IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSSELL S. BARRON– Director

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DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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November 27, 2017

Chad Mangum, Administrator
Access Home Care
240 West Burnside Avenue, Suite B
Chubbuck ID 83202

RE: Access Home Care, Provider #137110

Dear Mr. Mangum:

This is to advise you of the findings of the Medicare/Licensure survey at Access Home Care, which was concluded on November 16, 2017.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

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

After you have completed your Plan of Correction, return the original to this office by **December 11, 2017**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, comments or concerns, please contact Dennis Kelly, R.N. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137110	A. BUILDING _____ B. WING _____	11/16/2017

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ACCESS HOME CARE	240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202

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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency conducted on 11/13/17 to 11/16/17. Surveyors conducting the Medicare recertification survey were: Nancy Bax, RN, BSN, HFS, Team Lead Brian Osborn, RN, HFS Acronyms used in this report include: Ag - silver BG - Blood Glucose BID - Twice Daily CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CMS - Centers for Medicare and Medicaid DM - Diabetes Mellitus DPS - Director of Patient Services GERD - Gastroesophageal Reflux Disease HCl - Hydrochloride HPI - History and Physical Information HTN - Hypertension hx - history LPN - Licensed Practical Nurse MG - Milligram mg/dl - Milligram per deciliter MSW - Medical Social Worker OASIS - Outcome and Assessment Information Set OSA - Obstructive Sleep Apnea OT - Occupational Therapy PO - By Mouth POC - Plan of Care Pt - patient PT - Physical Therapy QIES - Quality Improvement and Evaluation	G 000	RECEIVED DEC 11 2017 FACILITY STANDARDS	

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

BSN 12/7/17

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 System RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care TKA - Total Knee Arthroplasty UTI - Urinary Tract Infection	G 000		
G 102	NOTICE OF RIGHTS CFR(s): 484.10(a)(1) The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the agency failed to ensure patients were provided a written notice of patients' rights in advance of furnishing care to the patient for 1 of 1 patient (Patient #1) whose SOC assessment visit was observed. This failure had the potential to result in patients not being aware of all their rights. Findings include: Patient #1 was a 47 year old female admitted to the agency on 11/14/17, with a primary diagnosis of seizure disorder. Additional diagnosis included cerebral palsy. Her referral information was reviewed, and her SOC comprehensive assessment was observed. A visit was made to Patient #1's home on 11/14/17 at 9:20 AM, to observe her SOC comprehensive assessment completed by the admission RN. The RN entered Patient #1's home, washed her hands, set up her supplies,	G 102	G102- All staff inservice held on 12/8/17 to review need for patient rights to be reviewed PRIOR to the administration of care. Director of Professional Services (DPS) from each location to implement weekly joint visits with clinical staff, including admission nurses, to ensure quality patient care, including proper order of care provided, is furnished by all staff at each visit. This joint visit will ensure that cares are being provided as ordered, following proper process. Any deviations in care will be addressed immediately at follow-up "coaching visit" with the clinician. DPS will complete joint visit audit, including SHP scorecard review, to track visit findings and demonstrate continued compliance with POC 2-4 times per month. Access will demonstrate 100% compliance with this standard by December 15th, 2017	

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G 102	Continued From page 2 and began to interview to obtain her health history. The RN then completed a physical assessment of Patient #1. At 11:52 AM, 92 minutes after the visit began, the RN stated she needed to complete paperwork for Patient #1's admission to home health. At that time, the RN reviewed the written notice of rights and responsibilities, and obtained Patient #1's signature on a consent form that included acknowledgment of receipt of written notice of rights and responsibilities. The Administrator and the DPS were interviewed together on 11/16/17 at 11:20 AM. The Administrator stated Patient #1's signature on the consent for services form, acknowledging receipt of written notice of rights and responsibilities, should have been obtained before services were initiated. The agency failed to ensure Patient #1 was provided with written notice of her rights prior to the initiation of services.	G 102		
G 107	EXERCISE OF RIGHTS AND RESPECT FOR PROP CFR(s): 484.10(b)(5) The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.	G 107	G107- Administrator met with the DPS/Clinical Managers from each location on 12/1/17 to review the process for documenting a complaint or grievance, including the investigation of the complaint. Administrator reviewed the Grievance Form which includes a section for investigation findings. Cont.	

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G 107	Continued From page 3 This STANDARD is not met as evidenced by: Based on agency policy review, agency complaint log review, and staff interview, it was determined the agency failed to document the investigation and resolution of complaints. This failure resulted in inadequate documentation of patient/patient representative complaints. Findings include: An agency policy "COMPLAINT/GRIEVANCE PROCESS," revised 10/2016, stated: - "The supervisor will investigate the grievance within five (5) days after receipt of such grievance ..." - "Resolution information will be communicated in writing to the patient or his/her representative filing the complaint." This policy was not followed. Examples include: Sixteen agency "PATIENT COMPLAINTS" forms, from 1/01/17 to 11/13/17, were reviewed. Sixteen of 16 forms failed to document patient/patient representative complaint investigations and/or resolutions as follows: 1. A patient complaint form, dated 1/07/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 2. A patient complaint form, dated 1/10/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 3. A patient complaint form, dated 1/13/17, did	G 107	Quality Assurance (QA) staff also inserviced on required documentation. QA will perform quarterly audit of complaint/grievance forms to ensure continued compliance with this regulation. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 107	Continued From page 4 not document an agency investigation, resolution, or if the patient/patient representative was notified in writing as to the resolution of the complaint. 4. A patient complaint form, dated 1/24/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 5. A patient complaint form, dated 1/24/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 6. A patient complaint form, dated 2/27/17, did not document if the patient/patient representative was notified in writing as to the resolution of the complaint. 7. A patient complaint form, dated 3/06/17, did not document if the patient/patient representative was notified in writing as to the resolution of the complaint. 8. A patient complaint form, dated 3/08/17, did not document if the patient/patient representative was notified in writing as to the resolution of the complaint. 9. A patient complaint form, dated 3/16/17, did not document if the patient/patient representative was notified in writing as to the resolution of the complaint. 10. A patient complaint form, dated 5/03/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint.	G 107		

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G 107	Continued From page 5 11. A patient complaint form, dated 5/11/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 12. A patient complaint form, dated 5/12/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 13. A patient complaint form, dated 5/22/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 14. A patient complaint form, dated 5/25/17, did not document an agency resolution or if the patient/patient representative was notified in writing as to the resolution of the complaint. 15. A patient complaint form, dated 6/14/17, did not document an agency investigation or if the patient/patient representative was notified in writing as to the resolution of the complaint. 16. A patient complaint form, dated 9/30/17, did not document if the patient/patient representative was notified in writing as to the resolution of the complaint. The Administrator and DPS were interviewed together on 11/16/17, beginning at 10:00 AM, and the agency complaint log was reviewed in their presence. They confirmed 16 of 16 patient/patient representative complaints did not have documented investigations and/or resolutions. The Administrator and DPS confirmed agency policy was not followed.	G 107		

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G 107	Continued From page 6 The agency failed to document the investigation and resolution of patient/patient representative complaints.	G 107		
G 144	COORDINATION OF PATIENT SERVICES CFR(s): 484.14(g) 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 medical record review and staff interview, it was determined the agency failed to ensure efforts to coordinate care were documented for 1 of 6 patients (Patient #8) who received care from more than 1 skilled discipline and whose records were reviewed. This failure had the potential to interfere with quality of patient care. Findings include: Patient #8 was a 78 year old female admitted to the agency on 6/15/17, with a primary diagnosis of DM type II. Additional diagnoses included bursitis and osteoarthritis. She received SN, PT, and aide services. Her record, including the POC, for the certification period 6/15/17 to 8/13/17, was reviewed. Patient #8's record included a PT evaluation completed on 6/15/17, signed by the Physical Therapist. The evaluation stated Patient #8 lived alone and stated "Patient home is cluttered, multiple throw rugs, stairs at entry and inside home without railing in home. Patient home is generally soiled from the kitchen to her bedroom.	G 144	G144- All-staff inservice held on 12/8/17 to review circumstances that would require coordination and communication between disciplines. Case Conference form in EMR updated to include section for staff to document intra-discipline communication. Form includes the following information: - Summary of patient status - Problems or concerns identified - Need for follow-up, including MD notification or referral to other service Staff inserviced on new form on 12/8/17. QA to ensure that form is completed with each new admission during admission review. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that staff communication and coordination is being documented. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 144	Continued From page 7 She is unable to perform housekeeping duties. She is at increased risk for falls secondary to clutter, soiled floor, clothing on floor in bathroom and bedroom." Additionally, it stated she was unable to prepare meals for herself. Patient #8's record did not include documentation of communication with her RN Case Manager regarding her safety issues or inability to prepare meals. There was no documentation regarding an MSW referral to address the concerns. The Administrator and the DPS were interviewed together 11/16/17 at 11:45 AM. They stated the concerns were discussed with the team during a case conference. They confirmed there was no documentation of a discussion or action taken regarding the concerns. The agency failed to ensure Patient #8's record included documentation of communication, coordination, or action taken to address her safety concerns.	G 144		
G 158	ACCEPTANCE OF PATIENTS, POC, MED SUPER CFR(s): 484.18 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 medical record review and staff interview, it was determined the agency failed to ensure the physician was informed of delay in implementation of OT services for 1 of 4 patients (Patient #10) who had orders for OT services and	G 158	G158- All-staff inservice held on 12/8/17 to review need for therapy evaluations to be completed within 48 hours of referral. New Occupational Therapist hired in the Preston office with improved availability to help us meet this requirement. Increase in staffing/ OT options will improve our ability to perform timely evaluations. DPS will ensure that therapy evals are scheduled and completed within 48 hours of patient admission. In addition, QA will complete full admission audit to ensure timely evals. Any variations will be reported to DPS and Administrator for follow up. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 158	Continued From page 8 whose records were reviewed. This failure resulted in the potential for omissions of care and unmet patient needs. Findings include: Patient #10 was a 76 year old female admitted to the agency on 9/27/17, with a primary diagnosis of severe protein malnutrition. Additional diagnoses included cachexia and dehydration. She received SN, PT, and OT services. Her record, including the POC, for the certification period 9/27/17 to 11/15/17, was reviewed. Patient #10's record included a physician's order for an OT evaluation, dated 10/10/17. Her record included an OT evaluation dated 10/20/17, signed by the Occupational Therapist. A communication note dated 10/20/17, signed by the Occupational Therapist, stated she had difficulty contacting Patient #10. There was no documentation stating Patient #10's physician was notified of the 10 day delay in implementation of OT services. The Administrator and the DPS were interviewed together on 11/16/17 at 11:55 AM. They confirmed Patient #10's record did not include documentation stating her physician of informed of the 10 day delay in implementation of OT services. The agency failed to ensure Patient #10's physician was informed of the delay in implementation of OT services.	G 158		
G 159	PLAN OF CARE CFR(s): 484.18(a) The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and	G 159	G159- All- staff inservice held on 12/8/17 to review the POC issues identified. Admitting clinicians to ensure that Plan of Care/485 is comprehensive and complete for each patient by completing a thorough review of the final POC prior to signature utilizing POC audit form which includes the following:	

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G 159	Continued From page 9 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 medical record review and staff interview, it was determined the agency failed to ensure POCs included all interventions and diagnoses for 4 of 12 patients (#2, #6, #7, and #8) whose records were reviewed. This failure had the potential to result in unmet patient needs and adverse patient outcomes. Findings include: 1. Patient #2 was a 72 year old female admitted to the agency on 11/08/17, with a primary diagnosis of retroperitoneal abscess following abdominal surgery. Additional diagnoses included DM type II, rheumatoid arthritis, atrial fibrillation, and depression. She was discharged from the hospital on 11/07/17. Patient #2 received SN, PT, and OT services. Her record, including the POC, for the certification period 11/08/17 to 1/06/18, was reviewed. Patient #2 was discharged from the hospital with negative-pressure wound therapy (NPWT) to her abdominal wound. NPWT is a therapeutic technique using foam dressings and a vacuum to promote healing in acute or chronic wounds. Patient #2's POC included an order to "change abdominal wound vac" 3 times a week. Her POC did not include specific orders for her NPWT, such as the type of foam to use, or the amount of	G 159	- Names/Dates accurate and complete - All pertinent diagnosis included - Wound care orders specific and comprehensive, including specific for NPWT - Complete interventions for diagnosis- (CHF, DM, UTI) - POC reconciled with MD referral order In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that POC is accurate, comprehensive and complete for all patients. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 159	Continued From page 10 negative pressure to use. During an interview on 11/15/17 at 1:30 PM, the RN Case Manager confirmed Patient #2's POC did not include specific NPWT orders. She stated the agency did not receive specific NPWT orders from the discharging hospital. Patient #2's POC did not include comprehensive orders for her wound care. 2. Patient #6 was an 89 year old female admitted to the agency on 9/22/17, with a primary diagnosis of UTI. Additional diagnoses included dorsalgia, CHF, and DM type II. She received SN and PT services. Her record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #6's primary diagnosis was UTI. Her record documented a history of frequent UTIs. Her SOC comprehensive assessment, completed on 9/22/17, signed by her RN Case Manager, stated Patient #6 completed self-catheterizations to drain her bladder 2 times a day. The National Institutes of Health website, accessed 11/20/17, included an article titled "Complications of intermittent catheterization: their prevention and treatment." It stated "Urinary tract infection is the most frequent complication in patients performing IC [intermittent catheterization.]" Additionally it stated, "The most important prevention measures are good education of all involved in IC, good patient compliance, the use of a proper material and the application of a good catheterization technique." Patient #6's POC did not include orders related to	G 159		

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G 159	Continued From page 11 her self-catheterization. It did not include an order to educate her regarding self-catheterization, or to observe her catheterize herself to ensure compliance with a technique to avoid the introduction of pathogens to her urinary tract. Patient #6's record included an SN visit note dated 10/11/17. The note stated Patient #6 was diagnosed with another UTI, and her physician ordered catheterizations to be completed by agency nurses to avoid future UTIs. During an interview on 11/15/17 at 10:15 AM, the RN Case Manager confirmed Patient #6's POC did not include orders to educate her regarding her self-catheterization technique, or to observe her self-catheterization. Patient #6's POC did not include orders pertinent to her primary diagnosis. 3. Patient #8 was a 78 year old female admitted to the agency on 6/15/17, with a primary diagnosis of DM type II. Additional diagnoses included bursitis and osteoarthritis. She received SN, PT, and aide services. Her record, including the POC, for the certification period 6/15/17 to 8/13/17, was reviewed. Patient #8's record included referral information sent to the agency by her physician. The information stated "I also requested home health to evaluate the patient to see if she could benefit from physical therapy for strengthening and weight loss as well as help with the lower extremity edema." Patient #8's POC did not include SN or PT interventions related to weight loss or lower extremity edema.	G 159		

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	137110	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HOME CARE	240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202

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G 159	Continued From page 12 The Administrator and the DPS were interviewed together 11/16/17 at 11:45 AM. They confirmed Patient #8's POC did not include interventions related to weight loss or lower extremity edema. Patient #8's POC did not include interventions related to weight loss or edema, as requested by her physician. 4. Patient #7 was an 81 year old male admitted to the agency on 10/09/17, with a primary diagnosis of essential tremor. Additional diagnoses included Alzheimer's, dementia, depression, and OSA. He received SN, PT, and OT services. His record, including the POC, for the certification period 10/09/17 to 12/07/17, was reviewed. Patient #7's medical record included an SOC comprehensive assessment, completed on 10/09/17, signed by the admitting RN. The comprehensive assessment included "Patient has hx of HTN...". Patient #7's medical record included a POC, dated 10/09/17, signed by the admitting RN. The POC did not include Patient #7's diagnosis of HTN. The Administrator and DPS were interviewed together on 11/16/17, beginning at 10:51 AM, and Patient #7's medical record was reviewed in their presence. They confirmed Patient #7's diagnosis of HTN was not included on his POC. The agency failed to ensure Patient #7's POC included all of his diagnoses.	G 159		
G 166	CONFORMANCE WITH PHYSICIAN ORDERS CFR(s): 484.18(c)	G 166		

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G 166	Continued From page 13 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 medical record review, observation, and staff interview, it was determined the agency failed to ensure verbal orders were taken and put in writing by an RN or qualified therapist for 2 of 12 patients (#2 and #11) whose records were reviewed. This failure had the potential to negatively impact coordination and clarity of patient care. Findings include: 1. Patient #2 was a 72 year old female admitted to the agency on 11/08/17, with a primary diagnosis of retroperitoneal abscess following abdominal surgery. Additional diagnoses included DM type II, rheumatoid arthritis, atrial fibrillation, and depression. She was discharged from the hospital on 11/07/17. Patient #2 received SN, PT, and OT services. Her record, including the POC, for the certification period 11/08/17 to 1/06/18, was reviewed. Patient #2 was discharged from the hospital with Negative-pressure wound therapy (NPWT) to her abdominal wound. NPWT is a therapeutic technique using foam dressings and a vacuum to promote healing in acute or chronic wounds. Patient #2's POC included an order to "change abdominal wound vac" 3 times a week. Her POC did not include specific orders for her NPWT,	G 166	G166- All- staff inservice held on 12/8/17 to review the POC issues identified. Clinicians will not provide any care without a written order PRIOR to the administration of care. DPS will complete joint visit, along with full chart review for that patient, to ensure that care is provided according to current Plan of care 2-4 times per month. Any deviations in care will be addressed immediately at follow-up "coaching visit" with the clinician. Staff, including QA staff, was also inserviced on receipt of MD orders. Only RNs or qualified therapists may accept verbal orders. Orders will only be accepted and written by qualified staff. QA to ensure compliance through review of 100% of all written orders. Access will demonstrate 100% compliance with this standard by December 15th, 2017	

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G 166	Continued From page 14 such as the type of foam dressings to use, or the amount of negative pressure to use. A visit was made to Patient #2's home on 11/15/17 at 12:00 PM, to observe an SN visit completed by the RN Case Manager. The RN Case Manager removed the vacuum and dressing from Patient #2's abdominal wound. After cleansing the wound, she applied Promogram Prisma Ag and black foam dressings to the wound, then reattached the NPWT vacuum. Patient #2's record did not include an order for Promogram Prisma Ag and black foam dressings. Patient #2's record included a communication note dated 11/13/17, signed by the RN Case Manager. The note stated Patient #2's physician's office was contacted and an order was obtained for Prisma dressing. During an interview on 11/15/17 at 1:30 PM, the RN Case Manager stated she contacted Patient #2's physician's office regarding wound care orders. She confirmed she did not put the order in writing, with date and signature. Patient #2's RN Case Manager failed to put verbal orders in writing. 2. Patient #11 was a 70 year old female admitted to the agency on 10/07/17, for care following a TKA. Additional diagnoses included atrial flutter and asthma. She received SN, PT, OT, and aide services. Her record, including the POC, for the certification period 10/07/17 to 12/05/17, was reviewed. Patient #11's record included a physician's verbal	G 166		

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G 166	Continued From page 15 order dated 10/11/17, for PT visits 2 times a week for 4 weeks. The order was electronically signed by an LPN. The Administrator and the DPS were interviewed together 11/16/17 at 12:00 PM. They confirmed the verbal order was taken and signed by an LPN. The agency failed to ensure verbal orders were taken by an RN or qualified therapist.	G 166		
G 173	DUTIES OF THE REGISTERED NURSE CFR(s): 484.30(a) The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure the RN revised the POC as needed for 1 of 12 patients (Patient #3) whose records were reviewed. This failure resulted in a POC that did not reflect the patient's identified needs. Findings include: Patient #3 was an 82 year old female admitted to the agency on 10/10/17, with a primary diagnosis of Stage 2 sacral pressure ulcer. Additional diagnoses included CHF, hypothyroidism, GERD, and chronic pain. She received SN and aide services. Her record, including the POC, for the certification period 10/10/17 to 12/08/17, was reviewed. Patient #3's medical record included 13 SN visit notes, from 10/13/17 to 11/10/17, signed by the	G 173	G173- All-staff inservice was held on 12/8/17 to review problem identified regarding care plan revision. Clinicians will report all concerns/ potential patient needs in a timely manner. In addition, staff instructed on utilization of MSW. MSW attending IDT, and a section of IDT has been designated to discuss patients with potential psychosocial needs/concerns. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that documented concerns are reported to appropriate members of IDT in a timely manner. Access will demonstrate 100% compliance with this standard by December 15th, 2017	

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G 173	Continued From page 16 RN Case Manager. For 13 of 13 SN visits, the RN Case Manager documented "very lonely" under Patient #3's psychosocial assessment. She did not document if an MSW referral was initiated based upon Patient #3's psychosocial assessments and identified need. The RN Case Manager was interviewed on 11/15/17, beginning at 10:47 AM, and Patient #3's medical record was reviewed in her presence. She stated her documentation of "very lonely" was copied and pasted on 13 of 13 SN visits. The RN Case Manager confirmed she did not initiate an MSW referral based upon Patient #3's psychosocial assessments and identified need. The agency failed to ensure the registered nurse initiated necessary revisions to Patient #3's POC.	G 173		
G 175	DUTIES OF THE REGISTERED NURSE CFR(s): 484.30(a) The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff interview, it was determined the agency failed to ensure the RN assessed and evaluated patients to determine and implement needed preventative nursing measures for 1 of 7 patients (Patient #2) who had a diagnosis of DM and whose records were reviewed. This failure resulted in a lack of provided preventative actions for the patient and significantly increased the potential for negative patient outcomes. Findings include:	G 175	G175- All- staff inservice was held on 12/8/17 to review problem identified regarding lack of preventative nursing care r/t DM II management. Staff will identify co-morbidities that may contribute to patient's ability to reach their goals on admissions. For any contributing diagnosis that may hinder progress, admitting clinician will be sure to include interventions to monitor/assess compliance and potential complication. QA nurse will ensure that interventions include potential for risk. In addition, 2-4 times per month the DPS will complete a joint visit along with full chart review for that patient, to ensure that care is provided with potential risks being considered and care planned accordingly. Any identified	

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G 175	Continued From page 17 Patient #2 was a 72 year old female admitted to the agency on 11/08/17, with a primary diagnosis of retroperitoneal abscess following abdominal surgery. Additional diagnoses included DM type II, rheumatoid arthritis, atrial fibrillation, and depression. She was discharged from the hospital on 11/07/17. Patient #2 received SN, PT, and OT services. Her record, including the POC, for the certification period 11/08/17 to 1/06/18, was reviewed. The National Institutes for Health website, accessed 11/20/17, included an article titled "Postoperative management of the diabetic patient." The article stated "Diabetic patients are at increased risk for adverse outcomes of surgery...Hyperglycemia [elevated blood glucose level] is associated with likely risks for poorer wound healing, increased susceptibility to infection..." Patient #2's POC included a diagnosis of DM type II, and an order to report a BG level greater than 400 mg/dl or less than 70 mg/dl to her physician. Her POC included an order for Metformin, a medication used to control BG, and an order to assess/teach medication management. Patient #2's record included an SOC comprehensive assessment dated 11/08/17, signed by the admitting RN, and 2 SN visit notes dated 11/10/17 and 11/13/17, signed by the RN Case Manager. Patient #2's SOC comprehensive assessment stated "Pt reports she checks BG occasionally and is compliant with metformin as ordered." The assessment did not include her BG level. The 2 SN visit notes dated 11/10/17 and 11/13/17, did not include her BG	G 175	issues or concerns in care and care planning will be addressed immediately at follow-up "coaching visit" with the individual clinician. Access will demonstrate 100% compliance with this standard by December 15th, 2017	

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G 175	Continued From page 18 level. They each stated there were no medication changes since the last visit, and stated "Demonstrated Medication Compliance." A visit was made to Patient #2's home on 11/15/17 at 12:00 PM, to observe an SN visit completed by the RN Case Manager. During the visit, Patient #2 stated she could not find her glucometer, used to monitor her BG levels. She stated she had not checked her BG level since her hospital discharge. Patient #2 stated she was not taking Metformin as ordered, as she had run out of pills "a couple days after coming home from the hospital." She stated she did not know how to obtain more medication. During an interview on 11/15/17 at 1:30 PM, the RN Case Manager stated she was not aware that Patient #2 was not taking Metformin as ordered. She confirmed she did not assess Patient #2's BG level or her compliance with medications, during the SN visits on 11/10/17 and 11/13/17, as ordered on her POC. Patient #2's RN Case Manager failed to assess her BG levels and her medication management, to prevent complications related to DM and wound healing.	G 175		
G 176	DUTIES OF THE REGISTERED NURSE CFR(s): 484.30(a) 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:	G 176	G176- All-staff inservice was held on 12/8/17 to review duties of RN r/t preparing clinical notes, coordinating services, informing physician/other personnel of changes in pt's condition and needs. With each admission, the admitting clinician will send a Kmail (email in the EMR) to all staff who will be involved in the patient's care. In addition,	

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G 176	Continued From page 19 Based on medical record review and staff interview, it was determined the agency failed to ensure RNs appropriately prepared clinical notes, and coordinated care with other clinicians for 3 of 12 of patients (#2, #3, and #11) 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. Patient #2 was a 72 year old female admitted to the agency on 11/08/17, with a primary diagnosis of retroperitoneal abscess following abdominal surgery. Additional diagnoses included DM type II, rheumatoid arthritis, atrial fibrillation, and depression. She received SN, PT, and OT services. Her record, including the POC, for the certification period 11/08/17 to 1/06/18, was reviewed. The National Institutes for Health website, accessed 11/20/17, included an article titled "Postoperative management of the diabetic patient." The article stated "Diabetic patients are at increased risk for adverse outcomes of surgery...Hyperglycemia [elevated blood glucose level] is associated with likely risks for poorer wound healing, increased susceptibility to infection..." a. SN services provided to Patient #2 included care of an open surgical wound on her abdomen. Her POC included a diagnosis of DM type II. SN visit notes dated 11/10/17 and 11/13/17, signed by the RN Case Manager, did not include an assessment of Patient #2's status related to DM, including her BG level. During an interview on 11/15/17 at 1:30 PM, the	G 176	each new admission will be discussed on the "daily call" and documented accordingly. The DPS will complete full chart audit on 2-4 charts per month to ensure that Kmail communication is happening timely through the messaging system within the EMR. In addition, the DPS will ensure that all new admissions are discussed on the daily call and that all pertinent staff are in attendance on the call. All patients with wound care orders will have their wound(s) measured weekly. The case manager will be responsible for measuring the wound. Measurements will only be included on the clinician note on the day of the measurement. If measurements aren't taken, no measurements will be included on that note. Both QA staff and DPS will perform chart audits to ensure that wound measurements are captured for the day of the measurement only. To prevent "copy and pasting" the "prepopulate" option within the EMR has been inactivated. To ensure that notes are reflective of real-time assessment, the DPS will complete full chart audit on 2-4 charts per month to ensure that notes are documented at each visit and reflect the cares performed for each given visit. QA staff to complete full chart audit upon completion of admission paperwork. QA staff will review documentation to ensure	

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G 176	Continued From page 20 RN Case Manager stated Patient #2's SOC comprehensive assessment was completed by another RN. She stated the documentation of the assessment was not complete prior to the SN visit completed by the RN Case Manager on 11/10/17. The RN Case Manager stated she was not aware of Patient #2's DM diagnosis when she completed the SN visit. She stated the admitting RN did not communicate with her regarding Patient #2's DM. The admitting RN and RN Case Manager failed to communicate pertinent information related to Patient #2's status. b. Patient #2's record included an SOC assessment dated 11/08/17, signed by the admitting RN, and 2 SN visit notes dated 11/10/17 and 11/13/17, signed by the RN Case Manager. Each of the 3 notes contained an assessment of her abdominal wound, including measurements, drainage, and inflammation. The 3 wound assessments were identical. During an interview on 11/15/17 at 1:30 PM, the RN Case Manager stated Patient #2's wound was assessed and measured during her SOC assessment on 11/08/17. She stated she did not measure the wound on 11/10/17 or 11/13/17. The RN Case Manager stated the wound assessments on the SN visit notes dated 11/10/17 and 11/13/17, were populated on the visit notes from the SOC assessment. The RN Case Manager confirmed the visit notes did not state the day the assessment and measurements were completed. Patient #2's SN visit notes did not include a clear and accurate assessment of the status of her	G 176	that assessment information is complete and accurate. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that documentation is complete and accurate. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 176	Continued From page 21 wound. 2. Patient #3 was an 82 year old female admitted to the agency on 10/10/17, with a primary diagnosis of Stage 2 sacral pressure ulcer. Additional diagnoses included CHF, hypothyroidism, GERD, and chronic pain. She received SN and aide services. Her record, including the POC, for the certification period 10/10/17 to 12/08/17, was reviewed. a. Patient #3's medical record included an SN visit note, dated 10/13/17, signed by the RN Case Manager. The note included an "Addendum Page," which was used for free-flow, narrative documentation. The RN Case Manager documented findings related to Patient #3's cardiovascular, respiratory, medications, psychosocial, and skilled intervention assessments on this page in 5 separate paragraphs. The RN Case Manager documented these 5 paragraphs identically onto 12 subsequent SN visit notes, dated 10/16/17, 10/18/17, 10/20/17, 10/23/17, 10/25/17, 10/27/17, 10/30/17, 11/01/17, 11/03/17, 11/06/17, 11/08/17, and 11/10/17. b. Patient #3's medical record included an SN visit note, dated 10/13/17, signed by the RN Case Manager. The note included a "Wound Care Worksheet," which was used for wound measurement and wound description documentation. The RN Case Manager documented the following information on this worksheet: - "Size: 0.3x0.2x0.2" - "Drainage: sanguineous"	G 176		

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G 176	Continued From page 22 The RN Case Manager documented these same wound measurements and wound drainage descriptions identically onto 12 subsequent SN visit notes, dated 10/16/17, 10/18/17, 10/20/17, 10/23/17, 10/25/17, 10/27/17, 10/30/17, 11/01/17, 11/03/17, 11/06/17, 11/08/17, and 11/10/17. The RN Case Manager was interviewed on 11/15/17, beginning at 10:47 AM, and Patient #3's medical record was reviewed in her presence. She confirmed her documented "Addendum Page" narratives were copied and pasted to each SN visit note. Additionally, the RN Case Manager confirmed Patient #3's wound measurements and wound drainage descriptions were copied and pasted to each SN visit note. Patient #3's SN visit notes did not include clear and accurate documentation. 3. Patient #11 was a 70 year old female admitted to the agency on 10/07/17, for care following a TKA. Additional diagnoses included atrial flutter and asthma. She received SN, PT, OT, and aide services. Her record, including the POC, for the certification period 10/07/17 to 12/05/17, was reviewed. Patient #11's record included an SOC comprehensive assessment dated 10/07/17, signed by the RN Case Manager. The assessment included a section titled "Skilled Intervention: Assessment/Instruction/Performance." The section contained a narrative note including information about DM, the medication Metformin (used to control BG in patients with DM), and the patient's left ankle ulcer. Patient #11 did not have	G 176		

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G 176	Continued From page 23 a diagnosis of DM, was not taking Metformin, and did not have an ankle ulcer. The Administrator and the DPS were interviewed together 11/16/17 at 12:00 PM. They reviewed the SOC assessment and confirmed the narrative was not applicable to Patient #11. They stated it was documented in the wrong patient's record. Patient #11's RN Case Manager failed to ensure her SOC assessment included accurate information.	G 176		
G 177	DUTIES OF THE REGISTERED NURSE CFR(s): 484.30(a) The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the agency failed to ensure the RN provided necessary information to patients or caregivers for 1 of 1 patient (Patient #2) whose flu vaccination was observed. This had the potential for the patient to experience adverse outcomes. Findings include: Patient #2 was a 72 year old female admitted to the agency on 11/08/17, with a primary diagnosis of retroperitoneal abscess. Additional diagnoses included DM type II, rheumatoid arthritis, atrial fibrillation, and depression. She received SN, PT, and OT services. Her record, including the POC, for the certification period 11/08/17 to 1/06/18, was reviewed. A visit was made to Patient #2's home on	G 177	G177- All-staff inservice was held on 12/8/17 to review duties of RN r/t counseling the patient. Clinicians instructed on proper order of care, including reviewing consent/ pertinent information BEFORE the administration of care. DPS will complete joint visit, along with full chart review for that patient, to ensure that care is provided appropriately 2-4 times per month. Access will demonstrate 100% compliance with this standard by December 15th, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137110	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HOME CARE	240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202

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G 177	Continued From page 24 11/15/17 at 12:00 PM, to observe an SN visit completed by the RN Case Manager. After arriving and washing her hands, the RN Case Manager administered a flu vaccination to Patient #2. She did not ask questions or provide education regarding the flu vaccination prior to the injection. The RN Case Manager completed vital signs and wound care to Patient #2. After completing wound care, the RN Case Manager asked Patient #2 if she had a reaction to a vaccination or a preservative in the past, or had a history of Guillain-Barre Syndrome, all contraindications to receiving a flu vaccination. She then asked Patient #2 to sign a consent form for the flu vaccination. The Administrator and the DPS were interviewed together 11/16/17 at 11:25 AM. The Administrator stated Patient #2 should have been questioned about contraindications, provided education, and signed consent for the flu vaccination prior to the injection. The RN Case Manager failed to educate Patient #2 regarding a flu vaccination prior to administration.	G 177		
G 224	ASSIGNMENT & DUTIES OF HOME HEALTH AIDE CFR(s): 484.36(c)(1) Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by:	G 224	G224- All-staff inservice was held on 12/8/17 to review requirement for Home Health Aide care plan. Every aide care plan will be reviewed by QA following care plan completion. QA will ensure that care plan is completed in its entirety. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that aide care plans are complete. Any deviations, will be	

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G 224	Continued From page 25 Based on medical record review and staff interview it was determined the agency failed to ensure written patient care instructions for aides were complete for 1 of 3 patients (Patient #11) who received home health aide services, and whose records were reviewed. This failure had the potential for patients to experience adverse outcomes. Findings include: Patient #11 was a 70 year old female admitted to the agency on 10/07/17, for care following a TKA. Additional diagnoses included atrial flutter and asthma. She received SN, PT, OT, and aide services. Her record, including the POC, for the certification period 10/07/17 to 12/05/17, was reviewed. Patient #11's record included an "Aide Care Plan" dated 10/09/17, signed by the RN Case Manager. The care plan did not include activities permitted. It did not include instructions to the aide regarding Patient #11's activity level or assistive devices to be used following her knee replacement. The Administrator and the DPS were interviewed together on 11/16/17 at 12:00 PM. They reviewed Patient #11's aide care plan and confirmed it did not include pertinent information related to her activity level and assistive devices. The RN Case Manager failed to ensure Patient #11's aide care plan included all information necessary to promote safe personal care.	G 224	reviewed with RN as needed and corrections will be completed. Access will demonstrate 100% compliance with this standard by December 15th, 2017	
G 225	ASSIGNMENT & DUTIES OF HOME HEALTH AIDE CFR(s): 484.36(c)(2) The home health aide provides services that are	G 225	G225- All-staff inservice was held on 12/8/17 to review HHA responsibility to perform cares as ordered per plan of care. Aides inserviced on the importance of completing	

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G 225	Continued From page 26 ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure the home health aide provided services in accordance with the aide POC for 2 of 3 patients (#3 and #5) who received home health aide services and whose records were reviewed. This failure had the potential to interfere with the safety and quality of patient care. Findings include: 1. Patient #3 was an 82 year old female admitted to the agency on 10/10/17, with a primary diagnosis of Stage 2 sacral pressure ulcer. Additional diagnoses included CHF, hypothyroidism, GERD, and chronic pain. She received SN and aide services. Her record, including the POC, for the certification period 10/10/17 to 12/08/17, was reviewed. Patient #3's medical record included an aide visit note, dated 10/25/17, signed by the aide. The following 4 aide tasks, assigned by the RN Case Manager to be completed each visit, were left blank: - "Pericare" - "Skin Care" - "Universal Precautions" - "Partial Bath" The aide note did not document a reason these 4	G 225	tasks as assigned on EVERY visit. Any deviation from the care plan is to be reported to the case manager, but each item must be addressed on every note. To ensure compliance, DPS will complete full chart audit on 2-4 charts per month to ensure that aide care plans are complete. In addition, peer audits will be completed by all staff 1-2 times quarterly. Special attention will be paid to ensure that aide notes are accurate and complete. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 225	Continued From page 27 tasks were left blank or if the RN Case Manager was informed. The RN Case Manager was interviewed on 11/15/17, beginning at 10:47 AM, and Patient #3's medical record was reviewed in her presence. She confirmed the aide's visit note was not complete. The RN Case Manager stated the aide would usually contact her if assigned tasks were refused by the patient or missed. She stated she was not contacted by the aide regarding these 4 missed tasks. The agency failed to ensure Patient #3's aide POC was followed. 2. Patient #5 was a 79 year old female admitted to the agency on 8/11/17, with a primary diagnosis of CKD. Additional diagnoses included DM type 2, obesity, and anemia. She received SN, PT, OT, and aide services. Her record, including the POC, for the certification period 10/10/17 to 12/08/17, was reviewed. Patient #5's medical record included an aide visit note, dated 10/12/17, signed by the aide. The following 5 aide tasks, assigned by the RN Case Manager to be completed each visit, were left blank: - "Assist in Ambulation" - "Back Rub/ Massage" - "Oral Hygiene Denture Care" - "Nail Care" - "Partial Bath"	G 225		

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G 225	Continued From page 28 The aide note did not document a reason these 5 tasks were left blank or if the RN Case Manager was informed. The Administrator and DPS were interviewed together on 11/16/17, beginning at 11:00 AM, and Patient #5's medical record was reviewed in their presence. They confirmed the aide visit note was incomplete and stated it was their expectation that all aide visit notes were to be filled out completely and accurately. The agency failed to ensure Patient #5's aide POC was followed.	G 225		
G 327	DATA FORMAT CFR(s): 484.20(d) The HHA must encode and transmit data using the software available from CMS or software that Conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set. This STANDARD is not met as evidenced by: Based on review of quality data and staff interview, it was determined the agency failed to ensure data transmitted to CMS included all items of the OASIS data set. This failure resulted in the inability to identify if the assessment record was submitted by the parent agency or a branch. Additionally, it prevented the agency from using quality data to identify outcomes for each of their locations. Findings included: Prior to the survey, the agency's quality data was obtained through the QIES system. The agency's "Risk Adjusted Outcome Report" for the period	G 327	G327- Administrator will follow up with EMR provider to ensure that OASIS submittals, which includes branch data labelled M0016, is reported according to submission with branch locator present. Administrator and Director of Operations will ensure that data is submitted with appropriate branch locator present. Compliance will be confirmed through OASIS submission audits by QA. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 327	Continued From page 29 8/2016 to 7/2017, included 431 cases for the entire agency. The report labeled "Parent" also included 431 cases. The reports for branches ending in 001 and 002 had no cases and no data. During an interview on 11/15/17 at 10:55 AM, the Administrator confirmed the data obtained through the QIES system did not include the agency's 2 branch locations. She was unable to explain the reason and stated she would look into it. During an interview on 11/16/17 at 10:30 AM, the Administrator stated the agency's software failed to transmit the branch location for each OASIS transmission. She stated the OASIS completed by the agency clinicians included the correct parent or branch location in OASIS item M0016, but the agency's software changed the entry to the parent location prior to transmission. The Administrator stated she identified the problem when she reviewed the agency's QIES data, but had not addressed it with the agency's software vendor prior to the time of the survey. The agency failed to ensure OASIS data transmitted to CMS included the branch location of each patient.	G 327		
G 337	DRUG REGIMEN REVIEW CFR(s): 484.55(c) 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.	G 337	G337- All-staff inservice was held on 12/8/17 to review requirements of drug regimen review. Admitting clinicians to reconcile ALL meds at the time of admit, including DC ordered meds and meds in patient home. SN will coordinate with MD if discrepancies are identified. In addition, all follow-up clinicians must address medication	

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G 337	Continued From page 30 This STANDARD is not met as evidenced by: Based on medical record review, observation, and patient and staff interview, it was determined the agency failed to ensure all patient medications were reviewed, included on the POC, and reconciled with the physician, for 4 of 12 patients (#2, #3, #7, and #8) whose records were reviewed. This failure placed patients at risk for adverse outcomes related to medications. Findings include: 1. Patient #2 was a 72 year old female admitted to the agency on 11/08/17, with a primary diagnosis of retroperitoneal abscess. Additional diagnoses included DM type II, rheumatoid arthritis, atrial fibrillation, and depression. She received SN, PT, and OT services. Her record, including the POC, for the certification period 11/08/17 to 1/06/18, was reviewed. A visit was made to Patient #2's home on 11/15/17 at 12:00 PM, to observe an SN visit completed by the RN Case Manager. After the SN care was completed, Patient #2's medications were reviewed, and compared to her POC and current medication record. Discrepancies were identified, as follows: - Medication in Patient #2's home included Gabapentin 100 mg. She stated she was taking 100 mg, 3 times a day. Her POC and medication record did not include Gabapentin. - Patient #2's POC and medication profile included Metformin, to control her BG. She stated she was not taking Metformin. - Patient #2's POC and medication profile	G 337	compliance. Case Manager will deliver completed med sheet and review meds, documenting any identified discrepancies. If discrepancies are identified, MD will be notified to reconcile the issue. In an effort to ensure that medication list is accurate and comprehensive, DPS will complete joint visit, along with full chart review for that patient, to ensure that med list is accurate and complete 2-4 times per month. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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G 337	Continued From page 31 included Lisinopril, for hypertension. She stated she was not taking Lisinopril. - Patient #2's POC and medication profile included Prednisolone, for rheumatoid arthritis. She stated she was not taking Prednisolone. Patient #2 stated she ran out of Metformin, Lisinopril, and Prednisolone, shortly after coming home from the hospital, and did not know how to get more medications. SN visit notes dated 11/10/17 and 11/13/17, documented Patient #2 was compliant with her medications. Her record did not include documentation of physician contact to resolve discrepancies with her medication orders. During an interview on 11/15/17 at 1:30 PM, the RN Case Manager stated she was not aware that Patient #2 did not have all medications as ordered on her POC. Additionally, she was not aware Patient #2 was taking Gabapentin, which was not included on her POC. The Administrator and the DPS were interviewed together 11/16/17 at 11:25 AM. They confirmed Patient #2's record did not include documentation of contact with her physician to resolve medication issues. The agency failed to ensure Patient #2's medications were reconciled with her physician, and that she had all ordered medications. 2. Patient #3 was an 82 year old female admitted to the agency on 10/10/17, with a primary diagnosis of Stage 2 sacral pressure ulcer. Additional diagnoses included CHF, hypothyroidism, GERD, and chronic pain. She	G 337		

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G 337	Continued From page 32 received SN and aide services. Her record, including the POC, for the certification period 10/10/17 to 12/08/17, was reviewed. a. Patient #3's medical record included a POC, dated 10/10/17, signed by the admitting RN. The POC included "Potassium Gluconate Oral 550 MG 1 Tab(s) Daily." Patient #3's medical record included a "Patient Medication Record," dated 10/10/17, signed by the admitting RN. The medication record did not include Potassium Gluconate. b. Patient #3's medical record included an "HPI," dated 10/11/17, signed by a nurse practitioner. The "HPI" stated "Patient also has a history of chronic pain for which she takes norco." Norco was not included on Patient #3's POC or medication record. The RN Case Manager was interviewed on 11/15/17, beginning at 10:47 AM, and Patient #3's medical record was reviewed in her presence. She confirmed Patient #3's Potassium Gluconate was not documented on her medication record. The RN Case Manager confirmed Patient #3 had prescribed Norco in her home, to take as needed for pain, but "was not currently taking it." She confirmed the Norco should have been included on Patient #3's POC and medication record. The agency failed to ensure Patient #3's medications were reconciled and accurate. 3. Patient #8 was a 78 year old female admitted to the agency on 6/15/17, with a primary diagnosis of DM type II. Additional diagnoses included bursitis and osteoarthritis. She received SN, PT, and aide services. Her record, including	G 337		

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G 337	Continued From page 33 the POC, for the certification period 6/15/17 to 8/13/17, was reviewed. Patient #8's record included an SOC comprehensive assessment completed on 6/15/17, signed by the RN Case Manager. The assessment stated she had pain that ranged from 0 to 5 on a scale of 0 to 10, with 10 being the worst pain. The assessment stated she took Aleve to relieve her pain. Patient #8's POC did not include Aleve. There was no documentation stating her physician was contacted to obtain approval of Aleve for pain control. The Administrator and the DPS were interviewed together 11/16/17 at 11:45 AM. They confirmed Patient #8's POC did not include the medication Aleve, that she was using for pain control. Patient #8's POC did not include all medications she was taking. 4. Patient #7 was an 81 year old male admitted to the agency on 10/09/17, with a primary diagnosis of essential tremor. Additional diagnoses included Alzheimer's, dementia, depression, and OSA. He received SN, PT, and OT services. His record, including the POC, for the certification period 10/09/17 to 12/07/17, was reviewed. Patient #7's medical record included a "Patient Medication Record," dated 10/16/17, signed by the admitting RN. The medication record included "Memantine [used for neurological conditions] HCl Oral 5 MG 1 Tab (s) PO BID." An OT home visit was observed in Patient #7's home on 11/15/17, beginning at 12:00 PM. At the	G 337		

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G 337	Continued From page 34 conclusion of the visit, the Occupational Therapist asked Patient #7's spouse if there were any medication changes recently. The spouse stated Patient #7's Memantine had recently increased from 5 mg twice a day to 10 mg twice a day. When asked if the RN Case Manager was aware, Patient #7's spouse stated, "oh yes, I told her over a week ago." The Administrator and DPS were interviewed together on 11/16/17, beginning at 10:51 AM, and Patient #7's medical record was reviewed in their presence. They confirmed Patient #7's medication record was not accurate regarding his Memantine dosage increase. The agency failed to ensure Patient #7's medications were reconciled and accurate.	G 337		

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N 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency conducted on 11/13/17 to 11/16/17. Surveyors conducting the Medicare recertification survey were: Nancy Bax, RN, BSN, HFS, Team Leader Brian Osborn, RN, HFS Acronyms used in this report include: CNA - Certified Nurse Assistant CPR - Cardiopulmonary Resuscitation MSW - Medical Social Worker	N 000	RECEIVED DEC 11 2017 FACILITY STANDARDS	
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: Please refer to G102.	N 016	N016 All staff inservice held on 12/8/17 to review need for patient rights to be reviewed PRIOR to the administration of care. Director of Professional Services (DPS) from each location to implement weekly joint visits with clinical staff, including admission nurses, to ensure quality patient care, including proper order of care provided, is furnished by all staff at each visit. This joint visit will ensure that cares are being provided as ordered, following proper process. Any deviations in care will be addressed immediately at follow-up "coaching visit" with the clinician. DPS will complete joint visit audit, including SHP scorecard review, to track visit findings and demonstrate continued compliance with POC 2-4 times per month. Access will demonstrate 100% compliance with this standard by December 15th, 2017	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
BSN		12/7/17

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N 026	Continued From page 1	N 026		
N 026	03.07020. ADMIN. GOV. BODY N026 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.viii. The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and must document both the existence of the complaint and the resolution of the complaint. This Rule is not met as evidenced by: Please refer to G107.	N 026		
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	N 051	N051- All-staff inservice was held on 12/8/17 to review personnel file requirement. Current personnel audit results reviewed with staff. Staff with expiring CPR will be notified 3 months prior to expiration. HR staff will follow up with staff weekly until CPR card submitted. In addition, this information will be reviewed weekly at administrative leadership meeting. Random personnel file audits will be completed by HR administrative staff. Any issues will be reported to Administrator for follow up. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	

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	OAS001015	A. BUILDING: _____ B. WING _____	11/16/2017

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N 051	Continued From page 2 rules or regulations. This Rule is not met as evidenced by: Based on agency personnel file review and staff interview, it was determined the agency failed to ensure all clinical staff maintained continuous CPR certifications. This failure had the potential for poor patient outcomes during life threatening emergencies. Findings include: Agency personnel files were reviewed on 11/16/17. The files of 1 CNA and 1 MSW included documentation of CPR certifications obtained on 11/15/17, after the start of the survey. Proof of certification prior to 11/15/17, was requested from the Administrator. - The CNA's date of hire was 8/01/13. Her previous CPR certification expired on 10/21/16. She was not CPR certified from 10/21/16 to 11/15/17 - The MSW's date of hire was 1/04/16. His previous CPR certification expired on 4/23/17. He was not CPR certified from 4/23/17 to 11/15/17. The Administrator was interviewed on 11/16/17, beginning at 10:30 AM, and agency personnel files were reviewed in her presence. She confirmed the CNA and the MSW had not maintained continuous CPR certifications. The agency failed to ensure all clinical staff maintained continuous CPR certifications.	N 051		
N 062	03.07021. ADMINISTRATOR	N 062	N062 All-staff inservice held on 12/8/17 to review circumstances that would require coordination and communication between disciplines. Case	

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N 062	Continued From page 3 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: Please refer to G144.	N 062	Conference form in EMR updated to include section for staff to document intra-discipline communication. Form includes the following information: - Summary of patient status - Problems or concerns identified - Need for follow-up, including MD notification or referral to other service Staff inserviced on new form on 12/8/17. QA to ensure that form is completed with each new admission during admission review. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that staff communication and coordination is being documented. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	
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: Please refer to G173.	N 094	N094 All-staff inservice was held on 12/8/17 to review problem identified regarding care plan revision. Clinicians will report all concerns/ potential patient needs in a timely manner. In addition, staff instructed on utilization of MSW. MSW attending IDT, and a section of IDT has been designated to discuss patients with potential psychosocial needs/concerns. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that documented concerns are reported to appropriate members of IDT in a timely manner. Access will demonstrate 100% compliance with this standard by December 15th, 2017	
N 096	03.07024. SK. NSG. SERV. N096 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:	N 096	N096 All- staff inservice was held on 12/8/17 to review problem identified regarding lack of preventative nursing care r/t DM II management. Staff will identify co-morbidities that may contribute to patient's	

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N 096	Continued From page 4 d. Initiates appropriate preventive and rehabilitative nursing procedures; This Rule is not met as evidenced by: Please refer to G175.	N 096	ability to reach their goals on admissions. For any contributing diagnosis that may hinder progress, admitting clinician will be sure to include interventions to monitor/assess compliance and potential complication. QA nurse will ensure that interventions include potential for risk. In addition, 2-4 times per month the DPS will complete a joint visit along with full chart review for	
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: Please refer to G176.	N 097	that patient, to ensure that care is provided with potential risks being considered and care planned accordingly. Any identified issues or concerns in care and care planning will be addressed immediately at follow-up "coaching visit" with the individual clinician. Access will demonstrate 100% compliance with this standard by December 15th, 2017 N097 All-staff inservice was held on 12/8/17 to review duties of RN r/t preparing clinical notes, coordinating services, informing physician/other personnel of changes in pt's	
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:	N 099	condition and needs. With each admission, the admitting clinician will send a Kmail (email in the EMR) to all staff who will be involved in the patient's care. In addition, each new admission will be discussed on the "daily call" and documented accordingly. The DPS will complete full chart audit on 2-4 charts per month to ensure that Kmail communication is happening timely through the messaging system within the EMR. In addition, the DPS will ensure that all new admissions are discussed on the daily call and that all pertinent staff are in attendance on the call.	

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N 099	Continued From page 5 Please refer to G177.	N 099	All patients with wound care orders will have their wound(s) measured weekly. The case manager will be responsible for measuring the wound. Measurements will only be included on the clinician note on the day of the measurement. If measurements aren't taken, no measurements will be included on that note. Both QA staff and DPS will perform chart audits to ensure that wound measurements are captured for the day of the measurement only. To prevent "copy and pasting" the "prepopulate" option within the EMR has been inactivated. To ensure that notes are reflective of real-time assessment, the DPS will complete full chart audit on 2-4 charts per month to ensure that notes are documented at each visit and reflect the cares performed for each given visit. QA staff to complete full chart audit upon completion of admission paperwork. QA staff will review documentation to ensure that assessment information is complete and accurate. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that documentation is complete and accurate. Access will demonstrate 100% compliance with this standard by December 15th, 2017. N099 All-staff inservice was held on 12/8/17 to review duties of RN r/t counseling the patient. Clinicians instructed on proper order of care, including reviewing consent/ pertinent information BEFORE the administration of care. DPS will complete	
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Please refer to G224.	N 122		
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: Please refer to G158.	N 152		
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:	N 153		

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N 153	Continued From page 6 a. All pertinent diagnoses; This Rule is not met as evidenced by: Please refer to G159.	N 153	joint visit, along with full chart review for that patient, to ensure that care is provided appropriately 2-4 times per month. Access will demonstrate 100% compliance with this standard by December 15th, 2017 N122	
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: Please refer to G159.	N 160	All-staff inservice was held on 12/8/17 to review requirement for Home Health Aide care plan. Every aide care plan will be reviewed by QA following care plan completion. QA will ensure that care plan is completed in its entirety. In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that aide care plans are complete. Any deviations, will be reviewed with RN as needed and corrections will be completed. Access will demonstrate 100% compliance with this standard by December 15th, 2017	
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: i. Medication and treatment orders; This Rule is not met as evidenced by: Please refer to G159.	N 161	N153/N160/N161 All- staff inservice held on 12/8/17 to review the POC issues identified. Admitting clinicians to ensure that Plan of Care/485 is comprehensive and complete for each patient by completing a thorough review of the final POC prior to signature utilizing POC audit form which includes the following: - Names/Dates accurate and complete - All pertinent diagnosis included - Wound care orders specific and comprehensive, including specific for NPWT - Complete interventions for diagnosis- (CHF, DM, UTI) - POC reconciled with MD referral order	
N 173	03.07030.07.PLAN OF CARE	N 173		

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N 173	Continued From page 7 N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Please refer to G337.	N 173	In addition, DPS will complete full chart audit on 2-4 charts per month to ensure that POC is accurate, comprehensive and complete for all patients. Access will demonstrate 100% compliance with this standard by December 15th, 2017. N173 All-staff inservice was held on 12/8/17 to review requirements of drug regimen review. Admitting clinicians to reconcile ALL meds at the time of admit, including DC ordered meds and meds in patient home. SN will coordinate with MD if discrepancies are identified. In addition, all follow-up clinicians must address medication compliance. Case Manager will deliver completed med sheet and review meds, documenting any identified discrepancies. If discrepancies are identified, MD will be notified to reconcile the issue. In an effort to ensure that medication list is accurate and comprehensive, DPS will complete joint visit, along with full chart review for that patient, to ensure that med list is accurate and complete 2-4 times per month. Access will demonstrate 100% compliance with this standard by December 15th, 2017.	