxygen flow rate or orders, parameters to report or orders to adjust the oxygen flow rate.</p> <p>3. Patient #6 was an 88 year old female admitted to the agency on 6/17/16, for care related to heart failure. Additional diagnoses included generalized muscle weakness and macular degeneration. She received SN services. Her record, including the POC, for the certification period 6/17/16 to 8/15/16, was reviewed.</p> <p>Patient #6's record included an order for home health services dated 6/15/16, and signed by an</p>	G 158			

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G 158	<p>Continued From page 26</p> <p>NP. Her record did not include an order for initiation of home health services signed by a physician.</p> <p>During an interview on 7/07/16 at 2:10 PM, the Assistant Director stated when they received a referral order from an NP, they called the physician's office to obtain a verbal order from the physician. She reviewed Patient #6's record and stated no physician's order was obtained for her SOC visit.</p> <p>Patient #6's home health services were initiated without a physician's order.</p> <p>4. Patient #7 was a 77 year old male admitted to the agency on 3/10/16 for care following a total knee replacement. Additional diagnoses included pressure ulcer of the right heel and COPD. He received SN, PT, and OT services. His record, including the POC, for the certification period 3/10/16 to 5/08/16, was reviewed.</p> <p>a. Patient #7's record included an order for home health services dated 3/07/16, and signed by an NP. His record did not include an order for initiation of home health services signed by a physician.</p> <p>During an interview on 7/07/16 at 2:30 PM, the Assistant Director reviewed Patient #6's record and stated no physician's order was obtained for his SOC visit.</p> <p>Patient #7's home health services were initiated without a physician's order.</p> <p>b. Patient #7's record included an order for wound care to his right heel dated 3/17/16, and</p>	G 158		
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G 158	Continued From page 27 signed by a PA. SN visit notes dated 3/19/16 and 3/21/16 documented wound care was provided per the order from the PA. During an interview on 7/07/16 at 2:30 PM, the Assistant Director reviewed Patient #6's record and stated the wound care order was signed by a PA at the wound care center. She stated the agency should have requested an order from the physician at the wound care center. She stated no physician order was obtained for the wound care provided on 3/19/16 and 3/21/16. Wound care was provided without a physician's order.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the agency failed to ensure the POC covered all interventions, equipment, or other appropriate items for 3 of 7 patients (#2, #3, and #7) whose records were reviewed. This had the potential to negatively impact quality and coordination of patient care. Findings include:	G 159	<u>G159</u> Plan of Care Staff was In-serviced by Director on 7/12 and 7/19/16 regarding developing a patient specific plan of care for patients. Plans of care (approved by physician) to include DME, supplies, and patient-specific interventions.	

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G 159	<p>Continued From page 28</p> <p>1. Patient #2 was an 83 year old male admitted to the agency on 2/25/16, for care related to COPD. Additional diagnoses included bronchitis and DM Type II. He received SN, PT, OT, and ST services. His record, including the POCs, for the certification periods 2/25/16 to 4/24/16, and 4/25/16 to 6/23/16, was reviewed.</p> <p>Patient #2's POC for the certification period 2/25/16 to 4/24/16, was not complete and accurate to reflect his needs. Examples include:</p> <p>a. Patient #2's POC included an order to educate him regarding administration of insulin. His POC did not include an order for insulin.</p> <p>b. Patient #2's POC included an order to instruct him in management of an indwelling urinary catheter, and to change his catheter monthly. His SN SOC comprehensive assessment, dated 2/25/16, signed by his RN CM, stated he did not have a urinary catheter.</p> <p>c. Patient #2's POC included a diagnosis of dependence on supplemental oxygen. His POC did not include an order for oxygen, an oxygen flow rate, or equipment used to deliver his oxygen.</p> <p>d. Patient #2's SN SOC comprehensive assessment, dated 2/25/16, signed by his RN CM, stated he had pain in his right leg that ranged from 4-10 on a scale of 0-10 with 10 being the worst pain. His POC did not include intervention to assess or treat his pain.</p> <p>e. Patient #2's POC included medications to be administered per nebulizer. His POC did not include a nebulizer.</p>	G 159	<p>Plan of care to include mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications, treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items. 20 charts will be audited monthly by Director or Designee until 100 % compliance is reached. Then 10 % of charts will be audited every quarter to ensure continued compliance. Anticipated date of compliance is 8/24/2016</p>		

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G 159	<p>Continued From page 29</p> <p>f. Patient #2's POC included an order to educate him in blood glucose monitoring. His POC did not include a blood glucose monitor or supplies to test his blood glucose level.</p> <p>g. Patient #2's SN SOC comprehensive assessment, dated 2/26/16, signed by his RN CM, stated he used assistive devices, including a rolling walker, cane, power wheelchair, elevated toilet seat and tub chair. His POC did not include these items.</p> <p>During an interview on 7/07/16 at 1:30 PM, the RN Case Manager reviewed Patient #2's POC. She stated he was not on insulin and did not have a urinary catheter. She was unable to explain why the orders were included on his POC. She stated his POC should have included his oxygen and oxygen equipment, nebulizer, blood glucose monitor and supplies and the assistive devices he used in his home. Additionally, she stated his POC should have included interventions to assess and treat his pain.</p> <p>Patient #2's POC was not accurate and complete to address all his needs.</p> <p>2. Patient #7 was a 77 year old male admitted to the agency on 3/10/16 for care following a total knee replacement. Additional diagnoses included pressure ulcer of the right heel and COPD. He received SN, PT, and OT services. His record, including the POC, for the certification period 3/10/16 to 5/08/16, was reviewed.</p> <p>Patient #7's POC included oxygen to be used continuously at 2 lpm. His POC did not include equipment used to deliver his oxygen.</p>	G 159			

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NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2110 NIAGARA ST IDAHO FALLS, ID 83404		
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G 159	<p>Continued From page 30</p> <p>Patient #7's record included an SN SOC comprehensive assessment dated 3/10/16, signed by the RN Case Manager. The assessment stated he used CPAP at night for sleep apnea. The assessment also stated he used a tub chair for bathing. Patient #7's POC did not include his CPAP device or tub chair.</p> <p>During an interview on 7/07/16 at 2:30 PM, the Director reviewed Patient #7's POC and stated it did not include his oxygen equipment, CPAP device or tub chair.</p> <p>Patient #7's POC did not include all equipment used in his home.</p> <p>3. Patient #3 was an 88 year old male admitted to the agency on 5/25/16, for care related to generalized muscle weakness. He received SN, PT, and MSW services. His record, including the POC for the certification period 5/25/16 to 7/23/16, was reviewed.</p> <p>Patient #3's POC was not complete and accurate to reflect his needs. Examples include:</p> <p>a. Patient #3's record included documentation his SOC comprehensive assessment was performed by a Physical Therapist on 5/25/16. The Physical Therapist documented Patient #3 had pain in both legs that ranged from 7-10 on a scale of 0-10 with 10 being the worst pain. His POC did not include interventions to assess or treat his pain.</p> <p>b. Patient #3's POC included a diagnosis of dependence on supplemental oxygen. His POC did not include equipment and other DME used</p>	G 159			

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G 159	Continued From page 31 for oxygen dellvery. c. Patient #3's SOC comprehensive assessment, dated 5/25/16, included DME of walker, tub chair, elevated toilet seat, grab bars, and a cane. His POC did not include those items. During an interview on 7/07/16 beginning at 11:00 AM, the Assistant Director reviewed Patient #3's record. She confirmed the POC developed and signed by the Physical Therapist did not include interventions related to his lower extremity pain. She stated the SOC comprehensive assessment listed his assistive devices, and confirmed they were not included on his POC.	G 159		
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the POC for 2 of 7 patients (#2 and #4) whose records were reviewed. This resulted in POCs that were developed and initiated without appropriate physician approval. Findings include: 1. Patient #2 was an 83 year old male admitted to the agency on 2/25/16, for care related to COPD. Additlional diagnoses included bronchitis	G 160	G160 Plan of Care	

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G 160	<p>Continued From page 32 and DM Type II. He received SN, PT, OT, and ST services. His record, including the POCs, for the certification periods 2/25/16 to 4/24/16, and 4/25/16 to 6/23/16, was reviewed.</p> <p>Patient #2's record included an SN SOC comprehensive assessment completed on 2/25/16, signed by the RN Case Manager. His POC included the statement "THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS IN BLOCK 23 ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 2/25/16." Block 23 included the electronic signature of the RN Case Manager.</p> <p>During an interview on 7/07/16 at 1:30 PM, the RN Case Manager was asked which physician she called to obtain orders. She stated she did not call a physician to obtain orders for Patient #2's POC. She stated it was not her practice to call the physician after completing a SOC assessment.</p> <p>Patient #2's POC was signed by a physician on 3/07/16. SN visits were completed on 3/01/16 and 3/03/16, prior to physician approval of his POC.</p> <p>SN visits were performed without physician approval of the POC.</p> <p>2. Patient #4 was a 42 year old female admitted to the agency on 2/11/16, with a primary diagnosis of catatonic schizophrenia. Additional diagnoses included generalized muscle weakness, obesity and DM-Type II. She received PT services. Her record, including the POCs, for the certification periods 2/11/16 to 4/10/16, 4/11/16 to 6/09/16, and 6/10/16 to 8/08/16, was</p>	G 160	<p>Staff was educated by Director on 7/12 and 7/19/16 on the need to contact the physician to approve the plan of care developed before the plan of care can be implemented. 20 charts will be audited every month by Director or Designee until 100 % compliance is reached, then 10% of charts will be audited quarterly to ensure continued compliance. Anticipated date of compliance is 8/24/2016</p>		

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G 160	Continued From page 33 reviewed. Patient #4's record included a PT SOC comprehensive assessment completed on 2/11/16, signed by the Physical Therapist, who was her Case Manager. Her POC included the statement "THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS IN BLOCK 23 ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 2/25/16." Block 23 included the electronic signature of the PT Case Manager. During an interview on 7/07/16 at 1:55 PM, the Physical Therapist was asked which physician she called to obtain orders. She stated she did not call a physician to obtain orders for Patient #2's POC. She stated she did not call the physician to approve the POC when she completed an SOC assessment. Patient #4's POC was signed by a physician on 3/02/16. PT visits were completed on 2/15/16, 2/17/16, 2/18/16, 2/22/16, 2/24/16, 2/26/16, and 2/29/16, prior to physician approval of his POC. PT visits were performed without physician approval of the POC.	G 160			
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 medical record review, observation,	G 164			

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G 164	<p>Continued From page 34</p> <p>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 1 of 7 patients (Patient #2) whose records were reviewed. This resulted in missed opportunities for the physician to alter patients' POCs to meet their needs. Findings include:</p> <p>Patient #2 was an 83 year old male admitted to the agency on 2/25/16, for care related to COPD. Additional diagnoses included bronchitis and DM Type II. He received SN, PT, OT, and ST services. His record, included the POCs, for the certification periods 2/25/16 to 4/24/16, and 4/25/16 to 6/23/16, was reviewed.</p> <p>Patient #2's POC included a diagnosis of heart failure. The Mayo Clinic website, accessed on 7/12/16, stated edema (swelling) in the legs and feet can be a symptom of heart failure.</p> <p>Patient #2's SN SOC comprehensive assessment dated 2/25/16 and signed by the RN Case Manager, stated he had 1+ edema in both lower legs. An SN visit note dated 3/08/16, signed by the RN Case Manager, stated he had 2+ edema in both lower legs. An SN visit note dated 3/15/16, signed by the RN Case Manager, stated he had 3+ edema in both lower legs. There was no documentation stating Patient #2's physician was notified of his increased edema.</p> <p>During an interview on 7/07/16 at 1:30 PM, the RN Case Manager reviewed Patient #2's record and stated she was unable to recall whether she notified his physician of his increased edema. She stated there was no documentation of</p>	G 164	<p>G164</p> <p>Periodic Review of Plan of Care</p> <p>Staff was in-serviced by Director on 7/12 and 7/19/2016 to promptly alert the physician to any changes that suggest a need to alter the plan of care and document the notification and any changes in the patient's medical record. Director / Designee will audit 20 charts monthly until 100% compliance is reached. Then 10 % of charts will be audited quarterly to ensure continued compliance. Anticipated date of compliance is 8/24/2016</p>		

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G 164	Continued From page 35 physician contact.	G 164		
G 166	<p>Patient #2's physician was not notified of a change in his condition.</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 policy review, 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 1 of 7 patients (Patient #1) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include:</p> <p>Patient #1 was a 46 year old female admitted to the agency on 2/20/15, for care related to MS. She received SN, PT, OT, and ST services. Her record, including the POCs for the certification periods 2/20/15 to 4/20/16 and 7/02/16 to 8/30/16, was reviewed.</p> <p>Patient #1's record included an order for wound care, received from her physician, by an LPN, dated 2/08/16.</p> <p>During an interview on 7/07/16 at 11:00 AM, the Director reviewed Patient #1's record. She stated the agency allowed LPNs to receive physician</p>	G 166	<p>G166</p> <p>Conformance with physician orders</p> <p>Staff was in-serviced on 7/12 and 7/19/16 by the Director that Physician orders can only be written / entered in the chart by an RN or Qualified Therapist. 20 charts will be audited monthly by Director or designee until 100 % compliance is reached then 10 % of charts will be audited quarterly to ensure continued compliance.</p>	

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G 166	Continued From page 36 orders. She stated she was not aware that the LPNs could not receive verbal orders from physicians.	G 166	Anticipated date of compliance is 8/24/2016	
G 337	The agency failed to ensure physician orders were received by an RN or qualified therapist. 484.56(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on review of medical records and staff interviews, it was determined the agency failed to ensure the comprehensive assessment included medications the patient was taking, as well as a medication review to evaluate for drug interactions, identify significant side effects, and identify duplicative therapy and non-compliance with drug therapy for 1 of 7 patients (Patient #5) whose records were reviewed. This resulted in the potential for patients to experience adverse outcomes related to medications. Findings include: Patient #5 was a 73 year old female admitted to the agency on 3/11/16, for care related to Dementia and weakness. She received SN, PT, OT, and SLP services. Her record, including the POCs, for the certification periods 3/11/16 to 5/09/16, and 5/10/16 to 7/08/16, was reviewed. Patient #5's record included an RN SOC	G 337	G337 Drug Regimen Review Staff was in-serviced on 7/12 and 7/19/16 by Director regarding the regulation that the comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug	

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G 337	<p>Continued From page 37</p> <p>Comprehensive Assessment, performed on 3/11/16. The assessment included a section for drug regimen review. It queries the clinician "Does a complete drug regimen review indicate potential clinically significant medication issues?" The RN responded "No problems found during review." The assessment included another query of "Has the patient/caregiver received instruction on special precautions for all high-risk medications?" The RN responded "Yes."</p> <p>Patient #5's record included "Client Coordination Note Report[s]," which were dated 3/13/16. The reports documented medication interactions for 3 of the medications Patient #5 was prescribed, as follows:</p> <ul style="list-style-type: none"> - Coumadin interacts with Duloxetine. Severity level 2-Severe Interaction. Action is required to reduce the risk of severe adverse interaction. - Coumadin interacts with Fluoxetine. Severity level 2-Severe Interaction. Action is required to reduce the risk of severe adverse interaction. - Coumadin interacts with Levothyroxine. Severity level 2-Severe Interaction. Action is required to reduce the risk of severe adverse interaction. <p>The 3 reports included an entry by the Assistant Director, dated 3/14/16, which stated they were "faxed to MD" on 3/14/16. The Assistant Director did not indicate which MD was notified. Patient #5's record did not include documentation that her physician responded to the medication interaction reports.</p> <p>See G-0157 as it relates to Physician A referring</p>	G 337	<p>therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. The patient's physician to be immediately notified and documentation entered into the medical record of the notification and any changes the physician orders. 20 charts will be audited monthly by Director or designee until 100% compliance is reached then 10% of charts will be audited quarterly to ensure continued compliance.</p> <p>Anticipated date of compliance is 8/24/2016</p>	
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G 337	<p>Continued From page 38</p> <p>Patient #5 to home health services, and Physician B directing her POC.</p> <p>During an interview on 7/07/16 at 10:04 AM, the Director reviewed Patient #5's record. She stated it was the expectation of the agency that the clinician performing the comprehensive assessment conduct a review of the patients' medications. She stated the EMR software allowed each medication to be entered into the program, and if interactions were noted, the clinician would be alerted immediately. The Director stated it was her expectation the clinician would relay that information verbally to the physician when they were contacted for further orders. The verbal communication of medication interactions would be followed by a written report which was sent to the physician. The Director was unable to find documentation of evidence the severe medication interaction reports were faxed to the physician. Additionally, she was unable to see documentation of follow up by the RN that she received direction from Patient #5's physician regarding the medications. When questioned if Physician A or Physician B received the medication interaction reports, the Director stated she was unable to determine who the reports were faxed to.</p> <p>Patient #5's SOC Comprehensive Assessment did not include a complete medication review.</p>	G 337			

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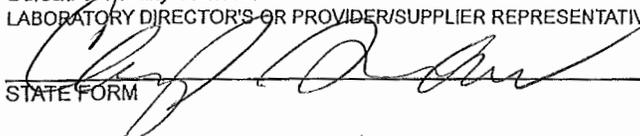
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your agency from 7/06/16 to 7/11/16. The surveyors conducting the complaint investigation survey were: Nancy Bax, RN, BSN, HFS Susan Costa, RN, HFS	N 000	<u>N035</u> Refer to G108	
N 035	03.07020. ADMIN. GOV.BODY N035 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xvii. The HHA must advise a patient in advance of any change in the plan of care before the change is made. This Rule is not met as evidenced by: Refer to G108	N 035		
N 039	03.07020. ADMIN.GOV. BODY N039 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: a) The extent to which payment	N 039	<u>N039</u> Refer to G114	

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TITLE

(X6) DATE



Administrator

8/1/16

Bureau of Facility Standards

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N 039	Continued From page 1 may be expected from third party payors.; and This Rule is not met as evidenced by: Refer to G114	N 039		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143	N 062	<u>N062</u> Refer to G143	
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G143	N 093	<u>N093</u> Refer to G143	

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FACILITY STANDARDS~~

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2016
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NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2110 NIAGARA ST IDAHO FALLS, ID 83404
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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)	(X6) COMPLETE DATE
N 151	Continued From page 2	N 151		
N 151	03.07030.PLAN OF CARE N151 030. PLAN OF CARE. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's plan of care. This Rule is not met as evidenced by: Refer to G157	N 151	<u>N151</u> Refer to G157	
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	<u>N152</u> Refer to G158	
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by:	N 155	<u>N155</u> Refer to G159	

Bureau of Facility Standards

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N 173	<p>03.07030.07.PLAN OF CARE</p> <p>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.</p> <p>This Rule is not met as evidenced by: Refer to G166 and G337</p>	N 173	<p><u>N173</u></p> <p>Refer to G166 and G337</p>	
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HEALTH & WELFARE

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July 21, 2016

Cheryl Abel, Administrator
Advanced Home Health
PO Box 1784
Idaho Falls, ID 83403

Provider #137116

Dear Ms. Abel:

An unannounced on-site complaint investigation was conducted from July 6, 2016 to July 11, 2016 at Advanced Home Health. The complaint allegation, findings, and conclusion are as follows:

Complaint #ID00007284

Allegation: The home health agency accepted patients for admission with the knowledge their primary physician would not oversee their plans of care or sign physician orders. The agency's Medical Director signed plans of care and orders for these patients.

Findings: An unannounced on-site complaint investigation was conducted from 7/06/16 to 7/07/16. During the investigation, surveyors reviewed 7 medical records, policies and procedures, observed 1 home visit, and interviewed patients, caregivers, and staff.

The Agency's Director and Assistant Director were interviewed. The Director provided a letter dated 12/04/15, and signed by a local physician. The letter stated "This letter is to inform you that as of January 1, 2016 I will no longer manage patients on Home Health and Hospice. These patients will either need to seek care from a different physician during this time or be followed by the Facilities Supervising Physician. Upon discharge from Home Health or Hospice, I will be happy to resume their healthcare needs."

The Director stated the agency received referrals from this physician and accepted the patients, knowing he would not direct their home health care or sign their plans of care. She stated when they received a referral from this physician, they sent the referral information to the agency's Medical Director to determine if the patient should be admitted to home health. She stated the agency would assist the patient to make an appointment with the Medical Director, however, the patient was not always seen prior to admission to the agency. The Director stated the Medical Director signed the patients' plans of care and directed their home health care prior to seeing them in his office.

One patient's record described an 83 year old male admitted to the agency on 2/25/16. His record included a referral for home health services, dated 2/23/16, from his primary care physician, the physician who stated he would not manage patients on home health. His plan of care was signed by the agency's Medical Director. A visit was made to this patient's home by the surveyor. During the visit, he stated he did not know the agency's Medical Director and had never seen him. He stated he had an appointment with his primary care physician the following day and that was the physician he contacted for his health care needs. He was not aware the agency's Medical Director was directing his home health care.

Another record described a 73 year old female admitted to the agency on 3/11/16. Her record included a referral for home health services, dated 3/08/16, from her primary care physician, the physician who stated he would not manage patients on home health. Her plan of care was signed by the agency's Medical Director. The patient's daughter, who was her power of attorney, was interviewed by phone. The daughter stated she was told her mother needed to make an appointment to be seen by the agency's Medical Director. The daughter stated she did not know the Medical Director and did not want to bring her mother to his office. She stated her mother's health care was provided by her primary care physician.

Another patient's record described a 42 year old female admitted to the agency on 2/11/16. Her record included a referral for home health services, dated 2/08/16, from her primary care physician, the physician who stated he would not manage patients on home health. Her plan of care was signed by the agency's Medical Director. There was no documentation stating she was informed her care was directed by the agency's Medical Director. Her record included documentation stating she continued to see her primary care physician while receiving home health services.

The Home Health Agency was cited at Code of Federal Regulations (CFR) 484.10(c) for failure to ensure patients were informed and involved in their plan of care, and at 484.18 for failure to accept patients for treatment on the basis of a reasonable expectation that the patient's needs can be met by the agency.

Cheryl Abel, Administrator
July 21, 2016
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Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

Dennis Kelly
on behalf of

NANCY BAX
Health Facility Surveyor
Non-Long Term Care

Dennis Kelly RN

DENNIS KELLY, RN
Co-Supervisor
Non-Long Term Care

NB/pmt