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

October 17, 2016

Jana Stowell, Administrator
St Alphonsus Home Health And Hospice
9199 West Black Eagle Drive
Boise, ID 83709-1572

RE: St Alphonsus Home Health And Hospice, Provider #137006

Dear Ms. Stowell:

Based on the survey completed at St Alphonsus Home Health And Hospice, on October 3, 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, Medication Supervision (42 CFR 484.18)**
- **Skilled Nursing Services (42 CFR 484.30)**

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 these conditions to be unmet, substantially limit the capacity of St Alphonsus Home Health And Hospice, 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 **October 27, 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 **November 17, 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))

- Termination (42 CFR 488.865)

We must recommend to the CMS Regional Office and /or State Medicaid Agency that your provider agreement be terminated (42 CFR 488.865) on **April 1, 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. 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

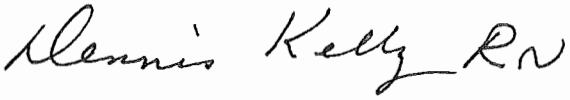
IDR Request Form

This request must be received by **October 27, 2016.** If your request for IDR is received after **October 27, 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, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

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

Saint Alphonsus

HOME HEALTH & HOSPICE

October 26, 2016'

Idaho Department of Health & Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

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OCT 28 2016
FACILITY STANDARDS

RE: Plan of Correction – St. Alphonsus Home Health and Hospice

To Whom It May Concern:

Enclosed you will find the plan of correction to the recent survey findings. We wish to thank the surveyors, who completed the survey and their bringing the items cited to our attention.

If you require additional information, please do not hesitate in call the St. Alphonsus Home Health and Hospice office, 208-332-2686.

Thank you.

Respectfully,

Marilyn Tatro, RN
Operations Liaison
Frontier Home Health and Hospice
St. Alphonsus Home Health and Hospice
mtatro@frontierhhh.com
Cell: 541-0219-0557

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

PRINTED: 10/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	137006		10/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS HOME HEALTH AND HOSPICE	9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency conducted from 9/26/16 to 10/03/16. The surveyors conducting the recertification were: Nancy Bax, RN, BSN, HFS, Team Leader Laura Thompson, RN, BSN, HFS Kristin Inglis, RN, HFS Rebecca Lara, RN, HFS Acronyms used in this report include: ALF - Assisted Living Facility BG - Blood Glucose BP - Blood Pressure CHF - Congestive Heart Failure CKD - Chronic Kidney Disease cm - centimeter COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DM - Diabetes Mellitus DME - Durable Medical Equipment DVT - Deep Vein Thrombosis ER - Emergency Room GERD - Gastroesophageal Reflux Disease H&P - History and Physical HHA - Home Health Agency HTN - High Blood Pressure LMSW - Licensed Master Social Worker LPN - Licensed Practical Nurse mg - milligram mg/dl - milligrams per deciliter ml - milliliter mm - millimeter MSW - Medical Social Work NSAID - Non-Steroidal Anti Inflammatory Drug OASIS - Outcome and Assessment Information	G 000	RECEIVED OCT 28 2016 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marilyn Peters	Qpa Liaison	10-26-2016

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 Set OT - Occupational Therapy PAC - Professional Advisory Committee POC - Plan of Care prn - as needed PT - Physical Therapy RN - Registered Nurse ROC - Resumption of Care SN - Skilled Nursing SOC - Start of Care ST - Speech Therapy VP - Vice President	G 000		
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients' rights were protected and promoted for 2 of 3 patients (#7 and #14) who had cognitive impairment or a language barrier whose records were reviewed. This failure had the potential to result in patients receiving care against their wishes and/or without understanding their financial obligations. Findings include: The agency did not ensure patients' rights were upheld and promoted during the admission process. Examples include: 1. Patient #7 was a 55 year old female admitted to the agency on 8/31/16, for services related to general muscle weakness. Additional diagnoses included major depression and aftercare following	G 101	**G 101 484.10 PATIENT RIGHTS** **Actions:** Mandatory educational sessions will be conducted November 1, 2 and 4 2016 with Agency Leaders (by Operation Liaison) and Staff (by Operations Liaison and Home Health Clinical Supervisors) on G101 deficiencies, corrective actions and policies 1-003/tools specific to each group's role and responsibilities. The Clinical Supervisor/Intake Coordinator will review and track ALL referrals/admissions prior to assigning to OASIS clinician for language barriers, provide Spanish Service agreement for beneficiaries whose primary language is Spanish. Identify translator that speak Spanish or primary language of the beneficiary to promote the ability of the patient to understand, protect and promote the individual patient's rights. The Clinical Supervisor/Intake Coordinator will review and track all referrals/admissions prior to assigning to an OASIS clinician for primary diagnosis of Dementia and/or mental confusion. The Intake Coordinator/OASIS clinician when establishing admission visit, will verify with family/caregiver who has the medical and/or financial power of attorney. If unable to verify, the OASIS clinician will call patient's PCP to clarify who is POA or if patient continues to make own health decisions. The Clinical Supervisors will track and report the number of patients admitted to the PI Committee during the November 2016 meeting regarding the number of admissions with actual or potential language barriers and action taken to assure language barrier was addressed with appropriate forms and documentation of utilization of interpreter. Patient # 7: Consent in Spanish was presented to the patient with interrupter present during the signing at his next scheduled visit 10/04/2016.	

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G 101	Continued From page 2 ankle surgery. She received PT, OT, and MSW services. Her record, including the POC, for the certification period 8/31/16 to 10/29/16, was reviewed. Patient #7's record included a letter of referral from her physician for home health services, dated 8/17/16, which stated she was Spanish speaking only. The agency's policy "FACILITATING COMMUNICATION" revised 10/11, stated "Written materials will be made available in the recognized major languages in the service area...Organization personnel will consistently and clearly communicate with patients in a language or form they can reasonably understand. The organization will facilitate communication by using special devices, interpreters, or other communication aids, as required." Additionally, it stated "For a patient who requires an interpreter...Document all language assisted care in the patient's clinical record." An SOC comprehensive assessment, dated 8/31/16, signed by the Physical Therapist, documented Patient #7's primary language was Spanish. The Physical Therapist also documented she required an interpreter. Patient #7's record included an "Admission Service Agreement," dated 8/31/16, which included consent for care/service, release of information, consent to photograph, insurance information, and financial disclosures for charges by the agency. The document was written in English, and signed by Patient #7.	G 101	Patient #14: Patient consent reviewed with next of kin, and updated to reflect correct signature. The Clinical Supervisors will track and report the number of patients admitted with actual or potential Diagnosis of Dementia and/or mental confusion to the PI Committee during the November 2016 meeting and action taken to assure that patient rights were protected. The PI Committee will determine what actions need to be taken, if data analysis indicates an opportunity exists. PDAC or non-PDAC decisions regarding continued monitoring will be reflected in the PI Committee minutes, November 2016. **That Led To Deficiency:** Above actions will 1) heighten awareness of individual and group responsibilities related to Policy 1-003, Rights and Responsibilities, Federal Regulation 418.10, Authentication 2) provide data to determine if the problem is wide-spread and requires PI intervention and 3) assign responsibility to ensure PI Committee documentation reflects analysis and any PI actions taken. **Monitoring and Tracking:** Preparatory PI meeting will be held November 2, 2016. The Director will ensure 100% referrals are reviewed for language barriers and diagnosis of Dementia and those patients are tracked to ensure patient rights and responsibilities are protected met by November 17, 2016. The PI Committee will analyze the referral (data) and determine if additional action plans are required during their November 2016 monthly PI meeting, determine if extension of tracking and trending is required **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17, 2016.	

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G 101	Continued From page 3 There was no documentation in Patient #7's record an interpreter was present during the SOC assessment or when she signed her admission paperwork. During an interview on 9/27/16 at 3:35 PM, the Nursing Clinical Supervisor and Therapy Clinical Supervisor reviewed the record and confirmed Patient #7's record documented she was Spanish speaking only. They also confirmed there was no documentation an interpreter was present during the SOC visit. During an interview on 9/28/16 at 10:00 AM, the Therapy Clinical Supervisor stated she had spoken with the Physical Therapist who performed the SOC assessment for Patient #7. She stated the Physical Therapist informed her a translator was present during the entire visit. The Therapy Clinical Supervisor again confirmed this was not documented in Patient #7's record. The agency failed to ensure Patient #7's rights were protected. 2. Patient #14 was an 87 year old male admitted to the agency on 9/09/16, for services related to dementia. Additional diagnoses included localized edema, cardiomegaly, and wheelchair dependence. He received SN, PT, and OT services. His record, including the POC, for the certification period 9/09/16 to 11/07/16, was reviewed. Patient #14's record included a referral, dated 9/07/16, signed by his physician which stated he had Lewy Body Dementia with behavioral disturbance. According to the National Institute on Aging, website accessed 10/04/16, Lewy Body	G 101		

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G 101	Continued From page 4 Dementia is a progressive disease which causes a decline in thinking similar to Alzheimer's disease, but also effects movement and mobility. Patient #14's physician documented he had increasing difficulty with his memory, and his daughter reported multiple instances over the last few weeks to months, where his cognition was impaired. An SOC comprehensive assessment, dated 9/09/16, signed by the RN, documented Patient #14 had a decline in mental, emotional, and behavioral status in the past 3 months. The RN also documented Patient #14 had impaired decision making abilities, and delusional, hallucinatory, or paranoid behavior at least once a week. The RN documented in the assessment Patient #14's daughter was present during the visit, and he lived with his wife. Patient #14's record included an "Admission Service Agreement," dated 9/09/16, which included consent for care/service, release of information, consent to photograph, insurance information, and financial disclosures for charges by the agency. The document was signed by Patient #14. During an interview on 9/30/16 at 11:30 AM, the Nursing Clinical Supervisor reviewed the record and confirmed Patient #14's diagnosis and his signature on the admission agreement. She stated Patient #14 should not have signed the admission form due to his diagnosis and medical history. The agency failed to ensure Patient #14's rights	G 101		

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G 101	Continued From page 5 were protected.	G 101		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the agency failed to ensure hand hygiene policies were followed for 1 of 10 patients (Patient #9) whose care was observed during a home visit. This resulted in the potential for cross contamination and subsequent patient infections. Findings include: Patient #9 was a 70 year old female admitted to the agency on 8/12/16, for services related to bilateral pneumonia and muscle weakness. Additional diagnoses included DM Type II and history of falling. She received PT, OT, and ST services. Her record, including the POC, for the certification period 8/12/16 to 10/10/16, was reviewed. A scheduled ST visit was observed on 9/27/16, at 3:00 PM. The Speech Therapist performed hand hygiene on arrival to Patient # 9's home. She then donned gloves. She wore the same pair of gloves throughout the visit. She performed the following: - Obtained Patient #9's vital signs - Placed of electrodes on Patient #9's neck	G 121	**G 121 484.12(c) Compliance within Accepted Professional Standards** **Actions:** Mandatory Education sessions will be conducted in November 1, 2, or 4, 2016 (staff required to select one of the posted dates/time to attend) with Agency Leaders (by Operations Liaison) and Staff (by Operations Liaison and Home Health Clinical Supervisors) on G121 deficiencies, corrective actions and policies/tools specific to each group's role and responsibilities. The Interim Director/ Clinical Supervisor met with Speech Therapist (ST), provided mentoring and coaching to the ST, instructing one on one with the ST professional standards of infection control, prevention of cross contamination of equipment during patient care, before returning to ST bag, bag technique. ST to attend mandatory scheduled staff meeting facilitated by Operations Liaison and Clinical Supervisor on November 1, 2 or 4, 2016 (staff required to select one of the posted dates/time to attend) to provide education on Policies and Procedures - Infection Control 9-001, Management of Exposures 9-003, Standard Precautions 9-007, Personal Protective Equipment 9-008, Hand Hygiene 9-009, Infection Control Expanded 9-001, and Bag Technique 9-014. Review with staff of available on-line CHEX educational Courses relating to Infection Control. Ongoing the Polices/ Procedures relating to the Infection Control program, Bag Technique will be reviewed annually with all agency staff. Annual on-site supervisory visits to be performed with each employee by the Clinical Supervisor or designee, monitoring each disciplines practice of performing and maintaining the professional Standards of Infection Control while providing care to agency patients. Documentation of all annual onsite supervisory visits for all disciplines will be filed in the disciplines personnel record.	

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G 121	Continued From page 6 - Adjusted the controls on a muscle stimulator - Charted - Touched her own face and nose - Placed the contaminated BP cuff and stethoscope on her lap - Cleaned contaminated equipment and placed it in the bag - Touched Patient #9 again to remove electrodes The Speech Therapist then removed one glove, folded contaminated items with her bare hand into the other glove. She performed hand hygiene with a gel cleanser after removing the gloves. The agency's policy "Hand Hygiene," revised 11/2013, stated personnel in the home setting will frequently wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings. The CDC regulations and guidelines for hand hygiene in a healthcare setting, published at the time of Patient #18's visit, stated: - "Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed) - After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings - After contact with inanimate objects (including	G 121	The PI Committee will determine what actions need to be taken, if data analysis indicates an opportunity exists. PDAC or non-PDAC decisions regarding continued monitoring will be reflected in the PI Committee minutes November 2016. **That Led To Deficiency:** Above actions will 1) heighten awareness of individual and group responsibilities related to Policies 9-001, 9-003, 9-007,9-008, 9-011, 9-014 and Federal Regulation 418.12c) Authentication 2) provide data to determine if the problem is wide-spread and requires PI intervention and 3) assign responsibility to ensure PI Committee documentation reflects analysis and any PI actions taken. **Monitoring and Tracking:** The Director will ensure that ST received mentoring/counseling and that all staff will have received education on policy and procedure. The Director will ensure that all annual supervisory visits that are due in October and November of 2016 using the Annual Skilled Staff Supervisory Visit Form, are completed and the staff demonstrated compliance to appropriate infection control and demonstrates appropriate bag technique by November 17, 2016. Preparatory PI meeting to be held November 2, 2016. The PI Committee will analyze the findings from the Annual Skilled Staff Supervisory visits answers to questions 7 and 8 then determine if further action is needed during the November 2016 meeting. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17, 2016	

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G 121	Continued From page 7 medical equipment) in the immediate vicinity of the patient - If hands will be moving from a contaminated-body site to a clean-body site during patient care - After glove removal" The agency's policy "Bag Technique" stated hands will be decontaminated prior to returning clean items to the bag. During an interview with the Clinical Nurse Supervisor on 9/27 at 8:40, she agreed the Speech Therapist did not follow the policy on hand hygiene. The agency failed to ensure hand hygiene guidelines were followed for Patient #9.	G 121		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: Based on staff interview, review of patient records, agency policies, personnel files, meeting minutes and other administrative documents, it was determined the Governing Body failed to provide effective administrative oversight of the HHA. This failure resulted in a lack of support and guidance to agency personnel. Findings include: 1. Refer to G123 as it relates to the Governing	G 122	**G 122 484.14 Organization, Services & Administrative** G122 Condition Plan of Correction is found with the standards identified under the condition G 122 STANDARDS: G123, G130, G 134, G 137, G141, G 144, G 153.	

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G 122	Continued From page 8 Body's failure to ensure lines of authority for delegation of responsibility were clearly understood by agency staff, accurately set forth in writing and readily identifiable. 2. Refer to G130 as it relates to the Governing Body's failure to ensure the agency's PAC established and annually reviewed the agency's policies. 3. Refer to G134 as it relates to the Governing Body's failure to ensure qualified personnel were employed and assigned. 4. Refer to G137 as it relates to the Governing Body's failure to ensure a qualified person was authorized in writing to act on behalf of the Administrator in her absence. 5. Refer to G141 as it relates to the Administrator's failure to ensure agency policies were followed and all personnel files for clinical staff contained current licensure. 6. Refer to G144 as it relates to the Governing Body's failure to ensure there was documented evidence to support effective care coordination. The cumulative effect of these systemic failures seriously impeded the agency's organizational functioning and negatively impacted the quality, coordination and safety of patient care.	G 122		
G 123	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are	G 123	**G123 484.14 Organization, Services & Administration**	

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G 123	Continued From page 9 clearly set forth in writing and are readily identifiable. This STANDARD is not met as evidenced by: Based on staff interview and review of agency organizational charts, it was determined the agency failed to ensure lines of authority for delegation of responsibility were clearly understood by the agency's clinical supervisors, were accurately set forth in writing and were readily identifiable. This resulted in confusion among the clinical supervisors regarding lines of authority and had the potential to interfere with the agency's ability to provide clear direction and guidance to staff. Findings include: An agency policy "DESIGNATION OF INDIVIDUAL IN ABSENCE OF AGENCY LEADER," last revised in 7/2011, included "Agency will have an Agency Leader or designee available at all times...In the event that the Agency Leader is absent, the Clinical Supervisor will assume the operational duties and responsibilities at Agency." The agency did not adhere to this policy as follows: The Therapy Clinical Supervisor was interviewed on 9/28/16, beginning at 2:30 PM. She stated the Agency Administrator was located in another state and worked from the local Boise office approximately "50 percent of the time." She stated the Administrator was not expected to be present in the Boise office during the survey. When asked who was identified in writing to act on behalf of the Administrator in her absence, she stated "I think it is me because I have been with	G 123	**Actions:** Education/ Orientation session was conducted in September 26, 2016 with Agency Clinical Supervisors and Business Office Manager on G123. The Chief Compliance Officer reviewed the saved delineation of Authority document located on shared computer L Drive. Chief Compliance Officer reviewed the process and responsibility of the Director to assure that delineation of Authority Document is current and shared verbally with agency leadership and staff and will be posted in a visible location within the agency. Education session was conducted on October 9, 2016 with Joint Venture Governing Body by Chief Compliance Officer. **That Led To Deficiency:** Above actions will 1) heighten awareness of Governing Body, Director, Clinical Supervisors and group responsibilities related to Policy 4-007, Federal Regulation 418.14(c); 2) Clarification of Frontier's value of assuring that delineation of authority is Registered Nurse and 3) clarify verbally Governing Body's approval of written delineation of authority. **Monitoring and Tracking:** The Director will ensure that Delineation of Authority process is approved, documented, shared at staff educational meeting November 1, 2, or 4, 2016: reviewed again verbally with Intake Coordinators, Business Office Manager, Clinical Supervisors November 2, 2016. Ongoing, the Director will review and update delineation of authority when there is a positional change of Director, Clinical Supervisory or Intake Coordinator and annually at Professional Advisory Committee meeting. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 123	Continued From page 10 the agency longer than the Nursing Clinical Supervisor, but I'm not sure." On 9/28/16, at approximately 3:30 PM, the Therapy Clinical Supervisor provided two organizational charts. The organizational charts did not clearly document lines of authority as follows: The agency document, "...Delineation of Authority...," dated 9/2016, indicated the line of authority began with the RN Director, transitioned to the RN Clinical Supervisor and finally to the RN Case Manager. The document did not include the Therapy Clinical Supervisor. Additionally, the document did not identify anyone to act for the Administrator in her absence. The agency document, "...Home Health & Hospice...," dated 6/29/16, included an organizational chart displaying lines of authority from the Home Health and Hospice Board of Managers at the top of the chart, to agency patients at the bottom of the chart. Included on the organizational chart were lines drawn from the RN Director, identified as the VP of Operations on this chart, to the Home Health RN Clinical Supervisor and the Therapy Clinical Supervisor, identified as the PT Clinical Supervisor on this chart. Neither the Nursing Clinical Supervisor or the Therapy Clinical Supervisor was designated to act on behalf of the Administrator in her absence. On 9/29/16 at approximately 11:20 AM, the Nursing Clinical Supervisor and the Therapy Clinical Supervisor were interviewed about which of them was chosen to act in the absence of the Administrator. They remained confused about	G 123		

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G 123	Continued From page 11 the agency's lines of authority and confirmed the organizational charts did not clearly identify either of them to act on behalf of the Administrator in her absence. Lines of authority were not clearly understood or accurately set forth in writing.	G 123	**G130 484.14 (b) Governing Body** **Actions:** Education/ Orientation session was conducted October 9, 2016 with Frontier Leadership, Saint Alphonsus Home Health and Hospice Joint Venture Board members on G130. The Chief Compliance Officer reviewed the deficiency and the regulations G130, G153 and 484.14(b) and 484.16 with the Governing Body and the Governing Body will ensure a sub-committee of the Professional Advisory Committee is identified to complete an annual review of the policies when the agency identifies a The Sub Committee will be minimally of a physician, RN and a community member that is neither an employee or an owner of the agency. The polices to be annually reviewed by a group from the Professional Advisory Committee that will minimally include a physician, registered nurse and community member who is neither an employee or owner of the agency. The subcommittee will minimally be agency policies that govern the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. Education session was conducted on October 9, 2016 with Joint Venture Governing Body by Chief Compliance Officer. **That Led To Deficiency:** Above actions will 1) heighten awareness of Governing Body, Frontier Leadership and group responsibilities related to Policy 4-007, Federal Regulation 418.14(c); 2) Clarification of Frontier's value of assuring that delineation of authority is Registered Nurse and 3) clarify verbally Governing Body's approval of written delineation of authority.	
G 130	484.14(b) GOVERNING BODY The governing body arranges for professional advice as required under §484.16. This STANDARD is not met as evidenced by: Based on staff interview, review of meeting minutes, and administrative documents, it was determined the agency failed to ensure the PAC established and annually reviewed policies. This resulted in a lack of oversight and direction to the agency. Findings include: Refer to G153 as it relates to the PAC's failure to ensure agency policies were established and annually reviewed. The governing body failed to ensure the PAC established policies and reviewed them annually.	G 130		
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel	G 134		

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G 123	Continued From page 11 the agency's lines of authority and confirmed the organizational charts did not clearly identify either of them to act on behalf of the Administrator in her absence. Lines of authority were not clearly understood or accurately set forth in writing.	G 123	**Continuation of:** **G130 484.14 (b) Governing Body** **Monitoring and Tracking:** The Governing Body will provide to the Professional Advisory Sub-Committee that annually reviews agency policies that governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and program evaluations. The sub-committee will minimally have one member that is neither and owner nor an employee of the agency. Compliance to the process will be verified at review of	
G 130	484.14(b) GOVERNING BODY The governing body arranges for professional advice as required under §484.16. This STANDARD is not met as evidenced by: Based on staff interview, review of meeting minutes, and administrative documents, it was determined the agency failed to ensure the PAC established and annually reviewed policies. This resulted in a lack of oversight and direction to the agency. Findings include: Refer to G153 as it relates to the PAC's failure to ensure agency policies were established and annually reviewed. The governing body failed to ensure the PAC established policies and reviewed them annually.	G 130	**Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel	G 134	**G134 484.14 (c) Administrator will employ qualified personnel and ensures adequate staff education and evaluations;** **Actions:** Education/ Orientation session was conducted in 09/28/2016 with Director, Clinical Supervisors, Business Office Manager and staff on G134, 484.14 (c) that Personnel records include qualifications and licensure that are kept current, HR Policy 1-005 and reviewed the process and responsibility of the Director to assure that all licensed staff have verified current licensure and if licensure lapses, the clinician is immediately taken off the schedule until proof of current licensure can be verified.	

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G 134	Continued From page 12 records and administrative documents, it was determined the agency failed to ensure the Administrator verified that all clinical staff possessed current licensure. Findings include: Refer to G141 as it relates to the Administrator's failure to ensure all clinical staff were qualified and possessed current licensure. The Administrator failed to ensure the agency employed qualified personnel with current licensure.	G 134	**That Led To Deficiency:** Above actions will 1) heighten awareness of Human Resource Manager, Director, Clinical Supervisors and group responsibilities related to Policy 1-005, Federal Regulation 418.14(c); 2) Authentication of currency of all licensures by Human Resources, Director, Clinical Supervisors and licensed staff 3) clarify Human Resource processes to assure licensed staff with lapsed licenses are taken off Patient schedules immediately. **Monitoring and Tracking:** The Director ensured that all licensed staff with scheduled patient visits have verified current licensure. Ongoing, the Director in collaboration with Human Resources will monitor status of all licenses minimally on a monthly basis and licensed clinician with be immediately removed from patient visit schedule until proof of active and current license. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016	
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 organizational charts, 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 the agency's ability to provide clear direction and guidance to staff. Findings include: An agency policy "DESIGNATION OF INDIVIDUAL IN ABSENCE OF AGENCY LEADER," last revised in 7/2011, included "Agency will have an Agency Leader or designee available at all times...In the event that the Agency Leader is absent, the Clinical Supervisor will assume the operational duties and responsibilities at Agency." The agency did not adhere to this policy as follows: The Therapy Clinical Supervisor was interviewed	G 137		

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G 134	Continued From page 12 records and administrative documents, it was determined the agency failed to ensure the Administrator verified that all clinical staff possessed current licensure. Findings include: Refer to G141 as it relates to the Administrator's failure to ensure all clinical staff were qualified and possessed current licensure. The Administrator failed to ensure the agency employed qualified personnel with current licensure.	G 134		
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 organizational charts, 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 the agency's ability to provide clear direction and guidance to staff. Findings include: An agency policy "DESIGNATION OF INDIVIDUAL IN ABSENCE OF AGENCY LEADER," last revised in 7/2011, included "Agency will have an Agency Leader or designee available at all times...In the event that the Agency Leader is absent, the Clinical Supervisor will assume the operational duties and responsibilities at Agency." The agency did not adhere to this policy as follows: The Therapy Clinical Supervisor was interviewed	G 137	**G137 484.14 (c) Administrator** **The agency failed to ensure a qualified person was authorized in writing to act in the absence of the Administrator.** **Actions:** Education and Orientation session was conducted in September 28, 2016 with Agency Clinical Supervisors and Business Office Manager on G137. The Chief Compliance Officer reviewed the saved delineation of Authority document located on shared L Drive. Chief Compliance Officer reviewed the process and responsibility of the Director to assure that delineation of Authority Document is current and shared verbally with agency leadership and staff Education session was conducted on October 9, 2016 with Joint Venture Governing Body by Chief Compliance Officer. The delineation of authority written form/ notification was update to reflect that the qualified individuals are authorized to act in the absence of the Administrator.	

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G 137	Continued From page 13 on 9/28/16, beginning at 2:30 PM. She said the Agency Administrator was located in another state and worked from the local Boise office approximately "50 percent of the time." She said the Administrator was not expected to be present in the Boise office during the survey. When asked who was identified to act on behalf of the Administrator in her absence, she stated "I think it is me because I have been with the agency longer than the Nursing Clinical Supervisor, but I'm not sure." On 9/28/16, at approximately 3:30 PM, the Therapy Clinical Supervisor provided two organizational charts. The organizational charts did not clearly document lines of authority as follows: The agency document, "...Delineation of Authority...," dated September of 2016, indicated the line of authority began with the RN Director, transitioned to the RN Clinical Supervisor and finally to the RN Case Manager. The document did not include the Therapy Clinical Supervisor. Additionally, the document did not identify a qualified person to act on behalf of the Administrator in her absence. The agency document, "...Home Health & Hospice...," dated 6/29/16, included an organizational chart displaying lines of authority from the Home Health and Hospice Board of Managers at the top of the chart, to agency patients at the bottom of the chart. Included on the organizational chart were lines drawn from the RN Director, identified as the VP of Operations on this chart, to the Home Health RN Clinical Supervisor and the Therapy Clinical Supervisor, identified as the PT Clinical	G 137	**That Led To Deficiency:** Above actions will 1) heighten awareness of Governing Body, clinical supervisors and group responsibilities related to Policy 4-007, Federal Regulation 418.14(c); 2) Clarification of Frontier's value of assuring that delineation of authority is Registered Nurse and 3) clarify verbally Governing Body's approval of written delineation of authority. **Monitoring and Tracking:** The Director will ensure that Delineation of Authority process is approved, documented, shared at staff meeting November 1, 2, or 4, 2016; and reviewed again verbally with clinical supervisors, November 3, 2016 during scheduled Leadership meeting with Operations Liaison. Ongoing, the Director will review and update delineation of authority when there is a positional change of Director, Clinical Supervisory or Intake Coordinator and annually at Professional Advisory Committee meeting. Each delineation of authority change will be visible posted within the agency for staff review **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016	

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G 137	Continued From page 14 Supervisor on this chart. Neither clinical supervisor was identified to act on behalf of the Administrator in her absence. On 9/29/16 at approximately 11:20 AM, the Nursing Clinical Supervisor and the Therapy Clinical Supervisor were interviewed about which of them was chosen to act in the absence of the Administrator. They remained confused and confirmed the organizational charts did not clearly identify either of them to act on behalf of the Administrator in her absence. The agency failed to ensure a qualified person was designated in writing to act in the absence of the Administrator.	G 137		
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on staff interview, review of agency personnel documents and review of agency occurrence reports, it was determined the agency failed to ensure the Administrator verified 1 of 3 LPNs, whose personnel documents were reviewed, possessed current professional state licensure. This resulted in services provided by unlicensed staff. Findings include: An agency policy "LICENSURE/CERTIFICATION/REGISTRATION,	G 141	**G141 484.14 (e) Personnel Policies** **Actions:** Education and Orientation session was conducted September 28, 2016 with Director, Agency Clinical Supervisors, Business Office Manager and staff on G141, 484.14 (e) that Personnel records include qualifications and licensure that are kept current , HR Policy 1-005 and reviewed the process and responsibility of the Director to assure that all licensed staff have verified current licensure and if licensure lapses, the clinician is immediately taken off the schedule until proof of current licensure can be verified. **That Led To Deficiency:** Above actions will 1) heighten awareness of Human Resource Manager, Director, clinical supervisors and group responsibilities related to Policy 1-005, Federal Regulation 418.14(e); 2) Authentication of currency of all licensures by Human Resources, Director, Clinical Supervisors and licensed staff 3) clarify Human Resource processes to assure licensed staff with lapsed licenses are taken off schedules immediately.	

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G 141	Continued From page 15 " last revised in 4/2013, included "All organization staff and independent contractors will be properly licensed, certified, registered and/or trained to meet specific job requirement." The agency did not adhere to this policy as follows: The agency occurrence report log was reviewed during the survey. Included in the log was an unsigned "EMPLOYEE REPORTABLE EVENT" form, dated 2/15/16. The form stated that an LPN was working for the agency without a license. Attached to the reportable event form was an undated "REPORT FORM FOR VIOLATION OF THE NURSING PRACTICE ACT" that was completed by the Director of Home Health and Hospice at the time. The form stated the LPN was hired on 7/06/15 and held a verified LPN license from the state of Utah. It stated the LPN was employed by the agency as an Intake Coordinator, a Clinical Liaison, and a field LPN. The form stated the agency notified the LPN, prior to 1/31/16, that her Utah license was due to expire. It stated the Director of Home Health and Hospice was notified on 2/15/16 the LPNs Utah license expired on 1/31/16 and the LPN did not have a current Idaho license. The form stated the LPN saw a total of 18 home health patients between 2/01/16 and 2/14/16, when she did not possess a current LPN license. The Nursing Clinical Supervisor was interviewed on 9/28/16 at approximately 11:20 AM. She reviewed the personnel documents regarding the LPN and said she recalled the situation. She stated the LPN also had a temporary Idaho license. She clarified the Idaho license was the license that expired, and said the LPN failed to obtain a permanent Idaho license. The Nursing Clinical Supervisor confirmed the LPN saw 18	G 141	**Monitoring and Tracking:** The Director ensured that all licensed staff with scheduled patient visits have verified current licensure. Ongoing, the Director in collaboration with Human Resources will monitor status of all licenses minimally on a monthly basis and will a licensed clinician with be immediately removed from patient visit schedule until proof of active and current license. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016	

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G 141	Continued From page 16 patients during the time she was working without a license. An LPN worked for the agency and conducted patient visits for a period of 14 days without a license. The agency failed to ensure all clinicians had a current license.	G 141		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record review, policy review, observation of case conference, and staff interview, it was determined the agency failed to ensure care coordination between disciplines was documented for 2 of 14 patients (#6 and #19) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include: The agency's policy "CARE COORDINATION" revised 10/2012, stated the purpose of the policy was "To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services." The policy stated "The clinicians will be responsible for facilitating communications about changes in the patient's status among the assigned personnel. Written evidence of care coordination will be recorded during the case conference and	G 144	**G144 484.14 (g) Coordination of Patient Services** **Actions:** Education sessions will be conducted November 3, 2016 with Agency Leaders (by Operations Liaison) and Staff November 1, 2, 4, 2016 (by Operations Liaison and Home Health Clinical Supervisors) on G144, 484.14 (g) deficiencies, corrective actions and policies 2-025 and 2-027, tools specific to each group's role and responsibilities. The PI Committee will determine what actions need to be taken, if data analysis indicates an opportunity exists. PDAC or non-PDAC decisions regarding continued monitoring will be reflected in the PI Committee minutes November 2016. **That Led To Deficiency:** Above actions will 1) heighten awareness of individual clinician and group responsibilities related to Policies 2-025 and 2-027and Federal Regulation 418.1 (g), Authentication 2) provide data to determine if the problem is wide-spread and requires PI intervention and 3) assign responsibility to ensure PI Committee documentation reflects analysis and any PI actions taken.	

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ST ALPHONSUS HOME HEALTH AND HOSPICE	9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709

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G 144	Continued From page 17 repeated in skilled nursing visit reports in the patient's clinical records." This policy was not followed. Examples include: 1. Patient #6 was a 66 year old male admitted to the agency on 9/21/16, for services related to traumatic injuries after a fall. Additional diagnoses included DM Type II, HTN, depression, and anxiety. He received PT, OT, and MSW services. His record, including the POC, for the certification period 9/21/16 to 11/19/16, was reviewed. An SOC comprehensive assessment dated 9/21/16, and signed by the Physical Therapist Case Manager included documentation Patient #6 was diagnosed with depression and anxiety. The Physical Therapist Case Manager documented Patient #6 had a history of Guillain-Barre syndrome, which continued to cause weakness. According to the Mayo Clinic website, accessed 10/05/16, Guillain-Barre syndrome is a disorder which attacks the body's immune system and symptoms may include weakness, tingling, unsteady gait, and severe pain. The Physical Therapist Case Manager documented Patient #6 was confused intermittently during the day and night and experienced anxiety daily. He also documented Patient #6 had long term depression and inadequate sleep and/or rest. The Physical Therapist Case Manager also documented Patient #6 was difficult to communicate with and was speaking nonsensically at times, and was heavily medicated during the evaluation visit. There was no documentation related to Patient #6's job status.	G 144	**Monitoring and Tracking:** The Performance Improvement Committee will monitor 25% of active and non-active clinical records for evidence of documented coordination of care to ensure ongoing quality of patient care and continuity of patient care utilizing, until the agency obtains 90% compliance, variances will be communicated during the monthly and quarterly PI meetings and addressed with one on one education with staff. Once compliance is obtained ongoing the agency will review 10% of the active and inactive clinical records, based on the average daily census of the agency. The PI Committee will analyze the findings from the audit tool for coordination of care and determine if further action is needed during the November meeting and next scheduled quarterly meeting. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17, 2016	

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G 144	Continued From page 18 An OT evaluation note, dated 9/22/16, and signed by the Occupational Therapist documented Patient #6 was put on administrative leave from his job. She did not include further documentation regarding the situation. The Occupational Therapist documented she coordinated care from her visit with the physician and Physical Therapist. There was no documentation of what was discussed. An MSW evaluation note, dated 9/27/16, and signed by the LMSW documented he and Patient #6 discussed his job situation. The visit note stated Patient #6 wanted to continue working for a couple of years, but due to his injuries he may not go back to work. There was no documentation of a further discussion why Patient #6 was on administrative leave. The LMSW did not document coordination with the Physical Therapy Case Manager or the Occupational Therapist regarding his visit. An agency case conference, on 9/29/16, was observed by 2 surveyors. The case conference was attended by the clinicians for the agency to discuss patients who were currently receiving services. At the conference there was a discussion regarding Patient #6 and his work status when it was stated Patient #6 was placed on administrative leave from his job for threatening to "shoot up the place" or "shoot some people" if he did not receive time off from his work. A clinician asked whether Patient #6 had access to a gun, but his clinicians did not know whether he did or not. Patient #6 was still on administrative leave while admitted to the agency.	G 144		

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G 144	Continued From page 19 Patient #6's record included a "Case Conference Report," dated 9/29/16. The report identified re-hospitalization, falls, pain, and medication compliance as a risk or safety concern for Patient #6. The action section of the report documented front loading of visits (increased frequency of visits at the beginning of the certification period), review and teaching of medications, and educating regarding his multiple fractures. The report was signed by the Physical Therapist Case Manager, the LMSW, the Nursing Clinical Supervisor, and the Therapy Clinical Supervisor. There was no documentation of the discussion regarding his job, the threat Patient #6 made while at work, or a plan for the clinicians to assess for patient safety. During an interview on 9/29/16 at 10:00 AM, the LMSW reviewed the record and stated "I always talk to patients about their depression." He stated during his evaluation Patient #6 told him he was doing "okay." When asked about Patient #6 being on administrative leave, the LMSW stated he had heard the information second hand, but could not remember where he heard it. He stated he heard Patient #6 threatened to "shoot up the place." The LMSW stated he talked with the Physical Therapist Case Manager about Patient #6 being on leave from his job, but confirmed this was not documented in the record. During an interview on 9/29/16 at 4:05 PM, the Physical Therapist Case Manager reviewed the record and stated Patient #6 denied being depressed during his evaluation visit. When asked about Patient #6 being on administrative leave the Physical Therapist Case Manager stated he heard this information from the Occupational Therapist. He stated he talked with	G 144		

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G 144	Continued From page 20 both the LMSW and Occupational Therapist regarding the situation, but confirmed this was not documented in the record. During an interview on 9/30/16 at 9:05 AM, the Occupational Therapist reviewed the record and confirmed Patient #6 told her he was on administrative leave from his job, and why he was on leave. She stated he told her he asked his supervisor for time off, which was refused, and he stated his reply to his supervisor was he would " ...start shooting the place up ..." or " ...I'll start shooting people up." The Occupational Therapist stated she could not remember his exact words, but they were to that effect. When asked if she had discussed the situation with anyone she stated she informed the Physical Therapist Case Manager. She stated she wanted to inform the Physical Therapist Case Manager of Patient #6's "state of mind." She confirmed the conversations with Patient #6 and the Case Manager were not documented in the record. The agency failed to ensure care coordination of issues relevant to the safe care of Patient #6 was documented in his record. 2. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, following a hospitalization for exacerbation of CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. Patient #19's record included an SOC comprehensive assessment dated 3/08/16, signed by the admitting RN, and an SN visit note	G 144		

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G 144	Continued From page 21 dated 3/15/16, signed by the RN Case Manager. No additional SN visits were documented. The agency's document "AFTER HOURS CARE COORDINATION TELEPHONE LOG" dated 3/22/16, was reviewed. It stated a call was received at 6:41 PM, regarding Patient #19. The document stated the caller reported Patient #19's BP was elevated and his BG level was 512. The American Diabetes Association website, accessed 10/04/16, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl. The document stated "sent patient to ER." Patient #19's record did not include documentation of the 3/22/16 after hours phone call. His record did not state his RN Case Manager was notified of the call, his symptoms, or his ER visit. Hospital records for Patient #19 were requested and reviewed. The ER physician's note documented he presented to the ER with an elevated BG level, elevated BP, and elevated cardiac enzymes. The hospital notes stated he was admitted for observation and discharged on 3/23/16. Patient #19's record did not include SN visits following his hospital discharge. Patient #19's record included a discharge summary dated 4/08/16, signed by the RN Case Manager. The summary stated "Home Health Agency was notified patient was in the Emergency Room on 3/22/16. It is unclear what happened to patient after this Emergency Room visit. Agency was unable to contact patient. Agency discharge at this time for non homebound status."	G 144		

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G 144	Continued From page 22 During an interview on 9/30/16 at 11:00 AM, Patient #19's RN Case Manager stated she did not remember how she knew he went to the ER on 3/22/16. The RN Case Manager confirmed there was no documentation in Patient #19's record regarding the after hours phone call or his ER visit on 3/22/16. The agency failed to ensure coordination between the on-call staff and the RN Case Manager occurred and was documented. This failure likely contributed to missed services for Patient #19.	G 144		
G 153	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 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: A request was made on 9/30/16, to review documentation of the PAC meetings for the last 12 months. The Therapy Clinical Supervisor presented a folder which included several documents related to the PAC.	G 153	**G153 484.16 Group of Professional Personnel** **Actions** Education and Orientation session was to be conducted in October 9, 2016 with Frontier Leadership, Saint Alphonsus Home Health and Hospice Joint Venture Board members on G153 The Chief Compliance Officer reviewed the deficiency and the regulations G153, 484.16 with the Governing Body and the Governing Body will ensure a sub-committee of the Professional Advisory Committee is identified to complete an annual review of the policies when the agency identifies a The Sub Committee will be minimally of a physician, RN and a community member that is neither an employee or an owner of the agency. The polices to be reviewed will minimally be agency policies that govern the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation and they will be listed on the signature page. Education session was conducted on October 9, 2016 with Joint Venture Governing Body by Chief Compliance Officer.	

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G 153	Continued From page 23 A form titled "Professional Advisory Committee," dated 4/06/16, documented the agenda and meeting minutes. One of the topics listed on the agenda was "Home Health and Hospice Policies and Procedures." The minutes for this topic stated "[Name of corporation] P&Ps [policies and procedures] are reviewed/approved by Home Office Executives, a Medical Director and a Montana PAC member. Note: A notebook with P&P Table of Contents is available for review." Another form, which was signed by the Administrator, a PAC member, a Governing Body Representative, and a Medical Director, stated "The following policies and procedures have been developed specifically for those services sponsored by [Name of corporation]. These policies and procedures are reviewed annually." However, the titles of the policies and procedures were not included on the form with the signatures. A separate document listed all of the policies for the agency and included a section to document the year and month the policy was updated. The document did not include a statement the policies were reviewed by the PAC. During an interview on 9/30/16 at 3:30 PM, the Compliance Officer reviewed the PAC documents. She stated she reviewed all of the policies herself biannually when she received updates from the company they purchased their policies from. The Compliance Officer stated the document with the signatures was to show the policies were reviewed. She confirmed the document did not state which policies, or if all of the policies, were reviewed. The Compliance Officer stated policies were reviewed when they	G 153	**That Led To Deficiency:** Above actions will 1) heighten awareness of Governing Body, Frontier Leadership and PAC responsibilities related to Policy 4-007, Federal Regulation 418.14(c); 2) Authentication that PAC membership in annual review of policy and procedures includes a community member. **Monitoring and Tracking:** The Governing Body will ensure a Professional Advisory Sub-Committee will annually reviews agency policies that governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and program evaluations. The sub-committee will minimally have one member that is neither and owner nor an employee of the agency. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016	

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G 153	Continued From page 24 were updated and revised. She confirmed the document did not state the policies were reviewed by the PAC, and she confirmed not all of the policies were updated in 2015. The agency failed to ensure the PAC established and annually reviewed the agency's policies.	G 153		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on record review, review of policies, observation, and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, the POCs included all pertinent information, the physicians were notified of changes in patients' conditions, drugs and treatments were administered as ordered, and verbal orders were signed by the physician. This resulted in unmet patient needs, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the agency's failure to ensure care was provided in accordance with POCs. 2. Refer to G159 as it relates to the agency's failure to ensure the POC included all pertinent diagnoses, types of services and equipment required. 3. Refer to G164 as it relates to the agency's failure to ensure professional staff promptly alerted the physician to changes in patients'	G 156	**G156 484.18 Acceptance of Patients, POC and Med Supervision** G156 Condition Plan of Correction is found within the standards identified under the condition G156 STANDARDS: G158, G159, G164, G165, G166	

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G 156	Continued From page 25 conditions that suggested a need to alter their POCs. 4. Refer to G165 as it relates to the agency's failure to ensure drugs and treatments were administered only as ordered by the physician 5. Refer to G166 as it relates to the failure of the agency to ensure verbal orders were put in writing and signed by the patients' physicians. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.	G 156		
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 medical records and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 5 of 20 patients (#3, #5, #15, #17, and #19) whose records were reviewed. This resulted in the potential for omissions of care and unmet patient needs. Findings include: 1. Patient #17 was a 52 year old female admitted to the agency on 12/27/15, for services related to an abscess of the foot. Additional diagnoses included cellulitis, depression, and HTN. She received SN services. Her record, including the POC, for the certification period 2/25/16 to 4/24/16, was reviewed.	G 158	**G158 484.18 Acceptance of Patients POC, Med Supervision** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all Case Managers assigned to patients # 3, #5, #15, #17, and #19. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, interventions, all administered to the patient as written on the initial 485 plan of care, notifications of changes to the MD, writing of supplemental orders. Writing of verbal orders at the time of obtaining of the patient's certifying primary care provider or another provider identified within the 485 POC or supplement orders that the clinician may accept orders from another provider. Writing/follow of correct frequency and durations, wound care orders written in detail/obtained prior to the provisions of hands-on care. Writing of orders for additional disciplines and follow-up on those orders, timely writing of orders/physician notifications for missed evaluations, timely writing of missed visit notes for those visits missed and clinician unable to reschedule, instruction Policy 2-057.1 – Missed Visits. Operations Liaison Power point attached.	

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G 158	Continued From page 26 a. Patient #17's POC for the certification period 2/25/16 to 4/24/16, included an order to provide wound care to her left foot. However, her POC did not include specific wound care orders, to determine the products to use and process to follow. Patient #17's record included a physician's order dated 3/09/16, with specific wound care orders. However, wound care was provided during SN visits on 2/29/16, 3/03/15, and 3/07/16, prior to receiving wound care orders. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and confirmed wound care orders were not included on her POC. She stated orders were received from the wound care center on 3/09/16, and confirmed wound care was provided during 3 SN visits before the orders were received. Patient #17's wound care was provided without a physician's order. b. Patient #17's record included a physician's order from a wound care clinic, dated 3/16/16, to increase the frequency of visits to every other day, to observe for redness and change her wound dressing. The order stated her next wound care appointment was in 1 week. Her record included an SN visit note dated 3/17/16. The next SN visit was documented on 3/24/16, 1 week later. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and stated her SN visits were not increased to every other day as ordered.	G 158	In-service training provided by the CS and AVP October 5, 2016, on Wound Care. Instruction included use of E-Z graph wound assessment tool, Frontier Wound Care Protocol, Quick assessment of Leg Ulcer – Clinical Fact sheet, Wound Photo documentation, and WOCN, Guidance on OASIS C1 Integumentary Items: Best Practice for Clinicians, in response to findings of patient #17. In-service provided to nursing staff, October 19, 2016. Wound Care – Wound Vac by a Boise KCI representative. Agency developing clinical pathway for the management of CHF, clinician guidelines establishing best practice to be completed by October 28, 2016 in response to the finding of Patient #15. Patients with primary diagnosis of CHF will have a base weight established at SOC and monitored as per written orders with established parameters for reporting, sudden weight gain of 3 pounds in 24 hours and 5 pounds within one week to MD. Instructed to include s/s of pitting edema and establishment of parameters to report to attending MD. Staff will be instructed on the new CHF clinical pathway November 1, 2, 4, 2016 by the Operations Liaison. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways, writing of/following of wound care orders. Policy 2-057.1 Missed Visits. **Monitoring and Tracking:** CS or designee will review 100% of clinical records with wound care, and diagnosis of CHF. Review of all orders, frequency/duration, and supplies, reporting parameters, SOC baseline weights and ordered weighing frequency until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate	

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G 158	Continued From page 27 The agency failed to provide SN visits for wound care as ordered by the physician. 2. Patient #15 was an 80 year old female admitted to the agency on 9/20/16, for services related to an acute gastrointestinal bleed. Additional diagnoses included enterocolitis related to Clostridium difficile (inflammation of the small intestine and the colon due to bacterial infection), GERD, atrial fibrillation (irregular heartbeat), HTN, CHF, CKD, and history of DVT. She received SN, PT, and OT services. Her record, including the POC, for the certification period 9/20/16 to 11/18/16, was reviewed. Patient #15's POC, dated 9/20/16, included orders for management of CHF. The orders stated the SN was to educate Patient #15 on signs and symptoms of CHF exacerbation and when to notify the RN or physician. The symptoms included a weight gain of 3 pounds overnight or 5 pounds in 7 days, wet frothy cough, increased shortness of breath or difficulty breathing, and lower extremity swelling. An SOC comprehensive assessment, dated 9/20/16, signed by the RN Case Manager did not document a baseline weight or CHF education for Patient #15. The American College of Cardiology website, accessed on 10/04/16, 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	G 158	the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 158	Continued From page 28 general, call if you gain 3 pounds or more in 2 to 3 days." However, there was no documentation stating Patient #15 was educated to weigh herself daily to monitor her symptoms of CHF. An SN visit note, dated 9/22/16, signed by the RN Case Manager, documented Patient #15 had 2 mm pitting edema (a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body), or swelling, in both of her lower extremities. The National Library of Medicine website, accessed 10/04/16, stated edema may be described as either pitting or non-pitting. Pitting edema leaves a dent in the skin after you press the area with a finger for about 5 seconds, and the dent will then slowly fill back in. It stated pitting edema is categorized by millimeters of depth of the indentation from 1 to 4 millimeters. The SN visit note did not include documentation of Patient #15's weight and there was no documentation of patient teaching related to CHF. During an interview on 9/30/16 at 11:50 AM, the Nursing Clinical Supervisor reviewed the record and confirmed the RN Case Manager did not document a weight at the SOC assessment visit or her subsequent visit. She also confirmed there was no teaching or education documented in either of the visit notes about CHF. Patient #15's orders on her POC were not followed related to management of her CHF. 3. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, DM	G 158		

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	137006		10/03/2016

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G 158	Continued From page 29 Type II, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed. Patient #3's POC, dated 5/22/16, included orders for SN visits 3 times a week for 1 week, 2 times a week for 8 weeks, and 4 visits as needed for falls or Foley catheter care. Patient #3 did not receive SN visits as ordered. Examples include: - During week 1, Patient #3 received SN visits on 5/22/16 and 5/25/16. Three SN visits were ordered, 2 SN visits were provided. - During week 3, Patient #3 received SN visits on 6/06/16, 6/09/16, and 6/11/16. Two SN visits were ordered, 3 SN visits were provided. There was no documentation in the SN visit notes a PRN visit was completed as ordered on the POC. There was no physician order for the additional visit. - During week 7, Patient #3 received SN visits on 7/03/16, 7/06/16, and 7/08/16. Two SN visits were ordered, 3 SN visits were provided. There was no documentation in the SN visit notes a PRN visit was completed as ordered on the POC. There was no physician order for the additional visit. - During week 8, Patient #3 received SN visits on 7/11/16, 7/13/16, and 7/15/16. Two SN visits were ordered, 3 SN visits were provided. There was no documentation in the SN visit notes a PRN visit was completed as ordered on the POC. There was no physician order for the additional visit.	G 158		

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G 158	Continued From page 30 - During week 9, Patient #3 did not receive SN visits. Two SN visits were ordered. During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor reviewed the record and confirmed SN visit orders were not followed. Patient #3's SN visits were not provided as ordered. 4. Patient #5 was a 65 year old male admitted to the agency on 8/14/16, for services related to insulin dependent DM. Additional diagnoses were brain cancer and HTN. He received SN, ST and MSW services. His record, including the POC, for the certification period 8/14/16 to 10/12/16, was reviewed. Patient #5's record included an SN visit note dated 9/22/16, signed by his RN Case Manager. The note stated the RN received a verbal order from Patient #5's physician for ST and OT evaluations. Patient #5's record did not include an OT evaluation. During an interview on 9/29/16 at 3:00 PM, the Nursing Clinical Supervisor reviewed Patient #5's record and stated the verbal order for an OT evaluation was not put into writing by the RN who accepted the order, so an OT evaluation visit was not scheduled. Patient #5 did not receive an OT evaluation as ordered by his physician. 5. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin	G 158		

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G 158	Continued From page 31 dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. Patient #19's POC included an order for SN visits 1 time a week for 9 weeks. His record included documentation of SN visits on 3/08/16 and 3/15/16. No additional SN visits were documented prior to his discharge on 4/08/16. Patient #19's record included 2 documents titled "MISSED VISIT REPORT," signed by the RN Case Manager, and dated 3/22/16 and 3/29/16. The documents stated SN visits were not performed on each of those dates because the RN was unable to reach Patient #19 by phone. Each document included a fax verification form, stating the missed visit report was faxed to Patient #19's physician on 5/16/16, 7 and 8 weeks after the missed visits. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager stated she may have been asked to complete the missed visit reports at a later date. She stated she should have dated the documents with the date she signed them. She confirmed Patient #19's physician was not notified of his missed SN visits until 5/16/16. The agency failed to notify Patient #19's physician when SN visits were not provided as ordered on his 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	**G 159 484.18(a) Plan of care** **Action:** **Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff**	

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G 159	Continued From page 32 equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of medical records, observation, and staff interview, it was determined the agency failed to ensure the POC included all interventions, medications, nutritional requirements, and supplies for 5 of 20 patients (#3, #4, #8, #15, and #19) whose records were reviewed. This had the potential to negatively impact quality and coordination of patient care. Findings include: 1. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF following hospital discharge. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. a. Patient #19's record included information from the hospital where he was discharged on 3/14/16. The information included his discharge medications. The medications included Levemir insulin (100 units/ml) with directions to take 25 units daily. Patient #19's POC included Levemir insulin (100 units/ml) with directions to take 100 units daily, instead of 25 units as directed on his hospital	G 159	attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 3, #4, #8, #15 and #19. Program will be provided by the Operations Liaison. Focus instruction will include medication management, updating the patient's individual medication profile, writing of correct medication orders, including oxygen and CPap. Review of specific orders received at the time of referral from the referral source, incorporating orders into the patient's plan of care. Writing and verification of orders received from the wound care clinics, how to document new wounds, completion of occurrence report as indicated, numbering of new wounds, communication to primary care physician, and including accepting orders from wound care physicians. Writing of resumption of care orders. Including identification of DME on the patient's initial plan of care and ROC if indicated. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, Policy 2-019, 2-020, 2-0253-001, 3-002, 3-003, 3-014. **Monitoring and Tracking:** CS or designee will review 100% of SOC 485s, medication profiles and all supplemental orders related to medications, new, changed and discontinued. Orders with new wounds identified. Until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 159	Continued From page 33 discharge orders. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager reviewed Patient #19's record and confirmed the dosage of Levemir insulin was incorrect on his POC. Patient #19's POC included an incorrect dose for his insulin. b. Patient #19's record included an SOC comprehensive assessment dated 3/08/16, and signed by the admitting RN. The assessment stated he was using oxygen in his home, and he used a CPAP machine at night. Patient #19's POC did not include an order for oxygen flow rate or whether it was used continuously or intermittently. His POC did not include his CPAP machine or supplies to deliver his oxygen. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager reviewed Patient #19's record and confirmed he used oxygen and CPAP. She stated his oxygen and CPAP were not included on his POC. c. Patient #19's record included home health orders from the hospital where he was discharged on 3/14/16. The orders included a cardiac diet, and stated "No added salt. Patients with Heart Failure should monitor their sodium intake." Patient #19's POC stated he was to follow a diabetic diet. His POC did not include orders for a cardiac diet or orders to monitor sodium intake. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager reviewed Patient #19's record and confirmed his POC should have included a	G 159		

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G 159	Continued From page 34 cardiac diet. Patient #19's POC did not include his oxygen and CPAP machine. Additionally, it did not include a cardiac diet as ordered. 2. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, DM Type II, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed. Patient #3's record for the certification period 5/22/16 to 7/20/16, included an SN visit note dated 6/09/16, signed by her RN Case Manager. The note identified 2 new wounds on her right buttock and 1 new wound on her left buttock. The note stated the wounds were related to injuries caused by her wheelchair and Hoyer lift. Patient #3's record included orders from a wound clinic for wound care beginning on 6/16/16. Wound care orders from the clinic were received on 6/16/16, 6/24/16, 7/07/16, and 7/18/16. The orders dated 7/18/16 were for VAC (Vacuum Assisted Closure) wound care. VAC uses negative pressure to remove fluid from the wound through suction by a mechanical device. The wound care orders were signed by physicians from the wound care clinic. There were no orders from Patient #3's primary physician stating wound care orders could be accepted from the wound clinic. A physician order, dated 7/15/16, signed by the	G 159		

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G 159	Continued From page 35 RN Case Manager, stated "SN recertified patient for wound care and catheter care. Wound care completed as directed by wound clinic more detailed POC to follow." The order did not specify where the wound was located, which wound clinic Patient #3 was going to, or the type and frequency of treatments she was receiving. The POC, for the certification period 7/21/16 to 9/18/16, signed by Patient #3's physician on 8/02/16, included orders for wound care which stated "Wound Care: Wet to dry to right IT [ischial tuberosity]. Cleanse with wound cleanser, wet to dry gauze with Microklenz, cover with Exudry, secure with tape." The wound orders mimicked the wound clinic orders dated 7/07/16. However, the wound care orders from the clinic were for the left ischial tuberosity, not the right. Additionally, the POC did not include an order from Patient #3's physician stating wound care orders may be taken and followed from the wound clinic physicians. Additional orders from the wound clinic, dated 8/01/16 and 9/21/16, were in Patient #3's record and were being followed for Patient #3's wound treatment. During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor stated the RN Case Manager who admitted Patient #3 and started the wound treatment was not available for interview. She reviewed the record and confirmed there were no orders from Patient #3's physician to accept and follow orders from the wound clinic. The Nursing Clinical Supervisor confirmed the POC for the second certification period did not include orders from the physician to accept and follow orders from the wound clinic. She also	G 159		

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G 159	Continued From page 36 confirmed the POC did not include the information necessary for wound treatment. The Nursing Clinical Supervisor confirmed Patient #3's wounds were documented inconsistently and incorrectly. The agency failed to ensure Patient #3's POC included all physicians who could write orders and modify her POC.Additionally, Patient #3's POC did not include clear and consistent orders for treatments. 3. Patient #4 was a 68 year old female admitted to the agency on 9/26/16, for services related to muscle weakness. Additional diagnoses were chronic pain and HTN. She received PT services. Her record, including the POC, for the certification period 9/26/16 to 11/24/16, was reviewed. Patient #4's record included an SOC comprehensive assessment dated 9/26/16, signed by the Physical Therapist. The assessment stated Patient #4 complained of right knee pain that resulted in difficulty in transferring. It stated her pain ranged from 2 to 6 on a scale of 0 to 10, with 10 being the worst pain. Patient #4's POC included a diagnosis of chronic pain. Her POC did not include interventions to monitor her pain, or to intervene to minimize her pain. During an interview on 9/29/16 at 4:40 PM, the Nursing Clinical Supervisor stated Patient #4's POC should have included interventions to address her chronic pain. Patient #4's POC did not include interventions to	G 159		

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G 159	Continued From page 37 address her chronic pain. 4. Patient #8 was an 84 year old female admitted to the agency on 7/20/16, for services related to a vaginal fistula. Additional diagnoses included atrial fibrillation and HTN. She received SN, PT, OT and MSW services. Her record, including the POC, for the certification period 9/18/16 to 11/16/16, was reviewed. Patient #8's home health services were placed on hold on 8/29/16, when she was admitted to the hospital for surgery. Her care was resumed on 9/07/16. Patient #8's record included an ROC assessment dated 9/07/16, signed by the RN. The assessment stated Patient #8 reported daily pain ranging from 0 to 6, on a scale of 0 to 10, with 10 being the worst pain. Patient #8's POC did not include interventions to monitor and address her pain. Physician orders received after her ROC did not include interventions to monitor and address her pain. During an interview on 9/29/16 at 3:25 PM, the Nursing Clinical Supervisor reviewed Patient #8's record and stated her POC was not updated following her ROC, to include interventions to monitor and address her pain. Patient #8's POC did not include interventions to monitor and address her pain. 5. Patient #15 was an 80 year old female admitted to the agency on 9/20/16, for services related to an acute gastrointestinal bleed. Additional diagnoses included enterocolitis related to Clostridium difficile, GERD, atrial fibrillation, HTN, CHF, CKD, and history of DVT. She received SN, PT, and OT services. Her	G 159		

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G 159	Continued From page 38 record, including the POC, for the certification period 9/20/16 to 11/18/16, was reviewed. Patient #15's record included an SOC comprehensive assessment completed on 9/20/16, and signed by the RN Case Manager. The POC did not include all DME available in her home. A home visit was conducted at Patient #15's home on 9/28/16, beginning at 11:30 AM. During the visit, discrepancies were observed between her POC and the DME in the home. Patient #15 had oxygen and oxygen supplies, a walker, a reacher to grab items, a toilet seat riser, and grab bars in her bathroom. These items were not included on her POC. During an interview on 9/30/16 at 11:50 AM, the Nursing Clinical Supervisor confirmed DME was missing from Patient #15's POC. Patient #15's POC did not include all DME.	G 159		
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 medical records and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 1 of 20 patients (Patient #19) whose records were	G 164	**G 164 484.18(b) Periodic Review of Plan of Care** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case manager assigned to patient #19. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, Care coordination – with the patient's primary care physician when significant changes occur, following best practices based on diagnosis, CHF, Diabetes Mellitus, establishing and writing of parameters to report to attending physician by the patient and nursing staff. Review of the on-call call process, documentation of	

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G 164	Continued From page 39 reviewed. This had the potential to result in missed opportunities for the physician to alter the patient's POC to meet his needs. Findings include: Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. 1. Patient #19's POC for the certification period 3/08/16 to 5/06/16 included an order to educate him regarding signs and symptoms of an exacerbation of his CHF, including a weight gain of 3 pounds overnight or 5 pounds in 7 days. The American College of Cardiology website, accessed on 10/04/16, 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." Patient #19's record included an SOC comprehensive assessment completed on 3/08/16, signed by the admitting RN. The assessment stated his weight was 185 pounds. The next SN visit was documented on 3/15/16, signed by the RN Case Manager. The visit note stated Patient #19's weight was 205 pounds, indicating a 20 pound weight gain in 1 week.	G 164	received calls and action taken for the benefit of the patient. Follow up with agency CS, other disciplines, and physician notification. Documentation of events within the clinical record. Agency developing clinical pathway for the management of CHF, clinician guidelines establishing best practice to be completed by October 28, 2016 in response to the finding of Patient #15 and #19. Patients with primary diagnosis of CHF will have a base weight established at SOC and monitored as per written orders with established parameters for reporting, sudden weight gain of 3 pounds in 24 hours and 5 pounds within one week to MD. Instructed to include s/s of pitting edema and establishment of parameters to report to attending MD. Staff will be instructed on the new CHF clinical pathway November 1, 2, 4, 2016 by the Operations Liaison. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways, on-call process and documentation. Policy 2-019 Physicians Participation in Plan of Care. **Monitoring and Tracking:** CS or designee will review 100% of calls received through the answering service, the nursing action for each call and documentation within the clinical record. Variances less than 90% will require an action plan and tracking and trending implemented. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review or revised the tracking and trending tool, or if the agency obtains 90% consistent compliance to re-evaluate the indicators revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS HOME HEALTH AND HOSPICE	9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709

(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 164	Continued From page 40 There was no documentation in Patient #19's record stating his physician was notified of his 20 pound weight gain. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager reviewed Patient #19's record. She stated at the time of the SN visit she did not realize he gained 20 pounds in 1 week. She stated she should have called Patient #19's physician to report his weight gain. 2. Patient #19's record included an SN visit note dated 3/15/16, signed by the RN Case Manager. The note stated Patient #19 told the RN he fell several days prior to the visit and was unable to get back to bed by himself. He complained of sore muscles due to the effort of getting up from the floor. There was no documentation in Patient #19's record stating his physician was notified of his fall. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager reviewed Patient #19's record. She stated she should have notified Patient #19's physician of his fall. 3. The agency's document "AFTER HOURS CARE COORDINATION TELEPHONE LOG" dated 3/22/16, was reviewed. It stated a call was received at 6:41 PM, regarding Patient #19. The document stated the caller reported Patient #19's BP was elevated and his BG level was 512. The American Diabetes Association website, accessed 10/04/16, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl. The document stated "sent patient to ER." Patient #19's record did not include documentation of the 3/22/16 after hours phone	G 164	**Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 164	Continued From page 41 call. His record did not state his physician was notified of the call, his symptoms, or his ER visit. During an interview on 9/30/16 at 11:00 AM, Patient #19's RN Case Manager confirmed there was no documentation in Patient #19's record stating his physician was notified of the after hours phone call or his ER visit on 3/22/16. The agency failed to ensure Patient #19's physician was notified of his 20 pound weight gain, his fall, and his symptoms that led to his ER visit.	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 and staff interview it was determined the agency failed to ensure drugs and treatments were administered only as ordered by the physician for 3 of 20 patients (#3, #17, and #19) 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: 1. Patient #17 was a 52 year old female admitted to the agency on 12/27/15, for services related to an abscess of the foot. Additional diagnoses included cellulitis, depression, and HTN. She received SN services. Her record, including the POC, for the certification period 2/25/16 to 4/24/16, was reviewed.	G 165	**G165 484.18 (c) Conformance with Physician Orders** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 3, #17, and #19. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, interventions, all administered to the patient as written on the initial 485 plan of care, notifications of changes to the MD, writing of supplemental orders. Writing of verbal orders at the time of obtaining of the patient's certifying primary care provider or another provider identified within the 485 POC or supplement orders that the clinician may accept orders from another provider. Writing/follow of correct frequency and durations, wound care orders written in detail/obtained prior to the provisions of hands-on care. Performing and documenting wound measurements weekly.	

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G 165	Continued From page 42 a. Patient #17's POC for the certification period 2/25/16 to 4/24/16, included an order to provide wound care to her left foot. However, her POC did not include specific wound care orders, to determine the products to use and process to follow. Patient #17's record included a physician's order dated 3/09/16, with specific wound care orders. However, wound care was provided during SN visits on 2/29/16, 3/03/15, and 3/07/16, prior to receiving wound care orders. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and confirmed wound care orders were not included on her POC. She stated orders were received from the wound care center on 3/09/16, and confirmed wound care was provided during 3 SN visits before the orders were received. Patient #17's wound care was provided without a physician's order. b. Patient #17's record included a physician's order from a wound care clinic, dated 3/16/16, to increase the frequency of visits to every other day, to observe for redness and change her wound dressing. The order stated her next wound care appointment was in 1 week. Her record included an SN visit note dated 3/17/16. The next SN visit was documented on 3/24/16, 1 week later. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and stated her SN visits were not increased to every other day as ordered.	G 165	In-service training provided by the CS and AVP October 5, 2016, on Wound Care. Instruction included use of E-Z graph wound assessment tool, Frontier Wound Care Protocol, Quick assessment of Leg Ulcer – Clinical Fact sheet, Wound Photo documentation, and WOCN, Guidance on OASIS C1 Integumentary Items: Best Practice for Clinicians, in response to findings of patient #3, #17 and #19. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, writing of/following of wound care orders. **Monitoring and Tracking:** CS or designee will review 100% of clinical records with wound care. Review of all orders, frequency/duration, and supplies, reporting parameters, until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 165	Continued From page 43 The agency failed to provide wound care as ordered by the physician. 2. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. Patient #19's record included an SOC comprehensive assessment completed on 3/08/16, and signed by the RN. The SOC assessment stated wound care was provided to Patient #19's right knee by the RN. Patient #19's record included an order for wound care dated 3/17/16. His record did not include wound care orders prior to 3/17/16. During an interview on 9/29/16 at 4:10 PM, the Nursing Clinical Supervisor reviewed Patient #19's SOC assessment and stated wound care was provided by the admitting RN prior to receiving physician orders for wound care. Patient #19's admitting RN provided wound care without a physician's order. 3. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, Type II DM, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed.	G 165		

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G 165	Continued From page 44 Patient #3's record included an SOC comprehensive assessment completed on 5/22/16, and signed by the RN. The assessment documented Patient #3 had no problems with her skin. Additionally, it stated she had no pressure ulcers, wounds, or open lesions. An SN visit note, dated 6/01/16, documented Patient #3 had 2 wounds. Wound #1 was on her right shin. There were no measurements or description of the wound. The RN cleansed the wound with normal saline and wound cleanser and applied an optifoam (adhesive foam dressing with a silicone border) dressing. Wound #2 was on her left groin area and was described by the RN as a blister, and measured 1 cm x 1 cm. The RN cleansed the wound with normal saline and wound cleanser and applied a skin barrier cream. The RN further documented she instructed Patient #3's daughter to clean her groin area 2 times a day and apply the skin barrier cream to the left groin wound. A wound assessment worksheet dated 6/01/16, signed by the RN, documented the size of the wound, the description of the wound, and marked where the wound was located on a picture of a human outline. There was also documentation of the treatment provided to Patient #3. The RN documented on the worksheet Patient #3 sustained the wound on 6/01/16, when she was pinched by her Hoyer lift (a lift designed to transfer patients from a wheelchair to the bed and vice versa). Patient #3's record did not include orders for wound care until 6/06/16, 5 days after wound treatment was provided.	G 165		

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G 165	Continued From page 45 During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor reviewed the record and confirmed there were no physician orders for the wound care and treatment provided during the 6/01/16 SN visit. The SN provided wound treatment for Patient #3 without her physician's order.	G 165		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure verbal orders were put in writing by an RN or qualified therapist for 1 of 20 patients (Patient #5) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include: The agency's policy "VERIFICATION OF PHYSICIAN ORDERS" revised 10/2012, stated "Verbal orders will be taken and documented only by professional, licensed home health personnel...The original order will be delivered to the physician (or other authorized licensed independent practitioner) for his/her signature." Patient #5 was a 65 year old male admitted to the	G 166	**G166 484.18 (c) Conformance with Physician Orders** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 5. Program will be conducted by the Operations Liaison. Program will include instruction on obtaining physician verbal orders, documentation of orders and submission of orders for signature. Review of agency policy 2-020 Verification of Physician Orders **That Led To Deficiency:** Above actions will 1) heighten awareness of verbal order process, Policy 2-020. **Monitoring and Tracking:** CS or designee will review 100% of verbal order documentation. Conduct one-on-one education with staff as indicated. Track and trend until agency demonstrates 90% compliance. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes.	

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G 166	Continued From page 46 agency on 8/14/16, for services related to insulin dependent DM. Additional diagnoses were brain cancer and HTN. He received SN, ST and MSW services. His record, including the POC, for the certification period 8/14/16 to 10/12/16, was reviewed. Patient #5's record included an SN visit note dated 9/22/16, signed by his RN Case Manager. The note stated the RN received a verbal order from Patient #5's physician for ST and OT evaluations. Patient #5's record did not include a written order for ST and OT evaluations, to be countersigned by his physician. During an interview on 9/29/16 at 3:00 PM, the Nursing Clinical Supervisor stated verbal orders were written on physician order forms, and sent to the ordering physician for signature. She reviewed Patient #5's record and stated the RN did not write the order to be sent to his physician for signature. The agency failed to ensure verbal orders were put into writing and sent to the ordering physician for signature.	G 166	**Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the POC, to reevaluate patients as needed, to initiate the POC and make necessary revisions, to use clear and correct documentation, to coordinate between the	G 168	**G 168 484.30 Skilled Nursing Services** G168 Condition Plan of Correction is found with the standards identified under the condition G 168 STANDARDS: G170, G172, G 173, G 176, G177	

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G 168	Continued From page 47 disciplines, and to ensure patients received counseling according to their needs. This negatively impacted quality, coordination, and safety of patient care. Findings include: Refer to G170 as it relates to the Agency's failure to ensure nurses followed the Plan of Care. Refer to G172 as it relates to the Agency's failure to ensure nurses re-evaluated the patients nursing needs. Refer to G173 as it relates to the Agency's failure to ensure nurses initiated the Plan of Care and necessary revisions. Refer to G176 as it relates to the Agency's failure to ensure nurses used clear and correct documentation and coordination between disciplines. Refer to G177 as it relates to the Agency's failure to ensure nurses counseled the family in meeting nursing and related needs. The cumulative effects of these negative practices seriously impeded the ability of the agency to provide services of adequate quality.	G 168		
G 170	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 record review and staff interview, it was determined the agency failed to ensure SN services were provided in accordance with the	G 170	**G170 484.30 Skilled Nursing Services** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 3, #5, #15, #17, and #19. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, interventions, all administered to the patient as written on the initial 485 plan of care, notifications of changes to the MD, writing of supplemental	

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G 170	Continued From page 48 plan of care for 4 of 14 patients (#3, #15, #17, and #19) who received SN care and whose records were reviewed. This had the potential to negatively impact the quality and safety of patient care. Findings include: 1. Patient #17 was a 52 year old female admitted to the agency on 12/27/15, for services related to an abscess of the foot. Additional diagnoses included cellulitis, depression and HTN. She received SN services. Her record, including the POC, for the certification period 2/25/16 to 4/24/16, was reviewed. a. Patient #17's POC for the certification period 2/25/16 to 4/24/16, included an order to provide wound care to her left foot. However, her POC did not include specific wound care orders, to determine the products to use and process to follow. Patient #17's record included a physician's order dated 3/09/16, with specific wound care orders. However, wound care was provided during SN visits on 2/29/16, 3/03/15, and 3/07/16, prior to receiving wound care orders. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and confirmed wound care orders were not included on her POC. She stated orders were received from the wound care center on 3/09/16, and confirmed wound care was provided during 3 SN visits before the orders were received. Patient #17's wound care was provided without a physician's order. b. Patient #17's record included a physician's order from a wound care clinic, dated 3/16/16, to	G 170	orders. Writing of verbal orders at the time of obtaining of the patient's certifying primary care provider or another provider identified within the 485 POC or supplement orders that the clinician may accept orders from another provider. Writing/follow of correct frequency and durations, wound care orders written in detail/obtained prior to the provisions of hands-on care. Writing of orders for additional disciplines and follow-up on those orders, timely writing of orders/physician notifications for missed evaluations, timely writing of missed visit notes for those visits missed and clinician unable to reschedule, instruction Policy 2-057.1 – Missed Visits. Operations Liaison Power point attached. In-service training provided by the CS and AVP October 5, 2016, on Wound Care. Instruction included use of E-Z graph wound assessment tool, Frontier Wound Care Protocol, Quick assessment of Leg Ulcer – Clinical Fact sheet, Wound Photo documentation, and WOCN, Guidance on OASIS C1 Integumentary Items: Best Practice for Clinicians, in response to findings of patient #17. Agency developing clinical pathway for the management of CHF, clinician guidelines establishing best practice to be completed by October 28, 2016 in response to the finding of Patient #15. Patients with primary diagnosis of CHF will have a base weight established at SOC and monitored as per written orders with established parameters for reporting, sudden weight gain of 3 pounds in 24 hours and 5 pounds within one week to MD. Instructed to include s/s of pitting edema and establishment of parameters to report to attending MD. Staff will be instructed on the new CHF clinical pathway November 1, 2, 4, 2016 by the Operations Liaison. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways, writing of/following of wound care orders. Policy 2-057.1 Missed Visits.	

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G 170	Continued From page 49 increase the frequency of visits to every other day, to observe for redness and change her wound dressing. The order stated her next wound care appointment was in 1 week. Her record included an SN visit note dated 3/17/16. The next SN visit was documented on 3/24/16, 1 week later. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and stated her SN visits were not increased to every other day as ordered. The agency failed to provide SN visits for wound care as ordered by the physician. 2. Patient #15 was an 80 year old female admitted to the agency on 9/20/16, for services related to an acute gastrointestinal bleed. Additional diagnoses included enterocolitis related to Clostridium difficile, GERD, atrial fibrillation, HTN, CHF, CKD, and history of DVT. She received SN, PT, and OT services. Her record, including the POC, for the certification period 9/20/16 to 11/18/16, was reviewed. Patient #15's POC, dated 9/20/16, included orders for management of CHF. The orders stated the SN was to educate Patient #15 on signs and symptoms of CHF exacerbation and when to notify the RN or physician. The symptoms included a weight gain of 3 pounds overnight or 5 pounds in 7 days, wet frothy cough, increased shortness of breath or difficulty breathing, and lower extremity swelling. An SOC comprehensive assessment, dated 9/20/16, signed by the RN Case Manager did not document a baseline weight or CHF education for	G 170	**Monitoring and Tracking:** CS or designee will review 100% of clinical records with wound care, and diagnosis of CHF. Review of all orders, frequency/duration, and supplies, reporting parameters, SOC baseline weights and ordered weighing frequency until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 170	Continued From page 50 Patient #15. The American College of Cardiology website, accessed on 10/04/16, 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." However, there was no documentation stating Patient #15 was educated regarding weighing herself daily to monitor symptoms of her CHF. An SN visit note, dated 9/22/16, signed by the RN Case Manager, documented Patient #15 had 2 mm pitting edema (a condition characterized by an excess of watery fluid collecting in the body) in both of her lower extremities. The National Library of Medicine website, accessed 10/04/16, stated edema may be described as either pitting or non-pitting. Pitting edema leaves a dent in the skin after you press the area with a finger for about 5 seconds, and the dent will then slowly fill back in. It stated pitting edema is categorized by millimeters of depth of the indentation from 1 to 4 millimeters. The SN visit note did not include documentation of Patient #15's weight and no documentation of education or teaching related to CHF. During an interview on 9/30/16 at 11:50 AM, the Nursing Clinical Supervisory reviewed the record and confirmed the RN Case Manager did not document a weight at the SOC assessment visit	G 170		

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G 170	Continued From page 51 or her subsequent visit. She also confirmed there was no teaching or education documented in either of the visit notes. Patient #15's orders were not followed related to management of her CHF. 3. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, Type II DM, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed. Patient #3's POC, dated 5/22/16, included orders for SN visits 3 times a week for 1 week, 2 times a week for 8 weeks, and 4 visits as needed for falls or Foley catheter care. Patient #3 did not receive SN visits as ordered. Examples include: - During week 1, Patient #3 received SN visits on 5/22/16 and 5/25/16. Three SN visits were ordered, 2 SN visits were provided. - During week 3, Patient #3 received SN visits on 6/06/16, 6/09/16, and 6/11/16. Two SN visits were ordered, 3 SN visits were provided. There was no documentation in the SN visit notes a PRN visit was completed as ordered on the POC. There was no physician order for the additional visit. - During week 7, Patient #3 received SN visits on 7/03/16, 7/06/16, and 7/08/16. Two SN visits were ordered, 3 SN visits were provided. There was no documentation in the SN visit notes a	G 170		

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G 170	Continued From page 52 PRN visit was completed as ordered on the POC. There was no physician order for the additional visit. - During week 8, Patient #3 received SN visits on 7/11/16, 7/13/16, and 7/15/16. Two SN visits were ordered, 3 SN visits were provided. There was no documentation in the SN visit notes a PRN visit was completed as ordered on the POC. There was no physician order for the additional visit. - During week 9, Patient #3 did not receive SN visits. Two SN visits were ordered. During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor reviewed the record and confirmed SN visit orders were not followed. Patient #3's SN visits were not followed as ordered. 4. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. Patient #19's record included an SOC comprehensive assessment completed on 3/08/16, and signed by the RN. The SOC assessment stated wound care was provided to Patient #19's right knee by the RN. Patient #19's record included an order for wound care dated 3/17/16. His record did not include wound care orders prior to 3/17/16.	G 170		

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G 170	Continued From page 53 During an interview on 9/29/16 at 4:10 PM, the Nursing Clinical Supervisor reviewed Patient #19's SOC assessment and stated wound care was provided by the admitting RN prior to receiving physician orders for wound care. Patient #19's admitting RN provided wound care without a physician's order.	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. 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 RN re-evaluated the nursing needs for 3 of 14 patients (#16, #17 and #19) who received SN services and 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: 1. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, following a hospitalization for exacerbation of CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. Patient #19's POC included orders for SN visits 1 time a week for 9 weeks. The POC stated "PRIMARY REASON FOR HOME HEALTH: CARDIOPULMONARY ASSESSMENT,	G 172	**G172 484.30(a) Duties of the Registered Nurse** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 6, #17, and #19. Program will be provided by the Operations Liaison. Focus instruction on implementing the patient's plan of care, interventions, all administered to the patient as written on the initial 485 plan of care, notifications of changes to the MD, writing of supplemental orders. Writing of verbal orders at the time of obtaining of the patient's certifying primary care provider or another provider identified within the 485 POC or supplement orders that the clinician may accept orders from another provider. Writing/follow of correct frequency and durations, wound care orders written in detail/obtained prior to the provisions of hands-on care. Writing of orders for additional disciplines and follow-up on those orders, timely writing of orders/physician notifications for missed evaluations, timely writing of missed visit notes for those visits missed and clinician unable to reschedule, instruction Policy 2-057.1 – Missed Visits. In-service will also include documenting to the plan of care: interventions and goals and complete assessment documentation. .	

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G 172	Continued From page 54 MEDICATION EDUCATION, FALL SAFETY EDUCATION, DISEASE PROCESS EDUCATION." The RN failed to provide on-going assessments of Patient #19 to identify and address his needs, as follows: The American College of Cardiology website, accessed on 10/04/16, 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." Patient #19's record included an SOC comprehensive assessment dated 3/08/16, signed by the admitting RN, and an SN visit note dated 3/15/16, signed by the RN Case Manager. No additional SN visits were documented. Patient #19's SN visit note, dated 3/15/16, stated his reported weight was 205 pounds, a 20 pound increase from his reported weight of 185 pounds during his SOC visit 1 week earlier. There was no documentation stating Patient #19's 20 pound weight gain was recognized or addressed by the RN Case Manager. The section of the visit note titled "CARDIOPULMONARY" was blank. The visit note stated he required further education on CHF, including monitoring his weight and sodium intake. Patient #19 did not receive additional SN visits, to provide education and assessment.	G 172	In-service training provided by the CS and AVP October 5, 2016, on Wound Care. Instruction included use of E-Z graph wound assessment tool, Frontier Wound Care Protocol, Quick assessment of Leg Ulcer – Clinical Fact sheet, Wound Photo documentation, and WOCN, Guidance on OASIS C1 Integumentary Items: Best Practice for Clinicians, in response to findings of patient #17. Agency developing clinical pathway for the management of CHF, clinician guidelines establishing best practice to be completed by October 28, 2016 in response to the finding of Patient #15. Patients with primary diagnosis of CHF will have a base weight established at SOC and monitored as per written orders with established parameters for reporting, sudden weight gain of 3 pounds in 24 hours and 5 pounds within one week to MD. Instructed to include s/s of pitting edema and establishment of parameters to report to attending MD. Staff will be instructed on the new CHF clinical pathway November 1, 2, 4, 2016 by the Operations Liaison. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways, writing of/following of wound care orders. Policy 2-057.1 Missed Visits. **Monitoring and Tracking:** CS or designee will review 100% of clinical records with wound care, and diagnosis of CHF. Review of all orders, frequency/duration, and supplies, reporting parameters, SOC baseline weights and ordered weighing frequency until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes.	

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G 172	Continued From page 55 The agency's document "AFTER HOURS CARE COORDINATION TELEPHONE LOG" dated 3/22/16, was reviewed. It stated a call was received at 6:41 PM, regarding Patient #19. The document stated the caller reported Patient #19's BP was elevated and his BG level was 512. The American Diabetes Association website, accessed 10/04/16, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl. The document stated "sent patient to ER." The agency's policy "PATIENTS ON HOLD" revised 10/12, stated "When the patient is discharged from the hospital, the clinician will contact the physician (or other authorized licensed independent practitioner), and an interim order will be written to resume home health services...All skilled disciplines will conduct an appropriate reassessment of the patient upon resumption of care." Hospital records for Patient #19 were requested and reviewed. The ER physician's note documented he presented to the ER with an elevated BG level, elevated BP, and elevated cardiac enzymes. The hospital notes stated he was admitted for observation and discharged on 3/23/16. Patient #19 did not receive an SN visit to assess his status following his hospitalization. The agency's policy "MISSED VISITS" revised 10/12, stated "If a visit is missed for any reason, the clinician should attempt to reschedule it for the same week so that the physician ordered frequency is maintained and would not be considered a missed visit. If a visit is missed and not rescheduled the clinician will: Notify the physician and clinical supervisor of the missed visit and reason for missed visit. Document in the	G 172	**Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 172	Continued From page 56 patient's clinical record the following information...Description of any unmet needs and how the patient's needs were met." Patient #19's record included 2 documents titled "MISSED VISIT REPORT," signed by the RN Case Manager, and dated Tuesday 3/22/16 and Tuesday 3/29/16. The documents stated SN visits were not performed on each of those dates because the RN was unable to reach Patient #19 by phone. Patient #19's record did not include documentation of additional attempts to contact him or to make an SN visit later the same week. Patient #19's 2 missed visit documents included fax verification forms, that stated the 2 missed visit reports were faxed to Patient #19's physician on 5/16/16, 7 and 8 weeks after the missed visits. Patient #19's record included a discharge summary dated 4/08/16, signed by the RN Case Manager. The summary stated "Home Health Agency was notified patient was in the Emergency Room on 3/22/16. It is unclear what happened to patient after this Emergency Room visit. Agency was unable to contact patient. Agency discharge at this time for non homebound status." During an interview on 9/30/16 at 11:00 AM, the RN Case Manager was asked if SN visits 1 time per week was a typical frequency for patients with CHF. She stated CHF patients were usually seen more often, but Patient #19 was on and off home health services several times, and kept going back to the hospital. She stated she was not as aggressive because Patient #19 was non-compliant. During the interview, the RN Case Manager	G 172		

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G 172	Continued From page 57 stated she did not realize Patient #19 gained 20 pounds in 1 week. She stated she would have been concerned and notified his physician if she had recognized the weight gain. She confirmed there was no documented cardiopulmonary assessment on her 8/15/16 SN visit note. During the interview, the RN Case Manager stated she did not see or talk to Patient #19 after his hospital admission on 3/22/16. She was asked about the missed visit notes she completed, dated 3/22/16 and 3/29/16. She could not explain why the notes were faxed to Patient #19's physician 7 to 8 weeks after the missed visits. She stated she may have been asked to complete the missed visits notes at a later date. The RN Case Manager stated it looked as though the 2 notes were written at the same time. During an interview on 9/29/16 at 4:10 PM, the Nursing Clinical Supervisor reviewed Patient #19's record. She stated the RN should have contacted Patient #19 after his hospital discharge. She confirmed there was no documentation that stated Patient #19 was contacted following his hospital discharge. She stated SN visit frequencies for patients with CHF are usually more frequent than 1 time per week. Patient #19's status was not evaluated to determine his SN needs. 2. An agency wound care protocol "[Corporate Name] Wound Care Protocol," undated, stated "The wound assessment will include: etiology, location, depth of tissue damage, size, wound bed, presence of foreign objects, wound edges/margins, condition of peri-wound skin,	G 172		

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G 172	Continued From page 58 drainage, presence of odor and pain." The protocol also stated "Wounds are measured no less than weekly. Wounds are measured using EZ graph wound assessment worksheet." The protocol stated the EZ graft wound assessment worksheet was to be used for documentation of all wounds. This protocol was not followed. Examples include: a. Patient #17 was a 52 year old female admitted to the agency on 12/27/15, for services related to an abscess of the foot. Additional diagnoses included cellulitis, depression, and HTN. She received SN services. Her record, including the POCs, for the certification periods 12/27/15 to 2/24/16, and 2/25/16 to 4/24/16, was reviewed. Patient #17's record included a recertification assessment dated 2/22/16, signed by the RN. The assessment included a description and measurement of Patient #17's foot abscess. However, it did not include a completed EZ graph wound assessment worksheet. Subsequent SN visits were documented on 2/29/16, 3/03/16, 3/07/16, 3/11/16, 3/17/16, 3/24/16, and 4/13/16. The 7 subsequent SN visit notes stated wound care was provided, but did not include a completed EZ graph wound assessment worksheet, or an assessment or measurements of her foot abscess. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and stated no wound assessments or measurements were documented between 2/22/16 and the end of her certification period on 4/24/16. The agency failed to ensure Patient #17's wound	G 172		

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G 172	Continued From page 59 was evaluated by the SN. b. Patient #16 was a 90 year old male admitted to the agency on 8/02/16, for services related to a stage II pressure ulcer on his coccyx. Additional diagnoses included gait abnormality, muscle wasting, HTN, and CHF. He received SN, PT, and OT services. His record, including the POC, for the certification period 8/02/16 to 9/30/16, was reviewed. Patient #16's POC included orders for SN visits 2 times a week for 3 weeks, 1 time a week for 6 weeks and 4 PRN visits for wound complications. His POC also included an order for skilled observation and for wound care using wound cleanser, mediseptic ointment, and a Mepilex dressing. Patient #16's SN visit notes showed wound measurements were not consistently completed per protocol as follows: 8/02/16 - wound measurements with EZ graph completed 8/08/16 - no wound measurements and no EZ graph 8/18/16 - wound measurements with EZ graph completed 8/22/16 - wound measurements with EZ graph completed 8/29/16 - no wound measurements and no EZ graph 9/14/16 - wound measurements completed without EZ graph 9/28/16 - wound measurements with EZ graph completed During an interview on 9/30/16, beginning at	G 172		

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G 172	Continued From page 60 10:30 AM, the Nursing Clinical Supervisor reviewed Patient #16's record. She said his wound care was not completed using the agency's wound care protocol. She stated, per agency protocol, wounds should be measured weekly, using an EZ graph. Patient #16's wound status was not consistently re-evaluated to determine his SN needs.	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 and staff interview, it was determined the agency failed to ensure the RN revised the POC for 2 of 14 patients (#3 and #8) who received SN services and whose records were reviewed. This resulted in POCs that did not reflect patient needs and health status. Findings include: 1. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, Type II DM, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed. Patient #3's record for the certification period 5/22/16 to 7/20/16, included an SN visit note dated 6/01/16, signed by an RN. The note	G 173	**G173 484.18(a) Duties of the Registered Nurse** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 3, #5, and #8. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, interventions, all administered to the patient as written on the initial 485 plan of care, notifications of changes to the MD, writing of supplemental orders. Writing of verbal orders at the time of obtaining of the patient's certifying primary care provider or another provider identified within the 485 POC or supplement orders that the clinician may accept orders from another provider. Writing of and following wound care orders prior to performing hands on care. Timely writing of missed visit notes for those visits missed and clinician unable to reschedule, instruction Policy 2-057.1 – Missed Visits. Writing of resumption of Care orders and updating and revision of the POC as required to patient changes. In-service training provided by the CS and AVP October 5, 2016, on Wound Care. Instruction included use of E-Z graph wound assessment tool, Frontier Wound Care Protocol, Quick assessment of Leg Ulcer – Clinical Fact sheet, Wound Photo documentation, and WOCN, Guidance on OASIS C1 Integumentary Items: Best Practice for Clinicians, in response to findings of patient #17.	

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G 173	Continued From page 61 identified 2 new wounds, 1 on her right shin and the other on her left groin. The RN documented she cleansed the wounds and applied dressings to both. However, Patient #3's POC was not updated or revised to include her new wounds and there was no order from her attending physician for the wound care. An SN visit note, dated 6/03/16, 2 days later, documented Patient #3 had no problems with wounds or skin integumentary. There was no documentation of the wounds identified at the previous visit, or of care provided to wounds. An SN visit note, dated 6/06/16, 5 days after the wounds were identified, did not include a description of the 2 wounds, to Patient #3's right shin and left groin. The RN Case Manager documented she applied barrier cream to areas with moisture associated skin damage, but did not specify where those areas were on Patient #3. However, in the narrative note, the RN Case Manager documented she spoke with Patient #3's physician regarding wound care orders for a shearing injury she received on her buttocks. The RN Case Manager did not include a description or measurement of the wound or wounds. A physician order, dated 6/06/16, 5 days after the wounds were identified, requested specific wound care orders. However, the order did not specify the location of the wound or whether there was 1 wound or several wounds that required care. An SN visit note, dated 6/09/16, included documentation of 3 new wounds to Patient #3's buttock area. There was no documentation of wounds to her right shin or her left groin area.	G 173	**That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways, writing of/following of wound care orders. Policy 2-057.1 Missed Visits. **Monitoring and Tracking:** CS or designee will review 100% of clinical records with wound care, and 10% of active and inactive clinical records based on the average daily census with review of all orders - frequency/duration, supplies, reporting parameters, SOC baseline weights until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 173	Continued From page 62 During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor stated the RN Case Manager was not available for interview. She reviewed the record and stated Patient #3's physician should have been notified and orders received for the wound care performed by the RN Case Manager on the day they were identified. Patient #3's POC was not revised and updated to meet her wound care needs. 2. Patient #8 was an 84 year old female admitted to the agency on 7/20/16, for services related to a vaginal fistula. Additional diagnoses included atrial fibrillation and HTN. She received SN, PT, OT and MSW services. Her record, including the POC, for the certification period 9/18/16 to 11/16/16, was reviewed. Patient #8's record included an ROC assessment dated 9/07/16, signed by the RN. The assessment stated Patient #8 reported daily pain ranging from 0 to 6, on a scale of 0 to 10, with 10 being the worst pain. Patient #8's POC did not include interventions to monitor and address her pain. Physician orders received after her ROC did not include interventions to monitor and address her pain. During an interview on 9/29/16 at 3:25 PM, the Nursing Clinical Supervisor reviewed Patient #8's record and stated her POC was not updated following her ROC, to include interventions to monitor and address her pain. Patient #8's POC was not updated and revised after her hospitalization to include interventions to monitor and address her pain.	G 173		

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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, a review of agency protocols, 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 5 of 14 of patients (#3, #5, #16, #19, and #20) who received SN services and whose records were reviewed. These failures resulted in a lack of clarity as to the course of patient care and negatively impacted quality and coordination of patient care. Findings include: 1. An agency wound care protocol "[Corporate Name] Wound Care Protocol," undated, stated "The wound assessment will include: etiology, location, depth of tissue damage, size, wound bed, presence of foreign objects, wound edges/margins, condition of peri-wound skin, drainage, presence of odor and pain." The protocol also stated "Wounds are measured no less than weekly. Wounds are measured using EZ graph wound assessment worksheet." The protocol stated the EZ graft wound assessment worksheet was to be used for documentation of all wounds. This protocol was not followed. Examples include: a. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included	G 176	**G176 484.18(a) Duties of the Registered Nurse** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 3, #5, #16, #19 and #20 Program will be provided by the Operations Liaison. Focus instruction on implementing the patient's plan of care, interventions, all administered to the patient as written on the initial 485 plan of care, notifications of changes to the MD, writing of supplemental orders. Writing of verbal orders at the time of obtaining of the patient's certifying primary care provider or another provider identified within the 485 POC or supplement orders that the clinician may accept orders from another provider. Writing of and following wound care orders prior to performing hands on care. Timely writing of missed visit notes for those visits missed and clinician unable to reschedule, instruction Policy 2-057.1 – Missed Visits. Writing of resumption of Care orders and updating and revision of the POC as required to patient changes. Documentation of On-call notes of calls received. Complete documentation of skilled nursing notes, care coordination between disciplines. In-service training provided by the CS and AVP October 5, 2016, on Wound Care. Instruction included use of E-Z graph wound assessment tool, Frontier Wound Care Protocol, Quick assessment of Leg Ulcer – Clinical Fact sheet, Wound Photo documentation, and WOCN, Guidance on OASIS C1 Integumentary Items: Best Practice for Clinicians, in response to findings of patient #17.	

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G 176	Continued From page 64 neuromuscular dysfunction, incontinence, Type II DM, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed. During Patient #3's first certification period 5/22/16 to 7/20/16, she developed wounds to her buttock and thigh areas on both sides. SN documentation of the wounds was inconsistent and incomplete. Examples include: Patient #3's record for the certification period 5/22/16 to 7/20/16, included an SN Visit Note dated 6/06/16, which documented a newly identified wound to her buttock area. The RN Case Manager stated in her narrative note the wound was caused by a shearing injury from Patient #3's Hoyer lift. The note did not include description or measurement of the wound. An SN Visit Note, dated 6/09/16, signed by the RN Case Manager, documented Patient #3 had 3 separate wounds to her buttock area. Wound #1 to her left buttock was measured at 3.2 cm x 2.1 cm x 0.1 cm. Wound #2 to Patient #3's left buttock was measured at 2.0 cm x 1 cm. Wound #3 was on her right buttock and measured at 2.0 cm x 2.0 cm. An SN Visit Note, dated 6/11/16, signed by an RN, documented Wound #1 was at the left ischial ramus (part of the lower pelvis) and Wound #2 was at the right ischial ramus. This was opposite from the previous visit note. Wound #1 was measured at 6.25 cm x 3.0 cm x 0.01 cm, an increase in the wound by 3 cm in length and almost 1 cm in width in 3 days. Wound #2 was	G 176	Agency developing clinical pathway for the management of CHF, clinician guidelines establishing best practice to be completed by October 28, 2016 in response to the finding of Patient #15 and #19. Patients with primary diagnosis of CHF will have a base weight established at SOC and monitored as per written orders with established parameters for reporting, sudden weight gain of 3 pounds in 24 hours and 5 pounds within one week to MD. Instructed to include s/s of pitting edema and establishment of parameters to report to attending MD. Staff will be instructed on the new CHF clinical pathway November 1, 2, 4, 2016 by the Operations Liaison. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways, writing of/following of wound care orders. Policy 2-057.1 Missed Visits. **Monitoring and Tracking:** CS or designee will review 100% of clinical records with wound care, and 10% of active and inactive clinical records based on the average daily census with review of all orders - frequency/duration, supplies, reporting parameters, SOC baseline weights until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 176	Continued From page 65 documented as "irregular." There were no measurements in the visit note for Wound #2. An SN Visit Note, dated 6/13/16, signed by an RN, documented Wound #1 was the right buttock and Wound #2 was the left buttock. This was opposite from the previous visit notes for Patient #3 and her wounds. The RN documented Wound #1 was a Stage II ulcer and Wound #2 was a Stage III ulcer. There was no additional documentation describing the wounds. According to the Johns Hopkins Medicine website, accessed 10/05/16, a Stage II ulcer is a "Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister." A Stage III ulcer is "Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining/tunneling." An SN Visit Note, dated 6/15/16, signed by the RN Case Manager, documented Wound #1 was on the left buttock and Wound #2 was the right buttock. The wound labeling was opposite from the visit on 6/13/16. Wound #1 was measured at 2 cm x 3 cm x 0.1 cm, a difference of 4.2 cm less in length in 4 days. Wound #2 was measured at 1 cm x 1 cm. An SN Visit Note, dated 6/20/16, signed by the RN Case Manager, documented Wound #1 was the left buttock and Wound #2 was the right buttock. Wound #1 was documented as "reddened," however there were no measurements. Wound #2 was measured at 2	G 176		

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G 176	Continued From page 66 cm x 2 cm x 0.2 cm. Patient #3's Wound #2 doubled in size and had deepened according to the RN Case Manager's documentation from the previous visit 5 days earlier. An SN Visit Note, dated 6/21/16, signed by the RN Case Manager, documented Wound #1 was the right buttock and Wound #2 was the left buttock, opposite from the previous visit note's documentation. Wound #1 was measured at 3.1 cm x 3.2 cm x 0.2 cm, an increase from the measurements 1 day prior. Wound #2 was documented as "reddened" and the RN Case Manager stated "no wound." Additionally, a new wound was documented as Wound #3 to the periarea. No description was included of Wound #3. An SN Visit Note, dated 6/27/16, signed by an RN, documented Wound #1 was the left ischial tuberosity (the bottom portion of the pelvic bone) and Wound #2 was the periarea. The labeling of Patient #3's wounds had changed from the previous visit note, and there was no documentation of the right buttock wound. Wound #1 was measured at 4 cm x 3 cm x 1 cm. Six days prior to this visit the RN Case Manager documented the left buttock was "reddened" with no open areas. An SN Visit Note, dated 6/29/16, signed by the RN Case Manager stated Patient #3 had no problems with her skin, and there was no documentation of Wound #1 or Wound #2. Additionally, there was no documentation of wound care. An SN Visit Note, dated 7/03/16, signed by an RN, documented Wound #1 was the left ramus,	G 176		

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G 176	Continued From page 67 and stated measurements of the wound were not due. There was no documentation of Wound #2. An SN Visit Note, dated 7/06/16, signed by the RN Case Manager, documented Wound #1 was the left ischial tuberosity. Wound #1 was measured at 4 cm x 3 cm x 0.4 cm. The RN Case Manager documented she performed wound care to the site. An SN Visit Note, dated 7/08/16, signed by the RN Case Manager documented wound care was performed. However, there was no documentation of Wound #1 or Wound #2, and there were no measurements. An SN Visit Note, dated 7/11/16, signed by the RN Case Manager documented Wound #1 was Patient #3's left ischial tuberosity and measured at 2 cm x 2 cm x 0.5 cm. An SN Visit Note, dated 7/13/16, signed by the RN Case Manager documented wound care was performed. However, there was no documentation of Wound #1, and there was no measurement or description. Nineteen SN visits were completed during the certification period dated 5/22/16 to 7/20/16. An EZ graph wound assessment form was utilized on 3 visits, for 1 of the 3 wounds which were identified. During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor stated the RN Case Manager was not available for interview. She reviewed the record and confirmed the wound documentation was not consistent and was incomplete for several visits. The Nursing Clinical	G 176		

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G 176	Continued From page 68 Supervisor stated wounds which were numbered should remain the same number and location when identified, until they are healed. She confirmed the wound protocol was not followed by the RNs who provided care to Patient #3. The RN failed to ensure Patient #3's clinical notes were consistent, complete, and followed agency policies and protocols. b. Patient #16 was a 90 year old male admitted to the agency on 8/02/16, for services related to a stage II pressure ulcer on his coccyx. Additional diagnoses included gait abnormality, muscle wasting, HTN, and CHF. He received SN, PT and OT services. His record, including the POC, for the certification period 8/02/16 to 9/30/16, was reviewed. Patient #16's POC included orders for SN visits 2 times a week for 3 weeks, 1 time a week for 6 weeks and 4 PRN visits for wound complications. His POC also included an order for skilled observation and for wound care using wound cleanser, mediseptic ointment and a Mepilex dressing. Patient #16's SN visit notes regarding wound measurements were not consistently prepared per protocol as follows: 8/02/16 - wound measurements with EZ graph completed 8/08/16 - no wound measurements and no EZ graph 8/18/16 - wound measurements with EZ graph completed 8/22/16 - wound measurements with EZ graph completed	G 176		

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G 176	Continued From page 69 8/29/16 - no wound measurements and no EZ graph 9/14/16 - wound measurements completed without EZ graph 9/28/16 - wound measurements with EZ graph completed During an interview on 9/30/16, beginning at 10:30 AM, the Nursing Clinical Supervisor reviewed Patient #16's record. She said his wound care was not completed or documented using the agency's wound care protocol. She stated, per agency protocol, wounds should be measured weekly and documented using an EZ graph and the clinician daily visit notes. Patient #16's RN failed to ensure visit notes accurately documented the care provided. c. Patient #20 was a 70 year old female admitted to the agency on 8/05/16, for services related to insulin dependent DM, and wound care. Additional diagnoses included COPD, HTN, atrial fibrillation, and dementia. She received SN services. Her record, including the POC, for the certification period 8/05/16 to 10/03/16, was reviewed. Two of Patient #20's 3 wound's condition and care were documented on the Assessment on 8/05/16. Three of Patient #20's wound's care and condition were documented on the skilled nurse visit note WOUND/OSTOMY CARE section and narrative notes, on 8/10/16. None of the patients wounds or wound care were documented on EZ graph wound assessment worksheets. During an interview on 10/03/16, at 2:30 PM, the Nursing Clinical Supervisor reviewed the nursing	G 176		

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G 176	Continued From page 70 notes related to Patient #20's wounds. She stated the documentation on Patient #20's wounds was incomplete and unclear, and agreed there was no documentation on an EZ Graft wound assessment worksheet. The RN failed to follow the agency protocol for wound care documentation. 2. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. a. Patient #19's POC for the certification period 3/08/16 to 5/06/16 included an order to educate him regarding signs and symptoms of an exacerbation of his CHF, including a weight gain of 3 pounds overnight or 5 pounds in 7 days. Patient #19's record included an SOC comprehensive assessment completed on 3/08/16, and signed by the admitting RN. The assessment stated his weight was 185 pounds. The next SN visit was documented on 8/15/16, and signed by the RN Case Manager. The visit note stated Patient #19's weight was 205 pounds, indicating a 20 pound weigh gain in 1 week. There was no documentation in Patient #19's record stating his physician was notified of his 20 pound weight gain. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager reviewed Patient #19's record. She stated at the time of the SN visit she did not realize he gained 20 pounds in 1 week. She	G 176		

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G 176	Continued From page 71 stated she should have called Patient #19's physician to report his weight gain. b. Patient #19's record included an SN visit note dated 3/15/16, signed by the RN Case Manager. The note stated Patient #19 told the RN he fell several days prior to the visit and was unable to get back to bed by himself. He complained of sore muscles due to the effort of getting up from the floor. There was no documentation in Patient #19's record stating his physician was notified of his fall. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager reviewed Patient #19's record. She stated she should have notified Patient #19's physician of his fall. The RN Case Manager failed to notify the physician of Patient #19's 20 pound weight gain and his fall. c. The agency's document "AFTER HOURS CARE COORDINATION TELEPHONE LOG" dated 3/22/16, was reviewed. It stated a call was received at 6:41 PM, regarding Patient #19. The document stated the caller reported Patient #19's BP was elevated and his BG level was 512. The American Diabetes Association website, accessed 10/04/16, stated a normal target blood sugar for a diabetic adult is less than 180 mg/dl. The document stated "sent patient to ER." Patient #19's record did not include documentation of the 3/22/16 after hours phone call. His record did not state his RN Case Manager was notified of the call, his symptoms, or his ER visit.	G 176		

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G 176	Continued From page 72 During an interview on 9/30/16 at 11:00 AM, Patient #19's RN Case Manager stated she did not remember how she knew he went to the ER on 8/22/16. The RN Case Manager confirmed there was no documentation in Patient #19's record regarding the after hours phone call or his ER visit on 3/22/16. The agency failed to ensure coordination between the on-call staff and the RN Case Manager occurred and was documented. 3. Patient #5 was a 65 year old male admitted to the agency on 8/14/16, for services related to insulin dependent DM. Additional diagnoses were brain cancer and HTN. He received SN, ST, and MSW services. His record, including the POC, for the certification period 8/14/16 to 10/12/16, was reviewed. Patient #5's record included an SN visit note dated 9/01/16, signed by his RN Case Manager. The note included a section titled "AIDE SUPERVISORY VISIT." The section was completed by the RN, and stated the aide was not present, the supervisory visit was scheduled, and the patient/family were satisfied. Patient #5's POC did not include an order for aide visits, and his record did not include documentation of aide visits. It was unclear why an aide supervisory visit note was completed. During an interview on 9/29/16 at 3:00 PM, the Nursing Clinical Supervisor reviewed Patient #5's record. She confirmed he was not receiving aide services. She stated the supervisory visit note applied to an LPN, not an aide. She stated the note was unclear and should have stated it was an LPN supervisory note.	G 176		

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G 176	Continued From page 73 Patient #5's supervisory visit documentation was not clear and accurate.	G 176	**G177 484.30(a) Duties of the Registered Nurse**	
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 2 of 14 patients (#15 and #19) who received SN services and whose records were reviewed. This created the potential for patients to experience adverse outcomes. Findings include: 1. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. Patient #19's POC included an order to educate him on the signs and symptoms of CHF, including a weight gain of 3 pounds overnight or 5 pounds in 7 days. His POC included an order for SN visits 1 time a week for 9 weeks, indicating his next SN visit would be 1 week after his SOC. Patient #19's record included an SOC comprehensive assessment dated 3/08/16, and signed by the admitting RN. The assessment did	G 177	**Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case managers assigned to patients # 15 and #19. Program will be provided by the Operations Liaison. Focus instruction on implementing the patient's plan of care, interventions, all administered to the patient as written on the initial 485 plan of care, notifications of changes to the MD, writing of supplemental orders. Establishment of baseline SOC weights. Complete documentation of skilled nursing notes, care coordination between disciplines. Agency developing clinical pathway for the management of CHF, clinician guidelines establishing best practice to be completed by October 28, 2016 in response to the finding of Patient #15 and #19. Patients with primary diagnosis of CHF will have a base weight established at SOC and monitored as per written orders with established parameters for reporting, sudden weight gain of 3 pounds in 24 hours and 5 pounds within one week to MD. Instructed to include s/s of pitting edema and establishment of parameters to report to attending MD. Staff will be instructed on the new CHF clinical pathway November 1, 2, 4th, 2016 by the Operations Liaison. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways.	

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G 177	Continued From page 74 not state Patient #19 received education on the signs and symptoms of CHF, or instructed to weigh himself daily and report a weight gain of 3 pounds overnight or 5 pounds in 7 days. During an interview on 9/29/16 at 4:10 PM, the Nursing Clinical Supervisor reviewed Patient #19's record. She confirmed there was no documention of CHF education during his SOC visit. The RN did not provide Patient #19 with education related to CHF as ordered on her POC. 2. Patient #15 was an 80 year old female admitted to the agency on 9/20/16, for services related to an acute gastrointestinal bleed. Additional diagnoses included enterocolitis related to Clostridium difficile, GERD, atrial fibrillation, HTN, CHF, CKD, and history of DVT. She received SN, PT, and OT services. Her record, including the POC, for the certification period 9/20/16 to 11/18/16, was reviewed. Patient #15's POC, dated 9/20/16, included orders for management of CHF. The orders stated the SN was to educate Patient #15 on signs and symptoms of CHF exacerbation and when to notify the RN or physician. The symptoms included a weight gain of 3 pounds overnight or 5 pounds in 7 days, wet frothy cough, increased shortness of breath or difficulty breathing, and lower extremity swelling. An SOC comprehensive assessment, dated 9/20/16, signed by the RN Case Manager did not document a baseline weight or CHF education for Patient #15.	G 177	**Monitoring and Tracking:** CS or designee will review 100% of clinical records with primary diagnosis CHF, and 10% of active and inactive clinical records based on the average daily census with review of all orders - frequency/duration, SOC baseline weight and ongoing weighing of patient as ordered and instruction to patient/caregiver until records demonstrates 90% compliance for two quarters. Findings to report to the PI committee monthly and final quarterly data to be reviewed with input from the PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 177	Continued From page 75 An SN visit note, dated 9/22/16, signed by the RN Case Manager, documented Patient #15 had 2 mm pitting edema in both of her lower extremities. The National Library of Medicine website, accessed 10/04/16, stated edema may be described as either pitting or non-pitting. Pitting edema leaves a dent in the skin after you press the area with a finger for about 5 seconds, and the dent will then slowly fill back in. It stated pitting edema is categorized by millimeters of depth of the indentation from 1 to 4 millimeters. The SN visit note did not include documentation of Patient #15's weight and there was no documentation she was provided education related to CHF. During an interview on 9/30/16 at 11:50 AM, the Nursing Clinical Supervisor reviewed the record and confirmed the RN Case Manager did not document a weight at the SOC assessment visit or her subsequent visit. She also confirmed there was no teaching or education documented in either of the visit notes. The RN failed to follow a physician order related to the management of Patient 15's CHF.	G 177		
G 195	484.34 MEDICAL SOCIAL SERVICES If the agency furnishes medical social services, 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.	G 195	**G195 484.34 Medical Social Services** **Action:** Clinical Supervisor will provide one on one education to the MSW week of 10/31/2016, case study review of patient number #6. MSW documentation and care coordination between disciplines, physician and protective agencies. CS will review with all staff during 11/3/16 home safety, identifying potential threats and reporting to local agency providers.	

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G 195	Continued From page 76 This STANDARD is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the agency failed to ensure the LMSW did an appropriate evaluation and assisted other clinicians in understanding the significant social and emotional factors related to the health of their patients for 1 of 6 patients (Patient #6) who received social services and whose records were reviewed. This had the potential to negatively effect the emotional health and coping mechanisms for the patient and family members. Findings include: Patient #6 was a 66 year old male admitted to the agency on 9/21/16, for services related to traumatic injuries after a fall. Additional diagnoses included DM Type II, HTN, depression, and anxiety. He received PT, OT, and MSW services. His record, including the POC, for the certification period 9/21/16 to 11/19/16, was reviewed. An agency case conference, on 9/29/16, was observed by 2 surveyors. The case conference was attended by the clinicians for the agency to discuss patients who were currently receiving services. At the conference there was a discussion regarding Patient #6 and his work status. Patient #6 was placed on administrative leave from his job for threatening to "shoot up the place" or "shoot some people" if he did not receive time off from his work. A clinician asked whether Patient #6 had access to a gun, but his clinicians did not know whether he did or not. Patient #6 was still on administrative leave while admitted to the agency.	G 195	**That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, documentation, care coordination and local agency community resources to protect the patient. **Monitoring and Tracking:** MSW will notify CS of any unusual patient incidents that would potentially cause harm to patient and or caregiver and staff. MSW will complete occurrence report as indicated, this will be reviewed by the CS and reported to the PI committee monthly and quarterly. PI committee to review to determine any further tracking and trending and formulate an action plan as needed. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 195	Continued From page 77 An MSW evaluation note, dated 9/27/16, and signed by the MSW documented he discussed Patient #6's work situation with him during the evaluation visit. The visit note stated Patient #6 wanted to continue working for a couple of years, but due to his injuries he may not go back. There was no documentation of a further discussion why Patient #6 was on administrative leave, or why he had chosen not to go back to work. The MSW did not document coordination with the Physical Therapy Case Manager or the Occupational Therapist regarding his visit. Patient #6's record included a "Case Conference Report," dated 9/29/16. The report identified re-hospitalization, falls, pain, and medication compliance as risks or safety concerns for Patient #6. The action section of the report documented visits would be front loaded (increased frequency of visits at the beginning of the certification period), review and teaching of medications, and education regarding his multiple fractures. The report was signed by the Physical Therapist Case Manager, the MSW, the Nursing Clinical Supervisor, and the Therapy Clinical Supervisor. There was no documentation of the discussion which took place during the case conference. During an interview on 9/29/16 at 10:00 AM, the LMSW reviewed the record and stated "I always talk to patients about their depression." He stated during his evaluation Patient #6 told him he was doing "okay." When asked about Patient #6 being on administrative leave the MSW stated he had heard the information second hand, but could not remember where he heard it. He stated he had heard Patient #6 threatened to "shoot up the place." The LMSW stated he did not evaluate whether Patient #6 had access to a gun or if he	G 195		

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G 195	Continued From page 78 felt the urge to hurt people. The LMSW stated he had talked with the Physical Therapist Case Manager about Patient #6's administrative leave from his job and why he was on leave, but confirmed this was not documented in the record. The agency failed to ensure Patient #6 received an appropriate and thorough evaluation by the MSW.	G 195		
G 215	484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient. This STANDARD is not met as evidenced by: Based on personnel file review and staff interview, it was determined 1 of 5 (home health aide #5) home health aides, whose personnel files were reviewed, had failed to complete the required 12 hours of training in the previous twelve month period. This had the potential to directly affect the quality and safety of care patients' received from the home health aide. Findings include: On 9/28/16 personnel files of 5 home health aides were reviewed. Aide #5 had 4 documented hours of education between the dates of 4/13/15 through 9/16/16. The Nursing Clinical Supervisor and Therapy Clinical Supervisor were interviewed on 9/28/16. They both stated the home health aide in question had a 2 month leave for a special	G 215	**G215 484.36(b) Competency Evaluation and In-Service Training** **Action:** Home Health Aide #5 has completed on 10.05.2016 all required education and has full-filled her required 12 hours of continuing education for the calendar year. **Monitoring:** Business office manager will continue to monitor all home health aide educational hours and notify CS if HHA is not obtaining the necessary required hours. Accumulative monthly findings will be reported to the PI monthly and quarterly committee, findings to be noted in the committee's minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 215	Continued From page 79 personal project during the previous months. They agreed she did not have the required 12 hours of education for the previous 12 month period. The agency failed to ensure the yearly 12 hour education requirement was completed by all home health aides.	G 215		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure medical records were complete and accurate for 5 of 20 patients (#3, #5, #8, #17, and #19) whose records were reviewed. This had the potential to interfere with clarity, coordination, and safety of care. Findings include: 1. Patient #5 was a 65 year old male admitted to the agency on 8/14/16, for services related to insulin dependent DM. Additional diagnoses were brain cancer and HTN. He received SN, ST, and MSW services. His record, including the POC, for the certification period 8/14/16 to	G 236	**G236 484.48 Clinical records** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with Business office staff attending one of the scheduled meetings staff attending one of the selected dates and scheduled meeting times. Instructed will be provide by the Operations Liaison. Review of required documentation of the OASIS assessments and clinical notes, documentation of supervisory visits LPN and HHA, patient care coordination and filing of the clinical records in the appropriate patient's clinical record. Review of documentation requirements – signatures of clinicians **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's clinical record requirements –5-001, 5-005, 5-006. **Monitoring and Tracking:** Business Office Manager or designee will review 10% of the active and inactive clinical records based on the average daily census for the correctness of the documentation filed within. They will track and trend all found errors and report findings to the PI committee monthly and quarterly until the agency has a 90% compliance. PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes.	

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G 236	Continued From page 80 10/12/16, was reviewed. Patient #5's record included an SN visit note dated 9/01/16, signed by his RN Case Manager. The note included a section titled "AIDE SUPERVISORY VISIT." The section was completed by the RN, and stated the Aide was not present, the supervisory visit was scheduled, and the patient/family were satisfied. Patient #5's POC did not include an order for Aide visits, and his record did not include documentation of Aide visits. During an interview on 9/29/16 at 3:00 PM, the Nursing Clinical Supervisor reviewed Patient #5's record. She confirmed he was not receiving Aide services. She stated the supervisory visit note applied to an LPN, not an Aide. She stated the note was unclear and should have stated it was an LPN supervisory note. Patient #5's supervisory visit documentation was not clear and accurate. 2. Patient #8 was an 84 year old female admitted to the agency on 7/20/16, for services related to a vaginal fistula. Additional diagnoses included atrial fibrillation and HTN. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period 9/18/16 to 11/16/16, was reviewed. Patient #8's record for the certification period 9/18/16 to 11/16/16 was provided by the agency. The record included the following documents that were dated prior to the start of her certification period: - PT care plan dated 6/19/16	G 236	**Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 236	Continued From page 81 - Transfer to an Inpatient Facility assessment dated 6/29/16 - Missed Visit Report dated 6/30/16 - Missed Visit Report dated 7/01/16 During an interview on 9/29/16 at 3:25 PM, the Nursing Clinical Supervisor reviewed Patient #8's record. She stated the documents were from a previous home health admission, and were filed in Patient #8's current record in error. Patient #8's medical record included documents from a previous home health admission. 3. Patient #17 was a 52 year old female admitted to the agency on 12/27/15, for services related to an abscess of the foot. Additional diagnoses included cellulitis, depression, and HTN. She received SN services. Her record, including the POCs, for the certification periods 12/27/15 to 2/24/16, and 2/25/16 to 4/24/16, was reviewed. Patient #17's record included a hand-written SN visit note dated 2/17/16. The note did not contain the nurse's signature. It could not be determined who completed the visit note. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed the SN visit note and confirmed that it was not signed by the nurse who completed the visit. Patient #17's SN visit note was not authenticated with a nurse's signature. 4. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF following a hospitalization. Additional diagnoses included insulin dependent DM,	G 236		

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G 236	Continued From page 82 COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. During an interview on 9/29/16 at 4:10 PM, the Nursing Clinical Supervisor stated Patient #19's record did not include referral information. On 9/29/16 at 5:10 PM, the Nursing Clinical Supervisor presented Patient #19's referral information. She stated it was filed in another patient's record. Patient #19's referral information was filed in another patient's record. 5. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, Type II DM, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed. Patient #3's record included a narrative note, dated 7/29/16, which stated the recertification visit was completed on 7/15/16, as instructed. The note was unsigned. During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor reviewed the note and confirmed it was unsigned. She stated she did not know why the narrative was placed in Patient #3's record. Patient #3's record included a narrative note that was not authenticated with a signature.	G 236		

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G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure encoded OASIS data reflected the patient's status at the time of assessment for 5 of 19 Medicare patients (#3, #6, #8, #14, and #19) whose records were reviewed. This resulted in the reporting of inaccurate data. Findings include: 1. Patient #8 was an 84 year old female admitted to the agency on 7/20/16, for services related to a vaginal fistula. Additional diagnoses included atrial fibrillation and HTN. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period 9/18/16 to 11/16/16, was reviewed. Patient #8's record included an ROC OASIS assessment dated 9/07/16, signed by the RN. OASIS item M2000 stated a drug regimen review identified clinically significant medication issues. OASIS item M2002 stated a physician or physician-designee was contacted within 1 calendar day to resolve the medication issues. Patient #8's record included a physician order request dated 9/08/16. The order request included a note to the physician stating Patient #8 had a documented allergy to NSAIDs, and was currently taking an NSAID, Meloxicam. The order request was signed by Patient #8's physician on 9/13/16, 6 days after her ROC.	G 322	**G322 484.20(b) Accuracy of Encoded OASIS Data** **Action:** Clinical Supervisors will provided educational program during case conference November 10, 2016 to disciplines completing OASIS assessments with focus on the following M items: M2000, M2002, M1350, and M2250. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's OASIS assessments and documentation requirements. **Monitoring and Tracking:** Clinical supervisor's will review 100% OASIS assessments and communicate required corrections to the individual discipline, providing one on one education as required. They will track and trend all found errors and report findings to the PI committee monthly and quarterly until the agency has a 90% compliance. PI committee to review to revised the tracking and trending tool, or if the agency obtains 90% compliance to re-evaluate the indicators and revised as needed ongoing. Findings and decisions will be recorded within the PI Committee Minutes. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 322	Continued From page 84 During an interview on 9/29/16 at 3:25 PM, the Nursing Clinical Supervisor stated the physician order request was sent to Patient #8's physician by fax on 9/09/16, and returned with his signature on 9/13/16. She confirmed the medication issue was not reconciled within 1 calendar day, and stated OASIS item M2002 was answered incorrectly. The agency failed to ensure Patient #8's ROC OASIS was accurate. 2. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed. Patient #19's record included an SOC OASIS comprehensive assessment completed on 3/08/16, and signed by the RN. OASIS item M1350 asked if Patient #19 had a skin lesion or open wound that was receiving intervention by the agency. The question was answered no. The SOC assessment stated wound care was provided to Patient #19's right knee by the RN. During an interview on 9/29/16 at 4:10 PM, the Nursing Clinical Supervisor reviewed Patient #19's SOC OASIS assessment and stated wound care was provided by the admitting RN, and OASIS item M1350 was answered incorrectly. The agency failed to ensure Patient #19's SOC OASIS was accurate. 3. Patient #3 was a 66 year old female admitted	G 322		

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G 322	Continued From page 85 to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, Type II DM, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification period 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, were reviewed. Patient #3's record included an SOC OASIS assessment dated 5/22/16, and signed by the RN Case Manager. Her OASIS assessment included an inaccurate answer. OASIS item M2250 asked about the physician ordered POC and diabetic foot care, which included monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care. It was answered as "N/A," which stated Patient #3 was not a diabetic or was missing her lower legs. However, Patient #3 had a diagnosis of Type II DM. During an interview on 9/30/16 at 10:10 AM, the Nursing Clinical Supervisor reviewed the SOC OASIS and confirmed M2250 was answered incorrectly. The agency failed to ensure Patient #3's SOC OASIS was accurate. 4. Patient #6 was a 66 year old male admitted to the agency on 9/21/16, for services related to traumatic injuries after a fall. Additional diagnoses included DM Type II, HTN, depression, and anxiety. He received PT, OT, and MSW services. His record, including the POC, for the certification period 9/21/16 to 11/19/16, was	G 322		

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G 322	Continued From page 86 reviewed. Patient #6's record included an SOC OASIS assessment dated 9/21/16, and signed by the Physical Therapist. His OASIS assessment included an inaccurate answer. OASIS item M2250 asked about the physician ordered POC and diabetic foot care, which included monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care. It was answered as "N/A," which stated Patient #6 was not a diabetic or was missing his lower legs. However, Patient #6 had a diagnosis of Type II DM. During an interview on 9/29/16 at 4:05 PM, the Physical Therapist who completed the SOC assessment confirmed M2250 was answered incorrectly. The agency failed to ensure Patient #6's SOC OASIS was accurate. 5. Patient #14 was an 87 year old male admitted to the agency on 9/09/16, for services related to dementia. Additional diagnoses included localized edema, cardiomegaly, and wheelchair dependence. He received SN, PT, and OT services. His record, including the POC, for the certification period 9/09/16 to 11/07/16, was reviewed. Patient #14's record included an SOC OASIS assessment dated 9/19/16, and signed by the RN Case Manager. His OASIS assessment included an inaccurate answer.	G 322		

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G 322	Continued From page 87 The RN Case Manager documented Patient #14 had pain to both his knees and shoulders. She documented his pain as 8 out of 10, on a 0 to 10 scale, with 10 being the worst pain. The RN Case Manager also documented the frequency of Patient #14's pain was all of the time. OASIS item M2250 asked if the physician ordered POC included interventions to monitor and mitigate pain. It was answered as "Yes." However, Patient #14's POC, dated 9/09/16, did not include interventions related to his pain. During an interview on 9/30/16 at 11:30 AM, the Nursing Clinical Supervisor reviewed the record and confirmed pain management and interventions were not included on Patient #14's POC. The agency failed to ensure Patient #14's SOC OASIS was accurate.	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 concern for 2 of 18 patients (#3 and #15) whose SOC records were reviewed. This failure placed patients at risk for negative outcomes. Findings	G 331	**G331 484.55(a)(1) Initial Assessment** Visit **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case manager assigned to patient #3. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, based on assessment documentation at SOC or ROC, patient care coordination between disciplines and MD, patient and caregivers. Thorough review of referral information pertinent to home health diagnosis and ongoing patient needs to formulate an accurate plan of care. . **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, communication and notification to MD as required, following best practice base on diagnosis, agency establishment of clinical pathways, Policy 2-019 Physicians Participation in Plan of Care.	

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G 331	Continued From page 88 include: 1. Patient #3 was a 66 year old female admitted to the agency on 5/22/16, for services related to paraplegia. Additional diagnoses included neuromuscular dysfunction, incontinence, Type II DM, depression, and bacteremia. She received SN, PT, OT, Aide, and MSW services. Her record, including the POCs, for the certification periods 5/22/16 to 7/20/16 and 7/21/16 to 9/18/16, was reviewed. Patient #3 was hospitalized in an inpatient rehabilitation unit from 5/13/16 to 5/20/16, for spinal cord rehabilitation. The referral information included diagnoses of incomplete paraplegia, spinal disorder and disease, bladder dysfunction, Type II DM, HTN, and depression. An SOC comprehensive assessment, dated 5/22/16, signed by an RN, stated Patient #3 had steroid induced Type II DM. There was no documentation of a BG level or further assessment regarding her diet. Patient #3's medication list included a steroid which was to be taken daily. Additionally, the RN documented diabetic foot exams were not applicable and Patient #3 was on a regular diet. Patient #3's record included referral information, with an H&P. It documented Patient #3 had difficulty with eliminating her bowels due to her diagnosis of paraplegia, and stated Patient #3 required daily suppositories in order to have regular bowel movements. Patient #3's SOC assessment documented Patient #3 had no problems with bowel elimination. During an interview on 9/30/16 at 10:10 AM, the	G 331	**Monitoring and Tracking:** CS or designee will review 100% of SOC Assessments, initials orders, diagnosis, interventions and goals planned for the patient. Inconsistent documentation and findings will be reviewed one on one with the clinicians and appropriate corrections made if indicated. CS will track and trend all findings and report to the PI committee monthly and quarterly. Variances less than 90% will require an action plan and tracking and trending implemented or plan for additional educational programs for individual staff or all staff. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 331	Continued From page 89 Nursing Clinical Supervisor reviewed the record and confirmed Patient #3 had a diagnosis of Type II DM. She stated the RN should have further assessed Patient #3 related to her diagnosis and included foot exams and education as part of her assessment. The Nursing Clinical Supervisor confirmed Patient #3 did have bowel elimination problems. Patient #3's initial assessment was not comprehensive to identify her needs related to her diagnoses of DM and paraplegia. 2. Patient #15 was an 80 year old female admitted to the agency on 9/20/16, for services related to an acute gastrointestinal bleed. Additional diagnoses included enterocolitis related to Clostridium difficile, GERD, atrial fibrillation, HTN, CHF, CKD, and history of DVT. She received SN, PT, and OT services. Her record, including the POC, for the certification period 9/20/16 to 11/18/16, was reviewed. Patient #15's record included an H&P from her most recent hospitalization which stated Patient #15 had a long history of problems with her cardiopulmonary system and bleeding. Patient #15 had atrial fibrillation, anemia, a previous DVT in her left upper arm, and a subdural hematoma (a collection of blood or bleeding in the brain). Patient #15's most recent admission to the hospital was for acute gastrointestinal bleeding following a colonoscopy with several biopsies. While admitted she suffered acute blood loss resulting in anemia, and received 3 units of blood. Patient #15's record included an SOC comprehensive assessment completed on	G 331		

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G 331	Continued From page 90 9/20/16, and signed by the RN Case Manager. The assessment was not comprehensive to identify all her needs. The RN Case Manager documented Patient #15 had no problems with bleeding or anemia (low blood levels). There was also no documentation of Patient #15's disorders related to her gastrointestinal system. During an interview on 9/30/16 at 11:50 AM, the Nursing Clinical Supervisor reviewed the record and confirmed Patient #15's comprehensive assessment did not include pertinent information from her history and most recent admission. She stated Patient #15 should have been assessed for her bleeding problems and her gastrointestinal issues should have been identified in the assessment. Patient #15's initial assessment was not comprehensive enough to identify her bleeding problems or her gastrointestinal issues.	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 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 observation, record review, policy review, patient and staff interview, it was determined the agency failed to ensure all medications patients were taking were reviewed and reconciled with the physician for 7 of 20 patients (#5, #8, #10, #14, #15, #17, and #19)	G 337	**G337 484.55(c) Drug Regime Review** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case manager assigned to patient #3, #8, #10, #14, #15, #17, and #19. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, including medication reconciliation. **That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485, medication profile, policy 3-001, 3-002, 3-003 and 3-014 and review of Medication Reconciliation handout.	

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G 337	Continued From page 91 whose records were reviewed. This placed patients at risk for adverse outcomes related to medications. Findings include: The agency's policy "MEDICATION PROFILE," last revised in October of 2015, stated "Patients receiving medications will have a current, accurate medication profile in the clinical record...Medication profiles will be updated for each change to reflect current medications and new and/or discontinued medications..." The agency's policy "ONGOING ASSESSMENTS" REVISED 10/12, stated "The physician will be notified to verify any changes in medications, including over-the-counter medications which might interact or be duplicative with other patient medications..." 1. Patient #5 was a 65 year old male admitted to the agency on 8/14/16, for services related to insulin dependent DM. Additional diagnoses were brain cancer and HTN. He received RN, ST and MSW services. His record, including the POC, for the certification period 8/14/16 to 10/12/16, was reviewed. a. Patient #5's record included an SN visit note dated 8/30/16, signed by an LPN. The note stated Patient #5 had a new medication, Trazodone (antidepressant). Patient #5's POC and medication profile did not include Trazodone. b. Patient #5's record included an SN visit note dated 9/08/16, signed by an LPN. The note stated Patient #5 began taking an oral chemotherapy drug 2 days prior. Patient #5's POC and medication profile did not include an oral chemotherapy drug.	G 337	**Monitoring and Tracking:** CS or designee will review 100% of SOC/Recertification/ROC assessments – submitted medication profiles and ongoing clinical audits 10% of active and inactive patient records, for medication compliance, until the agency achieves overall 90% compliance, Inconsistent documentation and findings will be reviewed one on one with the clinicians and appropriate corrections made if indicated. CS will track and trend all findings and report to the PI committee monthly and quarterly. Variances less than 90% will require an action plan, additional tracking and trending implemented or plan for additional educational programs for individual staff or all staff. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 337	Continued From page 92 c. Patient #5's record included an SN visit note dated 9/14/16, signed by his RN Case Manager. The note stated Patient #5 had a new medication, Prochlorperazine (anti-nausea). Patient #5's POC and medication profile did not include Prochlorperazine. d. Patient #5's record included an SN visit note dated 9/22/16, signed by his RN Case Manager. The note stated the RN instructed Patient #5 to begin taking Miralax (laxative) daily. Patient #5's POC and medication profile did not include Miralax. His record did not include documentation stating his physician was contacted to obtain an order for Miralax. During an interview on 9/29/16 at 3:00 PM, the Nursing Clinical Supervisor reviewed Patient #5's record. She stated his POC and medication profile were not updated to include his new medications. Patient #5's POC and medication profile did not include all medications he was taking. 2. Patient #8 was an 84 year old female admitted to the agency on 7/20/16, for services related to a vaginal fistula. Additional diagnoses included atrial fibrillation and HTN. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period 9/18/16 to 11/16/16, was reviewed. Patient #8's record included an ROC assessment dated 9/07/16, signed by the RN. The assessment stated Patient #8's home health services were being resumed following a hospitalization and surgery.	G 337		

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G 337	Continued From page 93 a. Patient #8's record included a medication profile dated 7/20/16, her SOC date, and a medication profile dated 9/07/16, her ROC date. The medication profile dated 9/07/16, included medications that were not listed on the medication profile dated 7/20/16, as follows: - Acetaminophen - Bisacodyl - Calcium Carbonate - Benadryl - Loperamide - Milk of Magnesia Patient #8's record did not include physician's orders for the new medications. b. On 9/27/16 at 9:30 AM, a visit was made to the ALF where Patient #8 resided, to observe an SN visit made by the LPN. After the visit, Patient #8's current medications were reviewed with the ALF's Medication Aide. The Medication Aide stated Patient #8 was receiving Cephalexin (antibiotic) daily, in addition to the medications listed on the home health medication profile. The ALF's order for Cephalexin was reviewed. The medication was originally ordered on 7/20/16, and stated "until surgery." The medication was resumed on 9/07/16, when Patient #8 returned to the ALF following her hospitalization and surgery. Cephalexin was not listed on Patient #8's home health medication profile. There was no documentation in her record stating Patient #8's physician was contacted to determine whether she should continue to receive the antibiotic. During an interview on 9/29/16 at 3:25 PM, the Nursing Clinical Supervisor reviewed the record.	G 337		

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G 337	Continued From page 94 She stated Patient #8's medication orders were not reconciled with her physician when her home health services were resumed. Patient #8's medications were not reviewed and reconciled when her home health services were resumed after her hospitalization and surgery. 3. Patient #17 was a 52 year old female admitted to the agency on 12/27/15, for services related to an abscess of the foot. Additional diagnoses included cellulitis, depression, and HTN. She received SN services. Her record, including the POC, for the certification period 2/25/16 to 4/24/16, was reviewed. Patient #17's record included a physician's order from a wound care clinic, dated 3/16/16. The order included Doxycycline (antibiotic) 100 mg to be taken 2 times a day for 10 days. Patient #17's POC and medication profile were not updated to include Doxycycline. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and confirmed her POC and medication profile were not updated to include Doxycycline. Patient #17's POC and medication profile did not include all medications she was taking. 4. Patient #19 was a 69 year old male admitted to the agency on 3/08/16, for services related to CHF. Additional diagnoses included insulin dependent DM, COPD, and a chronic ulcer on his right foot. He received SN services. His record, including the POC, for the certification period 3/08/16 to 5/06/16, was reviewed.	G 337		

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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
G 337	Continued From page 95 Patient #19's record included an SN visit note dated 3/15/16, signed by the RN Case Manager. The note stated he complained of pain that was relieved by taking Acetaminophen. Patient #19's POC and medication profile did not include Acetaminophen. During an interview on 9/30/16 at 11:00 AM, the RN Case Manager stated he was taking Acetaminophen for pain. She confirmed Acetaminophen was not included on his POC or medication profile. Patient #19's POC and medication profile did not include all medications he was taking. 5. Patient #10 was an 83 year old female admitted to the agency on 8/27/16, for services related to recovery from a right femur fracture. Additional diagnoses were HTN, history of falling, and osteoporosis. She received PT, OT, MSW and Aide services. Her record, including the POC, for the certification period 8/27/16 to 10/25/16, was reviewed. A scheduled aide visit was observed on 9/24/16 at 9:30 AM. After the aide visit was completed, Patient #10 was interviewed. When questioned about her shortness of breath and wheeze, she stated "Yes, and the doctor gave me an inhaler for my breathing, but I do not use it very much." The patient had an Albuterol inhaler. Patient #10's medication list did not include the Albuterol inhaler. The PT Case Manager was interviewed by phone on 9/30/16, at 9:10 AM. He stated his routine was to ask patients to show him all their	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137006		10/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS HOME HEALTH AND HOSPICE	9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709

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G 337	Continued From page 96 medications, including over the counter, "anything they take." He did not have a specific memory regarding Patient #10's inhaler. The agency failed to ensure that all Patient #10's medications were reviewed. 6. Patient #14 was an 87 year old male admitted to the agency on 9/09/16, for services related to dementia. Additional diagnoses included localized edema, cardiomegaly, and wheelchair dependence. He received SN, PT, and OT services. His record, including the POC, for the certification period 9/09/16 to 11/07/16, was reviewed. Patient #14's record included a medication profile dated 9/09/16 and signed by the RN Case Manager. The medication profile documented 20 over the counter medications, which included a pain reliever and several vitamins and herbal supplements. The RN Case Manager stated she notified Patient #14's physician, via fax, of his " ...excessive/inconsistent supplement use ..." Patient #14's record did not include a response or clarification from his physician about his multiple supplements until the POC was signed by his physician on 9/20/16, 11 days later. During an interview on 9/30/16 at 11:30 AM, the Nursing Clinical Supervisor reviewed the record and confirmed there was no response from Patient #14's physician until the POC was signed. She stated the RN Case Manager should have called the physician regarding her concerns about his over the counter medications and supplements.	G 337		

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G 337	Continued From page 97 Patient #14's medication profile was not reconciled with his physician in a timely manner when there were concerns by the RN Case Manager. 7. Patient #15 was an 80 year old female admitted to the agency on 9/20/16, for services related to an acute gastrointestinal bleed. Additional diagnoses included enterocolitis related to Clostridium difficile, GERD, atrial fibrillation, HTN, CHF, CKD, and history of DVT. She received SN, PT, and OT services. Her record, including the POC, for the certification period 9/20/16 to 11/18/16, was reviewed. Patient #15's record included a referral order from the discharging facility. The referral order documented a list of medications which were recommended to be continued. The list included rapid acting insulin with a sliding scale. Patient #15's POC medication list did not include insulin or a sliding scale. During an interview on 9/30/16 at 11:50 AM, the Nursing Clinical Supervisor reviewed the record and confirmed the medications ordered on the discharge referral included insulin. She stated she was unsure why that was not included or clarified with Patient #15's physician. Patient #15's medications were not reconciled when her home health services were started.	G 337	**G337 484.55(c) Drug Regime Review** **Action:** Mandatory staff and leadership education to be provided November 1, 2, 4th, 2016 with staff attending one of the selected dates and scheduled meeting times. Will also include all case manager assigned to patient #15. Program will be conducted by the Operations Liaison. Focus instruction on implementing the patient's plan of care, timeliness of completing the recertification OASIS will be addressed with staff.	
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days	G 339		

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G 339	Continued From page 98 beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on record review, policy review, observation and staff interview, it was determined the agency failed to ensure comprehensive assessments occurred during the last 5 days of every 60 day episode, and additional services were not provided until the comprehensive assessment was completed, for 1 of 3 patients (Patient #17) who received care for more than 60 days and whose records were reviewed. This resulted in the failure of the agency to have a current assessment and POC, and had the potential to impact the quality of patient care. Findings include: The agency's policy "REASSESSMENTS/RECERTIFICATION" stated "For each new episode of care, a comprehensive assessment will be completed no earlier than five (5) days before and no later than one (1) day before the calendar day on which the new episode of care began." Patient #17 was a 52 year old female admitted to the agency on 12/27/15, for services related to an abscess of the foot. Additional diagnoses included cellulitis, depression, and HTN. She received SN services. Her record, including the POC, for the certification period 2/25/16 to 4/24/16, was reviewed.	G 339	**That Led To Deficiency:** Above actions will 1) heighten awareness of patient's plan of care – 485 **Monitoring and Tracking:** CS or designee will review 100% of Recertifications and ensure that they are completely timely within the required 5 days prior to the end of the patient's episode of care. Variance will be addressed with the individual assessing clinician one on one education. Findings will be reported to the PI committee monthly and quarterly. The PI committee will determine if additional tracking or trending or education will be required. **Responsible:** The Interim Branch Director has overall responsibility for the corrective action and ongoing completion of this standard. **Completion Date:** All Corrective Actions will be initiated or completed by November 17 2016.	

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G 339	Continued From page 99 Patient #17's certification period ended on 4/24/16. Her record did not include documentation of a visit to perform a recertification assessment in the last 5 days of her certification period. Patient #17's record included a discharge assessment completed on 4/28/16, signed by the RN. During an interview on 9/29/16 at 3:45 PM, the Nursing Clinical Supervisor reviewed Patient #17's record and stated a recertification assessment was not performed, and the discharge assessment occurred after the end of her certification period. The agency failed to ensure Patient #17's comprehensive assessment was updated in the last 5 days of her certification period.	G 339		

Bureau of Facility Standards

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	OAS001175		10/03/2016

NAME OF PROVIDER OR SUPPLIER: ST ALPHONSUS HOME HEALTH AND HOSPICI

STREET ADDRESS, CITY, STATE, ZIP CODE: 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your agency conducted from 9/26/16 to 10/03/16. The surveyors conducting the recertification were: Nancy Bax, RN, BSN, HFS, Team Leader Laura Thompson, RN, BSN, HFS Kristin Inglis, RN, HFS Rebecca Lara, RN, HFS	N 000	**N002 03.07020.02 Admin Gov. Body** **Actions** **Education/ Orientation** session was conducted 09/28/2016 **with Director, Agency Clinical Supervisors, Business Office Manager and staff** on N 002 that Personnel records include qualifications and licensure that are kept current. HR Policy 1-005 and reviewed the process and responsibility of the Director to assure that all licensed staff have verified current licensure and if licensure lapses, the clinician is immediately taken off the schedule until proof of current licensure can be verified.	
N 002	03.07020.02. ADMIN.GOV.BODY N002 02. Structure. The administrative responsibilities of the agency shall be documented by means of a current organizational chart. This Rule is not met as evidenced by: Refer to G123 as related to the organizational charts did not clearly document lines of authority.	N 002	**That Led To Deficiency:** Above actions will 1) heighten awareness of Human Resource Manager, Director, clinical supervisors and group responsibilities related to Policy 1-005, Idaho State Regulations 03.07030.02); 2) Authentication of currency of all licensures by Human Resources, Director, Clinical Supervisors and licensed staff 3) clarify Human Resource processes to assure licensed staff with lapsed licenses are taken off schedules immediately.	
N 004	03.07020. ADM.GOV.BODY N004 03. Responsibilities. The governing body shall assume responsibility for: a. Adopting appropriate bylaws and policies and procedures. This Rule is not met as evidenced by: Refer to G130 as related to the governing body failed to ensure the PAC established policies and reviewed them annually.	N 004	**Monitoring and Tracking:** The Director ensured 09/30/2016 that all licensed staff with scheduled patient visits have verified current licensure. Ongoing, the Director in collaboration with Human Resources will monitor status of all licenses minimally on a monthly basis and will a licensed clinician with be immediately removed from patient visit schedule until proof of active and current license. **Completion Date:** All Corrective Actions will be initiated or completed by **November 17 2016**	

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OCT 28 2016
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marilyn Vatro — TITLE: Operations Director — (X6) DATE: 10-26-16

Bureau of Facility Standards

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	OAS001175		10/03/2016

NAME OF PROVIDER OR SUPPLIER: ST ALPHONSUS HOME HEALTH AND HOSPICI

STREET ADDRESS, CITY, STATE, ZIP CODE: 9199 WEST BLACK EAGLE DRIVE, BOISE, ID 83709

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your agency conducted from 9/26/16 to 10/03/16. The surveyors conducting the recertification were: Nancy Bax, RN, BSN, HFS, Team Leader Laura Thompson, RN, BSN, HFS Kristin Inglis, RN, HFS Rebecca Lara, RN, HFS	N 000		
N 002	03.07020.02. ADMIN.GOV.BODY N002 02. Structure. The administrative responsibilities of the agency shall be documented by means of a current organizational chart. This Rule is not met as evidenced by: Refer to G123 as related to the organizational charts did not clearly document lines of authority.	N 002	**N002 03.07020.02 Admin Gov. Body** **Actions** **Education/ Orientation** session was conducted 09/28/2016 **with Director, Agency Clinical Supervisors, Business Office Manager and staff** on N 002, that Personnel records include qualifications and licensure that are kept current. HR Policy 1-005 and reviewed the process and responsibility of the Director to assure that all licensed staff have verified current licensure and if licensure lapses, the clinician is immediately taken off the schedule until proof of current licensure can be verified. **That Led To Deficiency:** Above actions will 1) heighten awareness of Human Resource Manager, Director, clinical supervisors and group responsibilities related to Policy 1-005, Idaho State Regulations 03.07030.02); 2) Authentication of currency of all licensures by Human Resources, Director, Clinical Supervisors and licensed staff 3) clarify Human Resource processes to assure licensed staff with lapsed licenses are taken off schedules immediately.	
N 004	03.07020. ADM.GOV.BODY N004 03. Responsibilities. The governing body shall assume responsibility for: a. Adopting appropriate bylaws and policies and procedures. This Rule is not met as evidenced by: Refer to G130 as related to the governing body failed to ensure the PAC established policies and reviewed them annually.	N 004	**Monitoring and Tracking:** The Director ensured 09/30/2016 that all licensed staff with scheduled patient visits have verified current licensure. Ongoing, the Director in collaboration with Human Resources will monitor status of all licenses minimally on a monthly basis and will a licensed clinician with be immediately removed from patient visit schedule until proof of active and current license. **Completion Date:** All Corrective Actions will be initiated or completed by **November 17 2016**	

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FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marilyn Vitro
TITLE: Operations Director
(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your agency conducted from 9/26/16 to 10/03/16. The surveyors conducting the recertification were: Nancy Bax, RN, BSN, HFS, Team Leader Laura Thompson, RN, BSN, HFS Kristin Inglis, RN, HFS Rebecca Lara, RN, HFS	N 000		
N 002	03.07020.02. ADMIN.GOV.BODY N002 02. Structure. The administrative responsibilities of the agency shall be documented by means of a current organizational chart. This Rule is not met as evidenced by: Refer to G123 as related to the organizational charts did not clearly document lines of authority.	N 002	**N004 03.07020 Admin Gov. Body** **Actions** **Education/ Orientation** session was to be conducted October 9, 2016 **with Frontier Leadership, Saint Alphonsus Home Health and Hospice Joint Venture Board members** on N004. The Chief Compliance Officer reviewed the deficiency and the Idaho State Regulations 03.07020 regulations with the Governing Body and the Governing Body will ensure a sub-committee of the Professional Advisory Committee is identified to complete an annual review of the policies when the agency identifies a The Sub Committee will be minimally of a physician, RN and a community member that is neither an employee or an owner of the agency The polices to be annually reviewed by a group from the Professional Advisory Committee that will minimally include a physician, registered nurse and community member who is neither an employee or owner of the agency. The subcommittee will minimally be agency policies that govern the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation.	
N 004	03.07020. ADM.GOV.BODY N004 03. Responsibilities. The governing body shall assume responsibility for: a. Adopting appropriate bylaws and policies and procedures. This Rule is not met as evidenced by: Refer to G130 as related to the governing body failed to ensure the PAC established policies and reviewed them annually.	N 004		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marilyn Watso | TITLE: Corporate Director | (X6) DATE

N004 continued

That Led To Deficiency:

Above actions will 1) heighten awareness of Governing Body, Frontier Leadership and group responsibilities related to Policy 4-007, IDAHO Regulation 03.07020.02; 2) Clarification of Frontier's value of assuring that delineation of authority is Registered Nurse and 3) clarify verbally Governing Body's approval of written delineation of authority.

Monitoring and Tracking:

The Governing Body will have a Professional Advisory Sub-Committee that annually reviews agency policies that governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and program evaluations. The sub-committee will minimally have one member that is neither and owner nor an employee of the agency. Compliance to the process will be verified at review of

Completion Date: All Corrective Actions will be initiated or completed by **November 17 2016**

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: ST ALPHONSUS HOME HEALTH AND HOSPICI

STREET ADDRESS, CITY, STATE, ZIP CODE: 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709

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N 015	03.07020. ADMIN. GOV. BODY N015 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: a. Home health providers have an obligation to protect and promote the exercise of these rights. The governing body of the agency must insure patients' rights are recognized. This Rule is not met as evidenced by: Refer to G101 as related to the agency's failure to ensure patients' rights were protected.	N 015	**N015 03.070202 Adm. Gov. Body** **See G 101 484.10 Patient Rights Plan of correction**	
N 016	03.07020. ADMIN. GOV. BODY N016 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: b. A patient has a right to be informed of his rights and has a right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient's bill of rights will be included in the patient's medical record. This Rule is not met as evidenced by: Refer to G101 as related to the agency's failure to ensure patients' rights were protected.	N 016	**N016 03.07020 Admin Gov. Body** **See G 101 484.10 Patient Rights Plan of correction**	

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N 046	03.07021.02.ADMINISTRATOR 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 as related to the agency failure to ensure a qualified person was authorized in writing to act in the absence of the Administrator.	N 046	**N046 03.07021.02 Administrator** **See G 137 484.14 (c) Administrator** **Plan of correction**	
N 048	03.07021. ADMINISTRATOR N048 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: b. Providing staff orientation, continuing education, information on applicable laws, rules and policies, resource materials, and staff development to effectively implement and continue the program. This Rule is not met as evidenced by: Refer to G215 as related to the agency failure to ensure continuing education was completed by all home health aides.	N 048	**N048 03.07021 Administrator** **See G215 484.36(b) Competency Evaluation and In-Service Training** **Plan of correction**	
N 050	03.07021. ADMINISTRATOR N050 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: d. Insuring that personnel employed shall be qualified to perform	N 050	**N050 03.07021 Administrator** **See G 134 484.14(c) Administrator** **G141 484.14(e) Personnel Policies** **Plan of correction**	

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N 050	Continued From page 3 their assigned duties and that agency practices are supported by written personnel policies. This Rule is not met as evidenced by: Refer to G134 and G141 as related to the Administrator failure to ensure the agency employed qualified personnel with current licensure.	N 050		
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations. This Rule is not met as evidenced by: Refer to G141 as related to the failure to ensure personnel records contained current licensure of staff. This resulted in services being provided to patients by unlicensed staff.	N 051	**N051 03.07021 Administrator** **See G141 484.14(e) Personnel Policies Plan of correction**	

Bureau of Facility Standards

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N 062	Continued From page 4	N 062		
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 G144 as related to the agency failure to ensure care coordination of issues relevant to the safe care of patients were documented in the record.	N 062	**N062 03.07021 Administrator** **See G144 484.14(g) Coordination of Patient services** **Plan of correction**	
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 G331 as related to the failure of the RN to ensure an initial assessment was comprehensive to identify all patient needs.	N 093	**N093 03.07024 SK Nursing Service** **See G331 484.55(a) (1) Initial Assessment** **Plan of Correction**	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: ST ALPHONSUS HOME HEALTH AND HOSPICI

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N 094	Continued From page 5	N 094		
N 094	03.07024. SK. NSG. SERV. 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: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G173 as related to the agency failed to ensure the RN revised the POC to meet the patients needs.	N 094	**N094 03.07024 Sk. NSG. Serv.** **See G173 484.18(a) Duties of the Registered Nurse** **Plan of correction**	
N 097	03.07024. SK. NSG. SERV. N097 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G176 as related to the agency failure to ensure RNs appropriately prepared clinical notes, and coordinated care with the physician and other clinicians.	N 097	**N097 03.07024 SK Nursing Service** **See G176 484.18(a) Duties of the Registered Nurse** **Plan of correction**	
N 098	03.07024. SK. NSG. SERV.	N 098	**N098 03.07024 SK. NSG. SERV.** **See G176 484.18(a) Duties of the Registered Nurse** **Plan of correction**	

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N 098	Continued From page 6 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 as related to the agency failure to ensure RNs appropriately coordinated care with the physician and other clinicians.	N 098	**N099 03.07024 SK Nursing Service** **See G177 484.30(a) Duties of the Registered Nurse** **Plan of correction**	
N 099	03.07024.SK. NSG. SERV. N099 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: g. Counsels the patient and family in meeting nursing and related needs; This Rule is not met as evidenced by: Refer to G177 as related to the agency failure to ensure the RN provided necessary instruction to patients or caregivers.	N 099	**N 139 03.07026.02 SOC. SERV.** **See G176 484.34 Medical Social Services** **Plan of correction**	
N 139	03.07026.02.SOC.SERV. N139 02. Social Worker. A social	N 139		

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N 139	Continued From page 7 worker performs the following duties: a. Assists the physician and other team members in understanding the significant social and emotional factors related to health problems; This Rule is not met as evidenced by: Refer to G195 as related to the agency failure to ensure the MSW did an appropriate evaluation and assisted other clinicians in understanding the significant social and emotional factors related to the health of their patients.	N 139		
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, G159 as related to the agency to ensure patient care followed a written plan of care.	N 152	**N 152 03.07030.01 Plan of Care** **See G158 484.18 Acceptance of Patients POC, Med Supervision** **And** **G159 484.18(a) Plan of Care Plans of Correction**	
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:	N 155	**N 155 03.07030 Plan of Care** **See G159 484.18(a) Plan of Care Plan of Correction**	

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N 155	Continued From page 8 c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to 159 as related to the agency failure to ensure the POC included all interventions, medications, nutritional requirements, and supplies.	N 155		
N 160	03.07030.PLAN OF CARE N160 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: h. Nutritional requirements; This Rule is not met as evidenced by: Refer to G159 as related the agency failure to ensure the POC included all nutritional requirements.	N 160	**N 160 03.07030 Plan of Care** **See G159 484.18(a) Plan of Care Plans of Correction**	
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: i. Medication and treatment orders;	N 161	**N 161 03.07030 Plan of Care** **See G159 484.18(a) Plan of Care Plan of Correction**	

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N 161	Continued From page 9 This Rule is not met as evidenced by: Refer to G159 as related to the agency failure to ensure the POC included all interventions and medications.	N 161		
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: m. The patient and his family's teaching needs; This Rule is not met as evidenced by: Refer to G170 as related to the agency's failure to ensure the RN provided education to the patient and family as ordered in the POC.	N 165	**N 165 03.07030 Plan of Care** **See G170 484.30 Skilled Nursing Services Plan of Correction**	
N 167	03.07030.PLAN OF CARE N167 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: o. Other appropriate items. This Rule is not met as evidenced by: Refer to G159 as related to the agency failure to ensure patient POCs included all physicians who could write orders and modify the POC.	N 167	**N 167 03.07030 Plan of Care** **See G159 484.18(a) Plan of Care Plan of Correction**	

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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 G170 as related to wound care was provided without a physician's order.	N 170	**N 170 03.07030.04 Plan of Care** **See G170 484.30 Skilled Nursing Services Plan of Correction**	
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 as related to the agency failure to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care.	N 172	**N 172 03.07030.06 Plan of Care** **See G164 484.18 (b) Periodic Review of Plan of Care Plan of Correction**	
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	N 173	**N 173 03.07030.07 Plan of Care** **See G337 484.55 (c) Drug Regime Review Plan of Correction**	

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N 173	Continued From page 11 problems to the physician. This Rule is not met as evidenced by: Refer to G337 as related to the agency failure to ensure all medications patients were taking were reviewed and reconciled with the physician.	N 173		
N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to G236 as related to the agency failure to ensure medical records were complete and accurate.	N 174	**N 174 03.07031.01 Clinical Records** **See G236 484.48 Clinical Records Plan of Correction**	
N 179	03.07031.CLINICAL REC. N179 02. Contents. Clinical records must include: e. Drug, dietary treatment, and activity orders; This Rule is not met as evidenced by: Refer to G236 as related to the agency failure to ensure medication records were complete and accurate.	N 179	**N 179 03.07031 Clinical Record** **See G236 484.48 Clinical Records Plan of Correction**	
N 180	03.07031.CLINICAL REC. N180 02. Contents. Clinical records must include:	N 180	**N 180 03.07031 Clinical Record 0.07 Plan of Care** **See G236 484.48 Clinical Records Plan of Correction**	

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N 180	Continued From page 12 f. Signed and dated clinical and progress notes; This Rule is not met as evidenced by: Refer to 236 as related to the agency failure to ensure clinical records were signed by the appropriate clinicians.	N 180		
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 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. This Rule is not met as evidenced by: Refer to G130 and G153 as related to the agency failure to ensure the PAC established and annually reviewed the agency's policies.	N 193	**N 193 03.0704 Agency Evaluations** **See G130 484.14 (b) Governing Body Plan of Correction** **And** **G153 484.16 Group of Professional Personnel Plan of Correction**	
N 199	Criminal History and Background Check 009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Compliance with Department ' s Criminal History and Background Check. A home health	N 199	**N 199 Criminal History and Background Check Requirements**	

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N 199	Continued From page 13 agency must comply with IDAPA 16.05.06, " Criminal History and Background Checks. " (3-26-08) 02. Direct Patient Access Individuals. These rules apply to employees and contractors hired or contracted with after October 1, 2007, who have direct patient access. (3-26-08) 03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08) This Rule is not met as evidenced by: Based on review of personnel files, state licensing rules, and staff interview, it was determined the agency failed to ensure 2 of 2 (#1 and #2) contracted employees, whose personnel files were reviewed, had the required criminal background checks. Failure of the agency to ensure criminal background checks were completed had the potential to compromise patient safety. Findings include: The Idaho Administrative Procedures Act rules 16.05.06 state "...The criminal history applicant is required to disclose any pertinent information of crimes or offenses that would disqualify the	N 199	**N 199 Criminal History and Background Check Requirements** **Action:** Agency has rewritten process to obtain background checks on new employees. See Attached. Business office will review new process and follow. Business Office Manager to be instructed on the process November 1, 2016 by the Operations Liaison. Agency is currently 100% compliant with all employee background checks. Agency is currently 100% compliant with active licensure and certifications for all employees. 10/21/2016 **Monitoring:** Agency Business Office manager will review all employee hire paperwork prior to the assignment of patient visits. Missing items the employee will not be allowed to work with patients until requested information has been obtained. Active employees the Business Office Manager will run the employee expiration report monthly review upcoming dates of expiration and alert the employee and CS. If licensure is not received timely the employee will not be assigned patient visits.	

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N 199	Continued From page 14 individual from providing care or services to vulnerable populations." The personnel files of the two employees contracted through staffing agencies were reviewed on 9/28/16. The criminal background checks were as follows: 1. Staff #1 (an occupational therapistT) had a photograph of a 5 page report by a company called SterlingBackcheck, but no "Notice of Clearance" from the Idaho Department of Health and Welfare, which would have stated the results of the background check. 2. Staff #2 (an registered nurse) had a photograph of a 6 page report by a company called OneSource, but no "Notice of Clearance" from the Idaho Department of Health and Welfare, which would have stated the results of the background check. The Clinical Supervisor of Therapy and the Business Office Supervisor were interviewed on 9/30/16, at 10:10 AM. They both agreed the Idaho Health and Welfare criminal background checks had not been done. The Business Office Supervisor stated the staffing agency providing the employees took care of background checks. The agency failed to ensure the state required criminal background checks were completed on contracted employees.	N 199		